STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G322	A. BUILDING ______ B. WING ______	C 03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNE GROUP HOME	8205 BROWNE DRIVE CHARLOTTE, NC 28269

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide each employee with needed training to enable each employee to effectively and competently perform their duties relative to ensuring clients receive prompt medical care for client #2. The finding is: Review of facility records conducted in the home on 3/4/19 revealed client #2 was tranported to Urgent Care on the morning of 2/5/19 after being instructed to do so by the facility nurse because of cold and cough symptoms. Continued review of #2's record revealed client #2 was not seen at Urgent Care on the morning of 2/5/19 because of a long 41/2 hour wait time, but was instead transported back to the group home. Further review of the facility reports revealed a 2nd shift staff was instucted by the group home manager to take client #2 back to Urgent Cate to be seen during 2nd shift on 2/5/19. This directive was also written in the communication log in the group home by the GH Manager. Subsequent review of facility records revealed the staff assigned to return client #2 to Urgent Care on 2nd shift did not do so. Interview with the facility qualified intelllectual disablities professional (QIDP) and the facility nurse confirmed the staff member who was assigned to take client #2 to Urgent Care on 2nd	W 189		

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 189	Continued From page 1 shift on 2/5/19 was terminated for not taking the client to the hospital that evening as instructed. Continued interview with the QIDP and nurse revealed all other group home staff working 2nd shift on 2/5/19 stated they did not know about the need of client #2 to return to Urgent Care during their shift as they failed to read the communication log as policy requires per QIDP, nor did they received comunication from the group home manager or the facility nurse that evening. concerning client #2. Therefore the facility failed to provide adequate training to all staff members to enable their duties be performed competently and effectively. Subsquent interview with the facility Executive director revealed training for all group home staff to include the manager will be held today regarding utilizing all methods of communication to include reading the communication log and follow-up calls to the nursing staff on the day a client is orderd to the hospital emergency room or Urgent Care.	W 189		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing services were provided in accordance with client needs relative to assuring clients received prompt medical attention. While this affected 1 client (#2), this potentially affects all clients residing the home. The finding is:	W 331		

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W 331	Continued From page 2	W 331		

Record review on 3/4/19 of facility records regarding client #2 revealed on 2/5/19 the facility nurse gave a directive to the first shift group home (GH) staff to take client #2 to Urgent Care for evaluations of his symptoms of severe cough and cold. Continued review of facility records and reports dated 3/8/19 revealed while client #2 was initially transported on 2/5/19 to Urgent Care by the first shift GH staff, client #2 was not seen during this time at Urgent Care by a medical provider on 2/5/19 due to a 4-hour waiting period. Subsequent review, verified by the facility nurse, revealed after first shift staff returned client #2 to the GH, the GH supervisor verbally directed a second shift staff member to transport client #2 back to Urgent Care that evening of 2/5/19. In addition, the GH supervisor's directive was also logged into the Browne GH Communication Log as evidenced by review of said log on 3/4/19 by the surveyor. Further interview on 3/4/19 with the facility nurse revealed the second shift staff member assigned to transport client #2 back to Urgent Care on the evening of 2/5/19 did not do so.

Continued record review and review on 3/4/19 of the facility's investigative report dated 2/8/19 revealed client #2 was not seen at Urgent Care until the following day on 2/6/19. Further review revealed the facility's nurse inquiry regarding client #2's condition status is what prompted the GH staff on 2/6/19 to take immediate action and transport client #2 to Urgent Care on 2/6/19. Subsequent review, verified by the the qualified intellectual disabilities professional (QIDP), revealed client #2 was seen in Urgent Care on 2/6/19 and from there sent out for emergent hospital care admission on 2/6/19 to a large area

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W 331	Continued From page 3 hospital system and was discharged on 2/11/19. In addition, interview with the facility nurse on 3/4/19 revealed client #2 was hospitalized with double pneumonia. Continued interviews with the facility nurse and the QIDP on 3/4/19 revealed none of the other GH second shift staff working on 2/5/19 were aware client #2 should have been transported to the hospital that evening and no second shift GH staff working on 2/5/19 admitted to reading the Browne GH Communication Log as required per facility policy. Subsequently, the facility failed to provide urgent medical attention in accordance with client #2's medical care needs as initially directed by the facility nurse and as stated in facility policy and this resulted in a delay in medical care for client #2.	W 331		