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 01/24/2025

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 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to document significant events relative to hourly sleep checks, affecting 1 of 1 audit client (#1). The finding is: Record review on 1/24/25 for client #1 revealed sleep data sheets from 12/11/24 - 1/11/25. Continued review of the sleep data sheets for client #1 revealed incomplete data recording during 9:00pm - 7:00am for 13 out of 30 days. Interview with the Home Manager (HM) on 1/24/25 verified staff have been trained on completing the sleep data sheets. Continued interview with the HM revealed staff should be consistently checking on each resident hourly overnight and tracking sleep on the data sheets to prevent or decrease the chances of an unknown injury. Interview with the qualified intellectual disabilities professional (QIDP) on 1/24/25 revealed he was unaware of the missing sleep data and that staff are required to do one hour checks overnight for each resident at the home.	W 253	Qp will do an in-service to re-educate staff on the importance and policy regarding overnight bedroom checks for the safety of our individuals. Group home manager will monitor the logs daily to ensure the checks are being completed and documented correctly. RECEIVED FEB 11 2025 DHSR-MH Licensure Sect	3/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: QP — (X6) DATE: 2-6-2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.