

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

PRINTED: 02/13/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER BLUEWEST OPPORTUNITIES-MARS HILLS RESIDENTIAL SERV			STREET ADDRESS, CITY, STATE, ZIP CODE BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754		
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W 000	INITIAL COMMENTS	W 000			
W 122	Complaint Intake #NC159378 CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met.	W 122			
W 149	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. 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		DHSR - Mental Health FEB 24 2020 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jana M. Woody, COO

02-21-2020

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	<p>Continued From page 1</p> <p>#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.</p> <p>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.</p> <p>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.</p> <p>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</p>	W 149			

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W 149	<p>Continued From page 2</p> <p>tended to eat too fast, talk with his mouth full and not drink while eating.</p> <p>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.</p> <p>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".</p> <p>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</p>	W 149			

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W 149	<p>Continued From page 3</p> <p>(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.</p> <p>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.</p> <p>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</p>	W 149			

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W 149	<p>Continued From page 4 after 5/10/19.</p> <p>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.</p> <p>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.</p> <p>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".</p> <p>Interview with the facility program administrator</p>	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	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of the facility speech language pathology</p>	W 157			

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W 157	<p>Continued From page 7</p> <p>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.</p> <p>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".</p> <p>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</p>	W 157			

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W 157	<p>Continued From page 8 revealed additional staff training did occur.</p> <p>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.</p> <p>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.</p> <p>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</p>	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	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v)</p> <p>The comprehensive functional assessment must include nutritional status.</p> <p>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:</p> <p>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.</p> <p>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</p>	W 217			

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W 217	<p>Continued From page 10</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	W 217			

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W 217	<p>Continued From page 11</p> <p>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".</p> <p>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.</p> <p>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</p>	W 217			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER BLUEWEST OPPORTUNITIES-MARS HILLS RESIDENTIAL SERV			STREET ADDRESS, CITY, STATE, ZIP CODE BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754		
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W 217	<p>Continued From page 12</p> <p>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.</p> <p>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.</p>	W 217			

Plan of Correction for Complaint Survey 2/6/2020

W 122 Client Protections

The facility must ensure that specific client protections requirements are met.

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).

Cross reference corrections **W149, W157.**

DHSR - Mental Health

FEB 24 2020

W 149 Staff Treatment of Clients

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

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.

The agency created and filled 2 new positions in the fall of 2019: Quality Assurance Specialist, and Social Services Coordinator. These positions were not developed in response to the specific incident which is the subject of this complaint investigation and evidence of the agency's failure to meet the condition of client protections; however, the positions were developed to meet the need identified by agency executive management for implementation of quality assurance and improvement systems, such as would serve to protect clients from neglect as experienced by the client sampled here.

The following are from the job descriptions for these 2 positions:

Quality Assurance Specialist – Position Summary: The Quality Assurance Specialist serves as a part of the Operations Team to assist in ensuring overall compliance with all applicable governing and accreditation standards. The QAS serves as the primary catalyst for change and improvement in performance and quality of the organization. The QAS is responsible for conducting internal audits and collecting data for performance measurement goals. The QAS works closely with all Executive Team members and Program Directors/Administrators to gather information, to provide feedback on quality measures, and to support an overall organizational culture that embraces continual learning, development and improvement.

Some of the responsibilities of the QAS which pertain to the corrections for this citation include: /

1. Perform random, routine and targeted audits of records of persons served to assure adherence to regulatory requirements.
2. Identify recommendations as needed to address areas of deficiency as identified in internal audits.
3. Conduct random, routine and targeted on-site monitoring of Individual Support Plan implementation.

Lic. & Cert. Section

4. Identify recommendations as needed to address areas of deficiency as identified in on-site assessments.
5. Assign as needed and maintain record of on-site assessment by clinical and management team members.

Social Services Coordinator – Position Summary: The Social Services Coordinator is a part time, professional position responsible for serving as a resource to the interdisciplinary team for assuring that the IDT processes work to meet the needs of persons supported.

Some of the responsibilities of the SSC which pertain to the corrections for this citation include:

1. Review resident records on a rotating basis as assigned to ensure appropriate documentation of active treatment and health care services. Make recommendations to the Program Administrator for out of compliance issues.
2. Serve as participant on the quality assurance committee and complete assigned duties.

Ongoing, these responsibilities will be carried out by the QAS and CSS, and will serve to aid the IDT in preventing neglect. The internal audits they conduct will include cross referencing of recommendations from licensed clinical team members with Individual Program Plans, as well as checking that relevant evaluations are performed by clinicians as needed. If program objectives or procedures recommended by clinicians are identified as missing from a client's ISP, the Program Administrator will be notified immediately, and be responsible for addressing the identified need. Followup implemented by the Program Administrator or designee will be reported to the QAS.

As noted in the deficiency report, the agency terminated the employment of the QIDP responsible for coordinating, implementing and monitoring the sampled client's ISP. A new QIDP has been hired and has and will continue to receive training and support regarding monitoring of incidents which could precipitate critical safety issues for clients. Training will be conducted primarily by the Program Administrator, and administrative support will be provided by the QAS and CSS, as noted above. Documentation of said training will be kept by the agency's human resources department.

Responsible Persons: Program Administrator, Quality Assurance Specialist, Social Services Coordinator

Mechanism to ensure compliance: On-site assessments and review of records

Frequency of Mechanism: Assessments least monthly in each group home, at least annually for record reviews

Corrections complete by: 3/22/20

W 157 Staff Treatment of Clients

If the alleged violation is verified, appropriate corrective action must be taken.

The facility failed to show evidence of appropriate corrective action for 1 of 1 sampled client who died after a choking incident.

The agency created and filled 2 new positions in the fall of 2019: Quality Assurance Specialist, and Social Services Coordinator. These positions were not developed in response to the specific incident which is

the subject of this complaint investigation and evidence of the agency's failure to meet the condition of client protections; however, the positions were developed to meet the need identified by agency executive management for implementation of quality assurance and improvement systems, such as would serve to protect clients from neglect as experienced by the client sampled here.

The following are from the job descriptions for these 2 positions:

Quality Assurance Specialist – Position Summary: The Quality Assurance Specialist serves as a part of the Operations Team to assist in ensuring overall compliance with all applicable governing and accreditation standards. The QAS serves as the primary catalyst for change and improvement in performance and quality of the organization. The QAS is responsible for conducting internal audits and collecting data for performance measurement goals. The QAS works closely with all Executive Team members and Program Directors/Administrators to gather information, to provide feedback on quality measures, and to support an overall organizational culture that embraces continual learning, development and improvement.

Some of the responsibilities of the QAS which pertain to the corrections for this citation include:

1. Perform random, routine and targeted audits of records of persons served to assure adherence to regulatory requirements.
2. Identify recommendations as needed to address areas of deficiency as identified in internal audits.
3. Conduct random, routine and targeted on-site monitoring of Individual Support Plan implementation.
4. Identify recommendations as needed to address areas of deficiency as identified in on-site assessments.
5. Assign as needed and maintain record of on-site assessment by clinical and management team members.

Social Services Coordinator – Position Summary: The Social Services Coordinator is a part time, professional position responsible for serving as a resource to the interdisciplinary team for assuring that the IDT processes work to meet the needs of persons supported.

Some of the responsibilities of the SSC which pertain to the corrections for this citation include:

1. Review resident records on a rotating basis as assigned to ensure appropriate documentation of active treatment and health care services. Make recommendations to the Program Administrator for out of compliance issues.
2. Serve as participant on the quality assurance committee and complete assigned duties.

Ongoing, these responsibilities will be carried out by the QAS and CSS and will serve to aid the IDT in preventing neglect. The internal audits they conduct will include cross referencing of recommendations from licensed clinical team members with Individual Program Plans, as well as checking that relevant evaluations are performed by clinicians as needed. If program objectives or procedures recommended by clinicians are identified as missing from a client's ISP, the Program Administrator will be notified immediately, and be responsible for addressing the identified need. Follow-up implemented by the Program Administrator or designee will be reported to the QAS.

As noted in the deficiency report, the agency terminated the employment of the QIDP responsible for coordinating, implementing and monitoring the sampled client's ISP. A new QIDP has been hired and has and will continue to receive training and support regarding monitoring of incidents which could precipitate critical safety issues for clients. Training will be conducted primarily by the Program Administrator, and administrative support will be provided by the QAS and CSS, as noted above. Documentation of said training will be kept by the agency's human resources department.

Responsible Persons: Program Administrator, Quality Assurance Specialist, Social Services Coordinator

Mechanism to ensure compliance: On-site assessments and review of records

Frequency of Mechanism: Assessments least monthly in each group home, at least annually for record reviews

Corrections complete by: 3/22/20

W 217 Individual Program Plan

The comprehensive functional assessment must include nutritional status.

The facility failed to re-assess 1 of 1 sampled client's nutritional status including eating skills, after incidents of choking.

The corrections noted above for W149 and W157 will serve to correct this deficient practice as well. In addition to the routine audits, which will serve to ensure that formal evaluation and recommendations for intervention by the agency's SLP are sought appropriately, the agency's Dietary Manager will receive training regarding accurate documentation of informal recommendations from the agency's SLP. This training will be conducted by the Program Administrator.

Responsible Person: Program Administrator, Quality Assurance Specialist, Social Services Coordinator

Mechanism to ensure compliance: Review of records

Frequency of Mechanism: Annual record reviews and as needed

Corrections complete by: 4/6/20



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February 20, 2020

Mental Health Licensure and Certification Section
NC Division of Health Services Regulation
952 Old US Hwy 70
Black Mountain, NC 28711

DHSR - Mental Health

FEB 24 2020

Lic. & Cert. Section

Re: Complaint Investigation Survey 02/06/2020
BlueWest Opportunities – Mars Hill Residential
Provider Number 34G209
MHL # 057-003

Enclosed please find the Plan of Correction for BlueWest Opportunities – Mars Hill Residential for deficiencies cited during the complaint survey conducted February 6, 2020. Please plan to visit our facility on March 22, 2020 to review corrections made to facilitate compliance in these areas of deficiency.

If you have any questions related to this plan, please contact me at 828-251-2824.

Kind Regards,

Derek Briscoe, Program Administrator