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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
See Attached	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Governing body and Management failed to provide adequate operating direction over the facility by failing to develop a specific policy and training regarding bed bugs and other potential pests. The finding is: Afternoon observations at the group home on 9/19/18 at 4:00 PM, substantiated by interview with staff, revealed several of the homes to have client clothing bagged up due to bed bugs being found on site. Interview with the Site Manager revealed that bed bugs were found only in Pisgah on 9/18/18 in the living room area. Further interview revealed the contracted pest control service was contacted and had been on-site that morning to search for additional bugs and to spray the living room in Pisgah. Continued interview with the Site Manager revealed that it was reported to her that bed bugs were not found in any other location in Pisgah although it was unclear if the pest control company searched the other 3 homes on site. Continued observations at 5:00 PM in Pisgah revealed the living room open for use by the clients. Subsequent interviews with the Site Manager revealed she did not know what the pest control company sprayed but was told by maintenance staff that the pest control company said it should be fine for clients 30 minutes after spraying. Interviews with the qualified intellectual	W 104	*See attached	11.19.18

DHSR NH L & C Black Mountain WRO Received OCT 05 2018 by: SKH

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

Christine R Willenghom, QIDP | 10/4/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 104	Continued From page 1 disabilities professional (QIDP), the Site Manager and the Clinical Services Director revealed no knowledge of the plan to assure the beg bugs in Pisgah were eliminated other than the pest control company was coming back out to the group home next week. Review of the facility's 7/1/17 Pest Control Policy revealed any observations of pests should be reported to facility maintenance staff for further observation. If needed, facility maintenance will contact appropriate vendor and site management will be instructed regarding recommended procedures as instructed by the pest control vendor. The only other part of the policy noted that follow-up inspection from the vendor will occur based on their recommendations. Although the facility has a general policy regarding calling the pest control vendor and following their recommendations, the facility per interview with he QIDP and Clinical Services Director does not have a policy specific to bed bugs or other pests that may affect the clients in the home. For example, the policy does not contain information about how to assure clients and their belongings are cared for if bed bugs are found in clients' homes. In addition, the policy does not address best practice to assure bed bugs are not spread or ways the facility will handle a bed bug or other pest infestation other than follow the pest company recommendations. In that the facility failed to develop a more detailed policy regarding pest control that included the needs and safety of the clients, Management failed to provide operating direction over the client as required.	W 104		
W 137	PROTECTION OF CLIENTS RIGHTS	W 137		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 137	Continued From page 2 CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: The facility failed to assure 3 of 5 sampled clients residing in Beaucatcher and Hawksbill (#8, #21 and #31) were provided with clean appropriate clothing in good repair as evidenced by observation and interview. The findings are: A. Afternoon observations in Beaucatcher on 9/19/18 at 4:42 PM revealed staff assisting client #8 from his bedroom to an activity in the dining room. Further observations revealed the client to be wearing shorts with excessive food debris and stains on them. In addition, continued observations revealed the shorts were on the client backwards with his pants front zipper and side pockets located in the back. Interview with the clinical services director revealed the client is very picky about what he wears and will often not be happy until he finds the right clothes that suit him even if the clothes are dirty. Further interview revealed the group home needs to do a better job of assuring the client only wears clean clothing by washing his clothes more often or buying more than one item of preferred clothing to assure the client has a choice but can wear clean clothing. B. The facility failed to ensure 2 of 8 clients residing in Hawksbill had clothing that fit properly and in that was in good repair.	W 137		11.19.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 137	Continued From page 3 1. Observations in Hawksbill on 9/19/18 at 5:35 PM revealed client #31 to be walking outside in the driveway of the facility with staff when his pants were noted to fall down to around his ankles in full view of any passerby. Staff were observed to assist the client in pulling the pants back up. It was noted the client did have a belt on. However, the pants and belt were either too big for the client or staff failed to ensure the client had dressed properly before leaving the facility. Interview with the clinical services director revealed he was aware of some of client #31's clothing being a little big for him. 2. Observations in Hawksbill on 9/19/18 from 3:45 PM until 6:10 PM revealed client #21 to be wearing sweat pants with the knee out of the left pant leg and with food stains on the pants. It was noted the client to be both inside and outside of the facility and visible to any passerby. Continued observations, substantiated by interview with staff, revealed the client had worn the pants all day. Further interview with staff revealed he had not noticed the knee of the pants being torn out. Interview with the clinical services director, verified the clients pants knee was torn out and should have been changed. Therefore, the facility failed to ensure client #21 was dressed in clothing in good repair.	W 137		
W 207	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(2) Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by:	W 207		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 207	Continued From page 4	W 207		11.19.18

The facility failed to show evidence appropriate staff were involved and the team process occurred in the implementation of the use of alarms for 1 of 3 sampled clients residing in Hawksbill (#31) and 1 of 2 sampled clients residing in Sunset (#24) as evidenced by observations, interviews and review of records. The findings are:

A. The facility failed to show evidence of the team process in the decision to implement the use of an alarm for client #31 who resides in Hawksbill.

Observations in Hawksbill on 9/19/18, substantiated by interview with the clinical services director, revealed client #31 has an alarm he wears attached to his shirt when sitting in a chair in his personal bedroom. Continued interview with the clinical services director revealed the alarm is to alert staff when the client attempts to get out of his chair. Further interview revealed the client has an unsteady gait and has fallen in the past and needs staff assistance and a walker when ambulating.

Review of the records, verified by interview with the clinical services director, revealed no written consent from the guardians or the human rights committee was available in the record for review. Continued review of the records, verified by interviews with the clinical services director, revealed no evidence was available in the records to show what staff participated and the team process in deciding to implement the use of the alarm to alert staff when client #31 attempted to get out of his chair.

B. The facility failed to show evidence of a team process in the decision to implement the use of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 207	Continued From page 5 wheelchair alarm for client #24 who resides in Sunset. Observations in Sunset during the 9/19-20/18 survey revealed an alarm attached to the wheelchair of client #24. Interview with staff, substantiated by further observations, revealed an alarm sounds to alert staff when the client unfastens the wheelchair seatbelt and attempts to stand up due to the client's history of injuries from falling. Client #24 was observed at supper and breakfast assisting staff in pureeing her food and the alarm sounded when staff assisted the client to stand from her wheelchair in the kitchen. Review of client #24's individual support plan (ISP) dated 2/20/18 revealed no mention of the use of a wheelchair alarm. Further review of client #24's record revealed no team meetings or consultant recommendations regarding the use of the alarm. Interview with staff and the clinical services director revealed no one was sure how long the intervention had been used but a guardian consent for the wheelchair alarm was obtained 8/10/18. The facility failed to show evidence of a team process regarding the use, benefit and restrictive aspect of the client's wheelchair alarm.	W 207		
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:	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 263	Continued From page 6 The specially constituted committee, designated as the human rights committee (HRC), failed to ensure written informed consent was obtained for the restriction of client rights relative to the use of an alarm for 1 of 3 sampled clients (#31) residing in Hawksbill as evidenced by observations, interviews and review of records. The finding is: Observations in Hawksbill on 9/19/18, substantiated by interview with the clinical services director, revealed client #31 has an alarm he wears attached to his shirt when sitting in a chair in his personal bedroom. Continued interview with the clinical services director revealed the alarm is to alert staff when the client attempts to get out of his chair. Further interview revealed the client has an unsteady gait and has fallen in the past and needs staff assistance and a walker when ambulating. Review of the records, verified by interview with the clinical services director, revealed no written consent from the guardians was available in the record for review. Therefore, the facility failed to show evidence written consent was given for the use of the alarm for client #31 while in personal bedroom.	W 263		11.19.18
W 264	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(iii) The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.	W 264		11.19.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 264	Continued From page 7 This STANDARD is not met as evidenced by: The facility failed to show evidence the specially constituted committee referred to as the human rights committee (HRC) reviewed and approved the use of alarms for 1 of 3 sampled clients (#31) residing in Hawksbill as evidenced by observations, interviews and review of records. The finding is: Observations in Hawksbill on 9/19/18, substantiated by interview with the clinical services director, revealed client #31 has an alarm he wears attached to his shirt when sitting in a chair in his personal bedroom. Continued interview with the clinical services director revealed the alarm is to alert staff when the client attempts to get out of his chair. Further interview revealed the client has an unsteady gait and has fallen in the past and needs staff assistance and a walker when ambulating. Review of the records for client #31, verified by interview with the clinical services director, revealed no written consent from the HRC was available in the record for review. Therefore, the facility failed to show evidence HRC had approved the use of the alarm for client #31 while in personal bedroom.	W 264		
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	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HOMES-SWANNANOA	91 POPLAR CIRCLE SWANNANOA, NC 28778

(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 312	Continued From page 8 elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: The team failed to ensure 1 of 2 sampled clients (#14) residing in Pisgah the use of medications to control inappropriate behaviors were used only as an integral part of the individual support plan (ISP) and is directed specifically toward the reduction of and the eventual elimination of the behavior for which it is employed as evidenced by interview and review of records. The finding is: Review of the records for client #14 revealed physician's orders dated 8/31/18 prescribing Citalopram (Celexa) 40 mg take by mouth everyday at 8:00 AM for depression. Continued review of the records for client #14 revealed an ISP dated 10/9/17 which included a behavior support plan (BSP) to reduce the rate of behaviors disruptive to habilitation to zero episodes per month for 6 consecutive months. Further review of the BSP revealed target behaviors were defined as non-compliance, verbal disruption, physical aggression, tantrum behaviors, inappropriate sexual behaviors, stealing, bossing others and self-injurious behaviors. Additional review of the BSP, verified by interview with the clinical services director, revealed the BSP failed to identify depression as a target behavior for which Citalopram (Celexa) is given. Therefore, there is no method of measuring the effectiveness of the medication in the reduction of the behaviors for which it is given.	W 312		11-19-18

Regular clinical assessment and any follow-up thereby identified will be conducted by the clinical team, and regular chart reviews and assessment reviews will be conducted by the Director of Clinical Services, in order to ensure continued compliance with the expectation that appropriate facility staff must participate in interdisciplinary team meetings

Responsible persons: Clinical Services Director, QIDP

W 263 PROGRAM MONITORING & CHANGE

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.

The clinical team will receive training regarding the process by which informed consents are obtained.

Also, consents for the use of the alarms for the clients cited in the survey will be obtained.

Regular chart reviews and any follow-up thereby identified, will be conducted by the Director of Clinical Services and QIDP in order to ensure continued compliance with the expectation that 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.

Responsible persons: Clinical Services Director, QIDP

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.

The IDT will meet to discuss client #14's strengths and needs regarding behavior support for Axis I diagnosis of depression. Any followup thereby identified will be conducted.

The Behavior Specialist will consult with the Psychiatrist and the Licensed Psychologist at least quarterly to assure that any prescribed psychotropic medications are documented as lowest therapeutic dose(s) and addressed in the Behavior Support Plan as correlating with relevant diagnoses.

Regular chart reviews and any follow-up thereby identified, will be conducted by the Director of Clinical Services, QIDP or Assistant QIDP in order to ensure continued compliance with the expectation that quarterly any BSP updates include medications that correspond to target behaviors.

Responsible persons: Clinical Services Director, QIDP, Behavior Specialist, Psychiatrist, Psychologist