STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G184	A. BUILDING _____ B. WING _____	C 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON REA DRIVE GROUP HOME	3747 BON REA DRIVE CHARLOTTE, NC 28266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on May 13, 2024 for intake #NC00215855. Complaint allegations were unsubstantiated and additional unrelated deficiencies were cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of client records and interviews, staff failed to provide accurate detailed documentation on the Incident Report for an injury of unknown origin and complete the report in the timeframe required by the facility's policy for client #1. The findings are: Based on record review, Staff A and Staff B failed to document an accurate detailed description of client #1's injury on the incident report. Further record review revealed the Home manager (HM) failed to complete the Supervisor Review(Debriefing/Follow-up report) Section of the incident report within 72 hours so that this incident could be thoroughly investigated to determine or eliminate allegations of abuse, neglect, and exploitation. Review on 5/13/24 of client #1's body check sheets revealed staff A documented on 3/13/24 at 7:34am a bruise on client #1's right buttock. Continued review of the body sheets revealed no documented bruise on 3/14/24; sheet was	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 153	Continued From page 1	W 153		

incomplete. Subsequent review of the 3/17/24 and 3/19/24 body check sheets revealed bruise was visible on client #1's left buttocks.

Review on 5/13/24 of client #1's Incident Report dated 3/14/24 at 8:00am revealed Staff B reported "Around 5:30am staff was assisting client #1 with a morning shower. Staff noticed a quarter sized bruise located on his left buttock. PC was notified." Continued review of the incident report revealed the Supervisor Review section was not sufficient; did not include an accurate detailed description of the injury, actions taken or to prevent, who was present during debriefing, patterns or trends identified, or direction that was provided.

Review on 5/13/24 of client #1's picture taken of injury dated 3/14/24 revealed a bruise the size of a large fist on the left size of client #1's buttock.

Interview on 5/13/24 with the HM revealed he did not complete the debriefing/ follow-up(Inquiry) section of the incident report until 3/26/24 because he was unaware that he needed to document it on the form and that he sent his response via email. HM stated that no staff were aware of how and when client #1 got the bruise. Continued interview with the HM revealed client #1's guardian came to pick up the client on 03/19/24 and informed the facility that client #1 would not be returning until concerns regarding bruise were addressed. A further interview with the HM revealed that the size of the bruise was larger than a quarter size.

Interview on 5/13/24 with the qualified intellectual disabilities professional (QIDP) revealed based on the agency's policy, an inquiry should be

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W 153	Continued From page 2 completed following an injury of unknown origin. QIDP agreed the description of the injury was inaccurate. Continued interview with the QIDP revealed follow up/debriefing was not completed in a timely manner because the HM did not know that the inquiry form was to be included with an injury of unknown origin report. Further interview with the QIDP revealed the agency did not complete an internal investigation to determine the origin or injury. Review on 5/13/24 of the facility's policy "Incident Reporting Policy and Procedures", dated 7/13/23 states "In the case of injury of unknown source, the QP or Group Home Manager must complete an inquiry to attempt to determine the cause and date of the incident that caused the injury. This inquiry should be documented on the Supervisor Review section of the incident report for level 1 incidents etc. If the inquiry reveals concerns of abuse, neglect or exploitation, QA must be notified immediately and the requirements for allegations of abuse, neglect or exploitation must be followed. Incident reports should include a detailed description of the event, actions taken on behalf of the individual we support, and the individual's condition following the event. The PM or designee will conduct a debriefing of staff after each Level I incident within 72 hours and complete the Incident Debriefing/Follow up section on the Level 1 incident report form." Etc.	W 153		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record verification, the	W 331		

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W 331	Continued From page 3	W 331		

facility failed to provide nursing services in accordance with clients needs relative to bruises or injuries of unknown origin for 1 of 6 clients (#1). The finding is:

During a complaint investigation completed on 5/13/24, review of the facility's incident reports from 11/2023-5/2024 revealed one incident of a bruise discovered on client #1's body. Continued review of facility documentation revealed a photo with a large bruise on the lower left side of client #1's bottom the size of a fist.

Review of facility documentation on 5/13/24 revealed Level I incident report dated 3/14/24 at 5:30AM indicating that staff was assisting the client with a morning shower and noticed a "quarter sized bruise" located on his left buttocks. Review of a nurses' note dated 3/14/24 and facility summary of injury dated 4/19/24 identified the bruise on client #1's body as a "quarter size bruise on the left center buttocks". Continue review of facility documentation revealed an email correspondence from nursing dated 3/20/24 which indicated that nursing services "witnessed the unknown bruise" as a staff member showed it to nursing. Continued review of the facility inquiry did not reveal documentation relative to a nursing assessment following the discovery of the bruise on client #1's body.

Interview with the facility nurse on 5/13/24 revealed she instructed staff on 3/14/24 to continue to monitor client #1's bruise via body checks and no other medical instructions were provided due to the bruise being "a quarter size bruise". Continued interview with the facility nurse revealed that it is the agency protocol that any bruise larger than a quarter size would

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W 331	Continued From page 4 require further evaluation from a medical professional to determine additional treatment recommendations and instructions. Further interview with nursing revealed that she did not visit the client to complete a nursing assessment as the client was already at the day program once she received notification of the client's injury. Interview with nursing also revealed she provided medical recommendations prior to being able to review the photo of client #1's bruise. Additional interview with nursing revealed that nursing should have reviewed the photo of client #1's bruise along with completing a nursing assessment with additional treatment recommendations relative to the size of the bruise.	W 331		