		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 34G322		(X1) PROVIDER/SUPPLIER/CLIA	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		B. WING _			11/27/2018			
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
BROWNE GROUP HOME					05 BROWNE DRIVE IARLOTTE, NC 28269			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	I CORRECTIVE ACTION SHOULD BE COM REFERENCED TO THE APPROPRIATE		
W 249	CFR(s): 483.440(d)(1 As soon as the interd formulated a client's i each client must rece treatment program co interventions and ser and frequency to sup objectives identified in plan. This STANDARD is r The facility failed to a treatment program for regarding the implem equipment, a gait belt and record review. T Interview with the faci disabilities profession was hospitalized toda interview with the faci disabilities profession was hospitalized toda interview revealed client immediately after the and no fractures were Further interview revealed client fracture of client #3's to repair the fracture of tomorrow. Record review on 11/ a PCP containing a co) isciplinary team has individual program plan, ive a continuous active insisting of needed vices in sufficient number port the achievement of the in the individual program not met as evidenced by: assure a continuous active r 1 of 4 sampled clients (#3) entation of adaptive t, as evidenced by interview he finding is: ility qualified intellectual al (QIDP) revealed client #3 by for a broken hip. Further DP revealed client #3 fell to er client hurried past her and in behind in the group home, eeks ago. Continued ent #3 was examined fall in the emergency room	W 2	249				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	2F		TITLE		(X6) DATE	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(X6) DATE

PRINTED: 12/10/2018

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322			. ,		· · ·	(X3) DATE SURVEY COMPLETED		
		B. WING		11	11/27/2018			
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	Ξ			
BROWNE GROUP HOME				205 BROWNE DRIVE CHARLOTTE, NC 28269				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
W 249	Continued From page	e 1	W 249					
	the occupational ther are to use the gait be ambulating. Interview confirmed that staff a client #3 ambulates a standing to sitting, loa and any other ambula her day.	. Recommendations from apy evaluation states staff It with the client while v with the facility nurse re to use the gait belt when and makes transitions from ading and unloading the van ation or transition throughout						
W 460	client #3's gait belt wa was ambulating at the interview with the gro "other clients were be no one was holding of was accidently pushe floor hitting her shoul Subsequent interview client #3's gait belt sh ambulating. Therfore implement needed in number and frequence # 3's gait belt to preve	as not being held when she e time of her fall. Continued up home staff revealed eing assisted off the van and lient #3's gait belt when she ed from behind and fell to the der and hip area." with the QIDP confirmed hould have been held while e the facility failed to terventions in sufficient ey to support the use of client ent falls. ON SERVICES	W 460					
	Each client must rece well-balanced diet ind specially-prescribed o	cluding modified and						
	Based on observatio interview, the facility	not met as evidenced by: n, record review and staff failed to assure all menu to clients #2 and #5. The						

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Facility ID: 955423

If continuation sheet Page 2 of 4

	-	D HUMAN SERVICES				FORM	: 12/10/2018 APPROVED . 0938-0391
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G322		34G322	B. WING		_	11/27/2018	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BROWNE	GROUP HOME			205 BROWNE DRIVE CHARLOTTE, NC 2826	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 460 W 475	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Observations on 11/27/18 during the breakfast meal revealed clients #2 and #5 seated at the breakfast table eating hot cereal with milk and drinking juice. Clients #2 and #5 were observed being assisted and served these three breakfast items at approximately 6:00 AM. Continued observations revealed clients #2 and #5 completing their breakfast meal and taking their dishes to the kitchen area at approximately 6:10 AM. No other menu items were observed being offered or served to client #2 and #5. Continued observations at approximately 6:15 AM revealed the staff serving client #1 his breakfast items, making client #1 a piece of toast, and assisting him to butter the toast. Interview with the facility qualified intellectual disabilities professional on 11/27/18 revealed all clients are able to eat toast and should have been served toast with their breakfast meal. Review of the facility breakfast menu in the kitchen revealed the following: hot cereal with milk, toast with butter, juice, coffee, and water. Therefore the facility failed to serve all menu items to clients #2 and #5 as prescribed. MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure each place setting during the breakfast meal included appropriate eating utensils for 2 of 4 sampled clients (#2 and #5). The findings are:		W 460 W 475				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/10/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G322		B. WING			-	11/27/2018		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
BROWNE	GROUP HOME				205 BROWNE DRIVE HARLOTTE, NC 28269			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 475	Observations on 11/2 clients #1, #2, #5 wer having their breakfast juice. All clients were spoon as part of their client #1 who was late his toast. Client's #2 menu item of toast du Record review for clie a Life Skills Assessme stated client #2 " inde Interview with the dire client #5 also is able for independently. Continued interview of qualified intellectual of confirmed that all clie	7/18 at 6:01 AM revealed re seated at the dining table t meal of cereal, coffee, and e observed to have only a place setting except for er offered a knife to butter and #5 were missing their uring their breakfast meal. ent #2 on 11/27 /18 revealed ent dated 10/18/18 which ependently uses all utensils." ect care staff confirmed to utilize utensils	W	475				

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