PRINTED: 02/07/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G283		B. WING _	B. WING		02/05/2019		
NAME OF PROVIDER OR SUPPLIER  TROTTERS BLUFF				912 AVENT	DRESS, CITY, STATE, ZIP CODE FERRY ROAD PRINGS, NC 27540	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	3	W	000			
W 153	INITIAL COMMENTS  A complaint investigation was completed on February 5, 2019 for complaint intake #NC00147169. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to assure allegations was reported immediately to the facility administrator or designee as well as the Health Care Personnel Registry (HCPR) within twenty-four hours as required by NC General Statute 131E-256. This deficient practice was identified through interview with the Qualified Intellectual Disabilities Professional (QIDP). The finding is:  Facility management staff did not complete an IRIS report as required for a level two incident involving absence without leave (AWOL).  Interview on 2/5/19 with client #2 at the vocational center revealed he had a behavioral incident at the facility on 2/2/19. Client #2 reported the following: he ran out of the facility followed by direct care staff (DCS). Client #2 stated the QIDP was working at the facility. He stated the QIDP		W -	53			
		attempted to get him to ent building which serves as					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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.

Facility ID: 945339

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W 153	side in the grass. DC: him and DCS grabber on the grass. DCS the and then sat on him to up. Client #2 stated hand trying to bite staff and then started walk stated he again ran for the ditch near the roa he walked back into the dated 2/2/19 revealed incidents on that date a) 2/2/19: (2:15pm): A authorization (AWOL) redirected him. Incided b) 2/2/19 (5:30pm): A medication, left the horder of the walked by was working on 2/2/1 heard client #2 outsided attempted to get client He went into the officiand the QIDP follower which resulted in him rolled him on his side above his shoulders. hitting and trying to big after a few minutes of then started walking to she stated client #2 at the started client #2 at the started walking to she stated client #2 at the started walking to she stated client #2 at the started walking to she stated client #2 at the started walking to she started client #2 at the started client #2 at the started client #2 at the started walking to she started client #2 at the started client #2	to the office, then ran out S and the QIDP followed d him and pushed him down en rolled him on his stomach o prevent him from getting e was screaming, hitting f. He stated he calmed down ting back to the facility. He fom DCS and tried to sit in d. DCS redirected him and he facility.  the behavioral data sheet d client #2 had 2 behavioral is:	W	153			

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W 153	stated that DCS did ground, DCS did not the ground nor did D these allegations we Review on 2/5/19 of program (BSP) date objective statement" fewer challenging be consecutive months listed as: failure to m severe disruptive be allegations against seems and the severe disruptive be allegations against seems. Additional interview revealed AWOL is not the QIDP also confi an incident report not completed following client #2 engaged in leaving the facility. The facility administrator behavioral incident. STAFF TRAINING PCFR(s): 483.430(e)()  For employees who must focus on skills toward clients' behavioral incidents' behavioral incidents' behavioral clients' behavioral clients' behavioral incidents' behavioral incidents' behavioral incidents' behavioral clients' behavioral incidents' be	back into the facility. She not push client #2 to the place client #2 face down on pCS sit on him. She stated re not true.  client #2's behavior support d 9/7/18 revealed an [Client #2} will exhibit one or chavior per month for 11 "The target behaviors were nake responsible choices, havior, making false taff.  on 2/5/19 with the QIDP of included in client #2's BSP. rmed DCS did not complete or was an IRIS report this incident on 2/2/19 when AWOL behaviors twice The QIDP also confirmed the was not notified of this  ROGRAM 2)  work with clients, training and competencies directed vioral needs. not met as evidenced by: view and staff interviews, S) failed to demonstrate and to implement the least on to address client #2's ors The finding is:	W 1				
	Staff did not demons	strate competencies in					

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W 191	Interview on 2/5/19 center revealed he had the facility on 2/2/19 following: he ran out direct care staff. Clic intellectual disabilities working at the facility the incident and attered into the adjacent but office. He went into the grass. DCS and DCS grabbed him and grass. DCS then roll then sat on him to public the staff. He then started walking the again ran from Dunear the road. DCS back into the facility Review on 2/5/19 of dated 2/2/19 reveals incidents on that darea in 2/2/19; (2:15pm): authorization (AWO redirected him. Incidents on 2/2/19 (5:30pm): medication, left the DCS redirected him minutes.  Interview on 2/5/19 was working on 2/2/19 was working on 2/2/19 heard client #2 outs	with client #2 at the vocational had a behavioral incident at a. Client #2 reported the at of the facility followed by ent #2 stated the qualified resprofessional (QIDP) was any. He stated the QIDP saw rempted to get him to come aliding which serves as the the office, then ran out side in the QIDP followed him and and pushed him down on the revent him from getting up. Was screaming, hitting and the stated he calmed down and back to the facility. He stated CS and tried to sit in the ditch redirected him and he walked the client #2 had 2 behavioral te:	W	91				

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W 191	and the QIDP follow which resulted in hir rolled him on his sid above his shoulders hitting and trying to after a few minutes then started walking She stated client #2 to sit in the ditch neahim and he walked stated that DCS did ground, DCS did no the ground nor did Ethese allegations were resulted as: Failure to be consecutive months listed as: Failure to be Severe Disruptive Ballegations against so The QIDP tried to reby phone several time was not able to speak Attempts were made 2/5/19 by phone, he also unsuccessful.	ce, then ran outside. DCS red him and staff grabbed him in falling on the grass. Staff e with his arms extended i. Client #2 was screaming, bite DCS. The QIDP stated client #2 calmed down and back towards the facility. again ran from DCS and tried for the road. DCS redirected back into the facility. She not push client #2 to the toplace client #2 face down on DCS sit on him. She stated ere not true.  I client #2's behavior support d 9/7/18 revealed an Client #2's will exhibit one or ehavior per month for 11  "The target behaviors were make responsible choices, ehavior, Making false staff.  each the corporate NCI trainer nes on 2/5/19 however, she	W	191			

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W 191	revealed AWOL is not The QIDP also confirm to ensure client #2 did is a very busy road in confirm however the #2 by the shirt, lying hextended above his hold technique. Further additional NCI re-train DCS.	n 2/5/19 with the QIDP t included in client #2's BSP. med DCS exercised caution d not leave the yard as there front of the facility. She did technique of grabbing client nim on his side with his arms lead was not an approved er interview revealed ning may be needed by all		191				
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.		VV .	252				
	Based on record revi facility failed to ensur- accordance with indiv	not met as evidenced by: iew and interviews, the e data was collected in vidual program plan (IPP) cted 1 client (#2). The						
	Staff did not docur client #2 during an ab (AWOL) incident.	ment physically restraining sence without leave						
	center revealed he had the facility on 2/2/19. following: he ran out of direct care staff (DCS	ith client #2 at the vocational ad a behavioral incident at Client #2 reported the of the facility followed by S). Client #2 stated the QIDP incident and attempted to						

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W 252	serves as the office ran out side in the grollowed him and sthim down on the grows this stomach and the from getting up. Clie screaming, hitting a stated he DCS redii back into the facility. Interview on 2/5/19 was working on 2/2 heard client #2 outs attempted to get client #2 outs attempted to get client and the QIDP follow which resulted in hir rolled him on his side above his shoulders hitting and trying to after a few minutes then started walking. She stated client #2 to sit in the ditch ne him and he walked stated that DCS did ground, DCS did not the ground nor did I these allegations were program (BSP) date objective statement fewer challenging be consecutive months listed as: Failure to Severe Disruptive E	o the adjacent building which . He went into the office, then grass. DCS and the QIDP aff grabbed him and pushed ass. DCS then rolled him on en sat on him to prevent him ent #2 stated he was and trying to bite DCS. He rected him and he walked  with the QIDP revealed she rected him and he walked  with DCS. She stated she ent #2 to come into the office. ice, then ran out side. DCS wed him and staff grabbed him m falling on the grass. Staff the with his arms extended s. Client #2 was screaming, bite DCS. The QIDP stated client #2 calmed down and g back towards the facility. again ran from DCS and tried ar the road. DCS redirected back into the facility. She not push client #2 face down on DCS sit on him. She stated	W	252			

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W 252	physical restraint as a intervention for this p  Review on 2/5/19 of t dated 2/2/19 revealed incidents on that date a) 2/2/19: (2:15pm): A authorization (AWOL redirected him. Incide b) 2/2/19 (5:30pm): A medication, left the he Staff redirected him. minutes.  Additional interview or revealed AWOL is no The QIDP also confirt the physical restraint	a component of the rogram.  the behavioral data sheet diclient #2 had 2 behavioral es: Absence without high staff ent lasted about 40 minutes.  WOL, refusing to take puse without permission. Incident lasted about 15  an 2/5/19 with the QIDP to included in client #2's BSP.  med staff did not document	W	252				