PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	ECONSTRUCTION	(EX) AMOO	ATE SURVEY OMPLETED	
		34G231	B, WING		07/	03/2018	
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET CHADEOURN, NC 28491			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 8H CROSS-REFERENCED TO THE APP DEFICIENCY)	ÓÙLD RE	(X5) COMPLETION DATE	
E 032	CFR(s): 483,475(c)(3 [(c) The [facility] must emergency prepared that complies with Fa and must be reviewe	eans for Communication it develop and maintain an increase communication plan ederal, State and local laws and updated at least nunication plan must include	E 032	E 032 the Facility will develop an emergency preparedness commuthat compiles with Federal, State laws.	inication plan	8/31/18	
	emergency manager *[For ICF/IIDs at §48 alternate means for of ICF/IID's staff, Feder local emergency man This STANDARD is Based on document facility failed to devel communicating with a local governments di	the following: bal, regional, and local ment agencies. 3.475(c):] (3) Primary and communicating with the ral, State, tribal, regional, and		QP will in-service all staff member revision of the emergency prepar communication plan. QP will revisible annually.	edness	8/31/18	
	for communicating we governments during Review on 7/2/18 of preparedness (EP) princlude any information means of communication other does not have communication other when asked how the	the facility's emergency olan (revised 5/21/18) did not lon regarding alternate ation. on 7/3/18, staff indicated the ean alternate means of than the land line phone.		RECEIVED JUL 3 0 2018 DHSR-MH Licensure Se	ect		
LABORATORY	DIRECTOR'S OR PROVIDER	BUPPLIER RÉPRÉBENTATIVE'S MONATURE		TITLE		(XB) DATE	

Any deficiency statement ending with an asterist (*) denotes 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.

FORM CMS-2667(02-99) Provious Varsions Obsoloto

Event ID: 0PKE11

Facility 1D: 922664

If continuation sheet Page 1 of 35

7-30-18

PRINTED: 07/12/2018 FORM APPROVED

STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391
		IDENTIFICATION NUMBER:	A. BUILDI	√G_		COMP	PLETED
		34G231	B. WING_				
STRAWBE	ROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE, ZIP CODE 03 NORTH HOWARD STREET HADBOURN, NC 28431	<u> </u>	03/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		E Ve	(X5) COMPLETION DATE
E 037	they would likely need phone. During an interview of Intellectual Disabilities in regards to an alterr "nothing has been put EP Training Program CFR(s): 483.475(d)(1) (1) Training program. ASCs, PACE organized and dialysis facilities] (i) Initial training in empolicies and procedurate staff, individuals proving arrangement, and volume expected role. (ii) Provide emergency least annually. (iii) Maintaln document.	working, the staff indicated d to use their personal cell in 7/3/18, the Qualified is Professional (QIDP) stated nate mean of communication it in place." The [facility, except CAHs, affons, PRTFs, Hospices, must do all of the following: hergency preparedness to all new and existing ding services under unteers, consistent with their y preparedness training at	E	032	E 037 the Facility will assure each staff receive training of the emergency preparation and that all training are revised and	redness	B/31/18
	procedures. "[For Hospitals at §48 at §491.12:] (1) Traini or RHC/FQHC] must of the control of t	2.15(d) and RHCs/FQHCs ng program. The [Hospital do all of the following: tergency preparedness es to all new and existing ding on-site services under unteers, consistent with their y preparedness training at			QP and Program Manager will re-inservice staff members on emergency preparedne plan. Program Manager will in-service all new hires on emergency proparednes plan. QP will in-service facility annually.	253	8/31/18

FORM CMS-2587(02-99) Previous Versiona Obsoloto

Event ID; 0PKE11

Facility ID: 922664

If continuation sheet Page 2 of 35

PRINTED: 07/12/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94 G231	B. WING		Som Eligo
NAME OF PROVIDER OR SUPPLIER			EETADDRESS, CITY, STATE, ZIP CODE	07/03/2018
STRAWBERRY HOUSE		308	NORTH HOWARD STREET ADBOURN, NC 28491	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
E 037 Continued From page 2		E 037		
nospice must do all of the (i) Initial training in emergence and procedures hospice employees, and services under arranger expected roles. (ii) Demonstrate staff kno procedures. (iii) Provide emergency pleast annually. (iv) Periodically review an employees (Including not special emphasis placed procedures necessary to others. *[For PRTFs at §441.18] program. The PRTF must policies and procedures staff, individuals providing not special emphasis.	rgency preparedness to all new and existing dindividuals providing ment, consistent with their owledge of emergency preparedness training at and rehearse its as plan with hospice onemployee staff), with di on carrying out the o protect patients and 4(d):] (1) Training st do all of the following: gency preparedness to all new and existing ig services under revide emergency least annually. owledge of emergency tion of all emergency di:] (1) The PACE of the following: gency preparedness to all new and existing			

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STATEMENT C AND PLAN OF	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		94G231	B, WING			070	03/2018	
	ROVIDER OR SUPPLIER			30	REET ADDRESS, CITY, 8TATE, ZIP CODE 8 NORTH HOWARD STREET HADBOURN, NC 28431	1 077	00(20)6	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ÀF	(X5) COMPLETION DATE	
E 037	volunteers, consisted (ii) Provide emergent least annually. (iii) Demonstrate steprocedures, including what to do, where to case of an emergen (iv) Maintain document of the correction of the c	nctors, participants, and nt with their expected roles. In with their expected roles. If knowledge of emergency is informing participants of o go, and whom to contact in cy. In the following the factor of all training. The fitte following: In in emergency is and procedures to all new dividuals providing services and volunteers, consistent roles, in the participant of the training. If knowledge of emergency personnel must be oriented in responsibilities regarding may plan within 2 weeks of the training program must in the location and use of signals and firefighting.	E	037	DEF(GIENCY)			
	cooperation with fire	sts, fire prevention, and ofighting and disaster w and existing staff,						

FORM CMS-2567(02-00) Previous Versions Obsolete

Event ID: 0PKE11

Facility ID: 922864

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STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(/0)) (1)			1	0. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G231	B. WING				109/2040
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	03/2018
STRAWBE	ERRY HOUSE			9	103 NORTH HOWARD STREET CHADBOURN, NC 28491		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	·	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REPERENCED TO THE APPROPRI DEFICIENCY)	e	(X3) COMPLETION DATE
E 037	Continued From page	~ 4					
<u> </u>			E	037			
	individuals providing	services under arrangement,			,		
	and volunteers, cons	Istent with their expected					
	roles.						
	(II) Provide emergend	cy preparedness training at					
	least annually.	,					
	(III) Maintain docume	ntation of the training.	1				
	(IV) Demonstrate staff	f knowledge of emergency	ŀ				
	procedures,	3g					
	,						
	"[For CMHCs at §485	5.920(d):] (1) Training, The					
	CMHC must provide	Initial training in emergency					
	preparedness policies	s and procedures to all new					
	and existing steff ind	lividuals providing services					
	under errandement e	and volunteers, consistent	1				
	with their expected ro	dec and maintain					
		training. The CMHC must					
1	demonstrate etell inc	wiedge of emergency					
	procedurer Thoroch	or the Citi 10 much mount in					
	proceedings, mereali	er, the CMHC must provide					
	emergency preparedi annually.	ness training at least					
	amuany.		ł				
	This STANDARD is	not met as evidenced by:	1				[
		lew and interviews, the					
		e direct care staff were					
						ŀ	
	adadnately halled of	the facility's emergency					
	prepardness (EP) pla	in. I ne finding is:				İ	
	Staff had not have to	singal on the dealth of the					
		ained on the facility's EP					
	plan.						
	Review on 7/0/48 -54	he facility's EP plan (revised					
	5/21/18) did not inclu	de any information regarding					
	training of staff.	de en innomment tegatdiug					
	ជនារជាមួយ ឡងា.						
	During an intendess	n 7/2 - 7/3/18, staff (2)					
		ceived training on conducting					
		tornado, or bomb threat					
		owever, the staff could not	}				
	provide specifics rega	arding the facility's EP plan.	1		ļ		1

FORM CMS-2567(02-98) Previous Versions Obsolote

Event ID: 0PKE11

Facility ID: 922084

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PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0301

STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Tana	***************************************		OMB NO	0. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		CONSTRUCTION	(XS) DATE COMP	SURVEY PLETED
		34G231	B. WING_				
	ROVIDER OR SUPPLIER			30	REET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH HOWARD STREET	1 07/	03/2018
040.15				Ci	HADBOURN, NC 28431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	ť	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIA DEFICIENCY)	E	(X3) COMPLETION DATE
E 037	Continued From page	o 5 on 7/3/18, the Qualified	EO	37			
	Intellectual Disabilities revealed there was no if or when staff had be EP plan.	s Professional (QIDP) o documentation to indicate een trained on the facility's			•		
W 189	STAFF TRAINING PR CFR(s): 483.430(e)(1))	W 1	1	W189 The Facility will assure each staff will proper training of diets, drink consistencies, Aspiration/Swallowing guidelines at each m	and	8/16/18
-	initial and continuing t	de each employee with raining that enables the his or her duties effectively, tentiy.					
	Based on observation interviews, the facility	failed to ensure staff were arding each client's diet and					
	client #6's appropriate aspiration/swallowing 3 of 3 meals.	quately trained to ensure food/drink consistency and guldelines were followed at		r e	1. Habilitation Specialist will in-service all members on diet, food consistencies, and aspiration guidelines for client #6. Habilitation Specialist and Program man	đ	8/16/18
	at 12:24 pm, client #6 cheese, green peas at items were ground, dr client also consumed pudding consistency. scoop his liquids from client #6 consumed his	Client #6 used a spoon to his cup. At the lunch meal, s food quickly and ate			will observe and monitor weekly. QP will monitor monthly.		
	approximately 25% of prompts to drink, Clier while eating. Staff sta	the meal before drinking or ht#6 periodically coughed nding next to him provided k after the client coughed					

FORM CM9-2567(02-99) Previous Versions Obsolate

Event ID: 0PKE11

Facility ID: 922664

If continuation sheet Page 6 of 35

PRINTED: 07/12/2018
FORM APPROVED
OMB NO. 0038-0391

STATEMENT O	OF DEFICIENCIES	NA) PROMOCDIE EDITORIA	000			OMB NO	<u>0. 0938-0391</u>
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY
			A BUILDI	MG_	<u> </u>	COMP	LETED
		0.40724					
MANEGER	ROVIDER OR SUPPLIER	34G231	B. WING			07/	03/2018
MANUE OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
STRAWBE	RRY HOUSE			3	03 NORTH HOWARD STREET		
				С	CHADBOURN, NC 28491		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE	E	(X5) COMPLETION
		SOLDEN MAGINION (MICHON)	TAG		CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
					DEFICIENCY)		
W 189	Continued From page	. 6					
		30	W.	189			
	briefly.						
	Davis a dla -						
	During dinner observa	ations in the home on 7/2/18					
	at 5:59pm, client #6 c	onsumed baked chicken,					
	green beans, cream o	corn and chocolate chip					
	munns. The beans a	nd corn were loose and					
	runny while the chicke	en was molet and thick with					
	small chunks of meat	visible. Client#6's mllk				1	
	was initially nectar thi	ck as he began drinking it					
	officet he see wells as	ds the end of the meal, the					
	client began using a s	spoon to scoop his milk from					
	the glass as the milk i	had thickened to a pudding					
	consistency. As client	:#6 finished his meal, he			4 11 1 199 49		
	began cougning, A st	aff next to him hit him on his	}		1. Habilitation Specialist will inservice al	l staff	
	back twice. He contin	ued to cough while leaving			members on diet, food consistencies, a	ıd	0/25/40
	During the meet the	g his dishes from the table,			aspiration guidelines for client #6,		8/16/18
	quickly nutting large of	client consumed his food			Habilitation Specialist and Program mar	anger	
	mouth. A staff next to	poonfuls of food in his			will observe and monitor weekly.		
	contadio verbal promi	ots to "slow down"; however,			QP will monitor monthly.	i	
	pa was not consistent	lly prompted to drink any			,		
	liquids between spoor	of the effect to drink any					
	udaida petweeti abobi	ildis Of 100d,					
	During breakfast obse	ervations in the home on					
	7/3/18 at 7:37am. clie	nt#6 consumed Turkey				ļ	
	sausage, a waffle, mit	xed fruit, and oatmeal. The				ļ	
	oatmeal was dry and	thick while the Turkey					
	sausage was finely ch	ropped and dry. The client	-				
	also consumed orang	e juice, milk, prune juice	-				
	and water. The liquid	s initially resembled a					
	nectar type consisten	cy as client #6 picked up his					
	glass to drink. Toward	ds the end of the meal, the					
	drinks were thick and	pudding like when					
	consumed by the clien	nt using a spoon. It should					
	also be noted that the	client drank sips of his					
		lquid while waiting to serve					
	himself. Throughout						
	consumed his food qu						
	coughed. Staff C stoo	d next to him and					

FORM CMS-2607(02-99) Previous Versions Obsolete

Event ID: 0PKE11

Facility ID: 022804

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STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T CVON MAIN		CONOTRAL	OMR MC	0. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
		34G231	B. WING			07/	03/2018
NAME OF P	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	U3/2U16
STRAWBE	ERRY HOUSE			1	08 North Howard Street Hadbourn, NC 28491		
(X4) ID	EUMMARY 8T	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF. TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	FIF	(KG) COMPLETION DATE
W 189	Continued From page	e 7	w	189			
	encouraged the clien gave verbal prompts	t to continue coughing and to "slow down."					
	During observations	of medication administration			d Habilland o		
	consumed his crushe	8 at 7:10am, client #6 ed plils in pudding with thin			Habilitation Specialist will inservice a members on diet, food consistencies, a	all staff	
	liquid (water). The cl	lent immediately coughed			aspiration guidelines for client #6.	ana	
	after drinking the wat	er,			Habilitation Specialist and Program ma	nanger	8/16/18
	Interviews on 7/3/18	with staff revealed the			will observe and monitor weekly.		
	following regarding client #6's food/drink				QP will monitor monthly.		
	consistency and mea	ltime behavlors:					
	Staff C revealed clien	t #6's food goes in the			·	ļ	
:	blender for a pureed	consistency. The staff					
	get strengled." Addit	are "thickenedso he won't ional Interview revealed					
	client #6's liquids sho	uld be a "pudding"					
	consistency. The stat	f also indicated the client will					
	cough at times during	meals and they usually					
	Further interview indi	oughing to clear his throat. cated client #6 "eats fast"					
	and the only mealtim	e guidelines they follow are					
	to monitor client #6 a	t meals and tell him to "slow					
	down."						
	Staff A revealed clien	t #6 gets a pureed diet and					
	pudding thick liquids,	The staff stated they add					
		and the food "should be ed why the client's Turkey					
		I finely chopped, the staff					
		ot usually add liquid to the					
	client's meats. The st	aff also revealed oatmeel					
	,	processed in the blender.					
		the staff acknowledged nd oatmeal were not a					
	pureed consistency.	ine equical wels hat \$					
	Review on 7/3/18 of 6	client #6's IPP dated 6/1/18,		ļ			

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Event ID: 0PKE11

Facility ID: 922864

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PRINTED: 07/12/2018 FORM APPROVED

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		<u>), 0938-0391</u>
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		(X3) DATE	SURVEY PLETED
					1	
		34G231	B. WING			(Annoso
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 07/	<u>/03/2018</u>
STRAWE	RRY HOUSE			03 NORTH HOWARD STREET		
-				CHADBOURN, NC 28431		
(X4) ID PREFIX	SUMMARY 5T, (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	đi	PROVIDER'S PLAN OF CORRECTION	1	(X5)
TAG	REGULATORY OR I	LEC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	RE .	COMPLETION
	700			DEFICIENCY)	JAIL	VAIG
W 189	Confluenced France	a				
44 109	Continued From page		W 189			
	list posted in the hom	ders and a diet consistency · (dated 7/24/17) revealed				
	he receives a Heart H	le (dated //24/1/) revealed lealthy regular diet, "pureed				1
	smooth consistency"	with "pudding thick liquids."				
	Additional review of Guidelines for Aspirating and Swallowing dated 7/21/17 revealed, "Diet;					
				1. Habilitation Specialist will inservice	II a d'd	
	Regular diet pureed,,,	Liquids: Pudding	ļ	members on diet, food consistencies,	all stati	
	thickSupervision: 10	00% during meals and		aspiration guidelines for client #6.	ana	8/16/18
	snacks." The guidelin	nes noted the following:	Habilitation Specialist and Program men		nanger	1 20/20
	"1, Sits upright at 90 o	degree angle		will observe and monitor weekly.	•	
}	2. Takes a tablespoon amount of food			QP will monitor monthly.		
	3. Holds head up					
	4. Chews food					
	5. Performs voice che	ack throughout meal, prompt				
	between bites	allow again (clear mouth				
	6. Check mouth after clean	each swallow to make sure				
	7. Take one sip of liqu	lids at a time.				
	8. Perform voice chec	k throughout meal, prompt				
		allow again (clear mouth				
	between sips)					
	9. Wipes mouth with r	napkin (as needed)				
	Follow above steps u	ntil meal is completed.				
	After feeding:					
	Sweep mouth with sw	ab for any remaining food				
	particles	· ·				
}	Maintain 90 degree po	osition after feeding for 60				
ļ	minutes (1 hour)"					
		ne IPP revealed Rate of				
	Eating Guidelines dated 6/18/14, These		1			
	guidelines Indicated, '	'[Client#6] has the tendency				
	to eat too fast at times	s so these guidelines were				
{		ntent to help slow down and liting. Staff will start with a				

FORM CMS-2587(02-99) Provious Versions Obsoleto

Event ID: 0PKE11

Facility ID: 922684

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BLIILDING		SURVEY LETED
		34G231	B, WING_		07/	19/2040
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO SOS NORTH HOWARD STREET CHADBOURN, NC 28431	30°)3/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BEAPPROPRIATE	(X5) COMPLETION DATE
W 189	time to respond. If he first prompt then prom These guidelines will Staff will ensure that following steps in ord properly." Further remoted, "1. Takes sma Chews food complete Sips liquid5. Wipes Interview on 7/3/18 the Disabilities Profossion #6's current diet inclused by staff indicated the client's rate of eating and ast guidelines were also to be followed by staff interview, the QIDP pwhich included staff the food/drink consistency for aspiration/swallow completed in July 20 documents indicated training; however, the staff A, staff C and two home during the survitaining. During an interview of also confirmed client pureed smooth and he pudding consistency difficult to drink the lie properly. Additional cough during meals of the consistency of his	slow down." Give him a does not respond to the opt him again and so on, be followed on all shifts, [Client #6] completes the er for him to eat his meal view of the guidelines also ill mouthful of food2. sly3. Holds head up4. mouth with nepkin." The Qualified Intellectual and (QIDP) confirmed client des pureed foods and Additional interview guidelines to address his piration/swallowing current and should continue if at meals. During the rovided documentation raining on client #6's diet, y and the client's guidelines ving at meals had been	W 1	1. Habilitation Specialist will members on diet, food consi aspiration guidelines/ rate of Habilitation Specialist and Privill observe and monitor were QP will monitor monthly.	stencles, and eating for client #6. 'ogram mananger	8/16/18

FORM CMS-2587(02-99) Previous Versions Obsulate

Event ID: 0PKE11

Facility ID: 922684

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PRINTED: 07/12/2018 FORM APPROVED

STATEMENT	F DEFICIENCIES	(VA) DDALIBEA(NI)				<u>10. 0938-0391</u>
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;				TE SURVEY MPLETED
		94G231	B. WING			7/03/2018
NAME OF PR	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	110312016
STRAWEE	RRY HOUSE				03 NORTH HOWARD STREET	
	anti noose			С	HADBOURN, NC 28431	
(X4) ID	SUMMARY 6T	ATEMENT OF DEFICIENCIES	ID			
PRÉFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL L9C IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 189	Continued From page	e 10	100	189		
	training needed to be		00	108	W189 The Facility will assure each staff will receiv	70
	a cirtuig Hooded to be	COME.			proper training of diets, drink consistencies, and	8/16/18
	2. Staff were not ade	equately trained to prepare			•	
	foods/drinks to the ar	opropriate consistency.			Aspiration/Swallowing guidelines at each meal	
		, proprieta de l'acceptant de l'acce			'	
	During dinner prepara	ation observations in the			•	
	home on on 7/2/18 at	t 5:40pm, staff B prepared				
	client #6's food using	a blender. The staff added				
	an undetermined am	ount of water to pieces of				İ
		lended it up in the blender.				1
		eat was moist and thick with				
		en visible. The staff also				
		nd groon beans in the				
		added. These food items			2.QP and Habilitation Specialist will in-service	
	were served with exc	ess liquid noted.			all staff by demonstrating diet consistencies	8/16/18
	Orași a bas al Barbara				(food/drinks) for client #6. QP and Habilitation	1
	During preaktest prep	paration in the home on			Specialist will in-service all staff on the correct	i [
		aff A prepared client #6's usage using a blender. The			measurements for thick-lt, Habilitation Special	ist
		ermined amount of milk and			and Program manager will observe and monli	or
		fle and blended it in the			weekly. QP will monitor monthly.	
		ed, the waffle appeared soft			•	
		ed in a bowl. The staff then				
		ge to the blender and ground				
		consistency. No Ilquid was				
		e in the blender. The meat				
	was served dry and f	finely chopped, Client#6				
	also consumed oatm	eal for breakfast. The				
		nded in the blender and				
	appeared chunky, thi	lck and dry when served,				
	0.4-0.60					
		ne observations in the home				
		ral staff added varying				
ĺ		o client #6's liquids. The staff				
ĺ		neasure the amount of				
		en the client's liquids. Client which were of varying				
		wnich were of varying nes, his drinks were a nectar				
		ch allowed him to drink freely				
	"	··· ···· · · · · · · · · · · · · · · ·	1		•	

. FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PKE11

Facility ID: 922664

If continuation sheet Page 11 of 35

PRINTED: 07/12/2018 FORM APPROVED

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1737 1411	TIOLE	CONTRACTOR		D. 0938-0391	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONBTRUCTION A. BUILDING			(XS) DATE SURVEY COMPLETED	
		34G231	B. WING			A79	/DD 20040	
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE OB NORTH HOWARD STREET CHADBOURN, NC 28431	<u> </u>	03/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(Xb) COMPLETION DATE	
W 189	a pudding like consisuse a spoon to constude a spoon to constude a spoon to constude observation on 7/3/18 without Thick-it adde. Interview on 7/2/18 wis on a pureed diet at in the blender. Interview on 7/3/18 with generally do not add and his oatmeal is not before serving. Addit add Thick-it to his driplist of each client's die which identified pudd. Review on 7/3/18 of a kitchen counter in the "To Puree Food." The food processor or ble foodsSome foods conded liquid (e.g. dra soft-cooked)Most of liquid,Gravy, sauces thickness as needed. product is too thick. If add more food or thickness as needed. Product is too thick. If add more food or thickness as needed. The dining room table Chart Instant Food The dining room table Chart Instant Food The preparing liquids for reconsistencies. The damounts of Thick-it was a product in the amounts of Thick-it was a product in the consistencies.	r times, the client's drink was tency which required him to ume his drink. During one B, client #6 was given water d. with staff B revealed client #6 and they always blend his food with staff A indicated they liquid to client #6's meats at added to the blender client interview revealed they always his. The staff referred to a set posted in the kitchen ling thick liquids for client #6. In menu book located on the set home revealed instructions as instructions noted, "Use a nater to purse all an be blended without ined, canned or the foods require added for brothAdjust the Add extra liquid if the ithe product separates out, sken with a commercial 18 of a document taped to entitled, "Thick-it Mixing nicker" revealed guidelines ck-it to be used when sectar, honey and pudding	W	189				

FORM CMS-2567(02-00) Provious Versions Obsoleto

Event ID: 0PKE11

Facility ID: 922664

if continuation sheet Page 12 of 35

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CON	PLETED	
34G231 B. WING	07/03/2018	
STRAWBERRY HOUSE STRAWBERRY HOUSE STRAWBERRY HOUSE STRAWBERRY HOUSE CHADBOURN, NC 28431	144/2010	
(X4) ID PREFIX TAG GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) GEACH CORRECTION PREFIX TAG GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 189 Continued From page 12 mashed potato consistency. Interview on 7/3/18 with the facility's nurse confirmed client #5's foods and drinks should be prepared a specific way to obtain the pureed consistency. Additional interview indicated his meats should have water or broth added and some foods may need to be reheated and additional liquid added if dryness is noted. Further interview revealed client #5's should have his foods pureed smooth and his liquids should be a pudding consistency which would likely make it difficult to drink the liquid from a gless if done properly. The nurse acknowledged staff need to be retrelated on the food/drink consistencies for the home. 3. Staff were not adequately trained to ensure client #3's food/drink consistency was followed, edient #3's food/drink consistency was followed, edient #3's consumed 2 whole Turkey sausage links. Further observations revealed the saugage links, Further observations revealed the saugage links, Further observations revealed the saugage links where 2 inches in length. At no time was client #3's propied to cut his food. Further observations indicated a knife was at client #3's e place setting. During an interview on 7/3/18, staff C revealed client #3's e place setting. During an interview on 7/3/18, staff C revealed client #3's e sausage should have been cut by staff. Review on 7/3/18 of client #3's IPP dated 8/8/18 stated, "On 7/19/17 [Client #3] had a appt with Speech Therapiet at CRHS for a Clinical Swallow Assessment & Modified Barium Swallow Study, Dental soft client #3's place of client #3's physiclon orders signed 5/16/18 revealed, "Bite size consistency," Review of client #3's medical	8/16/18	

FORM CMS-2587(02-99) Previous Versions Obsoleto

Event ID; 0PKE11

Facility ID: 822664

If continuation sheet Page 13 of 35

PRINTED: 07/12/2018 FORM APPROVED

OTATIO 401 (64 -		TO SERVICE				ONR NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		340231	B. WING	·····		07/	a bomos
NAME OF PR	ROVIDER OR BUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	0//	03/2018
STRAWBE	RRY HOUSE			30	MI NORTH HOWARD STREET HADBOURN, NC 28431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(XS) COMPLETION DATE
W 189	with finely - chopped client #3's nutritional indicated his diet is "fundicated his "fundicated his diet is "fundicated his "fundicated his "fundicated his "fundicated his "f	18 stated, "Dental soft diet meats," Further review of evaluation dated 10/10/17 inely chopped" n 7/3/18, the facility's nurse current diet should have	W	189	B.QP and Habilitation Specialist will in-seall staff by demonstrating diet consistence (food/drinks) for client #3. QP and Habil Specialist will in-service all staff on the comeasurements for thick-it. Habilitation Seand Program manager will observe and weekly. QP will monitor monthly.	cles litation correct pecialist	8/16/18
	stated, "On 7/19/17 [I Speech Therapist at a Assessment & Modifi Studyhoney thick lind of client #3's nutrition Indicated, "Diet:hor During an interview or reported client #3's cofollowed by staff. c. During medication in the home on 7/3/1/1 consumed 5 pills with time was Thick-it add Immediately after bei	quids was ordered." Review all evaluation dated 10/10/17 ley thick liquids" In 7/3/18, the facility's nurse current diet should have been administration observation 8 at 9:05am, client #3			C, QP and Nurse will in-service all staff by demonstrating correct measurements for thic Nurse and Program Manager will monitor reweekly. QP will monitor monthly.		- 8/16/18

FORM CMS-2567(02-99) Previous Versions Obsdele

Event ID: DPKE11

Facility ID: 922664

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PRINTED: 07/12/2018 FORM APPROVED

OF DEFICIENCIES	(M) DECIRE CONTROL	Tarrent 1		OMB NO	D. 0938-0391	
CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE BURVEY COMPLETED	
	84G231	B. WING		07	/03/2018	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		100/2010	
ERRY HOUSE		1	303 NORTH HOWARD STREET			
			CHADBOURN, NC 28431			
I (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
a second glass of this During an immediate technician confirmed his water with Thick-it should be a second of the	Interview, the medication client #3 should have drank t added. In 7/3/18, the facility's nurse and have been added to equately trained to ensure stency was followed. In a cut into bite size a cut into bite size and up a clear liquid while	W 18	4. QP and Habilitation Specialis	t will in-service for client #5.	8/16/18	
During dinner observer 7/2/18, client #5's children pieces. Further observer for the coughed throughout in the coughed throughout in the coughed throughout in the coughed throughout in the coughed throughout in the coughed through the coughed the coughed the coughed in the co	cken was cut into bite size rvations revealed client #5 the meal. client #5's IPP dated 6/1/18 Client #5] had a appt with the at CRHS for a Clinic ent & MBSSDental Soft ed meatswith aspiration mmeneded." Review of orders signed 5/16/18 sistency is finely chopped. Illent #5's nutritional 17 indicated, "finely bods."		correct portion size for client #5. Habilitation Specialist and Progr	ram manager	8/16/18	
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page a second glass of thin During an immediate technician confirmed his water with Thick-it should be a second glass of thin During an interview of revealed Thick-it should be a second glass of thin During an interview of revealed Thick-it should be a second glass of thick-it should be a second gl	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 a second glass of thin (regular) water. During an immediate interview, the medication technician confirmed client #3 should have drank his water with Thick-it added. During an interview on 7/3/18, the facility's nurse revealed Thick-it should have been added to client #3's water. 4. Staff were not adequately trained to ensure client #5's food consistency was followed. a. During lunch observations in the home on 7/2/18, client #5's meat was cut into bite size pieces. Further observations revealed during the meal, client #5 vomited up a clear liquid while taking a sip of water. Client #5 coughed	PEPCIENCIES CORRECTION (X1) PROVIDER-BUPPLIER (X2) MULTIF A BUILDING S4G231 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDUE BY FULL RESULATORY OR LSG IDENTIFYING INFORMATION) Continued From page 14 a second glass of thin (regular) water. During an immediate interview, the medication technician confirmed client #3 should have drank his water with Thick-it added. During an interview on 7/3/18, the facility's nurse revealed Thick-it should have been added to client #3's water. 4. Staff were not adequately trained to ensure client #5's food consistency was followed. a. During lunch observations in the home on 7/2/18, client #5's meat was cut into bite size pieces. Further observations revealed during the meal, client #5's chicken was cut into bite size pieces. Further observations revealed client #5 coughed throughout the meal. During dinner observations in the home on 7/2/18, client #5's chicken was cut into bite size pieces. Further observations revealed client #5 coughed throughout the meal. Review on 7/3/18 of client #5's IPP dated 6/1/18 stated, "On 7/27/17, [Client #5's IPP dated 6/1/18 stated, "On 7/27/17, [Client #5] had a appt with Speech Therapy Dept at CRHS for a Clinic Swallowing Assessment & MBSSDental Soft diet with finely chopped meatswith aspiration precautions was recommended." Review of client #5's physician orders signed 5/18/18 revealed his diet consistency is finely chopped. Additional review of client #5's nutritional evaluation dated 4/7/17 indicated, "finely chopped texture all foods." During an interview on 7/3/18, the facility's nurse	A BUILDING B	A. OP and Habilitation Specialist will in-service staff on the correct portion size for client #5 sealed during the meal, client #5's routiled up a clear liquid while taking a sip of water. Client #5's replaced firroughout the meal. Review on 7/3/18 of client #5's replaced client #5 sealed during the meal, client #5's chicken was cut into bite size pieces. Further observations in the home on 7/3/18, in the first of the size pieces. Further observations revealed client #5's sealed during the meal, client #5's replaced throughout the meal. Review on 7/3/18 of client #5's replaced client #5's soughed throughout the meal. Review on 7/3/18 of client #5's replaced client #5's soughed throughout the meal. Review on 7/3/18 of client #5's replaced client #5's soughed throughout the meal. Review on 7/3/18 of client #5's replaced client #5's r	

FORM CMS-2567(02-99) Previous Versions Obsciete

Event ID: 0PKE11

Facility ID: 922684

If continuation shoet Page 15 of 35

PRINTED: 07/12/2018
FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/// MIN.	T) D) 10		OMB NO. 0938-039		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF D	PANADED OO A	34 G231	B, WING_	B. WING				
	ROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE, ZIP CODE 03 NORTH HOWARD STREET HADBOURN, NC 28431	<u>1 07/</u>	03/2018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION)		ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOIL		E Ve	(XII) COMPLETION DATE	
W 189	have been followed by staff. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor Individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee. Involve risks to		w.	262	W 262 The Facility will assure that the BSP client #5 and client #6 is reviewed and moni the Human Rights Committee.	's for lored by	8/31/18	
	Based on record revide failed to ensure the replans (BSP) for 2 of 4 were reviewed and moconstituted committee. The restrictive BSP's for the restri	ot met as evidenced by: ew and interview, the facility strictive Behavior Support audit clients (#5 and #8) poitored by the specially designated as the Human						
	behavior plan dated 4/ non-compliance behaviors of Tegretol and Vaicient #5's BSP dated use of Risperdal. Additional review of the meetings held on 3/30/4/10/18 revealed client only been reviewed du	ient #6's record revealed a 11/18 to address riors. The plan included the lium. Additional review of 4/11/18 incorporated the e facility's HRC minutes for 17, 7/17/17, 10/25/17, and t#8's behavior plan had ring the 7/17/17 meeting. clude any review of client						
	Interview on 7/3/18 wit	h the Qualified Intellectual						

FORM CMS-2507(02-98) Previous Versions Obsolete

Event ID: 0PKE11

Facility (D: 922804

If continuation sheet Page 16 of 35

PRINTED: 07/12/2018 FORM APPROVED

- DETINION				CIND MC	. 0938-0391
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	
	34G231	D. WING		ļ	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP CODE	1 07/	03/2018
RRY HOUSE			303 NORTH HOWARD STREET		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	PH.	(X5) COMPLETION DATE
Disabilities Profession HRC selects clients "meetings. The QIDP client #6 have not had plans consistently mo	nal (QIDP) revealed the randomly" for review at their confirmed client #5 and It their restrictive behavior	W 26			8/31/18
CFR(s): 483.440(f)(3) The committee should are conducted only with consent of the client,	(II) d insure that these programs Ith the written informed parents (if the client Is a	W 26	3		
This STANDARD is not met as evidenced by: Based on record review and interview, the facility falled to ensure a restrictive behavior support plan was only conducted with the written informed consent of all legal guardians. This affected 2 of 4 audit clients (#5, #6). The findings are: 1. Written informed consent was not obtained for client #5's restrictive Behavior Support Plan (BSP). Review on 7/3/18 of client #5's BSP dated 4/11/18 revealed his plan incorporated the use of Risperdal. Additional review of the record did not include written informed consent from the guardian for the BSP. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the consent paperwork had been sent to the guardian; however, it had not been returned as of the aurvey.				nt is signed	8/31/18
	Continued From page Disabilities Profession HRC selects clients "I meetings. The QIDP client #6 have not had plans consistently mo identified dates. PROGRAM MONITO CFR(s): 483.440(f)(3) The committee should are conducted only wi consent of the client, minor) or legal guardi. This STANDARD is n Based on record revi falled to ensure a rest plan was only conduct consent of all legal guardict audit clients (#5, #6). 1. Written informed co client #5's restrictive for (BSP). Review on 7/3/18 of co revealed his plan inco Risperdal. Additional include written inform guardian for the BSP. Interview on 7/3/18 w Disabilities Profession consent paperwork had guardian; however, it	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 Disabilities Professional (QIDP) revealed the HRC selects clients "randomly" for review at their meetings. The QIDP confirmed client #5 and client #6 have not had their restrictive behavior plans consistently monitored by the HRC for the identified dates. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive behavior support plan was only conducted with the written informed consent of all legal guardians. This affected 2 of 4 audit clients (#5, #6). The findings are: 1. Written informed consent was not obtained for client #5's restrictive Behavior Support Plan (BSP). Review on 7/3/18 of client #5's BSP dated 4/11/18 revealed his plan incorporated the use of Risperdal. Additional review of the record did not include written informed consent from the guardian for the BSP. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the consent paperwork had been sent to the guardian; however, it had not been returned as of	CORRECTION DENTIFICATION NUMBER: 34G231 D. WING	OVIDER OR SUPPLIER 346231 B. WIND STREET ADDRESS, CITY, STATE, JIP CODE 339 NORTH HOWARD STREET CHADBOURN, NC 28431 DEPONDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (SUCH) PEPCIENCY MUST BE PRECEDED BY FULL (REGULA/ORY OR LOS IDENTIFYING INFORMATION) COntinued From page 16 Disabilities Professional (QIDP) revealed the HRC solects clients "randomly" for review at their meetings. The QIDP confirmed client #5 and client #6 have not had their restrictive behavior plans consistently monitored by the HRC for the identified dates. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(f) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restrictive behavior support plan was only conducted with the written informed consent of all legal guardians. This affected 2 of 4 audit clients (#5, #9). The findings gre: 1. Written informed consent was not obtained for client #5 erstrictive Behavior Support Plan (BSP). Review on 7/3/18 of client #55 BSP dated 4/11/18 revealed his plan incorporated the use of Risperdal. Additional review of the record did not include written informed consent from the guardian; however, it had not been returned as of	CORRECTION (AS) PROVIDERINGHER (NUMBER 34G231 DOUBER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (BOCH) DEFICIENCY MUST BE PRECEDED BY PLLI. RESULATORY OR LIG. DEMINFYING INFORMATION) CONTINUED From page 16 Disabilities Professional (QIDP) revealed the HRC celestic client "Francomby" for review at their meetings. The QIDP confirmed client #5 and client #6 have not had their restrictive behavior plans consistently monitored by the HRC for the identified dates. CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, prents) (if the client is a minor) or legal guardians. This affected 2 of 4 audit clients (#5, #6)). The flindings are: 1. Written informed consent was not obtained for client #5's bsP dated 4/11/18 revealed his plan incorporated the use of Risperdal. Additional review of the record did not include written informed consent for the BSP. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the consent paperwork had been sent to the guardian for the BSP. Interview on 7/3/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the consent paperwork had been sent to the guardian, for the BSP.

FORM CM3-2567(02-99) Previous Versions Obsolete

Event ID: OPKE11

Facility ID: 922884

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	I om sau				D. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILD		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G231	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	07/	/03 <i>1</i> 2018
STRAWBI	ERRY HOUSE		303 NORTH HOWARD STREET				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		CHADBOURN, NC 28431			
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(Xs) Completion Date
W 263	Continued From page	17	w	263			
	client #6's restrictive E Review on 7/3/18 of c	lient#6's BSP deted 4/11/18			2. QP will ensure that client #6 BSP consent by the guardian. QP will monitor monthly.	; is signo	8/31/18
	revealed an objective challenging behaviors consecutive months, use of Tegretol and Vathe record dld not include consent from the guar	to exhibit 1 or fewer per month for 12 The plan incorporated the clium. Additional review of ude written informed dian for the BSP.					
W 369	consent paperwork ha guardian; however, it is the date of the survey. DRUG ADMINISTRAT CFR(s): 483.460(k)(2) The system for drug at that all drugs, including	nad not been returned as of ION dministration must assure	Ws		W369 The facility will ensure that all drugs v self administered without error for client #6, ; will monitor weekly. QP will monitor monthl	Nurso	8/31/18
	Based on observation interviews, the facility to medications were admined of 4 clients (#6) observation of medication of medication of medicated.	inistered without error for 1					
	the home on 7/3/18 at	7:10am, client #6 ent #8 did not receive any					

FORM CMS-2567(02-99) Provious Versions Obsolote

Event ID: 0PKE11

Facility ID: 922884

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PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE	
		1	A BOILE	_ פאווי		COMPLETED	
- The state of the		34G231	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE	07/	03/2018
STRAWAE	RRY HOUSE				03 NORTH HOWARD STREET		
					CHADBOURN, NC 28491		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	1	PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
					CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Œ	DATE
-							
W 369	Continued From page	18	100	360	Wizeo The Control Ma		
			"	308	W369 The facility will ensure that all drugs	will be	
	Review on 7/3/18 of c	ellent #6's physician's orders			self administered without error for client #6.	Nurse	8/31/18
	signed 5/16/18 Indicat	ted, "Systande .6% at 8am,	ĺ		will monitor weekly. QP will monitor month	dy.	
	2pm and 8pm."	·					
	Dendum on taken t						
	Confirmed allows #6 of	n 7/3/18, the facility's nurse				I	
	drops The nurse reve	nould have received his eye ealed client #6's orders for					
	his eve drons is curren	ntly for three times a day,					
W 371	DRUG ADMINISTRATION		W 371		W271 The facility will as well as the state of	4	
	CFR(s): 483.460(k)(4)		00	3/1	W371 The facility will ensure that client #6 actively participate in medication administra	Will	8/31/18
					metivery participate in medication administra	ition.	0/31/10
	The system for drug a	idministration must assure					
	that clients are taught	to administer their own					
	medications if the inter	rdisciplinary team					
	determines that self-ad	dministration of medications					
	does not specify other	ctive, and if the physician			TT but it is a		
	dood not apoonly date.	wise,			Habilitation Specialist will develop a medic	ation	
					goal and in-service staff, Habiliation Specia	list will	8/31/18
	This STANDARD is n	ot met as evidenced by:	1		monitor weekly. Nurses will monitor weekly QP will monitor monthly.	7-	
1	Based on observation	is, document review and			QI will include maninity.		
	interviews, the facility	failed to ensure client #8	ĺ				
	was taught to administ	ter his own medications as	1				1
	The finding is:	cted 1 of 4 audit clients.					
Í	the inding is.						
	Client #6 was not enco	ouraged to assist with the	1				
	administration of his m	nedications to his full					
	potential.						
1	manufacture 1		}				
	During observations of	f medication administration					
	#6 his mediantions in	at 7:10am, staff fed client pudding without prompting					
	him to participate with	padding williout prompling this task				ĺ	
	to beinelbace will!	HIM KACIN					
	Staff interview on 7/2/	18 revealed client #6 was				1	
		ions, because he will "get					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PKEH

Facility ID: 022604

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA				OMB NO. 0938-0391			
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X9) DATI	(X9) DATE BURVEY COMPLETED	
		34G231	B. WING_				
	ROVIDER OR SUPPLIER ERRY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET		07	07/03/2018	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		CHADBOURN, NC 28491			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
W 371	Continued From page the meds all over him		км	71			
	Review on 7/3/18 of c revealed he "eats inde	lient #6's IPP dated 6/1/18 ependently".					
W 382	however, acknowledg been given the opport medication administra DRUG STORAGE AN CFR(s): 483.460(I)(2)	in feed himself but will medications. The nurse; ed the client should have unity to feed himself during tion, D RECORDKEEPING all drugs and biologicals	Wa	32 W382 The facility will ensure all drugs a biologicals are locked safely during med administration.	und ication	8/31/18	
	Based on observation failed to ensure all dru remained locked. The The medications were unsupervised by the musupervised by th	left unsecured and nedication technician. ation administration in the Oam, the medication medication nedication room while cinto the living room. evealed a box of eye drops left out on the table. s revealed the medication if he surveyor was left alone on, where the closet is		Nurse will in-service all staff on proper the medication when leaving the medica while medications are being administere monitor weekly. QP will monitor month	iion room d, Nurse will	00-4-	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: OPKE11

Faullity ID: 922864

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PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X9) DATE SURVEY COMPLETED	
		94G291	B. WING		07/03/2018	
	ROVIDER OR SUPPLIER		1	BTREET ADDRESS, CITY, STATE, ZIP CODE BOS NORTH HOWARD STREET CHADBOURN, NC 28431	0114012410	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION DATE DATE	
W 382 W 383	technician confirmed have been left out un technician indicated a that all medications a except when being at Europe when being at Europe when being at Europe with the door to have been locked and kept locked up, except The staff also revealed in the procedure of key door locked.	interview, the medication the medications should not attended. The medication he had training to ensure re to be kept locked up, iministered. In 7/3/18, the facility nurse medication closet should hall medications should be at when being administered, dell staff have been trained expling the medication closet.	W 382	W383 The facility will casure that the medicloset is locked and medication technician v	cetion vill 8/31/18	
	This STANDARD is a Based on observation failed to assure only a access to the keys to potentially affected all finding is: The key to the medic assessable. During morning medic home on 7/3/18 at 8: technician exited the escorting a client back Further observations closet doors where o	not met as evidenced by: ns and interviews, the facility authorized persons have the medication closet. This I clients in the home. The		Nurse will in-service all staff on proper tectouse while administering medication. Nur Program Manager will monitor weekly. Quantitation monthly.	tuniques	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0PKE11

Facility ID: 022664

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 OG) DATE SURVEY COMPLETED	
		94G231	B, WING				
	ROVIDER OR SUPPLIER			STREET AUDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET CHADBOURN, NC 28431		07/	03/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIEB / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	! TE	(X4) COMPLETION DATE
W 436	2 minutes. During an immediate technician confirmed to closet should not have Further interview reveron the mediation technician and interview or confirmed the key should be key shoul	interview, the medication the key to the medication the key to the medication the key to the medication the been left in the lock, called the key should be kept incian at all times. 17/3/18, the facility's nurse ould not have been left in the pt on the medication. Further interview revealed ined. IENT ISH, maintain in good repair, see and to make informed to of dentures, eyeglasses, natified by the as needed by the client. Ot met as evidenced by: 15, record review and failed to ensure the near the specifically eyeglasses and the dients (#1). The compted to wear her		383	W436 Habilitation Specialist will formulate guideline and in-service all staff members of #1's eyeglasses guidelines. Habilitation Specialist will observe and monitor weekly. QP will monitor monthly.		8/31/18
		n the home on 7 <i>/2/</i> 18 from d 3:40pm until 6:47pm,					

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Facility ID: 922684

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/12/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 34G231 B. WING NAME OF PROVIDER OR SUPPLIER 07/03/2018 STREET ADDRESS, CITY, STATE, ZIP CODE STRAWBERRY HOUSE 909 NORTH HOWARD STREET CHADBOURN, NC 28431 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION DATE PREFIX (EAGH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 436 Continued From page 22 W 436 client #1 was sewing a potholder and looking at magazines. At no time was client #1 prompted or assisted to wear eyeglasses, During morning observations in the home on 7/3/18 from 6:28am until 9:25am, client #1 wore eyeglasses. Further observations revealed client #1 was sewing a potholder, During an Interview on 7/3/18, staff stated, "[Client#1] wears her glasses when she's sewing or doing a puzzle." Further interview revealed she wears her eyeglasses because "she can't see." When asked where client#1 keeps her eveglasses, the staff stated, "In her bag on the back of her wheelchair." Additional interview revealed client #1 will ask to wear her eyeglasses. Review on 7/3/18 of client #1's IPP dated 10/17/17 revealed there was no guidelines for staff regarding the wearing of her eyeglasses. During an interview on 7/3/18, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's IPP did not contain any guidelines in regards to how staff are to prompt

W 459

client #1 to wear her eyeglasses. DIETETIC SERVICES CFR(s): 483.480

The facility must ensure that spacific dietetic services requirements are met.

This CONDITION is not met as evidenced by: The facility failed to; ensure each client received

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Facility ID: 922664

W 459 \mid W459 The facility will ensure the specific dietetic

services requirements are met for each client.

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8/31/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/12/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (XS) DATE SURVEY A. BUILDING_ 94G291 B. WING NAME OF PROVIDER OR SUPPLIER 07/03/2018 STREET ADDRESS, CITY, STATE, ZIP CODE **303 NORTH HOWARD STREET** STRAWBERRY HOUSE CHADBOURN, NC 28431 SUMMARY STATEMENT OF DEFICIENCIES (XA) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (XS) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LISC IDENTIFYING INFORMATION) TAO CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 459 Continued From page 23 W 459 QP will in-service all staff on each client specific diet their modified and specially-prescribed diets QP will update the dict sheer. Program manger will 8/31/18 (W460); foods were served at an appropriate monitor weekly. QP will monitor monthly. temperature (473); food was served with the appropriate utensils (475); and menus for food actually served was kept for 30 days (481) The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services. W 460 FOOD AND NUTRITION SERVICES W 460 W460 The facility will casure that each client receive CFR(s): 483.480(a)(1) a nourishing well-balanced diet including modified 8/31/18 and specially-prescribed diets. Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility falled to ensure 3 of 4 audit clients (#3, #5, #6) received their modified and specially-prescribed diets as indicated. The findings are: 1. Client #6's appropriate food/drink consistency 1. QP and Habilitation Specialist will in-service was not followed at 3 of 3 meals. all smff by domonstrating diet consistencies During lunch observations in the home on 7/2/18 (food/drinks) for client #6. QP and Habilitation 8/31/18 at 12:24 pm, client #6 consumed macaroni and Specialist will in-service all staff on the correct cheese, green peas, and chopped steak. The measurements for thick-it. Habilitation Specialist food items were ground, dry, thick and chunky. and Program manager will observe and monitor The client also consumed liquid which was of a weekly. QP will monitor monthly. pudding consistency. Client#6 used a spoon to scoop his liquids from his cup. At the lunch meal.

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client #8 consumed his food quickly and ate approximately 25% of the meal before drinking or prompts to drink. Client #8 periodically coughed while eating. Staff standing next to him provided

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STATEMENT OF DEFICIENCIES AND PLAN OF CORPORATION (X1) PROVIDER/SUPPLIER/CLIA		045.		OMB NO. 0938-039	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(XX) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	34G231	B. WING]	
NAME OF PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	07/03/2018	
STRAWBERRY HOUSE			303 NORTH HOWARD STREET		
NAUD CONTRACTOR			Chadeourn, NC 28431		
PREFIX (EACH DEFICIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
During dinner obse at 5:59pm, client #6 green beans, crean muffins. The beans runny while the chic small chunks of me was initially nectar the glass as the mill consistency. As client began using a the glass as the mill consistency. As client began coughing. As back twice. He contitue table and remove During the meal, the quickly putting larger mouth. A staff next a sporadic verbal protein he was not consisted liquids between sporadic verbal protein he was not consisted liquids between sporadic verbal protein he was not consisted liquids between sporadic verbal protein he was not consisted liquids between sporadic verbal protein he was not consisted liquids between sporadic verbal protein he was finely also consumed orar and water. The liquid nectar type consisted glass to drink. Toward drinks were thick an consumed by the client also be noted that the prune juice as a thin himself. Throughout	rvations in the home on 7/2/18 3 consumed baked chicken, in corn and chocolate chip and corn were loose and cken was molst and thick with at visible. Client #6's milk thick as he began drinking it ards the end of the meal, the a spoon to scoop his milk from k had thickened to a pudding int #6 finished his meal, he staff next to him hit him on his linued to cough while leaving thing his dishes from the table. It is client consumed his food a spoonfuls of food in his to him gave the client mpts to "slow down"; however, intly prompted to drink any onfuls of food. Servations in the home on itent #6 consumed Turkey chopped and dry. The client age juice, milk, prune juice lids initially resembled a mcy as client #6 picked up his ards the end of the meal, the d pudding like when ent using a spoon. It should be client drank slps of his it iquid while waiting to serve	W 46			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/12/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 34G291 B. WING NAME OF PROVIDER OR SUPPLIER 07/03/2018 STREET ADDRESS, CITY, STATE, ZIP CODE STRAWBERRY HOUSE 303 NORTH HOWARD STREET CHADBOURN, NC 28431 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XII) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 460 Continued From page 25 W 460 coughed. Staff C stood next to him and encouraged the client to continue coughing and gave verbal prompts to "slow down." During observations of medication administration in the home on 7/3/18 at 7:10am, client #6 consumed his crushed pills in pudding with thin liquid (water). The client immediately coughed after drinking the water. Interviews on 7/3/18 with staff revealed the following regarding client #6's food/drink consistency: Staff C revealed client #6's food goes in the blender for a pureed consistency. The staff indicated his liquids are "thickened ...so he won't W460 QP and Habilitation Specialist will in-service get strangled." Additional interview revealed all staff by domonstrating diet consistencies client #6's liquids should be a "pudding" (food/drinks) for client #6, QP and Habilitation consistency. The staff also indicated the client will Specialist will in-service all smff on the correct 8/31/18 cough at times during meals and they usually mensurements for thick-it. Habilitation Specialist prompt him to keep coughing to clear his throat. and Program manager will observe and monitor weekly. QP will monitor monthly. Staff A revealed client #6 gets a pureed diet and pudding thick liquids. The staff stated they add his food to a blender and the food "should be smooth," When asked why the client's turkey sausage was dry and finely chopped, the staff indicated she does not usually add liquid to the client's meats. The staff also revealed oatmeal

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pureed consistency.

usually does not get processed in the blender. During the interview, the staff acknowledged client #6's sausage and oatmeal were not a

Review on 7/3/18 of client #6's IPP dated 6/1/18 revealed, "...On 7-19-17, [Client #6] had an appt at CRHS Speech Therapy Dept for a swallowing assessment & MBSS. They recommended NPO

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII			(XS) DATE SURVEY COMPLETED	
						TOWN TENED	
		34G231	B. WING		****		100 ma 4 a
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 07	/03/2018
STRAWB	ERRY HOUSE				03 NORTH HOWARD STREET		
(X4) ID	CI MALANTA CT	AWIA TO TO STORY			HADBOURN, NC 28431		
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI	E ATE	(XB) COMPLETION DATE
			<u> </u>		DÉFICIENCY)		
W 460	Continued From page	∍26	W	180			
	status due to the incr	eased risk of aspiration. On	1	100			
	7-20-17, a STAT inter	disciplinary team meeting]
	risk The speech that	he dysphasia & aspiration raplst recommendation was					
	discussed, along with	rapist recommendation was the consequences of					
	Implementing it. The	team decided to continue					
	allowing [Client #6] to	consume a pureed diet with					1
	pudding thick liquids. with all meals & snac	100% supervision is needed ks"					
	Additional review on 7	7/3/18 of client#6's IPP and					
	current physician's or	ders and a diet consistency					
	list posted in the hom	e (dated 7/24/17) revealed					
:	he receives a Heart H smooth consistency"	lealthy regular diet, "pureed with "pudding thick liquids."					
	Interview on 7/3/18 th	e Qualified Intellectual		ı			
	Disabilities Profession	nal (QIDP) confirmed client					
ļ	#6's current diet inclu- pudding thick liquids.	des pureed foods and					
	During an Interview or	n 7/3/18, the facility's nurse					
	also confirmed client	#6 should have his foods					
	pureed smooth and hi	is liquids should be a					
	pudding consistency v	which would likely make it					
	properly. Additional in	uid from a glass if done nterview revealed the client's		1			
	cough during meals of	ould be an indication that					
	the consistency of his	food or drinks was not					
	appropriate.						
	2. Client #6 did not re recommended.	ecelve prune juice as					
	reconnitional						
	During snack observa	tions in the home on 7/2/18	1				
	at 3:47pm, client #8 co	onsumed a pudding cup					
	and Kool-aid. The clie juice.	ent was not offered prune			·		
	juiou.						
					and rather American property and the Control of the		

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PRINTED: 07/12/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING_ COMPLETED 34G231 07/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 308 NORTH HOWARD STREET STRAWBERRY HOUSE CHADBOURN, NC 28491 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XII) COMPLETION DATE PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LIBC IDENTIFYING INFORMATION TAG DEFICIENCY) W 460 Continued From page 27 W 460 Review 7/2/18 of a dietary list (dated 7/24/17) posted in the home revealed client #6 should consume prune juice at breakfast and "4p snack." Additional review of the client's IPP dated 6/1/18 also indicated prune juice should be consumed at his 4:00pm snack. Staff interview on 7/3/18 revealed the client's diets posted in the home should be followed. Interview on 7/3/18 with the QIDP confirmed client #6 should have received prune Juice at enack time. 3. Client #3's food/drink consistency was not

FORM CMS-2567(02-99) Previous Versions Obsolets

followed.

a. During breakfast observations in the home on

sausage links. Further observations revealed the

sausage links where 2 inches in length. At no

time was client #3 prompted to cut his food.

client #3's place setting.

Further observations indicated a knife was et

During an interview on 7/3/18, staff C revealed

Review on 7/3/18 of client #3's lpp dated 6/6/18 stated, "On 7/19/17 [Client #3] had a appt with Speech Therapist at CRHS for a Clinical Swellow Assessment & Modified Barlum Swallow Study. Dental soft diet with chopped meats...was ordered." Additional review of client #3's physician orders signed 5/16/18 revealed. "Bite size consistency." Review of client #3's medical evaluation dated 6/6/18 stated, "...Dental soft diet with finely - chopped meats...." Further review of client #3's nutritional evaluation dated 10/10/17

client #3's sausage should have been cut by staff.

7/3/18, client #3 consumed 2 whole Turkey

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monitor monthly.

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8/31/18

3. A. Habilitation Specialist will in-service all staff

members on diet and food consistencies for

client #3. Habilitation Specialist will create a

goal to assist client #3 with cutting his food,

Habilitation Specialist will in-service staff to

ensure food is cut to the proper consistency.

Habilitation Specialist and Program manager

will observe and monitor weekly. QP will

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ \41.0	TIOL	-001075	OMB NO	D. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		SURVEY
						00,00	مين الله
MANUELONIN		94G231	B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		0//	/03/2018
STRAWBE	RRY HOUSE				03 North Howard Street		
(XA)15				٩	CHADBOURN, NC 28491		
(X4) ID PREFIX	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF	·~	PROVIDER'S FLAN OF CORRECTION		(X5)
TAG			TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X3) COMPLETION TE DATE	
			_		DEFICIENCY)	_	
W 460	Continued From page	28	,,,	400			
	indicated his diet is "fi		Į vv	460			
'		•					
	During an interview or	n 7/3/18, the facility's nurse					{
	been followed by staff	current diet should have					
	been followed by stall	•					
	b. During 3 of 3 meal	observations in the home,					
	client #3's liquids had	an inconsistent amount of			B.QP and Habilitation Specialist will in-servi	ice	
	then stirred by staff.	oped into his liquids and			all staff by demonstrating diet consistencies		
	During an Interview on 7/3/18, staff C reported they were never trained on how much Thick-It				(100d/drinks) for client #3. QP and Habilitati	on	
					measurements for thick in IVA VIVA	ct	0.00 % /% 0
					and Program manager will observe and	alist	8/31/18
	should be scooped int	o client #3's cups of liquid.			weekly. QP will monitor monthly.	tor	
Further interview rever		aled staff C was not aware vhich client #3's liquids					
	should be served.	Spippil & C# Theild 10th				į	
	Review on 7/3/18 of cl	lent #3's IPP dated 6/6/18					
	stated, "on 7/19/17 [CI	ient #3] had an appt with					
	Speech Therapist at C	RHS for a Clinical Swellow					
	Assessment & Modifie	d Berlum Swellow					
	of client #9's nutritions	ulds was ordered." Review I evaluation dated 10/10/17					
	indicated, "Diet:hone	y thick liquids"		- 1	B.QP and Habilitation Specialist will in-service all staff by demonstrating diet consistencies (food/drinks) for client #3. QP and Habilitation Specialist will in-service all staff on the correct measurements for thick-it. Habilitation Specialist and Program manager will observe and monitor weekly. QP will monitor monthly. C. QP and Nurse will in-service all staff by demonstrating correct measurements for thick-it and when thick it should be administered. Nurse and Program Manager will monitor med pass weekly. QP will monitor monthly.		
				}		by	
	During an interview on	7/3/18, the facility's nurse					
	followed by staff.	rrent diet should have been			C. OP and Nurse will in resides all attention		
}	www.wy wumit				demonstrating correct measurements for this	le it and	İ
	c. During medication a	administration observation			when thick it should be administered. Nurse	and	
in the home on 7/3/11		at 9:05am, client#3		1	Program Manager will monitor med pass we	ekly.	
	consumed 5 pills with t time was Thick-it adde	thin (regular) water. At no			QP will monitor monthly.		
	Immediately after being						
	surveyor, the medication	on technician gave client#3		ĺ			
}	a second glass of thin	(regular) water.					į
	During an immediate in	nterview, the medication		ļ			
	an university to	TOTAL TIO HEOHERICH		- 1			1

FORM CMS-2507(02-89) Previous Versions Obsolete

Event ID; OPKE11

Facility ID: 922664

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PRINTED: 07/12/2018 FORM APPROVED OMB NO 0938-0304

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(YO) MI II S	101 C	CONSTRUCTION		<u>0. 0938-0391</u>	
ID CORRECTION		IDENTIFICATION NUMBER:	A BUILDII	NO_	CONSTRUCTION	(X3) DATE COM	X3) DATE SURVEY COMPLETED	
NAMEGE	DOI 10 May 10 Ma	34G231	B. WING				07/03/2018	
NAME OF PROVIDER OR SUPPLIER STRAWBERRY HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET CHADBOURN, NC 28431					
(X4) ID PREFIX TAG	(CAUH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .BC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X3) COMPLETION DATE	
	During an interview or revealed Thick-It shou client #3's water. 4. Client #5's food colar. 4. Client #5's food colar. 4. Client #5's mean pleces. Further observations was recompled throughout the meal. During dinner observations of the coughed throughout the meal. During dinner observations of the coughed throughout the meal. Review on 7/3/18 of client #5's chic pieces. Further observations was recompled this diet consistent #5's physician or revealed his diet physician or revealed his diet physician or revealed his diet physician or revealed his diet physician or revealed his diet physician physician physician physician	client #3 should have drank added. 17/3/18, the facility's nurse ald have been added to existency was not followed. It was cut into bite size existency revealed during the dup a clear liquid while client #5 coughed It was cut into bite size existency into bite size existency act into bite size existency revealed client #5 remail. Itent #5's IPP dated 6/1/18 remail. Itent #5's IPP dated 6/1/18 remailswith aspiration and the meatswith aspiration existency is finely chopped. Itent #5's nutritional remails in indicated, "finely de." 7/3/18, the facility's nurse arment diet order should	WA	4 0 # 8 0	4. QP and Habilitation Specialist will in-serve staff on the correct portion size for alient #5. A. Habilitation Specialist will demonstrate correct portion size for client #5. Habilitation Specialist and Program manavill observe and monitor weekly. QP will monitor monthly.	the	8/31/18	
	MEAL SERVICES CFR(s): 483,480(b)(2)((ii)	W 47	73				

FORM CMS-2567(02-89) Provious Versions Obsolute

Event ID: 0PKE11

Facility ID: 922664

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PRINTED: 07/12/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V4) FED (DED) (DD) (DD)				OMB NO. 0938-039					
AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X9) DATE SURVEY COMPLETED					
		94G2S1	B, WING			07/07/07/0					
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE							
STRAWBE	ERRY HOUSE			303 NORTH HOWARD STREET							
***************************************				CHADBOURN, NC 28431							
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	OI	L	PROVIDER'S PLAN OF CORRECTION	N J					
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(XJ) COMPLETION DATE				
W 473	Continued From page 30 Food must be served at appropriate temperature.		w	473	W473 The facility will ensure all meal are a appropriate temperatures.	erved at	8/31/18				
	Based on observation interviews, the facility served at an appropria affected all clients restinding is: Food items were not temperature. During breakfast obsity/3/18 at 7:25 am, state oven and placed one added. The waffle was not taken. Addit revealed milk was restat 7:12 am and poure remained on the kitch dining room table unto began serving thems. Review of a note posithe home (no date) reheated to a temperature with their Should be at least 11	not met as evidenced by: ons, record review and realled to ensure foods were late temperature. This siding in the home. The served at an appropriate envations in the home on off removed waffles from the in the blender with cold milk as blended and served to The temperature of the food ional breakfast observations moved from the refrigerator d into pitchers. The milk nen counter and then the all 7:45am, when clients elves the milk. ted on a kitchen cabinet in evealed, "Hot food should be ure of 140 degreesCheck commeter before serving. O degreesCold foods emperature of 40 degrees			Staff will be in-service on meal preparation to check temperatures of food. Program mar Habiliation Specialist will monitor weekly. In monitor monthly.	ager and	8/31/18				
	minutes of leaving re deviceIf longer that foods" During an interview of	n 15 minutes, reheat hot									
	RCKUOMIAGGAG BGGIU	g cold milk to the Wallies				l	Į				

FORM CMB-2567 (02-99) Previous Versions Obsolete

Event ID: 0PKE11

Facility ID: 822864

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PRINTED: 07/12/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB N	O. 0938-0391	
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G231	B. WING				
	ROVIDER OR SUPPLIER ERRY HOUSE			//03/2018			
(X4) ID	6UMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	<u>_`</u>	CHADBOURN, NC 28431		
PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S FLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		: NE	(X5) COMPLETION DATE
	lowered the temperature to a note posted on a food temperatures. A a temperature gauge temperatures; however one in the kitchen. Interview on 7/3/18 witchen. Interview on 7/3/18 witche	with appropriate utensils. ot met as evidenced by: s, document reviews and falled to ensure food with a portion of the color of the co		473	W475 The facility will ensure all food is serv	red with	8/31/18
	protector and dycem mincluded in client #6's proceeding lunch and dinner on 7/2/18 at 12:30pm and dycem met under his During breakfast obser 7/3/18 at 7:37am, client food with a dycem met During additional obser	orogram plen. er observations in the home and 5:59pm, client#6 used		E	1. Staff will be in-service on the proper use of adaptive equipment in following client #6 IPP		8/31/18

FORM CMS-2587(02-89) Previous Versions Obsolete

Event ID; 0PKE11

Facility ID: 922884

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PRINTED: 07/12/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	X3) DATE	. 0938-0391 BURVEY LETED
		94G291	B. WING				
	ROVIDER OR SUPPLIER ERRY HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET CHADBOURN, NC 28491		07/03/2018	
(XA) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 475	in the coliar of his shir removed the cloth, with removed the cloth, with staff interview on 7/3 used as clothing protective home. Review on 7/3/18 of creveal any information clothing protector or colothing protector of colothing protector adaptive equipment so client's diet sheet. The information should also record. 2. Information to add a dycem mat and clothing lunch observations in the howas not underneath of colothing lunch and din on 7/2/18, client #5 had to colothing breakfast observations. During breakfast observations in the factor of the colothing breakfast observations in the howas not underneath of the colothing lunch and din on 7/2/18, client #5 had to colothing breakfast observations in the factor of the colothing breakfast observations in the howas not underneath of the colothing lunch and din on 7/2/18, client #5 had to colothing breakfast observations in the factor of the colothing breakfast observations and colothing breakfast observations in the factor of the colothing breakfast observations and colothing breakfast observations and colothing breakfast observations are colothing breakfast observations and colothing breakfast observations are colothing breakfast observations.	is neck and tucked the cloth of. The client periodically hile eteff replaced the cloth. It are client periodically hile eteff replaced the cloth. It are clients are etectors for all of the clients in client #6's record did not a regarding the use of a clycem mat at meals. It the Qualified Intellectual hel (QIDP) revealed all chould be identified on the help acknowledged the so be included in client #6's fining protector was not am plan. It is a client #5's the usage of thing protector was not am plan. It is a client #5's the usage of thing protector was not am plan. It is a client #5's the usage of thing protector was not am plan.	W	475	2. QP will review IPP and in-service staff on consider the state of a dinner napkin. Program manager we monitor weekly, QP will monitor monthly,	correct	8/31/18

FORM CMS-2587(02-99) Previous Versions Obvolote

Event ID: 0PKE11

Facility |D; 922884

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PRINTED: 07/12/2018 FORM APPROVED
OMB NO 0938-0391

8TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILDI		CONSTRUCTION	COMPI	
		34G231	B. WING			07/03/2018	
NAME OF PROVIDER OR SUPPLIER STRAWBERRY HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH HOWARD STREET CHADBOURN, NC 28431			07/03/2018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG				(75) COMPLETION DATE
W 475	5 Continued From page 33		w	47 5			
	client #5's napkin shounderneath his plate, stated client #5 used clothes from when for Review on 7/3/18 of 6/1/18 revealed there regarding the usage protector. During an interview of confirmed client #5's information in regarding the regarding the usage of the regarding the usage of the regarding the usage of the regarding the usage of the regarding the usage of the regarding	record did not contain any s to how staff are to use a					<i>,</i>
W 481	meals. MENUS CFR(s): 483.480(c)(2 Menus for food actualitie for 30 days. This STANDARD is a Based on observation	lly served must be kept on not met as evidenced by: ns and interviews, the facility ord of foods actually served	w	481	W481 The facility will ensure all food substi	itutions	8/31/18
•	Food substitutions we Dinner observations 5:59pm revealed clie chicken, green beans chocolate chip muffin menu noted barbequ	ere not documented, in the home on 7/2/18 at, ints were served baked is, cream style corn, and is. Review of the dinner is chicken, steamed orn, Angel food cake and			Program manager will in-service sinff on the way to document a food substitutions. Programanager will monitor weekly. QP will monito monthly.	ina.	8/31/18

FORM CMS-2567(02-09) Previous Versions Obsolete

Event ID: OPKE11

Facility ID: 922664

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			4 4	FORM	7: 07/12/2018 APPROVED			
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULT A. BLIILDI		CONSTRUCTION	OMB NO. 0938-0391 (K3) DATE SURVEY COMPLETED				
NAME OF BU		34G231	B. WING			07/m9/20411				
NAME OF PROVIDER OR SUPPLIER STRAWBERRY HOUSE				30	REET ADDRESS, CITY, STATE, ZIP CODE IS NORTH HOWARD STREET HADBOURN, NC 28431	07/03/2018 DE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIER / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
W 481	Breakfast observation 7:37am revealed clier turkey sausage, fruit of the breakfast menu not and assorted fruit, Engand assorted fruit, Engand substitutions were made breakfast meal. Addit they have not been to substitutions. Interview on 7/3/18 will Disabilities Profession	de for items at the dinner is in the home on 7/3/18 at ats were served oatmeal, cups and waffles. Review of oted oatmeal, turkey bacon, glish mulfins. 18 confirmed food de for items at the fonal interview indicated	W	481						

FORM CMS-2567(02-90) Provious Versiona Obsoleta

Event ID: 0PKE11

Facility ID: 922684

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