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

PRINTED: 05/20/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER TROTTERS BLUFF SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY DULL PRETIX TAG PROVIDER REGULATORY OR LS. DENTIFYING INFORMATION) W 130 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy off or 14 audit clients (#4) residing in the home. The finding is: During observations in the home on 5/18/21, at 4.18pm, client #4 was observed standing in front of the tolet and urinating. Further observations revealed the bathroom door remained open while another client walking past. There were two staff in the home, both where stiting in the living room. At no time was client #4 prompted to close the bathroom door nor did staff close the door. During an interview on 5/19/21, 5ff B revealed client #4 needs verbal prompting to close the bathroom door. Review on 5/19/21 of client #4's adaptive behavior inventory (ABI) dated 11/6/20 revealed he has partial independence to close the bathroom door. During an interview on 5/19/21, the qualified intellectual disabilities professional (QIDP) stated staff working in the home have been instructed to be "vigilant" with client #4 to ensure he closes the bathroom door for privacy. W 249 PGCRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
TROTTERS BLUFF SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIT			34G283	B. WING			05/	19/2021
PRÉFEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROTECTION OF CLIENTS RIGHTS CFR(s): 483.42(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 1 of 4 audit clients (#4) residing in the home. The finding is: During observations in the home on 5/18/21, at 4:18pm, client #4 was observed standing in front of the toilet and urinating. Further observations revealed the bathroom door remained open while another client walking past. There were two staff in the home; both where sitting in the living room. At no time was client #4 prompted to close the bathroom door or did staff close the door. During an interview on 5/19/21, Staff B revealed client #4 needs verbal prompting to close the bathroom door. Review on 5/19/21 of client #4's adaptive behavior inventory (ABI) dated 11/6/20 revealed he has partial independence to close the bathroom door. During an interview on 5/19/21, the qualified intellectual disabilities professional (QIDP) stated staff working in the home have been instructed to be "vigilant" with client #4 to ensure he closes the bathroom door for privacy. W 249 ROGGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has					912 AVENT FERRY ROAD	CODE		
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CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has		CFR(s): 483.420(a) The facility must er Therefore, the facilitreatment and care This STANDARD is Based on observation diled to ensure prive (#4) residing in the During observation 4:18pm, client #4 wof the toilet and uring revealed the bathroanother client walking in the home; both was client bathroom door nor During an interview client #4 needs ver bathroom door. Review on 5/19/21 behavior inventory he has partial indep bathroom door. During an interview intellectual disabilities staff working in the be "vigilant" with client bathroom door for patterns and the staff working in the be "vigilant" with client bathroom door for patterns and the staff working in the be the staff working in the be the staff working in the be the staff working in the betaff with the staff working in the betaff working in the betaff with the staff working in the	nsure the rights of all clients. ity must ensure privacy during of personal needs. Is not met as evidenced by: tions and interviews, the facility vacy for 1 of 4 audit clients home. The finding is: Is in the home on 5/18/21, at vas observed standing in front nating. Further observations from door remained open while ing past. There were two staff where sitting in the living room. In #4 prompted to close the did staff close the door. If on 5/19/21, Staff B revealed bal prompting to close the of client #4's adaptive (ABI) dated 11/6/20 revealed bendence to close the or 5/19/21, the qualified des professional (QIDP) stated home have been instructed to ent #4 to ensure he closes the privacy.		30			
		As soon as the inte	rdisciplinary team has					

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

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G283	B. WING		05/	/19/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 912 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 249	each client must re- treatment program interventions and so and frequency to su	ge 1 s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program	W 2	49		
	Based on observatinterviews, the facilicients (#4) receive treatment program interventions and se	s not met as evidenced by: tions, record reviews and ity failed to ensure 1 of 4 audit ed a continuous active consisting of needed ervices as identified in the Plan (IPP) in the area of self ding is:				
	4:18pm, client #4 w of the toilet and urir	s in the home on 5/18/21, at vas observed standing in front nating. Further observations t #4 finished urinating he did				
		on 5/19/21, Staff B revealed be verbally prompted to wash				
	behavior inventory	of client #4's adaptive (ABI) dated 11/6/20 revealed bendence to wash his hands.				
	intellectual disabiliti staff working in the	on 5/19/21, the qualified es professional (QIDP) stated home have been instructed to ent #4 to ensure he washes eting.				

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		34G283	B. WING		05/	19/2021
	PROVIDER OR SUPPLIER RS BLUFF			STREET ADDRESS, CITY, STATE, ZIP CODE 912 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 340 W 340	other members of tappropriate protect measures that inclutraining clients and health and hygiene This STANDARD is Based on observating that staff were suffit temperature and the to COVID-19 protocclients residing in the tand #6). The finding 5/19/21 at 5:50am, home. Further obsopened the door did the surveyor. Staff questions regarding observations reveal was not taken until office. Review on 5/18/21	cess (5)(i) nust include implementing with the interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate methods. s not met as evidenced by: tions, record review and ng services failed to ensure ciently trained in taking e wearing of gloves in regards col. This potentially effected all ne home (#1, #2, #3, #4, #5	W 3.			
	manager revealed should have been thome. Further inte	on 5/19/21, the assistant the surveyors' temperature aken before they entered the rview revealed all the staff e have been trained to ensure				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G283	B. WING _		05	/19/2021
	NAME OF PROVIDER OR SUPPLIER TROTTERS BLUFF			STREET ADDRESS, CITY, STATE, ZIP CODE 912 AVENT FERRY ROAD HOLLY SPRINGS, NC 27540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 340	all temperatures of should be taken. During an interview intellectual disabilitic confirmed the survey have been taken between taken take	anyone entering the home on 5/19/21, the qualified es professional (QIDP) eyors' temperature should efore they entered the home. observations in the home on m until 7:45am, Staff was disposable gloves. Additional led Staff A did change the mes. Further observations as observed not to wear on 5/19/21, Staff A revealed a staff the federal government vaccinated for COVID-19. e surveyor that he actually urveyor tell a another staff the home, that gloves should diling food; so that is when Staff an him too. on 5/19/21, the assistant gloves should only be worn esting clients with their personal on 5/19/21, the QIDP stated orn only during personal care during medication lying topical's). EATION	W 34			

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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		05	/19/2021
NAME OF PROVIDER OR SUPPLIER TROTTERS BLUFF				STREET ADDRESS, CITY, STATE, 912 AVENT FERRY ROAD HOLLY SPRINGS, NC 2754	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 368	The system for drug that all drugs are as the physician's order than the physician's o	g administration must assure dministered in compliance with ers. Is not met as evidenced by: ions, record reviews and ity failed to ensure idministered in compliance ers. This affected 1 of 4 inding is: Idication administration in 7:08am and 7:30am, client 1 Further observations lid not receive any other In 19/21 of client #1's physician jestrol 625 MG/5ML SUS." on 5/19/21, the qualified es professional (QIDP) should have received interview revealed Megestrol	W 3	68		