

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

PRINTED: 02/22/2020  
FORM APPROVED  
OMB NO. 0938-0391

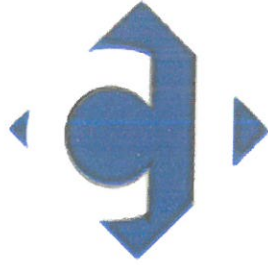
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G243</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESTSIDE RESIDENTIAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>467 CREEK ROAD</b> <b>ORRUM, NC 28369</b>
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(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 154	<p><b>STAFF TREATMENT OF CLIENTS</b> CFR(s): 483.420(d)(3)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: The facility failed to ensure 1 of 1 allegations of possible resident/ patient abuse by employee was thoroughly investigated. The finding is:</p> <p>During record review of the facility Incident response improvement system (IRIS) report on 2/7/2020, revealed an incident report had been completed when client #4 reported to the home manger that a staff had verbally abused her. The report revealed that the staff was immediately suspended pending the investigation.</p> <p>During interview on 2/7/2020 clients #2, #6 and #4 revealed they are interviewable and they understood about their rights. They were able to verbalized their rights and the chain of command if their rights were violated.</p> <p>During the record review on 2/7/2020 revealed that none of the clients who were intevieawable were interviewed during the investigation.</p> <p>During an interview on 2/7/2020 with the qualified intellectual disabilities professional (QIDP) via the phone revealed the 3 interviewable clients were not interviewed regarding the verabl abuse of cient #4</p>	W 154	<p>W 154 The facility will ensure that all evidence of all alleged violations are thoroughly Investigated.</p> <p><b>DHSR - Mental Health</b> <b>FEB 27 2020</b> <b>Lic. &amp; Cert. Section</b></p> <p>QP will complete IRIS reports, Conduct face to face interviews With staff and residents and complete In-house investigations within 5 business Days.</p>	4/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Sharbara Williams* Clinical Supervisor L  
TITLE  
TITLE  
(X6) DATE  
2/24/20

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.



**COMMUNITY  
INNOVATIONS, INC.**

Whiteville Office  
80 Alliance Drive  
Whiteville, NC 28472  
910-642-5697

[www.communityinnovations.com](http://www.communityinnovations.com)

February 24, 2020

Wambui Karanu, RN  
Nurse Consultant 1  
Mental Health Licensure & Certification Section

RE: Complaint Survey Completed February 7, 2020  
Westside Residential, 467 Creek Rd., Orrum, NC 28369  
Provider Number: 34G243  
MHL Number: 078-049  
Intake Number: NC00160552  
E-mail Address: [mbryant@communityinnovations.com](mailto:mbryant@communityinnovations.com)

DHSR - Mental Health

FEB 27 2020

Lic. & Cert. Section

Dear Mr. Meredith

Please find attached Plan of Correction for Complaint Survey completed on February 7, 2020.

If you have questions regarding this, please do not hesitate to contact Melissa Bryant, Regional Director at 910-642-5697.

Sincerely

Sharbara Williams <sup>by</sup> LBM

Sharbara Williams  
Clinical Supervisor



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

February 24, 2020

Ms. Melissa Bryant, Administrator  
Community Innovations, Inc.  
80 Alliance Dr.  
Whiteville, NC 28472

Re: Complaint Survey Completed February 7, 2020  
Westside Residential, 467 Creek Rd., Orrum, NC 28369  
Provider Number: 34G243  
MHL Number: 078-049  
Intake Number: NC00160552  
Email Address: [mbryant@communityinnovations.com](mailto:mbryant@communityinnovations.com)

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the complaint investigation survey completed on 2/7/2020.

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 does/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 <deficiency/ deficiencies> must be **corrected** within 60 days from the exit of the survey, which is **April 9, 2020**.

#### **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.

#### **MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

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 please remember never to send confidential information (protected health information) via email.**

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Wambui Karanu at 919-703-5581 or email me [Tabitha.karanu@dhhs.nc.gov](mailto:Tabitha.karanu@dhhs.nc.gov)

Sincerely,

*wkaranu.bsn, RN.*

Wambui Karanu, RN  
Nurse Consultant I

Cc: [DHSRreports@eastpointe.net](mailto:DHSRreports@eastpointe.net)

[\\_DHSR\\_Letters@sandhillscenter.org](mailto:_DHSR_Letters@sandhillscenter.org)

Leza Wainwright, Director, Trillium Health Resources LME/MCO

Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources  
LME/MCO