STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

(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
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: The facility failed to ensure the communication system used in the emergency plan (EP) included sufficient specific information in the needs of the individual clients as evidenced by interview and review of the facility's information sheet. The finding is: Review of the EP, verified by interviews with the manager of Snowbird Cottage and the clinical director, revealed emergency information regarding the residents of the group home was limited to the general information contained on an information face sheet. Continued review of the information sheet revealed a basic description of each client's communication skills and dietary needs were included on the face sheet. However, further review of the information did not reveal other specific client information such as behavioral issues, evacuation needs or describe how anyone unfamiliar with the clients should work with them in an emergency situation.	E 007		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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E 037	Continued From page 2 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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E 037	Continued From page 4	E 037		

CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to show evidence direct care staff were sufficiently trained in the use of the facility's emergency plan (EP). The finding is:

Interview with direct care staff in the four cottages regarding the facility's EP revealed an awareness of what to do during fire drills. However, continued interviews revealed no specific knowledge of what should be done during other types of emergency situations. Additional interview with direct care staff revealed no formal training has been provided regarding the facility's EP.

Interviews with the manager of Snowbird cottage, qualified intellectual disabilities professional (QIDP) and the clinical director verified no specific face to face training had been done with staff regarding the facility's EP. However, continued interview with the manager, QIDP and the clinical director, verified by review of a copy of the list of staff whom the information was sent to, revealed information had been distributed to all staff through the facility's electronic communication system. Further interviews with the manager, QIDP and clinical director revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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E 037	Continued From page 5 there is no method to ensure staff had actually read or understood the information regarding the EP. Therefore, the facility failed to show evidence staff had been sufficiently trained in the use of the facility's EP.	E 037		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: The facility failed to assure the right to privacy for clients in Roan and Spring Creek as evidenced by observation, interview and record verification. The findings are: A. In Roan, the facility failed to provide clients with the opportunity for personal privacy during morning observations on 5/15/18. Observations in Roan at 7:20 AM revealed staff and client #11 entering the laundry room and taking folded clothes to each client's room to put them away. Staff and client #11 were observed to enter rooms to complete their task without regard for who was already in the room, what was occurring in the room, or including the assistance of client's in their bedrooms. For example, at 7:30 AM staff and client #11 were observed to open the door and enter the bedroom shared by client #13 and client #15 to put clothes away. Client #13 was observed laying on his bed while the facility nurse was observed evaluating client #15's leg on his	W 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 129	Continued From page 6	W 129		

bed. After placing the clothes in the drawers, staff and client #11 were observed exiting the room and leaving the door open to the hallway.

Interview with staff revealed this is one of the daily chores client #11 helps with and it is the normal routine to put clothes away that were washed and folded by staff on 3rd shift. Interview with the qualified intellectual disabilities professional (QIDP) revealed client privacy should be respected and there may be better ways to assist clients with laundry chores. In addition, review of client #11's individual support plan (ISP) dated 8/9/17 revealed a behavior support plan (BSP) to address several disruptive behaviors including "invading others privacy" identified as entering other client's bedrooms without permission or reason. The facility not only failed to assure privacy for clients in Roan on 5/15/18 but were not modeling appropriate behaviors for client #11 to assist with his BSP.

B. In Spring Creek, the facility failed to provide clients with the opportunity for personal privacy relative to documentation. Observation in Spring Creek throughout the 5/14-15/18 survey revealed a sign off sheet on the staff office door visible to all hallway passerby's. Observation of the sign off sheet revealed the names of all client's in the home with staff signature indicting "BM/Hygiene book completed."

Interview with the QIDP revealed the sign off sheet is currently used for staff to sign off regarding hygiene completion of each client while other tracking is completed through an electronic system. Additional interview with the QIDP verified the personal information of clients should not be visible to home visitors.

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	34G092	A. BUILDING _____ B. WING _____	05/15/2018

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W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has 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 observation, record review and staff interview, the team failed to assure the behavior support plan (BSP) was implemented as prescribed for 1 of 3 sampled clients (#26) in Spring Creek. The finding is: Observation in the group home on 5/14/18 at 5:20 PM revealed client #26 sitting outside on the porch, listening to music with no staff supervision. Continued observation revealed client #26 to get up from her chair, walk across the porch and grab an open can of regular Mountain Dew soda and drink it. The client then threw the can on the ground and grabbed a hula hoop until the home manager walked by and the client came into the group home. Review of records for client #26 on 5/14/18 revealed a behavior support plan (BSP) dated 8/16/17 for target behaviors of stealing, crying, tantrum, invading others privacy and physical aggression. Continued review of the BSP revealed prevention strategies to include: During less structured times, staff should attempt to get the client actively involved with activities.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 249	Continued From page 8 Suggestions include playing with preferred items, going for a walk or exploring new leisure items and activities. This will decrease the likelihood of the client becoming bored and engaging in attention seeking/disruptive behavior. Interview with the home manager on 5/14/18 revealed client #26 should not have access to regular soda. Interview with the qualified intellectual disabilities professional (QIDP) on 5/15/18 verified client #26 should be offered activities as referenced in the BSP that involve her hands to keep the client from getting bored. Further interview with the QIDP verified by leaving the client unattended, not engaged in any physical activity and allowing the client access to an open can of regular soda that belonged to staff that the client's BSP was not followed.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the specifically constituted committee, designated as the Human Rights Committee (HRC), failed to ensure written, informed consents were obtained for the use of door alarms in the home for 2 of 2 sampled client's (#2 and #5) in Big Laurel. The finding is: Observations conducted in the home throughout the 5/14-5/15/18 survey revealed a loud alarm	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 263	Continued From page 9 sounded each time the front door or two side exterior doors were opened. Interview with group home staff on 5/14/18 revealed the exterior door alarms were in place because clients #3 and #8 had engaged in AWOL behavior in the past. A review of the records on 5/15/18 for clients #2 and #5 revealed no current consents were available related to the use of the door alarms. Interview with the facility clinical director (CD) on 5/15/18 confirmed no current guardian consents related to exterior door alarms had been obtained for client's #2 and #5. The CD indicated multiple clients in the home did not have current consents for the door alarms because of an oversight when obtaining annual consents.	W 263		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: The team failed to ensure medications to control inappropriate behaviors were used only as an integral part of the individual support plan (ISP) for 1 of 2 sampled client (#19) residing in Snowbird as evidenced by interview and review of records. The finding is: Review of the records for client #19 revealed physician's orders dated 4/25/18 revealed client #19's medication regime to include Abilify 10 mg.,	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

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BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 312	Continued From page 10 Zyprexa 15mg. BID and Risperdal 4 mg. TID. Further review of the records revealed quarterly drug reviews dated 3/2/18 stating the client received Risperdal, Abilify and Zyprexa to assist in controlling inappropriate behaviors. Continued review of the records for client #19 revealed a behavior support plan (BSP) dated 4/7/17 to demonstrate zero episodes of disruptive behaviors per month for 6 consecutive months implemented on 4/7/17. Continued review of the BSP revealed disruptive behaviors to be defined as verbal aggression, property destruction, tantrums, food stealing AWOL, PICA and self-injurious behaviors. Further review of the BSP revealed the client is to receive Risperdal, Zyprexa and Celexa. Additional review of the BSP failed to include the use of Abilify in the use of reducing disruptive behaviors. Interview with the behaviorist revealed the client is receiving Ability and the 4/7/17 BSP was the most recent plan in client #19's records. Continued interview with the behaviorist verified Abilify was not included in the BSP. As the use of Abilify is not identified in the BSP, the team has no measurable means of determining the effectiveness of the use of the medication in reducing the behavior for which it is given. Therefore, the use of Ability is not an integral part of the ISP for client #19.	W 312		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 436	Continued From page 11	W 436		

hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure 1 of 3 sampled clients (#27) in Spring Creek was taught to use and make informed choices about the use of their eyeglasses. The finding is:

Observations on 5/14/18 of client #27 revealed the client to wear glasses throughout observation times. Observation in the group home on 5/15/18 at 6:55 AM revealed client #27 to exit her bedroom without wearing glasses. The client was observed to walk down the hallway to the kitchen area and to wash her hands for her breakfast meal with verbal prompts by staff. Continued observation revealed the client to sit at the kitchen table, participate in the breakfast meal, walk back to her bedroom and continue her morning routine in her room with staff assistance at various times. Client #27 was observed to ask staff at three various times for her glasses and was told "you will get them in a minute when you get your medications." Observation at 8:02 AM revealed client #27 to exit the med room wearing her eye glasses.

Review of records for client #27 revealed a vision exam dated 9/1/17 indicating the client to have a diagnosis of high myopia, astigmatism, presbyopia and 2 cataracts with new bifocal myodisc glasses. Continued review of client #27's record revealed an individual support plan (ISP) dated 3/29/17 with objectives relative to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 436	Continued From page 12 handwashing, laundry, personal hygiene, activity participation, verbal choice making, toileting, rate of eating, toothbrushing and exercise. Additional review of current objectives and programs for client #27 revealed no training to address proper use and care of eyeglasses. Interview with staff on 5/15/18 revealed client #27 gets her glasses during her morning medication pass. Additional staff interview verified client #27 has a history of improperly caring for her eye glasses and therefore her glasses are kept locked in the medication room at night after the evening medication pass and kept locked until she gets them with her morning medications. Staff further indicated the client is nearly blind without her glasses. Interview with the qualified intellectual disabilities professional (QIDP) on 5/15/18 verified client #27 has limited vision without her glasses and due to improper care, the client's glasses are stored in the medication room at night. Further interview with the QIDP verified the client has no current training objective to address proper use and care of her eyeglasses.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: The facility failed to assure fire drills were conducted at least quarterly for each shift as evidenced by interview and record verification. The finding is: Review of facility fire drill reports for the past year	W 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-MADISON	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

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W 440	Continued From page 13 starting in 5/17 through 4/18 for each of the four homes (Big Laurel, Roan, Snowbird and Spring Creek) revealed several errors in ensuring fire drills for each shift were conducted quarterly for each shift of personnel. For example: A. Review of the first quarter 5/17 through 7/17 revealed the facility did not conduct any 2nd shift fire drills resulting in only three 2nd shift fire drills being conducted over the past year. B. Review of the third quarter 11/17 through 1/18 revealed no fire drills were conducted during the month on 1/18. Interview with administrative staff revealed staff attempted to make up the missed drills in 2/17 and corrective action was given to staff who failed to conduct the drills. Review of the make up drills in 2/17 and the scheduled drills in 2/17 revealed no drills were conducted in Big Laurel for 1st or 2nd shift. C. Review of the fourth quarter 2/18 through 4/18 revealed 3rd shift drills were missed in Big Laurel and Snow Bird during 3/18 as required.	W 440		