STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G231	A. BUILDING _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAWBERRY HOUSE	303 NORTH HOWARD STREET CHADBOURN, NC 28431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications were kept locked when not in the process of administering them. This potentially affected 1 of 3 audits (client #2). The finding is: Client #2's medications were left unlocked. During observations of the morning medication administration pass on 7/26/19, client #2's pills were left unlocked sitting in front of her when staff D left the room. During an interview on 7/26/19, when staff D was asked to do as she would do if there was nobody else in the room, she confirmed this is what she would do, she turned and locked the cabinet and left the medications in front of client #2 and walked out. Review of the record on 7/26/19 for client #2 revealed an individual program plan dated 9/24/19 which indicated client #2 is incompetent and has a legal guardian. Interview with the qualified intellectual disability professional (QDDP) on 7/26/19 confirmed the staff should not have left the unlocked medications in front of client #2.	W 382	W382 The facility will ensure all drugs and biologicals are locked safely during medication administration DHSR - Mental Health AUG 15 2019 Lic. & Cert. Section Nurse will in service all staff on proper way to secure the medication when leaving the medication room while medications are being administered. Nurses will monitor weekly. Clinical Supervisor will monitor monthly.	9/24/19
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Williams — TITLE: Clinical Supervisor — (X6) DATE: 8/9/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G231	A. BUILDING _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAWBERRY HOUSE	303 NORTH HOWARD STREET CHADBOURN, NC 28431

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W 436	Continued From page 1 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to assure client #2 was provided with a CPAP and had training to utilize her CPAP before discontinuing it. This affected 1 of 3 audit clients (#2). The finding is: Client #2's CPAP was discontinued without training. During observations on the morning of 7/26/19 client #2 did not have a CPAP machine in her room. Interview on 7/26/19 with client #2 confirmed she did not have a CPAP and that she would like to have one and would try to use it. She did not know why they had taken it away from her. Record review on 7/26/19 revealed client #2's individual program plan dated 9/24/18 which noted that a CPAP was discontinued by the provider "due to non-use." There was no other documentation about efforts to have client #2 utillize the CPAP. Interview with the QIDP (qualified intellectual disabilities professional) on 7/26/19 confirmed that the CPAP was discontinued and there was	W 436	W 436 The facility will ensure that all clients are taught to use and make informed choices about the use of any adaptive devices identified by the interdisciplinary team as needed by client. The Nursing staff will ensure that all medically necessary adaptive devices for clients are obtained and utilized per physicians/occupational therapist/physical therapist/speech therapist order and any other medical personnel as needed. Client #2 will be scheduled with doctor to determine CPAP need and usage. In service on machine usage will be provided by CPAP staff and CI nurses. Manager and Nursing staff will monitor usage daily. Habilitation Specialist will develop goal to assist client #2 in using equipment as ordered and to ensure that client is able to utilized the machine as independently as possible. Clinical Supervisor will monitor monthly.	9/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G231	A. BUILDING _____ B. WING _____	07/26/2019

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W 436	Continued From page 2 no evidence of training to use or make an informed decision not to use before discontinuing it.	W 436		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 8, 2019

Ms. Melissa Bryant, Director
80 Alliance Drive
Whiteville, NC 28472

Re: Recertification Completed 7/26/19
Strawberry Residential, 303 North Howard Street, Chadbourn, NC 28431
Provider Number:34G231
E-mail Address: swilliams@communityinnovations.com,
mbryant@communityinnovaqtins.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed 7/26/19. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice(s) that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is Sept 24, 2019.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and***