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 _____	09/30/2025

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

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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 observations and interviews, the facility failed to ensure staff were sufficiently trained in hygiene methods specific to ensuring soap and paper products were accessible in clients' bathrooms and chemicals to remain locked for 3 of 5 sampled clients (#2, #3, and #4). The findings are: A. Observations on 9/29/25 and 9/30/25 revealed two bathrooms in the group home utilized by clients. Continued observations revealed no soap or paper towels in both bathrooms throughout observations on 9/29/25 - 9/30/25. Interview with on 9/30/25 with the site supervisor (SS) revealed soap and paper towels are not kept in the bathrooms because of several clients who has PICA diagnosis. Further interview with the SS revealed soap and paper products remains locked up and distributed to clients when they need to go to the bathroom. Interview on 9/30/25 with the Program Manager (PM) verified all bathrooms should have an ample supply of soap and paper products available to all clients when occupying the bathrooms. Further interview with the PM revealed there are no consents to justify the need for soap and paper products to remain locked in the group home. B. Observations on 9/29/25 and 9/30/25 revealed a hallway closet to contain cleaning supplies and	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 189	Continued From page 1 other chemicals utilized by staff. Continued observations revealed the closet to remain shut and unlocked throughout observations on 9/29/25 - 9/30/25. Review of record for client #2 on 9/30/25 revealed a person centered plan dated 12/11/24. Further review of the PCP revealed a diagnosis to include PICA. Continued review of client's record, revealed a consent to keep all chemicals locked signed by the guardian on 9/15/25 and the human rights committee (HRC) on 9/18/25. Review of record for client #3 on 9/30/25 revealed a person centered plan (PCP) dated 12/11/24. Further review of the PCP revealed a diagnosis to include PICA. Continued review of client's record, revealed a consent to keep all chemicals locked signed by the guardian on 9/10/25 and the HRC on 9/11/25. Review of record for client #4 on 9/30/25 revealed a PCP dated 7/30/25. Further review of the PCP revealed a diagnosis to include PICA. Continued review of client's record, revealed a consent to keep all chemicals locked signed by the guardian on 9/10/25 and the HRC on 9/11/25. Interview on 9/30/25 with the area supervisor (AS) verified clients #2, #3 and #4 consents are updated. Further interview with the AS revealed all chemicals in the home needs to remain locked at all times.	W 189		
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment	W 250		

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W 250	Continued From page 2	W 250		

program and that is readily available for review by relevant staff.
This STANDARD is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure staff were provided an active treatment schedule for 5 of 6 sampled clients (#1, #2, #3, #4, and #5). The findings are:

Observations on 9/30/25 from 6 AM - 8:30 AM revealed client's #1 and client #2 to remain in their bedrooms. Further observations revealed client #3 to remain in his bedroom until 6:41AM, shower, sit in the common area until 7:30 AM then propelled to the dining table to participate in his breakfast meal.

Continued observations revealed client #4 to participate in the breakfast meal at 6:08 AM, sit in the common area, listening to gospel music, walk a lap around the kitchen and dining room area. At 6:35 AM staff offered him to shoot basketball. At 6:58 AM staff B offered him a musical activity, a connect four activity, then a jenga activity. At 7:55 AM, client #4 walked around the house, participated in medication administration and then sat at the dining table at 8:05AM with a magazine in hand.

Further observations with client #5 at 6:08 AM revealed the client to participate in the breakfast meal then to the kitchen to wash his dishes. At 6:34 AM client #5 participated in a walking activity, then sat in the common area listening and singing gospel music. Subsequent observations revealed client #5 to participate in medication administration at 6:58 AM, then return to the common area to listen to gospel music until 8:00 AM. Additional observations at 8:05 AM

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W 250	Continued From page 3 revealed client #5 to proceed to the bathroom, then to his bedroom. During an interview on 9/30/25 with site supervisor (SS) and staff B, when asked if the clients follow a daily or personal schedule, the staff stated, "No...we've been trying to do stuff to fit their personality." The staff noted they have been taking the clients for walks, doing leisure type activities, driving to the airport overlooking planes as they take off or land, or letting them watch movies. Staff further referenced the activity monthly schedule displayed on the wall in the dining room area. Review on 9/30/25 of client's #1, #2, #3, #4 and #5 records did not reveal a personal schedule. Further review of records did not provide evidence of a block time frame for formal activities/training programs that are relevant and/or purposeful based on each individuals need or interest. Interview on 9/30/25 with the Site Supervisor (SS) confirmed that the personal schedules were not available for review and none of the five clients attend an outside day program.	W 250		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review, and	W 340		

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W 340	Continued From page 4	W 340		

interview, the facility failed to provide nursing services in accordance with the clients' needs relative to providing drug education with the nurse/med tech for 2 of 6 sampled clients (#4 and #5). The findings are:

A. The facility failed to provide drug education during the medication administration for client #5.

Observations during the medication administration on 9/30/25 at 6:57 AM revealed Staff A to prepare client 5#'s medication in the med closet while client #5 stood behind him. Continued observation revealed client #5 to take his medications with a cup of water and he exited the office. Further observation revealed that at no time did Staff A inform client #5 of what medications he was taking, its purpose, side effects, and by which route.

Interview on 9/30/25 with the facility nurse confirmed that Staff A should have provided drug education to client #5.

B. The facility failed to provide drug education during the medication administration for client #4.

Observations during the medication administration on 9/30/25 at 7:57 AM revealed Staff A to prepare client #4's medication in the med closet while client #4 stood behind him. Continued observation revealed client #4 to take his medications with a cup of water and he exited the office. Further observation revealed that at no time did Staff A inform client #4 of what medications he was taking, its purpose, side effects, and by which route.

Interview on 9/30/25 with the facility nurse

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W 340	Continued From page 5 confirmed that Staff A should have provided drug education to client #4.	W 340		
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 interviews, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 1 of 6 sampled clients (#3). The finding is: During morning medication administration on 9/30/25 at 8:16 AM revealed Staff A prepared medications to administer to client #3. Continued observation revealed Staff A opened a capsule of Omeprazole 40mg and placed it in a medicine cup filled with applesauce. Further observation revealed Staff A fed the applesauce to client #3. Client #3 exited the medication room afterwards, without receiving any other medications. Additionally, surveyors arrived at the home at 6:00 AM and client #3 was in bed asleep until the Site Supervospr (SS) woke him up around 6:41 AM and got him dressed for breakfast. At no point was medications given to client #3 after 6:00 AM. Record review on 9/30/25 of client #3's Physician's Orders dated 7/10/25 revealed prescriptions for Aspirin LOW Chew, Docusate SOD, Finasteride, GNP Vit D3, Levetiraceta, Methenam HIP, Nitrofurantoin, Polyethylene Glycol Powder, Sucralfate, Tamsulosin, and Vitamin C to be given at 7:00 AM.	W 368		

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W 368	Continued From page 6 Interview on 9/30/25 with the SS revealed that Staff A administered client # 3's medication prior to 6:00 AM. Continued interview with the SS confirmed Staff A should have administered medications as prescribed on the physician's orders. Interview on 9/30/25 with the facility nurse revealed the current physician's order are the most recent orders. Further interview with the facility nurse confirmed staff should have administered medications as prescribed on the physician's orders not before 6:00 AM.	W 368		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure 1 of 6 sampled client (#3) received their specialty diet as prescribed. The finding is: Observations during the breakfast meal on 9/30/25 at 6:00 AM revealed client #3 to participate in the breakfast meal to include bran flake cereal, whole milk, whole wheat bread, margarine, and apple juice. Continued observations revealed client #3 to consume the breakfast meal and at no point did staff provide him with a cup of prune juice or Ensure. Record review on 9/29/25 for client #3 revealed a physician's order (PO) with a diet order dated 7/10/25. Continued review of the POs revealed	W 463		

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W 463	Continued From page 7 that client #3 is prescribed a regular pureed diet with double portions, Ensure active or Ensure drink 10 oz twice daily at 7 AM and 9 PM, Prune juice 4oz twice daily at 7 AM and 9 PM, snacks twice daily. Interview on 9/30/25 with the Site Supervisor (SS) confirmed client #3's diet as prescribed. Further interview with the SS confirmed that client #3 did not receive his prune juice or Ensure this morning. Continued interview with the SS revealed funds for groceries were not received on time and the home ran out of prune juice and Ensure. Subsequent interview with the SS revealed she is going to the grocery store today. Interview on 9/30/25 with the facility nurse confirmed client #3's diet as prescribed. Further interview with the facility nurse confirmed that staff should have provided client #3 with his prescribed diet to include prune juice and Ensure.	W 463		