STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G209	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-PISGAH HOUSE	**28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803**

(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 Complaint Intake #NC155590	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to notify promptly parents or guardians following reported verbal abuse and mistreatment of clients (W148); failed to ensure implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of clients (W149); failed to assure incidents of verbal abuse and mistreatment were reported to all appropriate officials in accordance with state law (W153); failed to assure incidents of verbal abuse and mistreatment were thoroughly investigated (W154); failed to implement client protection measures immediately after reported staff to client verbal abuse and mistreatment (W155); and failed to show evidence of appropriate corrective action following staff to client verbal abuse and mistreatment (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Client Protections.	W 122		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not	W 148		

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

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W 148	Continued From page 1 limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to notify promptly parents or guardians following two incidents of verbal abuse and mistreatment by staff, for 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct care staff person (B) reported to administrative staff on 8/20/19 that staff A had been verbally abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19. Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19 revealed staff C called to report "abuse and	W 148		

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W 148	Continued From page 2	W 148		

neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence of follow up to the reported abuse.

Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home".

Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the Electronic Health Record for the client's involved; assuring timely and accurate reporting to external agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee; completing an IRIS report, including (Health Care

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W 148	Continued From page 3 Personnel Registry (HCPR) within 24 hours; updating IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Further interview with the RSD on 10/11/19 indicated the facility had not initiated an investigation to follow-up with either reports of verbal abuse on 8/14/19 or on 8/20/19, and confirmed the facility did not provide guardian notification for any of the six clients in the home.	W 148		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure implementation of policies and procedures to prohibit abuse, neglect and mistreatment were implemented for two reported incidents of verbal abuse. The findings are: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct	W 149		

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care staff person (B) reported to administrative staff on 8/20/19 that staff A had been verbally abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19.

Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19 revealed staff C called to report "abuse and neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence of follow up to the reported abuse.

Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home".

Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the

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W 149	Continued From page 5 Electronic Health Record for the client's involved; assuring timely and accurate reporting to external agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee; completing an IRIS report, including Health Care Personnel Registry (HCPR) within 24 hours; updating IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Further interview with the RSD on 10/11/19 indicated the facility had not initiated an investigation to follow-up with either reports of verbal abuse on 8/14/19 or on 8/20/19, confirming the facility failed to follow its own abuse, neglect and mistreatment policies and procedures to assure the prevention of abuse, neglect and mistreatment of clients.	W 149		
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	W 153		

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W 153	Continued From page 6 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 staff interview and document review, the facility failed to assure two incidents of verbal abuse and mistreatment were reported to all appropriate officials in accordance with state law. The findings are: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct care staff person (B) reported to administrative staff on 8/20/19 that staff A had been verbally abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19. Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19	W 153		

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W 153	Continued From page 7 revealed staff C called to report "abuse and neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence of follow up to the reported abuse. Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home". Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the Electronic Health Record for the client's involved; assuring timely and accurate reporting to external agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee;	W 153		

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W 153	Continued From page 8 completing an IRIS report, including Health Care Personnel Registry (HCPR) within 24 hours; updating the IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Further interview with the RSD on 10/11/19 confirmed the IRIS, DSS and HCPR notifications were not completed in accordance with State law for two incidents of verbal abuse and mistreatment.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to assure two incidents of reported verbal abuse and mistreatment were thoroughly investigated for 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6). The finding is: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct care staff person (B) reported to administrative staff on 8/20/19 that staff A had been verbally	W 154		

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abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19.

Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19 revealed staff C called to report "abuse and neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence of follow up to the reported abuse.

Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home".

Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the Electronic Health Record for the client's involved; assuring timely and accurate reporting to external

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W 154	Continued From page 10 agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee; completing an IRIS report, including HCPR within 24 hours; updating IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Further interview with the RSD on 10/11/19 indicated the facility had not initiated an investigation to follow-up with either reports of verbal abuse on 8/14/19 or on 8/20/19, confirming the facility failed to thoroughly investigate reported verbal abuse by staff A on two occasions.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on staff interview and document review, the facility failed to implement client protection	W 155		

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W 155	Continued From page 11 measures for 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) immediately after two reports of staff to resident verbal abuse and mistreatment. The findings are: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct care staff person (B) reported to administrative staff on 8/20/19, that staff A had been verbally abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19 and then suspending staff A on 8/23/19. Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19 revealed staff C called to report "abuse and neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence	W 155		

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W 155	Continued From page 12 of follow up to the reported abuse. Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home". Further interview with the RSD and review of facility staffing records on 10/11/19 revealed staff A worked on 8/14/19, 8/15/19, 8/16/19, 8/19/19, 8/20/19, 8/21/19, and 8/22/19 before being suspended on 8/23/19. Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the Electronic Health Record for the client's involved; assuring timely and accurate reporting to external agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee;	W 155		

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(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 155	Continued From page 13 completing an IRIS report, including HCPR within 24 hours; updating IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Continued interview with the RSD on 10/11/19 confirmed staff A continued to work with all clients in the home for seven days following the report of verbal abuse made by staff C on 8/14/19, therefore the facility failed to protect all clients in the home from further verbal abuse and mistreatment.	W 155		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on staff interview and document review, the facility failed to show evidence of appropriate corrective action for two incidents of reported verbal abuse and mistreatment. The findings are: Interview with the facility residential services director (RSD) on 10/11/19 revealed a direct service staff person (A) was terminated from employment on 8/26/19 due to talking to client #4 in a "very bad way". The RSD indicated the verbal interaction was discovered when a video recording for the date of 8/19/19 was reviewed on 8/23/19. Further interview with the RSD revealed the video was reviewed by administrative/managerial staff because direct care staff person (B) reported to administrative staff on 8/20/19, that staff A had been verbally	W 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G209	A. BUILDING _____ B. WING _____	C 10/11/2019

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W 157	Continued From page 14	W 157		

abusive to client #4 on 8/19/19. The RSD described the behavior in the video by staff A toward client #4 as "hateful", and indicated demeaning and humiliating verbalization by staff A. The RSD did not provide evidence the facility started an investigation into this incident of verbal abuse, aside from reviewing facility video footage on 8/23/19 and then suspending staff A on 8/23/19.

Continued interview with the RSD also revealed that on 8/14/19, direct care staff (C) called the administrator on call to report verbal abuse by staff A toward client #4 . The administrator on call did not answer, so the staff left a voice message. Review of the voice message on 10/11/19 revealed staff C called to report "abuse and neglect". The voice message indicated staff A was "yelling" and "acting terrible" which "caused a client behavior". Further review with the RSD revealed the administrator on call reviewed this message on 8/15/19, and there was no evidence of follow up to the reported abuse.

Review of the only document provided related to the incidents of reported verbal abuse revealed a "personnel action request" signed on 8/26/19 which indicated staff A was terminated on 8/26/19 because the staff person was observed on video footage engaging in verbal abuse and mistreatment towards "several of the residents in the home".

Review of the facility's policies and procedures for abuse, neglect and exploitation on 10/11/19 revealed procedures for responding to allegations of abuse, neglect and mistreatment which included: Documenting the incident in the Electronic Health Record for the client's involved;

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W 157	Continued From page 15 assuring timely and accurate reporting to external agencies as directed on the investigation check-list; documenting all activities of the investigation including date, time, and facilitator of the action; summarizing all findings, conclusions, follow-up and corrective actions; and assuring all investigation files include a narrative summary, Incident Response Improvement System (IRIS) report, written statements from staff, and written statements or transcription of interview from clients. Review of the investigation check-list revealed instructions to include: assuring client protections by placing staff on administrative leave and assessing clients; notifying the local department of social services (DSS), the guardian and the human rights committee; completing an IRIS report, including HCPR within 24 hours; updating IRIS and HCPR within 5 working days; completing staff disciplinary actions; and follow-up and/or measures to prevent reoccurrence. Further interview with the RSD on 10/11/19 did not reveal evidence of corrective action beyond the termination of staff A, including but not limited to follow-up psychological and social care for clients, re-training of staff relative to abuse, neglect and mistreatment, and increased clinical monitoring of staff.	W 157		