STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G152	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRICKLAND BRIDGE HOMES A & B	**1818 STRICKLAND BRIDGE ROAD FAYETTEVILLE, NC 28304**

(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 survey was conducted on 5/18/21. Deficiencies were cited as a result of the complaint investigation for NC00177095 and NC00177097.	W 000		
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 interviews, record and policy reviews, staff failed to report an injury of unknown origin to the facility, in order to start an abuse investigation. This affected 1 of 6 clients (#5). The finding include: A review on 5/18/21 of a Staff Communication Log Sheet, dated 5/14/21 on 2nd shift, showed Staff A noted that Client #5 had a bruise on right upper arm. The source of the bruise was not recorded. Client #5 reported that Staff B was informed (date unknown) of the injury. Staff A wrote that she was unsure if the incident was reported (to manager). An additional review on 5/18/21 of the skin assessment form for Client #5 on 5/9/21 revealed that she had no injury after a return from therapeutic leave. The review of the Abuse Policy, April 2021	W 153		

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

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W 153	Continued From page 1 showed that "injuries of unknown origin may be the result of abuse and must be reported immediately." An interview on 5/18/21 with Staff B revealed that she did not recall specific details about Client #5 reporting a bruise on arm. Staff B stated that the facility had a virtual abuse training and went over what to do and who to call (manager) if they suspect or witness abuse. An interview on 5/18/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that if someone saw a bruise, it should have been an incident report and the QIDP should have been contacted by staff. The QIDP confirmed that there was no incident report or investigation conducted for injury of unknown origin for Client #5. The QIDP suggested that the bruise might have been caused by a vaccine shot that the guardian later disclosed. An interview on 5/18/21 with the Administrator revealed that if Client #5 told staff about a bruise and never suggested it was from the shot, then staff should have wrote it up on an incident report.	W 153		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the	W 189		

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W 189	Continued From page 2	W 189		

facility failed to ensure that staff were competently trained to prevent an abuse situation. This affected 1 of 6 clients (#1). The finding is:

A review on 5/18/21 of Client #1's Individual Program Plan (IPP) dated 8/30/20 showed a history of severe disruption, verbal aggression and physical aggression.

An additional review on 5/18/21 of an Investigation Summary, dated 5/10/21 alleged that Staff E became physically aggressive with Client #1 lunch, resulting in injuries to her skin on upper body. Staff E had become upset that Client #1 had another toilet accident which required Staff E to clean up again. Staff E was also upset because Client #1 would not stay in her room, as directed until the clean up was finished. During their exchange, Client #1 and Staff E both engaged in name calling and struck at each other. Staff E did not attempt to get assistance from Staff C, who was in the home. Staff C reported that initially she heard Client #1 yell out once but knew Staff E was with Client #1. Staff C said that Client #1 was known to verbal outbursts. Clients #3, #4, #5 and #6 were in the home during the incident and all reported hearing Client #1 yelling while interacting with Staff E. Staff C stated when the screaming got louder, she went to investigate. It was not documented how many minutes it took to respond. Staff C found Client #1 and Staff E outside the bedroom door and Client #1 immediately showed Staff C that she was injured.

A review on 5/18/21 of the witness statement, 5/6/21 from Staff E indicated that she was unsuccessful in getting Client #1 to stay in room after a toilet accident. Client #1 became verbally

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W 189	Continued From page 3 and physically aggressive toward Staff E who stated that she was trying to back away from Client #1's actions. Staff E admitted to grabbing Client #1's arms. Staff E stated she was physically defending herself from Client #1. An interview on 5/18/21 with Staff C revealed that the facility offers abuse training on an ongoing basis. Staff C was not concern initially when Client #1 screamed on 5/3/21 because Staff E was present. When Staff C made contact with Client #1 she saw marks on her arm. Once Staff C was alone with Client #1, she discovered Client #1 had bruises on neck and arms, and then became concern about physical abuse. An interview on 5/18/21 with the Administrator confirmed the facility offered ongoing training on the abuse policy to staff. The Administrator revealed Staff C was not known to hesitate to protect clients, had made previous abuse reports but initially thought Client #1 was having an outburst which was common. Once Staff C saw that Client #1 was injured by Staff E, she stayed with Client #1 until the nurse arrived to assess injuries. The Administrator suspended Staff E during the investigation and ultimately terminated Staff E's employment when physical abuse was substantiated.	W 189		