STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G283	A. BUILDING _____ B. WING _____	C 02/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TROTTERS BLUFF	912 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540

(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 000	INITIAL COMMENTS A complaint investigation was completed on February 5, 2019 for complaint intake #NC00147169.	W 000		4/1/19
W 153	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 saw the incident and attempted to get him to come into the adjacent building which serves as	W 153	QP will ensure that IRIS Report is Completed for all any level two incidents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — QP | TITLE 4/1/19 | (X6) DATE

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 153	Continued From page 1 the office. He went into the office, then ran out side in the grass. DCS and the QIDP followed him and DCS grabbed him and pushed him down on the grass. DCS then rolled him on his stomach and then sat on him to prevent him from getting up. Client #2 stated he was screaming, hitting and trying to bite staff. He stated he calmed down and then started walking back to the facility. He stated he again ran from DCS and tried to sit in the ditch near the road. DCS redirected him and he walked back into the facility. Review on 2/5/19 of the behavioral data sheet dated 2/2/19 revealed client #2 had 2 behavioral incidents on that date: a) 2/2/19: (2:15pm): Absence without authorization (AWOL), kicking, hitting, biting. DCS redirected him. Incident lasted about 40 minutes. b) 2/2/19 (5:30pm): AWOL, refusing to take medication, left the house without permission. DCS redirected him. Incident lasted about 15 minutes. Interview on 2/5/19 with the QIDP revealed she was working on 2/2/19 at the office when she heard client #2 outside with DCS. She stated she attempted to get client #2 to come into the office. He went into the office, then ran out side. DCS and the QIDP followed him and DCS grabbed him which resulted in him falling on the grass. Staff rolled him on his side with his arms extended above his shoulders. Client #2 was screaming, hitting and trying to bite DCS. The QIDP stated after a few minutes client #2 calmed down and then started walking back towards the facility. She stated client #2 again ran from DCS and tried to sit in the ditch near the road. DCS redirected	W 153		4/6/19

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W 153	Continued From page 2 him and he walked back into the facility. She stated that DCS did not push client #2 to the ground, DCS did not place client #2 face down on the ground nor did DCS sit on him. She stated these allegations were not true. Review on 2/5/19 of client #2's behavior support program (BSP) dated 9/7/18 revealed an objective statement" [Client #2} will exhibit one or fewer challenging behavior per month for 11 consecutive months." The target behaviors were listed as: failure to make responsible choices, severe disruptive behavior, making false allegations against staff. Additional interview on 2/5/19 with the QIDP revealed AWOL is not included in client #2's BSP. The QIDP also confirmed DCS did not complete an incident report nor was an IRIS report completed following this incident on 2/2/19 when client #2 engaged in AWOL behaviors twice leaving the facility. The QIDP also confirmed the facility administrator was not notified of this behavioral incident.	W 153	Staff will be retrained on proper NCI & NCI Plus less restrictive techniques.	4/1/19
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on record review and staff interviews, direct care staff (DCS) failed to demonstrate competencies needed to implement the least restrictive intervention to address client #2's inappropriate behaviors.. The finding is: Staff did not demonstrate competencies in	W 191		

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W 191	Continued From page 3 addressing client #2's inappropriate behaviors. 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. Client #2 stated the qualified intellectual disabilities professional (QIDP) was working at the facility. He stated the QIDP saw the incident and attempted to get him to come into the adjacent building which serves as the office. He went into the office, then ran out side in the grass. DCS and the QIDP followed him and DCS grabbed him and pushed him down on the grass. DCS then rolled him on his stomach and then sat on him to prevent him from getting up. Client #2 stated he was screaming, hitting and trying to bite staff. He stated he calmed down and then started walking back to the facility. He stated he again ran from DCS and tried to sit in the ditch near the road. DCS redirected him and he walked back into the facility. Review on 2/5/19 of the behavioral data sheet dated 2/2/19 revealed client #2 had 2 behavioral incidents on that date: a) 2/2/19: (2:15pm): Absence without authorization (AWOL), kicking, hitting, biting. DCS redirected him. Incident lasted about 40 minutes. b) 2/2/19 (5:30pm): AWOL, refusing to take medication, left the house without permission. DCS redirected him. Incident lasted about 15 minutes. Interview on 2/5/19 with the QIDP revealed she was working on 2/2/19 at the office when she heard client #2 outside with DCS. She stated she attempted to get client #2 to come into the office.	W 191		4/1/19

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W 191	Continued From page 4 He went into the office, then ran outside. DCS and the QIDP followed him and staff grabbed him which resulted in him falling on the grass. Staff rolled him on his side with his arms extended above his shoulders. Client #2 was screaming, hitting and trying to bite DCS. The QIDP stated after a few minutes client #2 calmed down and then started walking back towards the facility. She stated client #2 again ran from DCS and tried to sit in the ditch near the road. DCS redirected him and he walked back into the facility. She stated that DCS did not push client #2 to the ground, DCS did not place client #2 face down on the ground nor did DCS sit on him. She stated these allegations were not true. Review on 2/5/19 of client #2's behavior support program (BSP) dated 9/7/18 revealed an objective statement" [Client #2} will exhibit one or fewer challenging behavior per month for 11 consecutive months." The target behaviors were listed as: Failure to make responsible choices, Severe Disruptive Behavior, Making false allegations against staff. The QIDP tried to reach the corporate NCI trainer by phone several times on 2/5/19 however, she was not able to speak with him. Attempts were made to reach DCS staff on 2/5/19 by phone, however these attempts were also unsuccessful. Interview on 2/5/19 with the corporate quality assurance (QA) staff revealed the technique described by the QIDP that DCS used to restrain client #2 from AWOL was not an approved technique.	W 191	NCI trainer will return staff on Proper NCI techniques.	4/1/19

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W 191	Continued From page 5 Additional interview on 2/5/19 with the QIDP revealed AWOL is not included in client #2's BSP. The QIDP also confirmed DCS exercised caution to ensure client #2 did not leave the yard as there is a very busy road in front of the facility. She did confirm however the technique of grabbing client #2 by the shirt, lying him on his side with his arms extended above his head was not an approved NCI technique. Further interview revealed additional NCI re-training may be needed by all DCS.	W 191	Program Manager will inservice staff on proper documentation of behaviors and following the plans.	4/1/19
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. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure data was collected in accordance with individual program plan (IPP) objectives. This affected 1 client (#2). The findings are: 1. Staff did not document physically restraining client #2 during an absence without leave (AWOL) incident. 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, saw the incident and attempted to	W 252		

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W 252	Continued From page 6 get him to come into the adjacent building which serves as the office. He went into the office, then ran out side in the grass. DCS and the QIDP followed him and staff grabbed him and pushed him down on the grass. DCS then rolled him on his stomach and then sat on him to prevent him from getting up. Client #2 stated he was screaming, hitting and trying to bite DCS. He stated he DCS redirected him and he walked back into the facility. Interview on 2/5/19 with the QIDP revealed she was working on 2/2/19 at the office when she heard client #2 outside with DCS. She stated she attempted to get client #2 to come into the office. He went into the office, then ran out side. DCS and the QIDP followed him and staff grabbed him which resulted in him falling on the grass. Staff rolled him on his side with his arms extended above his shoulders. Client #2 was screaming, hitting and trying to bite DCS. The QIDP stated after a few minutes client #2 calmed down and then started walking back towards the facility. She stated client #2 again ran from DCS and tried to sit in the ditch near the road. DCS redirected him and he walked back into the facility. She stated that DCS did not push client #2 to the ground, DCS did not place client #2 face down on the ground nor did DCS sit on him. She stated these allegations were not true. Review on 2/5/19 of client #2's behavior support program (BSP) dated 9/7/18 revealed an objective statement" [Client #2} will exhibit one or fewer challenging behavior per month for 11 consecutive months." The target behaviors were listed as: Failure to make responsible choices, Severe Disruptive Behavior, Making false allegations against staff. The BSP did not include	W 252		4/1/19

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W 252	Continued From page 7 physical restraint as a component of the intervention for this program. Review on 2/5/19 of the behavioral data sheet dated 2/2/19 revealed client #2 had 2 behavioral incidents on that date: a) 2/2/19: (2:15pm): Absence without authorization (AWOL), kicking, hitting, biting. Staff redirected him. Incident lasted about 40 minutes. b) 2/2/19 (5:30pm): AWOL, refusing to take medication, left the house without permission. Staff redirected him. Incident lasted about 15 minutes. Additional interview on 2/5/19 with the QIDP revealed AWOL is not included in client #2's BSP. The QIDP also confirmed staff did not document the physical restraint on client #2 on the behavioral data sheet or on an incident report.	W 252		4/1/19