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 ______	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBURNE PLACE	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	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) 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 observation and interview, the facility failed to assure that privacy was maintained for 1 of 6 clients (#1) during personal care. The finding is: Observation in the group home on 5/10/23 at 7:43 AM revealed client #1 to be seated on the toilet in the bathroom with the bathroom door open to the extent client #1 could be observed from the hallway. Continued observation revealed staff E to enter the bathroom and open the door slightly wider while client #1 was moving from the toilet to the shower and was entirely undressed. Further observation revealed client #1 to shower with the door open. Subsequent observation revealed staff E to be present throughout client #1's shower and to not close the bathroom door for privacy until several minutes into the shower. Interview with the qualified intellectual disabilities professional (QIDP) on 5/10/23 verified that staff should be observing privacy during personal care by closing the client's bathroom door.	W 130		
W 187	DIRECT CARE STAFF CFR(s): 483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients: (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are	W 187		

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.

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W 187	Continued From page 1	W 187		

aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2;

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4;

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

This STANDARD is not met as evidenced by:

Based on observations and interviews, the facility failed to assure adequate staff-to-client ratios were met for 6 of 6 clients in the group home.
The finding is:

Morning observations in the home on 5/10/23 at 6:00 AM revealed five clients were up, dressed and out of their rooms. Continued observations revealed third shift staff to prepare breakfast at 6:15AM which consisted of waffles, scrambled eggs, apple juice, milk and coffee. Further observations revealed third shift staff to assist five clients with setting their place at the table, then fix their plates and drinks to participate in their breakfast meal. Subsequent observations revealed third shift to verbally prompt clients #1, #2, #3, #5, and #6 to take their dishes to the sink, rinse them off and place them in the dishwasher.

Additional observations revealed third shift staff to check on client #4 who refused to get out of bed while trying to keep an eye on clients #3 and #6 who decided to sit in the living and activity rooms following their breakfast meal. Continued observations revealed third shift staff was alone with all six clients until 7:05 AM when staff E entered the group home. Third shift staff then proceeded to begin medication administration. At 7:40 AM staff F entered the group home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 187	Continued From page 2 Review of clients records on 5/10/23 revealed a functioning diagnosis ranging from Moderate to Profound IDD. Interview with the third shift staff on 5/10/23 and review of the facility schedule revealed a 6:30 AM staff was scheduled to work. Continued interview with third shift staff revealed one staff is scheduled to come in at 6:30 AM and two staff scheduled to come in at 7:00 AM. Interview with the with the qualified intellectual disabilities professional (QIDP) on 5/10/23 revealed two staff are the minimum number of staff working when all six clients are up and dressed.	W 187		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 1 of 6 clients in the group home (#6) observed during medication administration. The finding is: During observations in the home on 5/10/23 at 6:15 AM, client #6 was observed to eat her breakfast. At 7:08 AM, Staff D was observed to administer 1 tablet of Alendronate 70 mg to client #6 who swallowed the tablet with water, along with Potassium chloride, 20 meq 1 tablet, Vitamin D3 2,000 IU 1 capsule, Fluvoxamine 50 mg 1	W 368		

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W 368	Continued From page 3 tablet, Levothyroxine 25 mcg 1 tablet, and Hydrochlorot 25 mg 1 tablet. Review on 5/10/23 of client #6's physician's orders dated 4/3/23 revealed an order for Alendronate 70 mg which reads, "Take 1 tablet by mouth once weekly on Wednesdays. Take at least 30 min before breakfast with 8 oz water ...Schedule WED AT 06:00" Interview on 5/10/23 with the facility registered nurse (RN) confirmed the Alendronate tablet should have been given at 6:00 AM, before client #6 ate breakfast.	W 368		