

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure individual support plans (ISP) included training objectives to address identified needs relative to non-compliance behaviors for 2 of 3 sampled clients (#3 and #6). The findings are:</p> <p>A. The ISP dated 5/29/19 failed to include training objectives to address behavior management needs relative to PICA and property destruction for client #3. For example:</p> <p>Observation on 12/2/19 at 3:45 PM revealed a hole in the seat of a sofa in the facility living room, consisting of a torn seat cushion and the leather ripped apart. Further observation revealed the hole in the seat cushion to be approximately 13 by 12 inches in diameter and 4 inches deep. Interview with staff C on 12/2/19 revealed that client #3 was responsible for making the large hole in the sofa with a clothes hanger and the client had ingested some of the sofa cushion fibers approximately one week ago.</p> <p>Review of records for client #3 on 12/3/19 revealed an ISP dated 5/29/19. Further review of the 5/29/19 ISP revealed program goals including bathing, setting his place setting at the table, carrying utensils to the sink, shaving, laundry,</p>	W 227			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	<p>Continued From page 1</p> <p>toothbrushing, and expressing his needs and wants by pointing, touching, or taking what snack or drink he wants. Further review of the record for client #3 did not reveal a behavior support plan (BSP) or training objectives relative to property destruction or PICA.</p> <p>Interview with staff C on 12/2/19 verified management was made aware of the sofa damage one week ago. Interview with the home manager on 12/2/19 confirmed management has purchased a new sofa for the group home. Interview with the qualified independent disabilities professional (QIDP) on 12/3/19 verified client #3 had a PICA diagnosis since admission on 4/11/19 and does not have current training objectives to address identified target behaviors. Further interview with the QIDP verified that she was not aware that client #3 had ingested the cushion fibers therefore an incident report was not completed. Continued interview with the QIDP confirmed that client #3 would benefit from training objectives to address target behaviors of PICA and property destruction.</p> <p>B. The ISP dated 8/14/19 failed to include training objectives to address behavior management needs relative to personal space, tantrums, verbal aggression, and refusal behaviors for client #6. For example:</p> <p>Observations in the group home on the afternoon of 12/2/19 from 3:10 PM to 3:20 PM revealed client #6 to sit at the dining table and look at a phone book. Client #6 was observed to stand in staff's personal space, attempting to hug, kiss staff's hand, and place his head on staff's chest, while dismissing multiple prompts to refrain from</p>	W 227			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	<p>Continued From page 2</p> <p>touching staff. Further observation at 3:45 PM revealed client #6 to avoid multiple prompts to use his walker during ambulation to his room while making grunting noises and shaking his hands. Client #6 continued to stand in the living room area while avoiding multiple prompts to engage in an activity. Subsequent observations at 4:15 PM revealed client #6 to enter into the medication room while cursing and avoiding multiple prompts to remain focused during his medication administration.</p> <p>Observations in the group home on the morning of 12/3/19 from 6:30 AM to 6:50 AM revealed client #6 to pace from the living room to his room and was prompted multiple times to participate in a group activity in which he refused. Further observations at 7:10 AM revealed client #6 to enter into the medication room, while prompted several times to refrain from cursing and remain focused while taking his medications. Continued observation revealed client #6 to shake his hands and stomp his feet several times while staff prompted the client to remain focused.</p> <p>Review of records for client #6 on 12/3/19 revealed an ISP dated 8/14/19. Further review of the ISP revealed program goals including toileting, bathing, privacy in the bathroom, toothbrushing, pacing himself during meals, and not interrupting others. Continued review of the ISP did not reveal a behavior support plan (BSP) or training objectives relative to verbal aggression, tantrums, personal space, or refusal.</p> <p>Interview with staff C on 12/3/19 verified client #6 has displayed inappropriate sexual gestures towards staff since his admission to the group home. Interview with the QIDP on 12/3/19</p>	W 227			

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

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 227	Continued From page 3 confirmed client #6 does not have a current BSP or training objectives relative to target behaviors. Continued interview with the facility QIDP verified client #6 would benefit from training objectives to address personal space, tantrums, verbal aggression, and refusal behaviors.	W 227			
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 observation, review of records and interview, the facility failed to assure the individual support plan (ISP) for 1 sampled client (#6) included needed interventions and services in sufficient number and frequency to provide a continuous active treatment program. The finding is: Afternoon observations in the group home on 12/2/19 from 3:15 PM until 4:35 PM revealed client #6 to sit at the dining table unengaged for 45 of 50 minutes. During the 5 minutes of engaged activity on 12/2/19 staff prompted client #6 to go to the medication room to take his afternoon medication. Further observations revealed during the unengaged time, client #6 was observed talking to staff and surveyors about	W 249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	<p>Continued From page 4</p> <p>being their boyfriend, refusing engagement in the card game with housemates at the table, and refusing to go on a planned outing to dinner with his housemates.</p> <p>Morning observations on 12/3/19 in the group home from 6:35 AM to 7:45 AM revealed client #6 to sit unengaged at the dining table or to walk around the group home for 55 of 70 minutes. During the 15 minutes of engagement, staff prompted client #6 to pack his lunch for (3 minutes) and take his medications (approximately 12 minutes). During the additional 55 minutes of unengaged time staff was observed to try to engage client #6 in a card game at the table, to which client #6 cursed and refused. Interview with staff A revealed client #6 is difficult to engage at times and likes "to walk around and talk mainly".</p> <p>Review of client #6's Individual Support Plan (ISP) dated 8/14/19 on 12/3/19 revealed the client to have 5 training objectives in the home including brushing his teeth, providing privacy by knocking on doors, refraining from pacing during meals, toileting with assistance, and not interrupting others during conversations. Interview with the qualified intellectual disabilities professional (QIDP) on 12/3/19 revealed client #6 currently has no other active treatment programming.</p> <p>Further review of client #6's ISP revealed a current Life Skills Assessment reflecting client #6 has partial but not full skill in identifying safety signs, recognizing danger signs, recognizing and organizing his clothing, identification of coins, knowing his address and phone number, and knowing the side effects of his medications.</p>	W 249			

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

PRINTED: 12/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2019
NAME OF PROVIDER OR SUPPLIER BROWNE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 249	Continued From page 5 Interview with the QIDP on 12/3/19 verified that client #6 needs additional active treatment programming to address his identified needs.	W 249		