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

| 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 _____ | 04/27/2021 |

| 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 210 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)<br><br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure the interdisciplinary team performed accurate assessments within 30 days after admission. This affected 1 of 1 newly admitted audit clients (#2). The finding is:<br><br>Review on 4/26/21 of client #2's record revealed he was admitted to the facility on 10/23/20. Further review revealed he has diagnoses of Mild Intellectual Disabilities, Psychotic Disorder/Schizophrenia and Type II Diabetes Mellitus. Further review of client #2's record revealed the facility had not completed the following assessments: Occupational therapy, Physical Therapy and Speech.<br><br>Interview on 4/27/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that Occupational Therapy, Physical Therapy and Speech assessments were not completed following client #2's admission on 10/23/20. | W 210 | **W 210** The facility will ensure accurate assessments are conducted within 30 days of admission.<br><br>For client #2 the team will conduct accurate assessments (occupation therapy, physical therapy and speech). In the future assessments will be conducted within 30days of admission. The Nursing staff will schedule all new admission appointments within 30 days and QP will monitor to ensure all are completed.<br><br>DHSR - Mental Health<br>MAY 12 2021<br>Lic. & Cert. Section | 6/27/21 |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed | W 249 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shabara Williams — TITLE: Clinical Supervisor — (X6) DATE: 5/10/2021

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.

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| W 249 | Continued From page 1<br>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 3 of 4 audit clients (1, #2, #4) received a continuous active treatment program consisting of needed interventions and services to support the achievement of objectives identified in the Individual Program Plan (IPP) in the areas of meal preparation and following dietary guidelines. The findings are:<br><br>A. During observations on 4/27/21 at 6:50am staff A came into work and started preparing breakfast. Staff A prepared hot water for oatmeal, got bacon out of the refrigerator and bread for toast. Client #2 came into the kitchen and asked about setting the table and staff A told him she would let come and get him after she got breakfast started. At about 6:58am, staff A located plates, silverware, and napkins and set the dining room table while client #2 was in his bedroom.<br><br>Review on 4/27/21 of client #2's adaptive behavior inventory (ABI) dated 12/1/20 revealed he can select correct plates, flatware for the table independently and that he can set the table independently.<br><br>Interview on 4/27/21 with the qualified intellectual disabilities professional (QIDP) and the habilitation specialist confirmed client #2 can | W 249 | **W 249** The facility's interdisciplinary team will ensure that all individuals receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual's program plan.<br><br>QP and Habilitation Specialist will ensure that all staff are trained on client's # 1, 2 and 4 goals and guidelines relating to mealtime preparation and dietary. Habilitation Specialist will develop goals to assist clients in participating with meal preparation at their highest level of functioning and | 6/27/21 |

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| W 249 | Continued From page 2<br>assist with setting the dining room table and should be given opportunities to assist when possible.<br><br>B. During observation of the supper meal on 4/26/21 at 5:55pm, staff D assisted client #4, who is blind, in adding 2 scoops of thickener into two glasses at his placesetting. Staff assisted client #4 in pouring water and koolaid into these glasses and then used a spoon to stir the thickener into each beverage.<br><br>During further observations of supper at 6:09pm, staff E assisted client #4 with pouring a second glass of water from a pitcher into his cup. Thickener was not added to his water before he picked up his glass and consumed it.<br><br>Review on 4/26/21 of client #4's IPP dated 10/6/20 revealed his order revealed which indicates he is prescribed a heart healthy, calorie controlled, dental soft diet with honey thickened liquids.<br><br>Interview on 4/27/21 with the QIDP and with the facility Nurse confirmed all of client #4's beverages should be thickened as indicated in his IPP and physician orders dated 2/17/21.<br><br>C. During observations of supper on 4/26/21 at 6:15pm, client #1 was served cabbage, barbeque chicken (deboned), corn and a medium sized biscuit. She consumed her meal independently without prompts to alternate beverages and to slow her pace of eating. She held her biscuit in her hand and bit pieces off of it at a time. She did not cough during the meal or have difficulty consuming her meal. | W 249 | create guidelines based off of swallowing studies for each client as needed. Staff will be in serviced by Habilitation Specialist on appropriate ways to train goals and use swallowing guidelines. Habilitation Specialist will monitor weekly, Manager will monitor weekly and QP will monitor monthly. | |

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| W 249 | Continued From page 3<br>During observations of breakfast on 4/27/21 at 8:00am, client #1 had oatmeal, bacon and toast with orange juice and water. Client #1's bacon was cut up into smaller pieces. She consumed her breakfast independently without verbal cues to slow her pace of eating.<br><br>Review on 4/27/21 of client #1's swallowing guidelines (undated) indicated, "One small bite/sip at a time, clear mouth between bites/sips, repeat saliva swallows after each bite/sip, alternate liquids with solids, minimize distractions during meals/snacks."<br><br>Interview on 4/27/21 with the QIDP and facility Nurse indicated these swallowing guidelines for client #1 are current and are incorporated into her IPP. The QIDP stated these guidelines should be followed at meals. | W 249 | | |
| W 260 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(2)<br><br>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure 2 of 2 audit client's (#1, #2, ) individual program plans (IPP)'s were revised at least annually. The findings are:<br><br>A. Review on 4/26/21 of client #2's record revealed he was admitted to the facility on 10/23/20. Further review of client #2's record revealed He had a medical evaluation, dated | W 260 | **W 260** The facility will ensure that all client IPP's are updated annually.<br><br>Interdisciplinary team and QP will ensure that IPP meetings occur annually for clients 1 and 2 and that the plan identifies yearly goals and the plan is in client medical record as well as in the home. | 6/27/21 |

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| W 260 | Continued From page 4<br>2/5/21 a nutritional evaluation dated 11/4/20, an adaptive behavior inventory dated 12/1/20 and a psychology evaluation (undated). However his individual program plan (IPP) could not be located.<br><br>Interview on 4/26/21 with the QIDP revealed client #2's admission to the facility on 10/23/20 an interdisciplinary team meeting was held on 2/5/21. The QIDP was able to locate a sign in sheet and some notes from that meeting, however she confirmed the IPP was not further developed.<br><br>B. Review on 4/27/21 of client #1's record revealed she was admitted to the facility on 9/19/14 and that her last IPP meeting was held 10/8/19.<br><br>Interview on 4/27/21 with the QIDP revealed client #1's last IPP was held on 10/8/19 and that her IPP has not been updated since that last meeting in 2019. | W 260 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#4). The findings are: | W 263 | **W 263** The facility will ensure that written informed consent of the client parent or legal guardian is obtained. | 6/27/21 |

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| W 263 | Continued From page 5<br><br>Review on 4/26/21 of client #4's individual program plan (IPP) dated 10/6/20 revealed he has a behavior support program (BSP) dated 9/26/20 to address the target behaviors of severe disruption, PICA and property destruction. Further review of his IPP revealed client #4 had been appointed a legal guardian who was recently deceased in 2020 and that a successor petition for guardianship has been filed with the Clerk of Court's office.<br><br>Review on 4/26/21 of client #4's BSP dated 9/26/20 revealed this program to address severe disruption, PICA and property destruction includes the use of exclusionary time out (ETO) and the use of Risperidone 2mg. and Lorazepam 05 mg. BID. Further review of this program revealed there is no guardian consent for this program.<br><br>Interview on 4/27/21 with the qualified intellectual disabilities professional (QIDP) confirmed client #4 is without a legal guardian at the present time until after his successor guardianship hearing later this week. Further interview revealed this BSP has been inserviced and implemented. Additional interview confirmed this program includes the use of exclusionary time out, Risperidone 2mg. and Lorazepam 05 mg. BID. | W 263 | For all clients, the QP will ensure that consent forms are signed by guardian and in medical record yearly or as needed for changes. QP for client #4 will review all consents once new guardianship is obtained and have written informed consent signed and in client medical record. | |
| W 340 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(i)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate | W 340 | | |

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| W 340 | Continued From page 6<br>health and hygiene methods.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview nursing services and the interdisciplinary team, failed to ensure staff were trained to assure adequate hygiene to prevent the spread of possible contaminants during blood glucose checks for for 2 of 4 audit clients ( #2 and #4). The findings are:<br><br>During observation of the medication administration pass on 4/27/21 at 7:10am for client #2 revealed staff G located 2 glucometers in the medication closet in the facility office. Both glucometers were determined by staff G to not be working when the glucometers indicated the batteries were low. Staff G then located a third glucometer, turned it on, stuck a test strip into the meter and then asked client #2 which finger he would prefer for her to stick. Staff G stuck his 2nd right finger, then applied the blood on the test strip and read the value on the glucometer. After finishing with measuring client #2's blood sugar, staff G documented the value on the electronic medication administration record (MAR), put the components of the glucometer back in its container and put it on the shelf of the medication closet.<br><br>Immediate interview with staff G revealed client #2 "is new to the facility and nursing has not ordered a glucometer that is to be used to measure his blood sugar, so we just use one of these, or the one that belongs to another client."<br><br>Further observations of the medication pass on 4/26/21 at 7:40am of client #4 revealed staff G located the same glucometer that she used at | W 340 | **W 340** The facility will ensure that the Nursing staff and interdisciplinary team members ensure implementation and accessibility of supplies, medications and equipment relative to appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. | 6/27/21 |

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| W 340 | Continued From page 7<br>7:10am with client #2. She unzipped the container containing the glucometer and then turned on the glucometer. Staff G then told client #4 that she was going to use his 5th right finger for the blood stick. Staff G then stuck the test strip into the glucometer, stuck client #4's 5th right finger and read the reading on the glucometer. Staff G documented the value on the electronic MAR, put the components of the glucometer back in its container and put it on the shelf of the medication closet.<br><br>Interview on 4/27/21 with the facility Nurse indicated she was not aware if the facility had a policy about the use of glucometers. She did state during the medication administration course training for direct care staff that they are instructed that each client should have their own glucometer that is only used for that individual client. Further interview revealed she was reasonably certain staff should be checking batteries for the glucometers frequently and notify nursing when the individual glucometers were not working. Additional interview revealed that in the event one glucometer is used for two blood sugar readings, that direct care staff are taught to use antibacterial wipes (kept in the medication closet) to clean the glucometer between uses before storing it away in the medication closet. In addition, the Nurse confirmed direct care staff had not communicated with nursing that the glucometers were not working in the facility. | W 340 | For all clients including client # 2 and #4 the Nurses will visit the home on a monthly bases to check medical equipment used by our clients to ensure in good working order and to check all medications to ensure that there are adequate amounts to administer for the month. The Nursing staff will maintain contact with pharmacy supplies to order new equipment when needed. Program manager will monitor weekly, Nursing staff will monitor monthly and QP will monitor monthly. | |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. | W 368 | | |

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| W 368 | Continued From page 8<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the system for drug administration failed to assure all drugs and supplements were administered in compliance with physician's orders for 2 of 4 audit clients (#1, #4). The findings are:<br><br>A. During observations of medication administration on 4/27/21 at 7:40am after taking client #4's blood glucose, staff G punched out Chlorthalidone 25mg. (1), Multivitamin (1), Lorazepam 0.5 mg. (1) , Potassium Chloride ER 20 meq. (1) and Vitamin D3 1000 units(1) into a pill cup. Staff G poured a small 4 ounce cup of water and then held the pill cup to client #4's mouth for him to take the pills. She then handed client #4 a cup of water to drink. Thickener was not added to the cup of water.<br><br>Immediate interview on 4/27/21 with staff G confirmed that she had not added thickener to client #4's water.<br><br>Review on 4/26/21 of client #4's IPP dated 10/6/20 revealed his order revealed which indicates he is prescribed a heart healthy, calorie controlled, dental soft diet with honey thickened liquids.<br><br>Interview on 4/27/21 with the QIDP and with the facility Nurse confirmed all of client #4's beverages should be thickened as indicated in his IPP and physician orders dated 2/17/21.<br><br>B. During observations of the medication administration pass on 4/27/21 at 7:25am, client | W 368 | **W 368** The facility will ensure that all drugs are administered in compliance with physician's orders.<br><br>The nursing staff will in service all staff on beverage consistency of client #4 during medication administrations, orders for client #1 crushed medications during administration and swallowing guidelines for client #1 based off swallowing exam results. Nursing staff will monitor weekly medication administration as it affects all clients in the home to ensure compliance. | 6/27/21 |

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| W 368 | Continued From page 9<br>#1 assisted in tearing the packages of pills that contained Eliquis 5 mg. (1) Allopurinol 10 mg. (1), Cetirizine 10 mg.(1), Docusate Sodium 100 mg. (1),Torsemide 10mg. (1), Vitamin D 225mg. (1), Pantoprazole (1), Magnesium Citrate 200 mg. (1), Folic Acid 1 mg. (1), Phenobarbital 32.4 mg. (1), and Acetaminophen 650 mg. (2). She also assisted client #1 with eye drops and nasal spray. Staff G handed the cup of pills to client #1, assisted her in pouring a cup of water and then watched as client #1 consumed the pills.<br><br>Observation 4/27/21 in the medication area of the facility office revealed a sign on the medication room door " Please crush all of (client #1's name) pills during medication administration."<br><br>Immediate interview on 4/27/21 with staff G confirmed she forgot to crush client #1's pills during medication administration.<br><br>Review on 4/27/21 of instructions named, "Swallowing Guidelines" indicated, "meds crushed and given in applesauce unless contraindicated."<br><br>Interview on 4/27/21 with the facility Nurse confirmed that all of client #1's medications should be crushed and administered in applesauce as posted. | W 368 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. | W 369 | | |

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| W 369 | Continued From page 10<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to ensure all medications were administered without error. This affected 1 of 4 audit clients (#1) observed receiving medications. The finding is:<br><br>During observations of the medication administration pass on 4/27/21 at 7:25am, client #1 assisted in tearing the packages of pills that contained Eliquis 5 mg. (1) Allopurinol 10 mg. (1), Cetirizine 10 mg.(1), Docusate Sodium 100 mg. (1),Torsemide 10mg. (1), Vitamin D 225mg. (1), Pantoprazole (1), Magnesium Citrate 200 mg. (1), Folic Acid 1 mg. (1), Phenobarbital 32.4 mg. (1), and Acetaminophen 650 mg. (2). She also assisted client #1 with eye drops and nasal spray. Staff G handed the cup of pills to client #1, assisted her in pouring a cup of water and then watched as client #1 consumed the pills.<br><br>Immediate interview with staff G on 4/27/21 revealed client #1 was currently out of Polyethylene Glycol (17 grams). Staff G explained she administered the last dose on 4/26/21 and that she had forgotten to inform nursing that this medication needed to be reordered.<br><br>Review on 4/27/21 of client #1's physician orders dated 2/17/21 revealed Eliquis 5 mg. (1) Allopurinol 10 mg. (1), Cetirizine 10 mg.(1), Docusate Sodium 100 mg. 91),Torsemide 10mg. (1), Vitamin D 225mg. (1), Pantoprazole (1), Magnesium Citrate 200 mg. (1), Folic Acid 1 mg. (1), Phenobarbital 32.4 mg. (1), Acetaminophen 650 mg. (2),Pataday eye drops, Fluticasone nasal spray (1) spray to each nostril and Polyethylene | W 369 | **W 369** The facility will ensure that the system for all drug administration including those that are self-administered and ensure administered without error for all individuals.<br><br>The facility Nurses will in service all staff on correct medication administration procedures of all medications prescribed by physicians for client # 1, and on how to check equipment and reporting procedures on medication needs as well as equipment malfunctions. The Nurses will visit the home on a monthly bases to check medical equipment used by our clients to ensure in good working order and to check all medications to ensure that there are adequate amounts to administer for the month. The Nursing staff will maintain contact with Pharmacy when medications are needed and ensure they | 6/27/21 |

| 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 _____ | 04/27/2021 |

| 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 369 | Continued From page 11<br>Glycol (17 grams).<br><br>Interview on 4/27/21 with the facility Nurse revealed direct care staff are to inform nursing of any medications that need to be reordered before the client's last dose of medication. Further interview revealed nursing had not been informed this medication for client #1 was out of stock. | W 369 | are delivered to the homes. Program Manager will monitor weekly and Clinical Supervisor will monitor monthly. | |

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

April 29, 2021

Ms. Melissa Bryant, Division Director
Community Innovations, Inc.
80 Alliance Drive
Whiteville, North Carolina 28472

Re: Recertification Completed on April 27, 2021
Strawberry House, 303 North Howard Street, Chadbourn, North Carolina 28431
Provider Number : 34G231
MHL: 024-019
E-mail Address: mbryant@communityinnovations.com
jjordan@communityinnovations.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed on April 27, 2021. 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 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 deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **June 27, 2021**.

**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 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 Kimberly McCaskill at (919)218-9152 or email at: Kim.McCaskill@dhhs.nc.gov.

Sincerely,

Kimberly C. McCaskill

Kimberly C. McCaskill, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSR@Alliancebhc.org
QM@partnersbhm.org
DHSRreports@eastpointe.net
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO