

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

PRINTED: 10/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/23/2021
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	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	W 000		
W 322	<p>PHYSICIAN SERVICES CFR(s): 483.460(a)(3)</p> <p>The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a medical assessment in a timely manner for client #1. This affected 1 of 6 audit clients. The finding is:</p> <p>A review on 9/23/21 of a General Event Reports (GER) dated 9/10/21, revealed that on 9/3/21 at 6:30 PM, Staff A observed client #1 with a bruise on the right leg while assisting him with a bath. Staff A reported that client #1 admitted to scratching himself. Additional information on the report, filled out by Life Skill Coach (LSC) revealed that the cause of the bruise was self-injurious behaviors. The bruise was minor with multi-coloration and 2 cm x 1 cm x 0 cm in size. Treatment was not recommended.</p> <p>Review on 9/23/21 of text messages between the guardian of client #1 and the Assistant Resident Manager (ARM) revealed the following conversations:</p> <p>On 9/7/21 at 12:51 PM the ARM received a text from the guardian who relayed client #1 asked if the doctor was going to look at his bruise. The guardian asked the ARM to follow up with an appointment for the injury. The guardian expressed that she was unsure if the injury hurt</p>	W 322		

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 322	<p>Continued From page 1</p> <p>client #1 but "think it would be good to document." The Qualified Intellectual Developmental Professional (QIDP) responded to the guardian that the nurse was present; and would look at injury today.</p> <p>On 9/8/21 at 8:31 AM, the ARM notified the guardian that client #1 had an appointment to see the physician on 9/9/21.</p> <p>Review on 9/23/21 of a Physican Exam revealed on 9/9/21 client #1 had a Telehealth visit with the physician for a contusion on lower leg and epilepsy. The summary contained 1 of 4 pages and did not have an examination of client #1's leg. There was no information if the physician made recommendations for treatment of the injury.</p> <p>Review on 9/23/21 revealed a Quarterly Nursing Report dated 9/14/21. The nurse went to the home to assess client #1's injury from 9/3/21. The nurse found the right inner knee had old bruising.</p> <p>Interview on 9/23/21 with the ARM revealed she saw the bruise on client #1's leg on 9/3/21. The ARM said the bruise looked old, by color (bluish-yellow) and had a scab on it. The ARM said that she notified the guardian on 9/3/21 in advance of her 9/4/21 visit with client #1.</p> <p>Interview on 9/23/21 with the nurse revealed that she does not always travel to the home to examine a bruise, that was described by staff as "no big deal." The nurse acknowledged that she wrote notes in client #1's chart, while at the office on 9/7/21 but did not go to the home to examine the injury until 9/14/21.</p>	W 322			

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W 322	Continued From page 2 Interview on 9/23/21 with the QIDP revealed that the facility failed to request a doctor's exam for client #1 initially because "we did not think he needed medical attention." The QIDP also confirmed that the nurse did not travel to the home to examine the bruise on client #1 until 9/14/21. Interview on 9/23/21 with the Regional Director (RD) revealed that it was the nurse's responsibility to examine a client's bruise in person within 24 hours. The RD further stated the nurse makes the call if there is a need for medical attention.	W 322		