COMMUNITY INNOVATIONS, INC.

www.communityinnovations.com

1100 HOLLY SPRINGS RD SUITE 100 ROAD – HOLLY SPRINGS, NC 27540
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FACSIMILE TRANSMITTAL SHEET

TO: NC Dept of Health & Human Services

FROM: Tonya Beckwith

COMPANY:

DATE: 6/1/2021

FAX NUMBER: (919) 715-8078

TOTAL NO. OF PAGES INCLUDING COVER: 8

PHONE NUMBER:

NOTES/COMMENTS: POC for Trotter's Bluff

THANK YOU.

May 1, 2021
NC Department of Health and HumanServices
2718 Mail Services Center, Raleigh,NC 27699-2718
Eugina Barnes,BSW,QIDP

Dear Eugina Barnes:
Thank you for coming out to complete our annual survey at Trotters Bluff home. Please find enclosed our plan of correction for the annual recertification. Should you have any please feel free to contact me @ (919)656-3707.

Thank you,
Tonya Beckwith
QIDP, Community Innovations

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 21, 2021

Richard Gary, Regional Director
Community Innovations
1100 Holly Springs Road, Suite 100
Holly Springs, NC 27540

Re: Recertification Survey May 18 - 19, 2021
Trotters Bluff, 912 Avent Ferry Road, Holly Springs, NC 27540
Provider Number 34G 283
MHL# 092-131
E-mail Address: rgary@communityinnovations.com

Dear Mr. Gary:

Thank you for the cooperation and courtesy extended during the recertification survey completed on May 18 - 19, 2021.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **July 18, 2021**.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSR@Alliancebhc.org
File

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

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

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 _____	05/19/2021

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 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 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 nor 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 130	Staff will be inserved on Privacy of residents and Privacy while in Bathroom Program Manager will monitor weekly QP will monitor monthly.	6/18/2021
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 249	Continued From page 1 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 1 of 4 audit clients (#4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of self help skills. 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 after client #4 finished urinating he did not wash his hands. During an interview on 5/19/21, Staff B revealed client #4 needs to be verbally prompted to wash his hands. Review on 5/19/21 of client #4's adaptive behavior inventory (ABI) dated 11/6/20 revealed he has partial independence to wash his hands. 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 washes his hands after toileting.	W 249	Staff will be inserviced on Prompting clients washing hands after using Bathroom Program Manager will monitor weekly QP will monitor monthly.	6/18/2021

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W 340	Continued From page 2	W 340		6/16/21
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 observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in taking temperature and the wearing of gloves in regards to COVID-19 protocol. This potentially effected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings are: A. During morning observations in the home on 5/19/21 at 5:50am, the surveyor entered the home. Further observations revealed Staff A who opened the door did not take the temperature of the surveyor. Staff A did not ask the surveyor any questions regarding COVID-19 protocol. Further observations revealed the surveyors' temperature was not taken until 8:41am when they entered the office. Review on 5/18/21 of note posted on the front door of the facility stated, "Temps Taken Here On Every Shift Daily." During an interview on 5/19/21, the assistant manager revealed the surveyors' temperature should have been taken before they entered the home. Further interview revealed all the staff working in the home have been trained to ensure	W 340		

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W 340	Continued From page 3 all temperatures of anyone entering the home should be taken. During an interview on 5/19/21, the qualified intellectual disabilities professional (QIDP) confirmed the surveyors' temperature should have been taken before they entered the home. B. During morning observations in the home on 5/19/21 from 5:50am until 7:45am, Staff was observed wearing disposable gloves. Additional observations revealed Staff A did change the gloves at various times. Further observations revealed Staff B was observed not to wear gloves. During an interview on 5/19/21, Staff A revealed a surveyor who works for the federal government told him that gloves are suppose to be worn because he is fully vaccinated for COVID-19. Staff A then told the surveyor that he actually heard the federal surveyor tell a another staff person working in the home, that gloves should be worn when handling food; so that is when Staff A just took it to mean him too. During an interview on 5/19/21, the assistant manager revealed gloves should only be worn when staff are assisting clients with their personal care. During an interview on 5/19/21, the QIDP stated gloves should be worn only during personal care for the clients and during medication administration (applying topical's).	W 340	Staff will be retrained on COVID-19 Protocol and staff will be retrained on proper use of gloves. Program Manager/Assistant Manager will monitor weekly QP will monitor monthly.	6/18/2021
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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W 368	Continued From page 4 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered in compliance with physician's orders. This affected 1 of 4 clients (#1). The finding is: During morning medication administration in home on 5/19/21 at 7:08am and 7:30am, client 1 consumed six pills. Further observations revealed client #1 did not receive any other medications. During review on 5/19/21 of client #1's physician orders stated, "Megestrol 625 MG/5ML SUS." During an interview on 5/19/21, the qualified intellectual disabilities professional (QIDP) confirmed client #1 should have received Megestrol. Further interview revealed Megestrol for client #1 comes in liquid form.	W 368	Staff member will take medication administration class over. Incident report will be submitted to CI, QM Dept. Program Manager/Assistant manager will monitor weekly. QP will monitor monthly.	6/18/2021