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 _____	07/15/2025

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
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 036	Continued From page 1 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to ensure all staff were trained on the EP plan. The finding is: Review on 7/15/25 of the facility's EP plan and other documentation revealed no staff training for the Emergency Plan. Interview on 7/15/25 with the Home Manger indicated no staff training on the facility's Emergency Preparedness Plan could be located	E 036		

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E 036	Continued From page 2 for new and existing staff.	E 036		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific information to support his independent use of a assistive pouring device. This affected 1 of 4 audit clients. The finding is: During 3 of 3 mealtime observations in the home on 7/14 - 7/15/25, various staff assisted client #4 at the meal. Client #4 is blind and required assistance to locate various food items on his plate. Each staff was also noted to place a small battery operated device at the rim of his cups. The device emitted a noise as liquid was poured into the glass reached the extended metal prongs on the end of the device. Client #4 was provided full physical assistance to pour all liquids and was not observed to independently pour from a pitcher. Interview on 7/15/25 with Staff B revealed the device is used to assist client #4 with knowing when his glass is full when pouring. The staff acknowledged the client does not pour without staff assistance. Review on 7/14/25 of client #4's IPP dated 10/18/24 revealed he is blind. Additional review of the plan did not include any information regarding the battery operated device or it's use.	W 240		

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W 240	Continued From page 3 Interview on 7/15/25 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) indicated staff have used the device with client #4 at meals for a longtime. Additional interview confirmed there was no information in the client's IPP regarding the device or how it should be used to support client #4 at meals.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of food preparation and lifting techniques. This affected 3 of 4 audit clients (#1, #4, and #6). The findings are: A. During 3 of 3 meal preparation observations in the home on 7/14 - 7/15/25, various staff completed all food preparation tasks. With the exception of client #5 briefly pressing the button on the food processor at dinner and breakfast, no	W 249		

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W 249	Continued From page 4 clients were prompted or assisted to participate with any food preparation tasks. Interview on 7/15/25 with Staff K revealed clients only operate the food processor or set the table to assist before meals. The staff stated, "That's all I know." Review on 7/15/25 of client #1's Adaptive Behavior Inventory (ABI) dated 2/4/25 revealed she requires partial assistance to prepare beverages, sandwiches, salads, desserts and convenience foods; identify fruits, vegetables, dairy products, meats, and breads; fry, boil and bake foods; and to prepare breakfast, lunch and dinner meals. Additional review of the ABI indicated the client can independently identify/use kitchen equipment/furnishings. Review of client #4's IPP dated 10/18/24 revealed he should be encouraged to assist with household chores such as preparing meals. Additional review of the plan included a need to learn to use kitchen appliances such as the stove, oven, toaster and can opener. Interview on 7/15/25 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be assisting in the kitchen with food preparation tasks and staff have been trained in this area. B. During observations in the home on 7/14/25, various staff assisted client #6 with repositioning and/or toileting needs. During afternoon observations on 7/14/25, two staff provided assistance to reposition client #6. Later, during evening observations, one staff repositioned the client in her bedroom.	W 249		

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W 249	Continued From page 5 Interview on 7/15/25 with Staff J revealed client #6 is repositioned using a mechanical lift and requires two people during lifting. Additional interview with Staff A indicated she lifts client #6 using the mechanical lift and the client can be repositioned by one person. Review on 7/14/25 of client #6's Pressure Relief guidelines dated 6/30/14 revealed, "[Client #6] is to be transferred via Hoya lift to chair (wheelchair) [if she desires] X 2 persons..." Interview on 7/15/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated there have not been any changes with client #6's guidelines and they remain in place.	W 249		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) was revised after client #6 had successfully completed an identified objective. This affected 1 of 4 audit clients. The finding is: Review on 7/15/25 of client #6's record revealed an objective to exhibit one or fewer challenging behaviors per month for 11 consecutive months. Additional review of progress notes for the objective from January '23 - May '25 revealed no	W 255		

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W 255	Continued From page 6 documented behaviors. During an interview on 7/15/25, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the objective should be completed based on the lack of documented behaviors for over 2 years.	W 255		
W 263	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 reviews and interview, the facility failed to ensure written informed guardian consent was obtained for a restrictive behavior plan. This affected 2 of 4 audit clients (#4 and #6). The findings are: A. Review on 7/14/25 of client #4's Behavior Support Plan (BSP) dated 7/5/24 revealed an objective that client #4 will exhibit 1 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the plan included the use of Risperdal and Ativan. Further review of the record revealed a written informed consent for the BSP signed on 6/3/24 by client #4's guardian. No current consent was available for review. B. Review on 7/14/25 of client #6's BSP dated 7/5/24 revealed an objective that client #6 will exhibit 1 or fewer challenging behaviors per month for 11 consecutive months. Additional review of the plan included the use of Valium and Oxycodone. Further review of the record revealed	W 263		

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W 263	Continued From page 7 a written informed consent for the BSP signed on 6/13/24 by client #6's guardian. No current consent was available for review. Interview on 7/15/25 with the ICF Regional Director confirmed no current behavior plan consent had been obtained for client #4 and client #6.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure drugs used for the control of inappropriate behaviors were used only as an integral part of the Behavior Support Plan (BSP) directed towards the reduction or elimination of behaviors for which the drugs were employed. This affected 1 of 4 audit clients (#4). The finding is: Review on 7/15/25 of client #4's BSP dated 7/5/24 revealed an objective to exhibit 1 or fewer challenging behaviors (Severe Disruption, PICA, Property Destruction) per month for 11 consecutive months. Additional review of the plan noted the use of Risperdal and Ativan to address the client's target behaviors. Further review of BSP progress notes and Quarterly HRC notes revealed the client exhibited two target behaviors over the past 12 months. Interview on 7/15/25 with the Qualified Intellectual	W 312		

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W 312	Continued From page 8 Disabilities Professional (QIDP) and the facility's nurse indicated client #4 continues to ingest Risperdal and Ativan to address his target behaviors; however, the interdisciplinary team has not considered an adjustment in his behavior medications based on his low behavior incidents over the past year.	W 312		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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 health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, record/document review and interviews, the facility failed to ensure staff were sufficiently trained regarding the appropriate use of latex gloves. This affected 1 of 4 audit clients (#6). The finding is: During breakfast observations in the home on 7/15/25 at 7:35am, Staff I applied latex gloves and began to feed client #6 her breakfast meal. The staff continued to wear the gloves throughout the entire meal. Interview on 7/15/25 with Staff I revealed she had been working at the home since January '25 and had been trained to wear latex gloves when feeding client #6 due to "fluids" coming from her mouth. Review on 7/15/25 of client #6's Individual Program Plan (IPP) dated 5/16/25 did not indicate latex gloves should be worn while feeding the	W 340		

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W 340	Continued From page 9 client. Additional review of the facility's policy for Universal Precautions - Handwashing and Glove Use (last revised 01/2024) revealed, "Gloves should be worn when: Exposure to blood or other body fluids, excretions or sections are likely." Further review of the policy did not indicate gloves were required while feeding clients. Interview on 7/15/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff have not been trained to wear latex gloves while feeding client #6.	W 340		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) 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, record reviews and interviews, the facility failed to ensure each client received their modified and specially-prescribed diets. This affected 2 of 4 audit clients (#2 and #6). The findings is: During breakfast observations in the home on 7/15/25 at 7:35am, client #2 and client #6 consumed turkey bacon, oatmeal, biscuits and peaches. Closer observation of the turkey bacon revealed it was ground, thick and dry. Both clients consumed the bacon without difficulty. Interview on 7/15/25 with Staff K revealed the turkey bacon should be pureed, however, they could not get it to the pureed consistency after several attempts. Additional interview indicated	W 460		

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W 460	Continued From page 10 several clients should consume pureed food, including client #2 and client #6. Review on 7/14/25 of a client's diet list posted on the refrigerator in the home (no date) revealed client #2 consumes a "dental soft with pureed meats" texture and client #6 should consume a pureed texture. Additional review of client #2's physician's orders (5/2025 - 5/2026) revealed she consumes a "pureed diet". Additional observation of pictures of pureed foods posted in the dining room of the home noted with a pureed consistency, "All foods are prepared to a smooth consistency by grinding and then pureeing them. Appearance is smooth like pudding." Interview on 7/15/25 with the Home Manager confirmed the posted diet list should be followed and staff should have substituted pre-processed sausage meat instead of the turkey bacon.	W 460		