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BLUEWEST OPPORTUNITIES-SWANNANOA RESIDENTIAL	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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were sufficiently trained relative to client positioning at meals for 1 of 2 sampled clients (#27) in Beaucatcher. The finding is: Observations in the group home on 9/10/19 at 6:25 PM revealed client #27 to participate in the supper meal that included beef casserole, refried beans and fruit. Continued observation of client #27 at the supper meal revealed the client to sit in a wheelchair at the table, to feed herself with staff assistance when needed and to utilize a swivel spoon utensil. Continued observation revealed client #1 to have excessive food spillage while self feeding, dropping food into both the wheelchair and the client's lap. Review of records for client #1 on 9/11/19 revealed a an occupational therapy (OT) evaluation dated 7/23/19. Review of the OT evaluation revealed client #1 to have a pureed diet with thin liquids. Further review of the OT evaluation revealed client #1 to have a thoracic cushion in her dining chair due to a diagnosis of severe kyphoscoliosis. The 7/2019 OT evaluation further reflected the recommendation at meals that staff need to ensure client #1 is transferred from her wheelchair to the wooden chair for optimal positioning to feed herself	W 189		11/11/19

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

Derek Briscoe | Program Administrator | 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 189	Continued From page 1 successfully. Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/19 revealed client #1 should have been transferred to the wooden dining chair that is used for client #27 at all meals to support proper positioning of the client while self feeding.	W 189		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the team failed to ensure the individual service plan (ISP) for 1 of 4 sampled clients (#1) in Beaucatcher included objective training to address needs relative to behavior management. The finding is: Observation in the group home on 9/11/19 at 8:25 AM revealed client #5 to walk down the hallway of the group home after the breakfast meal and attempt to hold onto this surveyor by the pants and to grab and pull this surveyor's hand. Continued observation from 8:30 AM until 8:45 AM revealed staff C and Y to observe client #1 to follow this surveyor around the facility, attempting to grab this surveyor by the pant leg and hand while providing no redirection of client #1. Observation further revealed client #1 to walk close to client #17 in the facility hallway and client	W 227		11/10/19

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W 227	Continued From page 2 #17 to state "No, get away from me". Observation at 8:48 AM revealed Staff Y to prompt client #1 to a morning routine activity of changing clothes to which the client complied. Review of records for client #1 on 9/11/19 revealed an ISP dated 12/4/19. Review of the ISP revealed current training objectives to address daily living skills and hygiene. Further review of the ISP revealed no behavior support guidelines, objectives or interventions to address observed behaviors of pulling on others, following or invading the personal space of others. Interview with the clinical director and qualified intellectual disabilities professional (QIDP) on 9/11/19 verified client #1 did not have a behavior support plan. Further interview with the clinical director and QIDP confirmed client #1 has a history of behavior that included pulling on staff that is usually related to communication. Additional interview verified client #1 will invade the personal space of others in an effort to get attention. Interview with the clinical director and QIDP confirmed client #1 could be benefit from training to address identified needs of pulling behavior and invading the personal space of others.	W 227		
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	W 249		11/10/19

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W 249	Continued From page 3 plan.	W 249		

This STANDARD is not met as evidenced by:
Based on observations, review of records and staff interviews, the facility failed to ensure objectives and guidelines listed in the individual service plans (ISP's) were implemented as prescribed for 3 of 3 sampled clients in Sunset (#9, #25 and #29) and 1 of 2 sampled clients in Beaucatcher (#27). The findings are:

A. The facility failed to ensure a meal preparation objective was implemented as prescribed for client #9.

Observations in Sunset on 9/10/19 at 4:35 PM revealed clients #9, #25 and #29 to be seated at the dining table for snack. Further observations at that time revealed staff A in the kitchen operating a food processor to puree cookies without the assistance of any clients. Continued observations at 4:45 PM revealed clients #9, #25 and #29 eating the pureed cookies for the snack meal.

Observations on 9/10/19 at 5:27 PM revealed staff V in the kitchen processing dinner food items without assistance from any clients. Further observations at 6:00 PM revealed staff Z processing dinner food items without the assistance of clients and at that time, clients #9, #25 and #29 were sitting at the dining table. Continued observations at 6:10 PM revealed clients #9, #25 and #29 eating pureed dinner items consisting of beef and re-fried beans, bean salad, and mashed potatoes.

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W 249	Continued From page 4	W 249		

Review of the record for client #9 on 9/11/19 revealed an ISP dated 3/1/19 which included a nutrition section, which indicated the client has a regular, pureed diet. Further review of the ISP revealed an objective implemented 11/6/18 for client #9 to initiate pushing down on a switch to puree meal items 75% of the time for three consecutive months.

Interview with the qualified intellectual disabilities professional (QIDP) on 9/11/19 confirmed the food processing objective was current and confirmed the objective should be trained at all opportunities.

B. The facility failed to ensure a meal preparation guideline was implemented as prescribed for client #25.

Observations in Sunset on 9/10/19 at 4:35 PM revealed clients #9, #25 and #29 to be seated at the dining table for snack. Further observations at that time revealed staff A in the kitchen operating a food processor to puree cookies without the assistance of any clients. Continued observations at 4:45 PM revealed clients #9, #25 and #29 eating the pureed cookies for the snack meal.

Observations on 9/10/19 at 5:27 PM revealed staff V in the kitchen processing dinner food items without assistance from any clients. Further observations at 6:00 PM revealed staff Z processing dinner food items without the assistance of clients and at that time, clients #9, #25 and #29 were sitting at the dining table. Continued observations at 6:10 PM revealed clients #9, #25 and #29 eating pureed dinner items consisting of beef and re-fried beans, bean

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W 249	Continued From page 5	W 249		

salad, and mashed potatoes.

Review of the record for client #25 on 9/11/19 revealed an ISP dated 11/11/18 which included a nutrition section, which indicated the client has a regular pureed diet. Further review of the ISP revealed a current meal preparation guideline for the client to puree her food items.

Interview with the QIDP on 9/11/19 confirmed the food processing guideline was current and confirmed the guideline should be followed at all opportunities.

C. The facility failed to ensure a meal preparation guideline was implemented as prescribed for client #29.

Observations in Sunset on 9/10/19 at 4:35 PM revealed clients #9, #25 and #29 to be seated at the dining table for snack. Further observations at that time revealed staff A in the kitchen operating a food processor to puree cookies without the assistance of any clients. Continued observations at 4:45 PM revealed clients #9, #25 and #29 eating the pureed cookies for the snack meal.

Observations on 9/10/19 at 5:27 PM revealed staff V in the kitchen processing dinner food items without assistance from any clients. Further observations at 6:00 PM revealed staff Z processing dinner food items without the assistance of clients and at that time, clients #9, #25 and #29 were sitting at the dining table. Continued observations at 6:10 PM revealed clients #9, #25 and #29 eating pureed dinner items consisting of beef and re-fried beans, bean salad, and mashed potatoes.

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W 249	Continued From page 6	W 249		

Review of the record for client #29 on 9/11/19 revealed an ISP dated 4/11/19 which included a nutrition section, which indicated the client has a 1200 calorie, low fat, pureed diet. Further review of the ISP revealed a current meal preparation guideline for the client to push the button on the food processor to help puree her food.

Interview with the QIDP on 9/11/19 confirmed the food processing guideline was current and confirmed the guideline should be followed at all opportunities.

D. The facility failed to ensure meal guidelines were implemented as prescribed for client #27.

Observations in the group home on 9/10/19 at 6:25 PM revealed client #27 to participate in the supper meal that included beef casserole, refried beans and fruit. Continued observation of client #27 at the supper meal revealed the client to sit in a wheelchair at the table, to self feed with staff assistance when needed and to utilize a swivel spoon utensil. Continued observation revealed client #1 to have excessive food spillage while self feeding, dropping food into the wheelchair and onto the client's lap. At no time during observation of the supper meal was it observed for staff to offer client #27 additional food to replace spillage.

Observation in the group home on 9/11/19 of client #27 during the breakfast meal revealed the client to sit in a wooden chair, to eat her complete breakfast meal with hand over hand staff assistance and to utilize a swivel spoon utensil. It was not observed during the breakfast meal for client #27 to have the opportunity to self feed

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W 249	Continued From page 7 during any part of the meal. Review of records for client #27 on 9/11/19 revealed mealtime guidelines dated 8/28/19. Review of the 8/28/19 meal guidelines revealed a schedule frequency for all snacks and meals. Continued review of meal guidelines for client #27 revealed a teaching method that indicated 1) Staff will encourage client #27 to feed herself as much as possible. 2) Staff may assist the client in feeding herself by gently putting pressure on the underside of her dominant elbow (to reduce severity of tremors). 3) If the client spills any of her food, please replace the food spilled with more food. 4) After client #27 has been eating 30 minutes, staff may then provide the client with hand over hand assistance to finish her meal. Interview with the QIDP on 9/11/19 verified the meal guidelines for client #27 remain current. Continued interview with the QIDP revealed additional food should have been offered to the client to address spillage during meals. The QIDP further confirmed staff should not begin hand over hand assisting client #27 with eating unless the client has been eating 30 minutes and is continuing to take a long time to finish her meal.	W 249		
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, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		11/10/19

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W 436	Continued From page 8	W 436		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain in good repair, a wheelchair for 1 of 2 sampled clients (#2) in Pisgah. The finding is:

Observation in the group home 9/10/19 revealed client #2 sitting in a wheelchair at the dinner table. Observation of client #2's wheelchair revealed a spoke with a sharp edge to protrude outward from the client's tire . Further observation revealed client #2 conversing with the qualified intellectual disabilities professional (QIDP) pointing at the spoke stating it needed to be repaired. The QIDP was observed to respond to client #2 during conversation with "I know" and further explained a special tool was needed to complete the repair.

Observation in the group home on 9/11/19 at 9:05 AM revealed while loading on the van, client #2 informed and pointed out to the internal physical therapy staff that the spoke on her wheelchair needed to be repaired. Further observation revealed the internal PT staff to respond to client #2 with acknowledgement and the need to contact the wheelchair company to come out and take a look at the wheelchair.

Interview with the internal PT staff on 9/11/19 revealed the staff to be responsible for repairs and maintenance of adaptive equipment. Interview with group home staff on 9/11/19 revealed client #2's wheelchair had been in need of repair due to the protruding spoke for almost two weeks. Further interview with the QIDP on 9/11/19 revealed she was made aware of the

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W 436	Continued From page 9 condition of client #2's wheelchair by the PT staff on 9/5/19 or 9/6/19. The QIDP also revealed that she was not made aware PT personnel had to contact the wheelchair company to complete the repairs. The QIDP further verified the exposed spoke to be a safety issue.	W 436		

Blue West Opportunities – Swannanoa Site

Plan of Correction – Survey 9/11/19

W189

The facility must provide each employee with the initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Specific example: positioning a client at meals

The Motoric Specialist, William Joseph and Lisa Duncan, CDM, CFPP will complete retraining of meal time routine for client #27. Training will include adaptive equipment needs, meal consistency and positioning for meals.

Regular clinical assessment will occur ongoing, at least monthly in each group home, and will provide staff with the opportunity for retraining as needed, in order to ensure continued compliance with the expectation that the facility must provide each employee with the initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Responsible Persons: William Joseph, Motoric Specialist; Lisa Duncan, Clinical Support Specialist; Christine Willingham, QIDP

Mechanism to ensure compliance: Clinical Assessment

Frequency of Mechanism: Formally, at least monthly in each group home; informally, at least weekly in each group home

W227

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment needs. Objectives are developed for those needs which are considered to be most likely to improve the client's ability to independently function in his/her daily life, as determined by the assessment. There is a clear link between the specific objectives and the functional assessment data and recommendations.

William R. McCuller, Ph.D., Licensed Psychologist, HSP-P; and Javarous Wilson, Behavior Analyst, and Christine Willingham, QIDP will create a new behavior support plan for client AJ addressing behaviors disruptive to habilitation.

After receiving consent from the guardian and HRC, Javarous Wilson will hands-on train those people working with AJ about the behavior support plan and continue to monitor the progress.

Christine Willingham, QIDP and Javarous Wilson will round to assess effectiveness and active implementation of BSPs.

Responsible Persons: Javarous Wilson, Behavior Specialist; Dr. William McCuller, Psychologist; Christine Willingham, QIDP

Mechanism to ensure compliance: Clinical Assessment

Frequency of Mechanism: Formally, at least monthly in each group home; informally, at least weekly in each group home

W249

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.

Specific example: a) The facility failed to ensure a meal preparation objective was implemented for clients. b) S.C.'s meal time guidelines were not followed and no food was replaced for spillage.

The assistant QIDP, Stephanie Handy and Lisa Duncan CDM, CFPP will complete retraining of meal time routines for clients #25, #27, #9 and #29, including adaptive equipment needs, meal consistency, positioning for meals, and training needs.

In addition, weight monitoring will continue to ensure S.C.'s caloric needs are met, as evidenced by staying in her ideal weight range. (80 to 94 pounds)

Regular clinical assessment will occur ongoing, at least monthly in each group home, and will provide staff with the opportunity for retraining as needed, in order to ensure continued compliance with the expectation that 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.

Responsible Persons: Stephanie Handy, QIDP Assistant; Lisa Duncan, Clinical Support Specialist; Christine Willingham, QIDP

Mechanism to ensure compliance: Clinical Assessment

Frequency of Mechanism: Formally, at least monthly in each group home; informally, at least weekly in each group home

W436

The facility must furnish, maintain in good repair and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Specific example: This STANDARD is not met as evidenced by: based on observation and interview, the facility failed to maintain in good repair, a wheelchair for 1 of 2 sampled clients (#2) in Pisgah.

Program Administrator will train facility staff responsible for coordinating supports and assessing needs for changes in supports regarding the facility's protocols for IDT process. The training will include review of expectations for assessment, notification and documentation.

The Motoric Specialist, William Joseph and Christine Willingham, QIDP will train all staff on the process for reporting and maintaining all resident devises, as follows:

Process for reporting repairs needed and maintaining resident equipment

All staff are instructed to access Therap and Scomm their Supervisor, Motoric Specialist and QIDP with any broken or in need of repair equipment as soon as found. If anyone believes that there is an immediate danger to residents of staff, then report via walkie-talkie or call On-Site Supervisor immediately.

Regular assessments in the group homes and chart reviews, and any follow-up thereby identified, will be conducted by the Program Administrator and QIDP, in order to ensure continued compliance with the expectation that the facility must furnish, maintain in good repair and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Responsible Persons: Derek Briscoe, Program Administrator; William Joseph, Motoric Specialist; Christine Willingham, QIDP

Mechanism to ensure compliance: Clinical Assessment

Frequency of Mechanism: Formally, at least monthly in each group home; informally, at least weekly in each group home