STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G323	A. BUILDING ______ B. WING ______	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-MONTFORD HOUSE	5 KENMORE STREET 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 #'S NC154876 AND NC155588	W 000		
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/record review and staff interview, the facility failed to assure 1 of 1 incident reviewed with the potential for neglect and/or abuse, was investigated thoroughly. The finding is: Review of the facility's internal electronic incident logging system on 9/13/19 revealed an incident which occurred on 8/10/19 in the afternoon. Further review of the report revealed an incident involving client #1 and client #5. Continued review of the report revealed client #5 was observed entering client #1's bedroom while he was in the room. Client #5 was observed entering the bedroom, as staff (B) witnessing the incident, thought the client was entering a bathroom on that hall, and not the client's room. Client #5 was observed leaving client #1's room with redirection by staff B. Staff B then reported the incident immediately to managerial staff. Interview with staff B on 9/13/19 revealed the incident to be described as above and indicated client #5 was in client #1's room for no more than 2 minutes. Staff B indicated that both client's were fully clothed when observed after client #5 left the bedroom. Interview with the facility's	W 154	RECEIVED OCT - 7 2019 DHSR NH L & C Black Mountain / WRO	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Derek Briscoe, Program Administrator
TITLE
(X6) DATE 9.30.19

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 154	Continued From page 1 program director and the qualified intellectual disabilities professional (QIDP) revealed that staff members working at the time were interviewed about the incident on 8/10/19 and 8/11/19. The program director also indicated client #1 was interviewed on 8/11/19 at which time he gestured to his genitals when asked about client #5 entering his room. It should be noted these two client's have a history of possible possible physical/sexual interaction while residing a a different facility. Further interview with the program director and QIDP revealed nursing staff assessed both clients on 8/11/19 with no significant findings. Continued interview with the program director revealed a formal investigation had not been initiated for this incident and the program director indicated a formal investigation should have been completed based on the nature of the incident and the possibility for neglect and/or abuse.	W 154		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to ensure interventions used to manage inappropriate client behaviors were incorporated into the individual service plans (ISP's) for 2 of 2 sampled clients (#1 and #5).	W 289		

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W 289	Continued From page 2	W 289		

The findings are:

A. The facility failed to update client #1's behavior support plan (BSP) with interventions which had been implemented to prevent inappropriate behaviors. For example:

Observations in the facility on 9/13/19 at 8:20 AM revealed colored tape at the threshold of the "men's" hallway and the "women's" hallway. Further observations revealed door chimes which were activated when the bedroom doors for client #1 and client #5 were opened. Interview with direct care staff A and B on 9/13/19 revealed the colored tape had been placed at the threshold of the "men's" hallway to prompt client #5 to not go down the hallway without being accompanied by staff, and the colored tape at the threshold of the "women's" hallway to prompt client #1 to not go down the hallway. Further interview with staff A and B revealed the chimes had been added to the doors of client's #1 and #5 approximately two weeks prior to the survey. The staff members indicated they had not been formally trained on the use of the door chimes or the colored tape, though they did know the restrictions were added to assist with better supervision of client #1 and #5.

Review of the record for client #1 revealed an ISP dated 5/6/19 which contained a behavior support plan (BSP) dated 6/24/18. Review of the BSP revealed interaction techniques for target behaviors, which included monitoring the client closely when with peers to ensure appropriate personal space and refraining from inappropriate touch. Further review did not reveal evidence of documentation of using colored tape as a barrier, or door chimes as restrictive behavioral

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W 289	Continued From page 3 interventions. Review of facility electronic documents also revealed an e-mail sent to all facility staff on 8/11/19 related to the "supervision protocol" at the group home, which included directions to not leave client #1 un-supervised when in the common areas of the home and not allowing client #5 to use the bathroom on the "men's" hallway unless accompanied by staff. Interview with the qualified intellectual disabilities professional (QIDP) and the program director on 9/13/19 revealed the colored tape had been added to the threshold of the "women's" hallway to prompt client #1 from not going down that hallway. The QIDP indicated this colored tape was added when the client moved into the home on 7/13/19. The QIDP indicated the door chime was added to client #1's bedroom door on 9/11/19 so staff members would have increased awareness if client #1 left his room or if someone entered his room. The QIDP confirmed the colored tape and the door chime had not been added to the client's BSP and confirmed no staff had been formally trained on the use of the restrictive interventions until 8/29/19 when some staff were trained on client #1's "supervision guidelines" and client #5's "safety rules". B. The The facility failed to update client #5's behavior support plan (BSP) with interventions which had been implemented to prevent inappropriate behaviors. For example: Observations on 9/13/19 at 8:20 AM revealed colored tape at the threshold of the "men's" hallway and the "women's" hallway. Further observations revealed door chimes which were activated when the bedroom doors for client #1 and client #5 were opened. Interview with direct	W 289		

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W 289	Continued From page 4 care staff A and B on 9/13/19 revealed the colored tape had been placed at the threshold of the "men's" hallway to prompt client #5 to not go down the hallway without being accompanied by staff, and the colored tape at the threshold of the "women's" hallway to prompt client #1 to not go down the hallway. Further interview with staff A and B revealed the chimes had been added to the doors of client's #1 and #5 approximately two weeks prior to the survey. The staff members indicated they had not been formally trained on the use of the door chimes or the colored tape, though they did know the restrictions were added to assist with better supervision of client #1 and #5. Review of the record for client #5 revealed an ISP dated 6/28/19 which included a BSP dated 4/19/19. Review of the BSP revealed restrictive interventions for target behaviors, which did not include the use of colored tape or a bedroom door chime. Review of facility electronic documents also revealed an e-mail sent to all facility staff on 8/11/19 related to the "supervision protocol" at the group home, which included directions to not leave client #1 un-supervised when in the common areas of the home and not allowing client #5 to use the bathroom on the "men's" hallway unless accompanied by staff, which was not included in the BSP. Interview with the QIDP and the program director on 9/13/19 revealed colored tape had been added to the threshold on the "men's" hallway on 8/11/19 due to an incident which occurred on 8/10/19. The QIDP indicated the colored tape was added to prompt client #5 to not go down the "men's" hallway without supervision from staff. The QIDP indicated the door chime was added to the	W 289		

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W 289	Continued From page 5 bedroom door for client #5 on 9/11/19 due to an incident which occurred on 8/10/19, so staff would have increased awareness if client #5 left her room or if someone entered the client's room. The QIDP confirmed the colored tape and the door chime had not been added to the client's BSP and confirmed no staff had been formally trained on the use of the restrictive interventions until 8/29/19 when some staff were trained on client #1's "supervision guidelines" and client #5's "safety rules".	W 289		

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Plan of Correction for Complaint Survey 9/13/19

W 154 Staff Treatment of Clients

The facility must have evidence that all alleged violations are thoroughly investigated.

The facility failed to assure an incident reviewed with the potential for neglect and/or abuse was investigated thoroughly.

The Chief Operations Officer will provide formal training to facility staff responsible for initiating and conducting investigations of possible abuse, neglect or exploitation of clients. The training will include review of the facility's protocols for reporting, investigating, documenting and notifying pertinent parties of incidents of alleged or possible abuse/neglect/exploitation.

Training will recur at regular intervals, at least annually, in order to ensure continued compliance with the expectation that the facility must have evidence that all alleged violations are thoroughly investigated.

Responsible Persons: Chief Operations Officer

Mechanism to ensure compliance: Recurring training

Frequency of Mechanism: At least annually with each facility staff member responsible for investigating alleged violations.

W 289 Management of Inappropriate Client Behavior

The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.

The facility failed to ensure interventions used to manage inappropriate client behaviors were incorporated into the individual service plans for 2 clients. The facility failed to update 2 clients' behavior support plans with interventions which had been implemented to prevent inappropriate behaviors.

The Program Administrator will conduct formal training with facility staff responsible for coordinating individual support plans (QIDPs). The training will include review of the facility's protocols for use of an interdisciplinary team process in planning and implementing changes in support. The training will also include review of the facility's protocol for due process for client rights restrictions.

The interventions noted during the survey will be discussed by the interdisciplinary team, and included into the plans of the 2 clients involved, with the support of documented interdisciplinary team consensus, to include the documented consent of the guardians and Human Rights Committee.

Regular assessments in the group home and chart reviews, and any follow-up thereby identified, will be conducted by the Program Administrator, in order to ensure continued

compliance with the expectation that the use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.

Responsible Person*:* Program Administrator

Mechanism to ensure compliance*:* Assessments and review of records

Frequency of Mechanism*:* At least quarterly