STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G213	A. BUILDING _____ B. WING _____	05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBURNE PLACE	2524 SHELBURNE PLACE CHARLOTTE, NC 28227

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W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, review of records and interview the facility failed to ensure sufficient interventions were implemented to assure that objectives listed in the person centered plan (PCP) were implemented as prescribed relative to behavior management for 1 of 4 sampled clients (#1). The finding is: Observation in the group home on 5/29/19 at 8:20 AM revealed client #1 to be dressed and ready to leave for the vocational site and to walk in circles in her bedroom with the lights off. Additional observation revealed client #2, #3, #5 and #6 to engage in various leisure activities in the living room with staff A and B. Continued observation at 9:15 AM revealed client #1 to walk the hallway of the group home until 9:20 AM when the client began to cry in the hallway before returning to her room to cry. At 9:30 AM staff B was observed to walk to client #1's room and state "What's wrong with you?". Observation of client #1 from 8:20 AM to 9:25 AM when the client loaded the facility van for transport to her vocational site revealed no prompting from staff to engage client #1 in active treatment or leisure activity.	W 249	W 249 RHA Health Services NC, LLC will ensure all Direct Care staff are re-trained and in-serviced on the Behavior Support Plans (BSPs) including appropriate redirection strategies for all individuals supported in the home. All BSPs are monitored monthly by the Psychologist and Behavior Analyst for any needed updates and revisions. Clinical staff will monitor the implementation of the individual BSPs during ongoing Interaction Assessments that occur monthly in the facility. Clinical staff will continue to provide ongoing support to the Direct Care Staff during Interaction Assessments and natural occuring incidents to appropriately address behavior concerns. All Interaction Assessments are reviewed and trended monthly in our CQI meetings. RECEIVED JUN 12 2019 DHSR NH L & C Black Mountain / WRO	7/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Regional Administrator — (X6) DATE: 6/10/19

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.

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W 249	Continued From page 1 Review of records for client #1 on 5/29/19 revealed a PCP dated 4/25/18. Review of the 4/25/18 PCP revealed a behavior support plan dated 9/11/18 for target behavior of aggression, self injury, taking objects from others and AWOL. Further review of the behavior support plan revealed prevention measures to target behaviors that included client #1 should be engaged in activities frequently throughout the day to decrease her agitation, staff should remember to encourage choice in activities and control by phrasing prompts in the form of a question. Interview with the facility qualified intellectual disabilities professional (QIDP) on 5/29/19 revealed staff should have prompted client #1 throughout the morning regarding activities to engage the client. Further interview with the QIDP verified staff did not implement the behavior plan for client #1 as written by allowing the client to remain in her bedroom area unengaged for over an hour.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide teaching	W 436	W 436 RHA Health Services NC, LLC will ensure all Direct Care Staff are in-serviced on ensuring individuals' personal items are not locked up or out of their possession without having completed due process and approved through our Human Rights Committee. All Rights Limitations will be reviewed and trained with the Direct Care Staff at the time of implementation or the monthly House Meeting. All Rights Limitations will be monitored monthly our CQI meetings and quarterly at the Human Rights Committee meetings.	7/29/19

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W 436	Continued From page 2 relative to eyeglasses for 1 of 4 sampled clients (#2). The finding is: Observation in the group home on 5/29/19 at 7:20 AM revealed client #2 to sit at the kitchen table and request her glasses from staff A. Staff A was observed to retrieve client #2's eyeglasses from a locked medication cabinet and return to the kitchen area to give the client her eyeglasses. Observation of client #2 throughout the morning of 5/29/19 revealed the client to wear her eyeglasses consistently after receiving them from staff A. Review of records for client #2 on 5/28-29/19 revealed a PCP dated 2/15/19. Review of the 2/15/19 PCP revealed current objective training to address medication administration, exercise, beverage preparation at meals, communication and community participation. Additional review of records for client #2 revealed no objective training relative to locking the client's eyeglasses in the medication cart of the group home. Additional review of records for client #2 revealed no formal behavior plan or identified behavior issues to support the need for locking client #2's eyeglasses away from the client. Interview with Staff A on 5/29/19 revealed client #2's glasses are kept locked at night due to the client sometimes misplacing her glasses in her room. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed client #2's eyeglasses should not be kept in the medication cart of the group home. Further interview with the QIDP revealed client #2 has no history of improper care or losing her eyeglasses that she was aware of. The QIDP further verified additional assessment was	W 436		

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W 436	Continued From page 3 needed to ensure the clients eyeglasses were not restricted from the client without identified need and training.	W 436		