

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G213	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2022
NAME OF PROVIDER OR SUPPLIER SHELBURNE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2524 SHELBURNE PLACE CHARLOTTE, NC 28227		
(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 130	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 1 of 3 clients (#6) during medication administration. The finding is:</p> <p>Observations in the group home on 4/29/22 at 7:54 AM revealed client #6 to sit at the dining table participating in the breakfast meal. Continued observations revealed staff to administer medication to client #6 at the dining table as other clients and staff sat at the table. Observations did not reveal staff to offer privacy to client #6 by moving the client to a private area during medication administration.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 4/29/22 revealed that staff was attempting to administer the medication (fluvoxamine 50 mg) to client #6 prior to the medication window closing at 8:00 AM. Continued interview with the facility nurse on 4/29/22 verified that staff should have taken client #6 to her room to ensure privacy during medication administration. Further interview with the QIDP and nurse confirmed that all clients should be offered privacy during medication administration.</p>	W 130			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.