#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/04/2025 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 8	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		34G184	B. WING_		07/20	/2025
	PROVIDER OR SUPPLIER  DRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP C 3747 BON REA DRIVE CHARLOTTE, NC 28266	ODE	72025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	CFR(s): 483.440(c)(3)  The comprehensive from the include speech and later the second and the se	unctional assessment must anguage development. Not met as evidenced by:  n, record review and all habilitation plan (IHP) for (#4) failed to include a nassessment to determine commendations to increase The finding is:  Dut the recertification survey revealed client #4 to not breakfast mealtimes. At servation did staff prompt communication output  or client #4 on 7/29/25 8/14/24 which indicated m goal to use his device.  the record for client #4 on nomunication assessment eview of the 8/2017 ment verified client #4 munication output device lew of the record for client rent, updated ment to determine its, as well as approve communication	W2	RECEINAUG 11  DHSR-MH Licen	2025	

Any deficiency statement ending with an asteriak (\*) 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.

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OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						0.0930-0391
CENTERS FOR MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY
		34G184	B. WING			/29/2025
NAME OF PROVIDER OR SUI BON REA DRIVE GROU				STREET ADDRESS, CITY, STATE, ZIP C 3747 BON REA DRIVE CHARLOTTE, NC 28266	CODE	
(AT) ID	DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
communicate determine intervention verified the been updated disabilities on day two PROGRAM CFR(s): 48  As soon as formulated each client treatment intervention and freque objectives plan.  This STAM Based or interviews continuous of needed identified for 4 of 6 findings at A. The facommunicate at 4:45P	th the H tion assist fundates. Continuous fundates.	M revealed an updated essment would be used to so were needed for this used interview with the HM inication assessment has not qualified intellectual conal (QIDP) was not available tification survey for interview.  MENTATION (1)  Ardisciplinary team has so individual program plantocive a continuous active consisting of needed dervices in sufficient number support the achievement of the down in the individual program.  Is not met as evidenced by a factorial and the individual program consisting of the down in the individual program.  It is not met as evidenced by a factorial and the individual program consisting the interview and the individual program consisting the interview and interview and it is not met as evidenced by a factorial and the individual program consisting the interview and it is not met as evidenced by a factorial and the individual program consisting the interview and it is not met as evidenced by a factorial and the individual program consisting the interview and it is not met as evidenced by a factorial and the individual program consisting the interview and it is not met as evidenced by a factorial and the individual program consisting the interview and it is not met as evidenced by a factorial and the individual program consisting the interview.	W 2	Comprise from	assessment. Dp w.ll any Changes.	4-5-20

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CENTE	13 FOR WIEDICARE	& INIEDICAID SERVICES			OM	IB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3	OMPLETED
		34G184	B. WING			07/29/2025
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	£ .	
PONDE	DBN/C CDOUD HOME		37	47 BON REA DRIVE		
BUN KEA	A DRIVE GROUP HOME		C	HARLOTTE, NC 28266		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From page	na 2	141040			
*** 240	1		W 249			
		M revealed client #4 to				
		meal. At no point during the				
	communication outp	f prompt client #4 to use his out device.				
	Morning observation	ns on 7/29/25 at 6:50 AM				
	revealed client #4 to	sit at the dining table to				
	prepare for the brea					
		AM revealed client #4 to				
	complete the breakfa					
		the medication room. At no				
		ervation did staff prompt				
	client #4 to use the c	communication output device.				
	Review of the record	for client #4 on 7/29/25				
		ed 8/14/24 which indicated				
	the following program					
		ut device, exercise goal, put				
		after dinner, participate in				
İ	meal prep three time	s a week (M/VV/F), and				
		ty. Further review of the				
		evealed a communication				
		9/17 which indicated the				
		communication output				
		Continued review of the				
		id not reveal an updated				
	communication asset	ssment since 8/2017.				
	Interview with the hor	me manager (HM) on				
	7/29/25 revealed clie	nt #4's use of the				
	The control of the second	it device is optional. Further				
		revealed staff should have				
	· · · · · · · · · · · · · · · · · · ·	use the communication				
		ralified intellectual disabilities				
	professional (QIDP) v					
	interview on day two	of the recertification survey.				
		provide a continuous				
	active treatment programment	ram for 4 of 6 clients (#2.				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G184	(X2) MULTIPLE A. BUILDING _ B. WING	CONSTRUCTION	(X3) DATE S COMPLI	
	NAME OF PROVIDER OR SUPPLIER BON REA DRIVE GROUP HOME		S	TREET ADDRESS, CITY, STATE, ZIP CODE 747 BON REA DRIVE CHARLOTTE, NC 28266		
(X4) ID PREFIX TAG	/EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	from 4:00 PM to 8 #4 and #5 to sit a staff attempted to game activity. Fu clients #3 and #5 of unstructured ti not reveal staff to complete their m Observations did #5 in a structured Morning observations from 6:30 AM to #4, #5, and #6) a and watch an ex observations fro clients and staff 60 minutes of ur did not reveal st activities.  Review of the re revealed a indiv 9/7/24 which ind setting goal dur Review of the re client has a pro preparation on Interview with ti #3 and #4 inter current. Further clients should it	ations in the facility on 7/28/25 5:30 PM revealed clients #2, #3, It the dining room table while get the clients to participate in a rther observations revealed to sit at the table for 75 minutes me. Continued observations did prompt clients #3 and #4 to eal preparation program goals. Inot reveal staff to engage client d activity for a total of 75 minutes. Intions in the facility on 7/29/25 6:50 AM revealed clients (#2, #3, and staff to sit in the living area sercise video. Further m 7:15 AM to 8:15 AM revealed to sit in the living room area for instructured time. Observations aff to engage clients in structured ecord for client #3 on 7/29/25 idual habilitation plan (IHP) dated dicated the client has a table ing mealtimes. ecord for client #4 revealed the gram goal to assist with meal	W 249	De will re-educed  on importance of  running required  Op will ensure  are clear and  to staff	sects.	9-5-202

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		34G184	B. WING		07/	29/2025
	ROVIDER OR SUPPLIER		3	077	0112312023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	CFR(s): 483.470(g)(2) The facility must furnis and teach clients to use choices about the use hearing and other comand other devices idea interdisciplinary team. This STANDARD is not be a subject to the second and other devices idea interdisciplinary team. This STANDARD is not be a subject to the second and other devices idea interdisciplinary team. This STANDARD is not be a subject to the second and the second interviews, the facility adaptive equipment waudited clients (#1, #4). A. The facility failed to wheelchair was in good observations in the face recertification survey for the second and the second wheelchair throughout observations revealed wheelchair with his feed revealed the left arm results with the HM also reveal using his wheelchair munsteady gait and left so interview with the HM in wheelchair should be in the second and the second an	sh, maintain in good repair, se and to make informed of dentures, eyeglasses, munications aids, braces, intified by the as needed by the client, ot met as evidenced by: ins, record review and failed to ensure that as in good repair for 2 of 4 ). The findings are:  ensure client #4's d repair. For example:  cility during the rom 7/28/25-7/29/25 insulate in a manual the facility. Further client #4 to self-propel the it. Continued observations est was missing from the emanager (HM) on as not made aware that was missing. Interview led client #4 has been ore often lately due to an side weakness. Further evealed client #4's in good repair.	W 436			

CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF	CENTERS FOR MEDICARE & MEDICAID SERVICES  ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE S COMPL	
		34G184	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	1 0772	372020
	NIDER OR SUPPLIER		374	7 BON REA DRIVE ARLOTTE, NC 28266		
(X4) ID PREFIX TAG	JEACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  TAG  CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)				(X5) COMPLETION DATE
W 436	revealed client #1 to activities such as matricipation in measure activities. Further of to participate in varieyeglasses. Obser #1's eyeglasses to dresser.  Review of the recovision consult date client has the followed by the consult indicated to sugar control and eyeglasses. Further consult indicated to sugar control and eyeglasses. Followed in the HM revealed with the HM revealed maintained and in MENUS CFR(s): 483.480(  Menus must be passed on observance of the passed on observance activities and passed on observance.	efacility during the sy from 7/28/25-7/29/25 or participate in various heal preparation in the kitchen, altimes, and board game observations revealed client #1 rious activities without his vations also revealed client sit in his room on top of his and for client #1 revealed a red 12/19/24 which indicated the wing diagnosis: Myopia, pathy both eyes, mild cataracts review of the 12/2024 vision the client should work on blood continue wearing current wup in one year.  HM on 7/29/25 revealed client are broken. Further interview aled client #1 should be getting a asses. Continued interview with client #1's eyeglasses should be a good repair.	W 436	Of the important  Verpry equipment.  Condition to s  Chents. Group  moneyer will	upport	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G184	B. WING		07/29/2025
	ROVIDER OR SUPPLIER  DRIVE GROUP HOME				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
	Observation in the g PM revealed all six of #6) to begin participal consisting of the folloground beef, 1 cup to salad dressing or 1 t Kool-Aid and water. prescribed dinner me beef, 1 cup tomato w potatoes, 1/2 cup me olive oil.  Observation in the gr AM revealed all six of #6) to begin participal consisting of the follograpes, sliced grapet scrambled eggs, sug water. Further observation in half and butter revealed the 2 bagels toast because it was home for the meal.  Interview on 7/29/25 (HM) verified the hom a copy was available with the HM revealed tomato wedge, 1/2 cu melon had not been p had the bagels. Contirevealed the spaghet substituted because to been shopped for in a intellectual disabilities	clients (#1, #2, #3, #4, #5 and ation in the dinner meal owing: baked spaghetti with ossed salad, 1 tosp Caesar isp olive oil, sugar free Further observation the enu consisted of 4 oz roast wedge, 1/2 cup mashed elon or fresh fruit, and 1 tsp roup home on 7/29/25 at 6:47 clients (#1, #2, #3, #4, #5 and ation in the breakfast meal owing: fruit (watermelon, fruit), 2 bagels - buttered, par free jelly, 2% milk and vation revealed the 2 bagels tituted with a slice of toast ed. Further observation is were substituted for the not readily available in the with the home manager me follows a client menu and for review. Further interview I the 4 oz roast beef, 1 cup up mashed potatoes, 1/2 cup purchased for the meal nor inued interview with the HM tit and bagels were being the prescribed meal had not advance. The qualified is professional (QIDP) was view on day two of the	W 477	Dietician will is manys are pre- in advance acceptate information are each indivi- ap will mens	ercied

CENTERS FOR MEDICARE & MEDICAID SERVICES

ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING	STRUCTION	COM	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  BON REA DRIVE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  3747 BON REA DRIVE  CHARLOTTE, NC 28266			07/29/2025	
(X4) ID PREFIX TAG	YEACH DESICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 480	Menus must include menu items. This STANDARD Based on observations, the fact audited clients (#1) the appropriate pot their prescribed disportion sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the post of the sizes and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. For example, the sizes and served correspondiets and served correspondiets. F	de the average portion sizes for is not met as evidenced by: ations, record reviews, and sility failed to ensure 5 of 6 in #2 #3, #4 and #5 ) received ortion sizes in accordance with lets. The findings are: led to verify that the menu lists observe that the portions it is not met and the clients #1's prescribed	W 480			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G184	B. WING		07/29/2025
	PROVIDER OR SUPPLIER  A DRIVE GROUP HOME		07/29/2025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 480	Record review on 7 habilitation plan (IH that client #1's currer added salt, whole of take meds with application in the formal salt in the formal	/29/25 revealed an individual P) dated 8/21/24 which states ent diet is diabetic diet, no r normal consistency and may lesauce.  Ome manager (HM) on that client #1's diet order is aff should have followed his diet. The qualified es professional (QIDP) was erview during the second day survey.  It o verify the menu lists eserve that the portions to the clients #2's prescribed end group home on 7/28/25 at eledinner meal to be baked diet. To up tossed salad, 1 ressing or 1 tsp olive oil, and water. Continued end client #2 to serve himself a ground beef, toss salad and dressing all in large quantity ing. Further observation consume the entire meal.  Group home on 7/29/24 at the breakfast meal to be fruit end, sliced grapefruit), 1 slice in half, scrambled eggs, nilk and water. Continued dictient #2 to serve himself it, and toast without observation revealed client bestervation revealed client bestervation revealed client bestervation revealed client to the state of the s	W 480		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G184	B. WING			7/29/2025	
	ROVIDER OR SUPPLIER  DRIVE GROUP HOME		3747	ET ADDRESS, CITY, STATE, ZIP CODE BON REA DRIVE RLOTTE, NC 28266			
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 480	Continued From page	ge 9	W 480				
	10/5/24 which state	/29/25 revealed an IHP dated is that client #2's current diet is thealthy and afternoon snack.					
	client #2's diet orde should have followed diet. The QIDP was	IM on 7/29/25 confirmed that er is current, and that staff ed his prescribed menu and s not available for interview day of the recertification					
	portion sizes and o	d to verify the menu lists observe that the portions to the clients #3's prescribed e:					
	5:44 PM revealed spaghetti with groutbsp Caesar salad sugar free Kool-Air observations revealed spaghetti wapply Caesar sala and without measirevealed client #3	e group home on 7/28/25 at the dinner meal to be baked and beef, 1 cup tossed salad, 1 dressing or 1 tsp olive oil, d and water. Continued aled client #3 to serve himself ith ground beef, toss salad and d dressing all in large portions uring. Further observation to consume the entire meal of the salad that needed to be seeces.					
	7:35 AM revealed (watermelon, graph buttered toast slice sugar free jelly, 20 observations revealed eggs, appearation revealed eg	the group home on 7/29/24 at the breakfast meal to be fruit pes, sliced grapefruit), 1 slice and in half, scrambled eggs, milk and water. Continued ealed client #3 to serve himself fruit, and toast. Further aled staff A to assist client #3 milk and water. Subsequent				short Pers 10	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G184	B. WING _			7/29/2025
	ROVIDER OR SUPPLIER  DRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, Z 3747 BON REA DRIVE CHARLOTTE, NC 28266		TIESTEUZO
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
	observation revealed entire breakfast mea  Record review on 7/2 9/7/24 which states to heart healthy, double take meds with apple  Interview with the HM client #3's diet order is should have followed diet. The QIDP was induring the second da survey.  D. The facility failed to portion sizes and observed correspond to diets. For example:  Observations in the g 5:43 PM revealed the spaghetti with ground tbsp Caesar salad dresugar free Kool-Aid all observations revealed staff to serve himself I beef, toss salad and all in large portions and Further observations in the great form the consume the entire modes of the consume the entire modes of the consume the entire modes of the consume the graphs, buttered toast sliced in sugar free jelly, 2% mit observations revealed.	client #3 to consume his  29/25 revealed an IHP dated that client #3's current diet is portions at lunch and may sauce.  I on 7/29/25 confirmed that is current, and that staff his prescribed menu and tot available for interview by of the recertification  overify the menu lists erve that the portions the clients #4's prescribed  roup home on 7/28/25 at dinner meal to be baked beef, 1 cup tossed salad, 1 tessing or 1 tsp olive oil, and water. Continued I client #4 to be assisted by baked spaghetti with ground apply Caesar salad dressing and without measuring. Evealed client #4 to	W4	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI		(X3) DATE SURVEY COMPLETED	
		34G184	B. WING	and the same of th	07	//29/2025
	ROVIDER OR SUPPLIER		3747	ET ADDRESS, CITY, STATE, ZIP CO BON REA DRIVE RLOTTE, NC 28266	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 480	assist client #4 with Subsequent observations in 6:45 AM revealed water fee ielly.	ervation revealed staff A to a serving him milk and water. Vation revealed client #4 to breakfast meal.  7/29/25 revealed an IHP dated es that client #4's current diet is size, chopped meats, add moisture to all foods.  HM on 7/29/25 confirmed that er is current, and that staff yed his prescribed menu and as not available for interview day of the recertification  ed to verify the menu lists observe that the portions d to the clients #5's prescribed e:  the group home on 7/28/25 at the dinner meal to be baked bund beef, 1 cup tossed salad, 1 d dressing or 1 tsp olive oil, aid and water. Continued ealed client #5 to be served of baked spaghetti with ground and apply Caesar salad r observation revealed client #5	W 480			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
4		34G184	B. WING		07/29/2025
NAME OF PROVIDER OR SUPPLIER  BON REA DRIVE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE  3747 BON REA DRIVE  CHARLOTTE, NC 28266	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
W 480	double portions of sci toast. Further observ pour client #5's milk a observation revealed entire breakfast meal.  Record review on 7/2 8/18/24 which states heart healthy, bite siz portions at lunch, afte fruit, 2 scoops of Mus BID at breakfast and pudding or applesaud Interview with the HM client #5's diet order i should have followed	rambled eggs, fruit, and ration revealed staff A to and water. Subsequent client #5 to consume his  9/25 revealed an IHP dated that client #5's current diet is e, chopped meats, double ernoon snack, 1 serving of cle Milk shake with 2% milk dinner, ½ cup of yogurt, we with lunch daily.  I on 7/29/25 confirmed that is current, and that staff his prescribed menu and ot available for interview	W 480	Dietician wil ens Portion sizes are included in meno for staff to follow.  Ap will menitor	-