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
	34G092	A. BUILDING ______ B. WING ______	C 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-MARS HILLS RESIDENTIAL SERV	**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
W 000	INITIAL COMMENTS Complaint Intake #NC159378	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 ensure implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of clients (W149) and failed to ensure appropriate corrective action was taken relative to a finding of neglect (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.	W 122		
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, record review and document review, the facility failed to implement policies and procedures to prevent neglect by not ensuring procedures to assure client safety for 1 of 1 sampled client (#1). The findings are: Review of facility investigations on 2/6/20 revealed a death investigation for client #1. Further review of the investigation revealed client	W 149		

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

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 149	Continued From page 1	W 149		

#1 died from a choking incident which occurred during the dinner meal on 10/21/19. The investigation summary indicated that when the client started choking, facility staff attempted to dislodge the food using abdominal thrusts, and were unsuccessful and 911 was called. The summary indicated emergency services personnel were also unsuccessful with life saving measures and client #1 died at the facility.

Continued review of the facility investigation revealed an interview statement summary from staff A. The summary indicated staff A was in the dining room when the choking incident began. Staff A indicated the client likely choked on a Brussel sprout piece or pieces and indicated client #1 was talking with food in his mouth, and was told to "please stop talking, finish chewing", just prior to choking. Review of the interview statement summary from staff G indicated he had chopped the client's food including the Brussel sprouts using a fork and knife.

Further review of the facility investigation conclusion section on 2/6/20 revealed the question whether client #1's food was modified to meet the prescribed chopped to 1/2 inch piece diet. The conclusion summary indicated that though inconclusive, it was likely that there remained a portion of the client's food which had remained in pieces larger than the prescribed chopped to 1/2 inch pieces.

Review of client #1's 3/13/19 ISP on 2/6/20 revealed an attached habilitation plan which included documentation that client #1 was on a diet which included food being chopped into 1/2 inch pieces to prevent choking due to a fast rate of eating. The documentation indicated the client

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W 149	Continued From page 2 tended to eat too fast, talk with his mouth full and not drink while eating. Review of the facility speech language pathology evaluations on 2/6/20 for client #1 revealed the last one completed was on 2/2/16. The evaluation indicated it was completed due to a rapid rate of eating and non-compliance with re-direction on cues to slow the rate of eating and clearing the mouth. This evaluation included the recommendation to change the client's diet to chopped. Review of the facility accident/incident reports on 2/6/20 revealed an incident report for client #1 dated 5/10/19. The incident report indicated that when the client had finished a meal, he started coughing. Review of the note from the facility dietician for this incident dated 5/20/19 revealed the client was observed after the incident and indicated the client eats at a fast pace and does not seem to tolerate many staff verbal prompts. The note also indicated that she consulted with the "Q assistant" about the possibility of adding "some type of formal eating program". Further review of the facility accident/incident reports revealed an incident report for client #1 dated 7/12/19. Review of the incident description revealed that while client #1 was eating dinner he started coughing. The report indicated the Heimlich maneuver and back thrusts were used to dislodge a piece of pot roast. Review of the note from the dietician related to the incident dated 7/15/19 indicated the roast beef consistency was incorrect based on the prescribed diet and the staff working with the client had been recently trained. A note from the qualified intellectual disabilities professional	W 149		

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W 149	Continued From page 3 (QIDP) dated 7/22/19, also indicated that staff had been trained regarding correct food consistency but training would be "reissued" for these staff. Review of training records on 2/6/20 revealed additional staff training did occur. Continued review of the facility accident/incident reports revealed an incident report for client #1 dated 10/6/19. Review of the incident description revealed that while client #1 was eating breakfast he began to choke, and staff had to "pat" his back to clear his air way. Review of the note from the dietician dated 10/17/19 indicated that the client appeared to be frustrated due to staff prompts to sit upright, slow down and take drinks, and that the client "does not seem to tolerate what he views as multiple verbal prompts". The note also indicated that follow-up would include continued monitoring and re-inservice of staff on how to provide the client with non-verbal and verbal prompts while eating. Review of the QIDP note related to this incident dated 10/23/19 included agreement with the dietician and "no changes are needed at this time". Client #1 died on 10/21/19 during a choking incident as described above in the facility investigation documentation. A review of meal assessments on 2/6/20 by the facility dietician from 5/2019 through 2/2020 revealed (2) meal assessments on 5/1/19 and 12/11/2019. Interview with the dietician verified she had conducted an on-site meal assessment (1) time on 12/1/2019, since client #1's death on 10/21/19. Additional interview with the dietician verified client #1 had choking/coughing incidents on 5/10/19, 7/12/19 and 10/17/19 before his death from choking on 10/21/19. Subsequent interview with the dietician verified she had no evidence of increased monitoring of client #1	W 149		

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W 149	Continued From page 4 after 5/10/19. Continued review of the facility investigation revealed a section identified as actions to be taken. Review of actions to be taken revealed the only corrective action recommended by the interdisciplinary team and management was to change protocols for food consistency modification. This included chopping Brussel sprouts, broccoli, cauliflower and okra in a food processor instead of using a fork and knife for all clients on modified diets including chopped. Observations at the facility (Big Laurel Building) on 2/6/20 at 12:00 PM revealed eight client's being assisted with and served modified diets. The observations included clients with chopped diets and pureed diets. All clients observed were served modified diets as prescribed and all clients were well monitored during the meal. Three direct care staff members (A,B,C) were interviewed at that time regarding training related to the new protocols for processing Brussel sprouts, broccoli, cauliflower and okra. All three staff confirmed they had received training. Review of the facility training records on 2/6/20 revealed a training for all facility staff which occurred on 10/29/19 related to the new food processing protocol. Review of the facility abuse, neglect and exploitation policies and procedures on 2/6/20 revealed the definition of "neglect" included the statement "Any situation in which staff do not carry out duties or responsibilities which in turn affect the health, safety, or well being of a resident". Interview with the facility program administrator	W 149		

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W 149	Continued From page 5 (PA) on 2/6/20 indicated the QIDP had failed to follow up with incidents within three days as per facility protocol, including the choking incident which occurred on 10/17/19 as described above. The PA also confirmed the dietician monitoring only occurred on 5/1/19 and 12/11/19, and should have occurred at least monthly. The PA additionally confirmed the speech language therapist should have evaluated client #1 on at least an annual basis. Further interview with the PA confirmed the client did not have a program objective related to eating/dining and this lack of client training had occurred since 2017. Therefore, the facility failed to prevent neglect for client #1, by failing to assure protocols and procedures were followed and/or monitored to assure health and safety.	W 149		
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, record review and document review, the facility failed to show evidence of appropriate corrective action for 1 of 1 client (#1) who died after a choking incident. The findings are: Review of facility investigations on 2/6/20 revealed a death investigation for client #1. Further review of the investigation revealed client #1 died from a choking incident which occurred during the dinner meal on 10/21/19. The investigation summary indicated that when the client started choking, facility staff attempted to	W 157		

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W 157	Continued From page 6 dislodge the food using abdominal thrusts, and were unsuccessful and 911 was called. The summary indicated emergency services personnel were also unsuccessful with life saving measures and client #1 died at the facility. Continued review of the facility investigation revealed an interview statement summary from staff A. The summary indicated staff A was in the dining room when the choking incident began. Staff A indicated the client likely choked on a Brussel sprout piece or pieces and indicated client #1 was talking with food in his mouth, and was told to "please stop talking, finish chewing", just prior to choking. Review of the interview statement summary from staff G indicated he had chopped the client's food including the Brussel sprouts using a fork and knife. Further review of the facility investigation conclusion section on 2/6/20 revealed the question whether client #1's food was modified to meet the prescribed chopped to 1/2 inch piece diet. The conclusion summary indicated that though inconclusive, it was likely that there remained a portion of the client's food which had remained in pieces larger than the prescribed chopped to 1/2 inch pieces. Review of client #1's 3/13/19 ISP on 2/6/20 revealed an attached habilitation plan which included documentation client #1 was on a diet which included food being chopped into 1/2 inch pieces to prevent choking due to a fast rate of eating. The documentation indicated the client tended to eat too fast, talk with his mouth full and not drink while eating. Review of the facility speech language pathology	W 157		

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W 157	Continued From page 7	W 157		

evaluations on 2/6/20 for client #1 revealed the last one completed was on 2/2/16. The evaluation indicated it was completed due to a rapid rate of eating and non-compliance with re-direction on cues to slow the rate of eating and clearing the mouth. This evaluation included the recommendation to change the client's diet to chopped.

Review of the facility accident/incident reports on 2/6/20 revealed an incident report for client #1 dated 5/10/19. The incident report indicated that when the client had finished a meal, he started coughing. Review of the note from the facility dietician for this incident dated 5/20/19 revealed the client was observed after the incident and indicated the client eats at a fast pace and does not seem to tolerate many staff verbal prompts. The note also indicated that she consulted with the "Q assistant" about the possibility of adding "some type of formal eating program".

Further review of the facility accident/incident reports revealed an incident report for client #1 dated 7/12/19. Review of the incident description revealed that while client #1 was eating dinner he started coughing. The report indicated the Heimlich maneuver and back thrusts were used to dislodge a piece of pot roast. Review of the note from the dietician related to the incident dated 7/15/19 indicated the roast beef consistency was incorrect based on the prescribed diet and the staff working with the client had been recently trained. A note from the qualified intellectual disabilities professional (QIDP) dated 7/22/19, also indicated that staff had been trained regarding correct food consistency but training would be "reissued" for these staff. Review of training records on 2/6/20

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W 157	Continued From page 8 revealed additional staff training did occur. Continued review of the facility accident/incident reports revealed an incident report for client #1 dated 10/6/19. Review of the incident description revealed that while client #1 was eating breakfast he began to choke, and staff had to "pat" his back to clear his air way. Review of the note from the dietician dated 10/17/19 indicated that the client appeared to be frustrated due to staff prompts to sit upright, slow down and take drinks, and that the client "does not seem to tolerate what he views as multiple verbal prompts". The note also indicated that follow-up would include continued monitoring and re-inservice of staff on how to provide the client with non-verbal and verbal prompts while eating. Review of the QIDP note related to this incident dated 10/23/19 included agreement with the dietician and "no changes are needed at this time". Client #1 died on 10/21/19 during a choking incident as described above in the facility investigation documentation. Continued review of the facility investigation revealed a section identified as actions to be taken. Review of actions to be taken revealed the only corrective action recommended by the interdisciplinary team and management was to change protocols for food consistency modification. This included chopping Brussel sprouts, broccoli, cauliflower and okra in a food processor instead of using a fork and knife for all clients on modified diets including chopped. Interview with the facility program administrator (PA) on 2/6/20 confirmed no additional corrective action was taken by facility administration/management except for the termination of the qualified intellectual disabilities	W 157		

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W 157	Continued From page 9 professional (QIDP). Therefore, the facility failed to assure administrative and clinical follow-up to a choking incident resulting in the death of client #1, included appropriate and comprehensive corrective action.	W 157		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to re-assess 1 of 1 sampled client's (#1) nutritional status including eating skills, after incidents of choking. The finding is: Review of facility investigations on 2/6/20 revealed a death investigation for client #1. Further review of the investigation revealed client #1 died from a choking incident which occurred during the dinner meal on 10/21/19. The investigation summary indicated that when the client started choking, facility staff attempted to dislodge the food using abdominal thrusts, and were unsuccessful and 911 was called. The summary indicated emergency services personnel were also unsuccessful with life saving measures and client #1 died at the facility. Continued review of the facility investigation revealed an interview statement summary from staff A. The summary indicated staff A was in the dining room when the choking incident began. Staff A indicated the client likely choked on a Brussel sprout piece or pieces and indicated client #1 was talking with food in his mouth, and	W 217		

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W 217	Continued From page 10 was told to "please stop talking, finish chewing", just prior to choking. Review of the interview statement summary from staff G indicated he had chopped the client's food including the Brussel sprouts using a fork and knife. Further review of the facility investigation conclusion section on 2/6/20 revealed question whether client #1's food was modified to meet the prescribed chopped to 1/2 inch piece diet. The conclusion summary indicated that though inconclusive, it was likely that there remained a portion of the client's food which had remained in pieces larger than the prescribed chopped to 1/2 inch pieces. Review of client #1's 3/13/19 ISP on 2/6/20 revealed an attached habilitation plan which included documentation client #1 was on a diet which included food being chopped into 1/2 inch pieces to prevent choking due to a fast rate of eating. The documentation indicated the client tended to eat too fast, talk with his mouth full and not drink while eating. Review of the facility speech language pathology evaluations on 2/6/20 for client #1 revealed the last one completed was on 2/2/16. The evaluation indicated it was completed due to a rapid rate of eating and non-compliance with re-direction on cues to slow the rate of eating and clearing the mouth. This evaluation included the recommendation to change the client's diet to chopped. Review of the facility accident/incident reports on 2/6/20 revealed an incident report for client #1 dated 5/10/19. The incident report indicated that when the client had finished a meal, he started	W 217		

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W 217	Continued From page 11 coughing. Review of the note from the facility dietician for this incident dated 5/20/19 revealed the client was observed after the incident and indicated the client eats at a fast pace and does not seem to tolerate many staff verbal prompts. The note also indicated that she consulted with the "Q assistant" about the possibility of adding "some type of formal eating program". Further review of the facility accident/incident reports revealed an incident report for client #1 dated 7/12/19. Review of the incident description revealed that while client #1 was eating dinner he started coughing. The report indicated the Heimlich maneuver and back thrusts were used to dislodge a piece of pot roast. Review of the note from the dietician related to the incident dated 7/15/19 indicated the roast beef consistency was incorrect based on the prescribed diet and the staff working with the client had been recently trained. A note from the qualified intellectual disabilities professional (QIDP) dated 7/22/19, also indicated that staff had been trained regarding correct food consistency but training would be "reissued" for these staff. Review of training records on 2/6/20 revealed additional staff training did occur. Continued review of the facility accident/incident reports revealed an incident report for client #1 dated 10/6/19. Review of the incident description revealed that while client #1 was eating breakfast he began to choke, and staff had to "pat" his back to clear his air way. Review of the note from the dietician dated 10/17/19 indicated that the client appeared to be frustrated due to staff prompts to sit upright, slow down and take drinks, and that the client "does not seem to tolerate what he views as multiple verbal prompts". The note also	W 217		

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W 217	Continued From page 12 indicated that follow-up would include continued monitoring and re-inservice of staff on how to provide the client with non-verbal and verbal prompts while eating. Review of the QIDP note related to this incident dated 10/23/19 included agreement with the dietician and "no changes are needed at this time". Client #1 died on 10/21/19 during a choking incident as described above in the facility investigation documentation. Interview with the program administrator (PM) on 2/6/20 confirmed client #1 had not had a speech language pathology assessment since 2/2/16 even though the client continued to have issues with eating rapidly. Interview with the facility dietician on 2/6/20 revealed that speech language assessments are supposed to be completed annually when a client has new or ongoing eating issues. The dietician indicated she had consulted with the speech language pathologist by phone regarding client #1 on multiple occasions since the last evaluation, but no evidence was available.	W 217		