AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION		TE SURVEY MPLETED		
		B. WING			R		
34G231			B. WING			08/16/2018	
NAME OF PROVIDER OR SUPPLIER STRAWBERRY HOUSE				STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
				303 NORTH HOWARD STREET CHADBOURN, NC 28431			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
{E 032}	Primary/Alternate M CFR(s): 483.475(c)	leans for Communication (3)	{E 03	32}			
	emergency prepare that complies with F and must be review	st develop and maintain an dness communication plan ederal, State and local laws ed and updated at least nunication plan must include					
	<ul><li>(3) Primary and alter communicating with</li><li>(i) [Facility] staff.</li><li>(ii) Federal, State, transferred emergency managed</li></ul>	the following: ibal, regional, and local					
	alternate means for ICF/IID's staff, Fede local emergency ma	83.475(c):] (3) Primary and communicating with the eral, State, tribal, regional, and anagement agencies. a not met as evidenced by:					
{E 037}	EP Training Prograr CFR(s): 483.475(d)		{E 03	37}			
	ASCs, PACE organi	n. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following:					
	policies and proced staff, individuals pro	emergency preparedness ures to all new and existing oviding services under olunteers, consistent with their					
	<ul><li>(ii) Provide emerger</li><li>least annually.</li><li>(iii) Maintain docum</li></ul>	ncy preparedness training at entation of the training. aff knowledge of emergency					
		482.15(d) and RHCs/FQHCs					

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.

## PRINTED: 08/17/2018

CENTER STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	FORM OMB NO (X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED	
		34G231	B. WING				२ 16/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
STRAWBE	ERRY HOUSE				03 NORTH HOWARD STREET CHADBOURN, NC 28431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{E 037}	at §491.12:] (1) Traini or RHC/FQHC] must of (i) Initial training in em- policies and procedum staff, individuals provi arrangement, and volue expected roles. (ii) Provide emergence least annually. (iii) Maintain documen (iv) Demonstrate staff procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in em- policies and procedum hospice employees, a services under arrang expected roles. (ii) Demonstrate staff procedures. (iii) Demonstrate staff procedures. (iii) Demonstrate staff procedures. (iii) Provide emergence least annually. (iv) Periodically review emergency prepared employees (including special emphasis place procedures necessary others. *[For PRTFs at §441. program. The PRTF m (i) Initial training in em- policies and procedum staff, individuals provi	Ing program. The [Hospital do all of the following: nergency preparedness es to all new and existing ding on-site services under unteers, consistent with their y preparedness training at ntation of the training. 'knowledge of emergency 8.113(d):] (1) Training. The f the following: nergency preparedness es to all new and existing and individuals providing gement, consistent with their knowledge of emergency cy preparedness training at w and rehearse its ness plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and 184(d):] (1) Training must do all of the following: nergency preparedness es to all new and existing	{E 0	37}			

Facility ID: 922664

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CENTER	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUUT			FORM	0: 08/17/2018 APPROVED 0: 0938-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	` '			COMPLETED	
		34G231	B. WING _				、 16/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
STRAWBERRY HOUSE					03 NORTH HOWARD STREET HADBOURN, NC 28431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{E 037}	<ul> <li>(ii) After initial training preparedness training (iii) Demonstrate staff procedures.</li> <li>(iv) Maintain documer preparedness training</li> <li>*[For PACE at §460.8 organization must do (i) Initial training in empolicies and procedur staff, individuals proviarrangement, contract volunteers, consistent (ii) Provide emergence least annually.</li> <li>(iii) Demonstrate staff procedures, including what to do, where to ge case of an emergency (iv) Maintain documer</li> <li>*[For CORFs at §485. CORF must do all of t (i) Provide initial training preparedness policies and existing staff, individue arrangement, a with their expected ro (ii) Provide emergence and existing staff, indiantain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergence their first workday. The staff.</li> </ul>	<ul> <li>a, provide emergency</li> <li>a t least annually.</li> <li>knowledge of emergency</li> <li>antation of all emergency</li> <li>4(d):] (1) The PACE</li> <li>all of the following:</li> <li>hergency preparedness</li> <li>es to all new and existing</li> <li>ding on-site services under</li> <li>tors, participants, and</li> <li>t with their expected roles.</li> <li>y preparedness training at</li> <li><sup>c</sup> knowledge of emergency</li> <li>informing participants of</li> <li>go, and whom to contact in</li> <li>y.</li> <li>and training.</li> <li>and procedures to all new</li> <li>ividuals providing services</li> <li>ind volunteers, consistent</li> <li>les.</li> <li>y preparedness training at</li> </ul>	{E 0	37}			

If continuation sheet Page 3 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		34G231	B. WING			08/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
STRAWBE	ERRY HOUSE				303 NORTH HOWARD STREET CHADBOURN, NC 28431		
(X4) ID PREFIX TAG				I PROVIDER'S PLAN OF CORRECTION IX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{E 037}	The CAH must do all (i) Initial training in en- policies and procedur reporting and extingu and where necessary personnel, and guests cooperation with firefi authorities, to all new individuals providing s and volunteers, consi- roles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For CMHCs at §485 CMHC must provide in preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno- procedures. Thereafte emergency preparedr annually.	gnals and firefighting 25(d):] (1) Training program. of the following: hergency preparedness res, including prompt ishing of fires, protection, r, evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected ry preparedness training at htation of the training. f knowledge of emergency and procedures to all new ividuals providing services and volunteers, consistent les, and maintain training. The CMHC must pwledge of emergency er, the CMHC must provide	{E (	037			
W 000	INITIAL COMMENTS		w	000			
	A revisit was conduct	ed on 8/16/18 for condition					

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PRINTED: 08/17/2018

	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION		0.0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED			
			1			R		
		34G231	B. WING			08/16/2018		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
STRAWR	RRY HOUSE			3	03 NORTH HOWARD STREET			
STRAWD				C	CHADBOURN, NC 28431			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHO		LD BE COMPLE		
W 000	Continued From page	× 4	10/	000				
VV 000	level deficiencies cite		VV	000				
		encies have been corrected,						
		liance was found. Standard						
		d during the 7/2 - 7/3/18						
	survey will require an compliance.	other revisit to ensure						
{W 189}	STAFF TRAINING PF	ROGRAM	{W -	189}				
	CFR(s): 483.430(e)(1			,				
	The facility must prov	ide each employee with						
		training that enables the						
	employee to perform efficiently, and compe	his or her duties effectively,						
	emolentiy, and compe	stority.						
		not met as evidenced by:						
{W 262}	PROGRAM MONITO CFR(s): 483.440(f)(3)		{W 2	262}				
	The committee chould	d ravious and						
		d review, approve, and grams designed to manage						
		or and other programs that,						
		committee, involve risks to						
	client protection and i	rights.						
	This STANDARD is r	not met as evidenced by:						
(14/ 000)			0.4/2	1001				
{W 263}	PROGRAM MONITO CFR(s): 483.440(f)(3)		{W 2	203}				
	The second in the second							
		d insure that these programs ith the written informed						
		parents (if the client is a						
	minor) or legal guardi	an.						

Facility ID: 922664

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PRINTED: 08/17/2018

STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		34G231	B. WING	R 08/16/2018	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
STRAWBI	ERRY HOUSE			NORTH HOWARD STREET NDBOURN, NC 28431	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
{W 263}		e 5 not met as evidenced by:	{W 263}		
{W 369}	DRUG ADMINISTRA CFR(s): 483.460(k)(2		{W 369}		
	that all drugs, includi	administration must assure ng those that are e administered without error.			
	This STANDARD is	not met as evidenced by:			
{W 371}	DRUG ADMINISTRA CFR(s): 483.460(k)(4		{W 371}		
	that clients are taugh medications if the int determines that self-	administration of medications ective, and if the physician			
	This STANDARD is	not met as evidenced by:			
{W 382}	DRUG STORAGE A CFR(s): 483.460(I)(2	ND RECORDKEEPING )	{W 382}		
	The facility must kee locked except when administration.	p all drugs and biologicals being prepared for			
	This STANDARD is	not met as evidenced by:			
{W 383}	DRUG STORAGE AI CFR(s): 483.460(I)(2	ND RECORDKEEPING	{W 383}		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/17/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
34G231		B. WING			R 08/16/2018		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
STRAWBE	ERRY HOUSE				3 NORTH HOWARD STREET HADBOURN, NC 28431		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
{W 383}	Continued From page	6	(14/2	021			
100 2007	1.0	ons may have access to the	{W 3	03}			
	keys to the drug stora						
	This STANDARD is r	not met as evidenced by:					
{W 436}	SPACE AND EQUIPM	MENT	{W 4	36}			
	CFR(s): 483.470(g)(2	)					
	and teach clients to u choices about the use hearing and other cor and other devices ide	sh, maintain in good repair, se and to make informed e of dentures, eyeglasses, mmunications aids, braces, entified by the as needed by the client.					
	This STANDARD is r	not met as evidenced by:					

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