Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-299	A. BUILDING: _____ B. WING _____	R 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANBERRY PLACE	1909 STANBERRY PLACE FAYETTEVILLE, NC 28301

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on December 14, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 3 current clients.	V 000	DHSR - Mental Health Dec 3 0 2021 Lic. & Cert. Section	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	See attachment	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tiffany Dennis — 12/21/21

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement strategies to address client needs for 1 of 3 audited clients (#1). The findings are: Review on 12/9/21-12/10/21 of client #1's record revealed: -43 year old male. -Admitted on 10/21/11. -Diagnoses of Impulse Control Disorder, Mild Intellectual Disability and Other Schizophrenia. Review on 12/9/21-12/10/21 of client #1's treatment plan dated 7/1/21 revealed: -"What (Short Range Goal) [Client #1] will refrain from eloping various places such as the group home, day program, and other community buildings such as the hospital and fire department. [Client #1] will reduce the number of behaviors incidents to less than 2 per month for six consecutive months. How (Support/Intervention) Staff will monitor [Client #1's] behavior and report all incidents to the QP (Qualified Professional). The QP will complete IRIS (North Carolina Incident Response Improvement System) reports as necessary." -The treatment plan did not include any strategies for client #1's elopement goal. Review on 12/9/21-12/10/21 of the facility's level II incident reports revealed: -9/10/21, level II, "Incident comments...On 9/10/21 at 1:30am in the morning [Client #1] open	V 112		

Stanberry Place Group Home

Plan of Correction

W112 – On 12/20/21, the QP met with client #1 and his guardian to discuss strategies to prevent elopement. Strategies were added to his treatment plan and all Stanberry Place staff will be trained on that information by 1/15/2022. The QP will review the new strategies monthly to measure the effectiveness of each strategy. The treatment plan may be updated after analyzing incidents over a period of time.

V118 – By 2/15/2022, all staff will be re-trained in medication administration. The group home manager and QP will coordinate will all physicians to ensure the orders are current and all medications are available. The group home manager/QP will observe staff weekly to ensure they administering medications correctly and completing documentation.

V367 – By 2/15/2022, all Stanberry Place staff will be trained on incident reporting. The QP will document all level II and II reports in the IRIS system. All level II incident reports will be submitted within 72 hours of the incident date. Level III incidents will be reported within 24 hours. The administrative team will review all incidents and determine if it meets the criteria for an IRIS report.

V736 – By 2/15/2022 all repairs citied at Stanberry Place will be corrected. The group home manager and QP will conduct a thorough walk through and identify areas of the facility that need to be addressed. The group home manager will oversee all home repairs. The group home manager will conduct a thorough facility inspection quarterly.

Sophia B. Pierce & Associates, Inc.
1422 Murchison Road
PO Box 2813
Fayetteville, NC 28302
Phone (910) 488-8477 Fax (910) 822-1951

December 21, 2021

Dear Tareva Jones,

Thank you for your recent visit to our facility on December 14, 2021. We have received the list of deficiencies and have already started making adjustments to comply with state regulations and guidelines. Enclosed you will find our plan of correction for those deficiencies. If you have any questions or concerns, please contact our office at (910) 488-8477.

Sincerely,

Tiffany Harrington
Qualified Professional