CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G092	B. WING			04/	27/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
				в	LUE RIDGE HOMES DRIVE #50		
BLUEWES	ST OPPORTUNITIES-MAI	RS HILLS RESIDENTIAL SERV		N	IARS HILL, NC 28754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 249	each client must rece treatment program co interventions and serv and frequency to sup) isciplinary team has ndividual program plan, ive a continuous active	W	249			
	Based on observation interviews, the facility sampled clients (#20) continuous active treat of needed intervention individual support plan Observation throughout revealed client #20 in various times, pulled his pants back up. Control revealed client #20 at up with verbal direction with no direction as station look at the client until Observation of staff revealed down for staff to touch time the client pulled staff supervision of client times to monitor the control and verbal engagement	n (ISP). The finding is: but the 4/26-27/21 survey snowbird to stand up at down his pants, then pulled portinued observations times pulled his pants back on from staff and other times taff were observed to just he pulled up his pants. edirection revealed at lient #20 pulled his pants in the clients leg at which his pants up. Observation of ent #20 revealed staff at lient closely with physical ent while at other times client ged and visually monitored.					
	prompted client #20 to	o pull his pants up was it	_		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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.

	-	ID HUMAN SERVICES				FORM	APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G092 B.				04/27/2021		
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				в	BLUE RIDGE HOMES DRIVE #50			
BLUEWES	T OPPORTUNITIES-MAI	RS HILLS RESIDENTIAL SERV		N	MARS HILL, NC 28754			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE	
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	AIE		
	1							
W 249	Continued From page	e 1	W	249				
	observed for staff to c	offer client #20 an activity						
	choice.							
	Observation of client	#20 on 4/26/21 at 4:15 PM						
	-	sit in a chair outside in the						
		with no shirt. Continued						
	• • •	staff to assist the client with						
		to go for a walk. Further						
		client #20 to remain outside						
		nt engagement by staff while						
		e driveway of the group						
		t 6:10 PM revealed client						
		roup home with verbal						
		participate in the dinner						
		ng observations was it						
	observed for staff to u							
	communication board	l to support a transition.						
	Observation of client	#20 on 4/27/21 at 6:45 AM						
	revealed the client to	sit in the dining room and to						
	stand up at various tir	mes to pull his pants down.						
	Client #20 was furthe	r observed to pull his pants						
		tion from various staff and						
	at times with no redire	ection. Observation of						
	activity engagement r	evealed client #20 to sit in						
	the dining room from	6:45 AM until 7:28 AM and						
	U	ntil verbally prompted to fix						
	his plate for breakfast							
	-	fast meal client #20 was						
		t in the dining room, to take						
		vn his pants, then pull his						
		erbally directed by staff to						
		ch time the client left the						
		e during this observation						
	-	d for staff to use any object						
	cue or communication							
	transition.	i board to support a						
	Review of records for	client #20 on 4/22/21						

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/06/2021 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		34G092	B. WING _				04/27/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				BLUE	E RIDGE HOMES DRIVE #50		
BLOLVAL	ST OFF ORTONITIES-WA			MAR	S HILL, NC 28754		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 2	249			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 922427

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/06/2021 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G092	B. WING				04/27/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE				
BLUEWEST OPPORTUNITIES-MARS HILLS RESIDENTIAL SERV					LUE RIDGE HOMES DRIVE #50 ARS HILL, NC 28754				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD B		(X5) COMPLETION DATE	
W 249	intervals and pat the of when pants are up. In reinforcer of an appro- client prefers. Review of client #20's demonstrates a short tasks, keep duration f short. Continued revis should be assigned to engagement. The BS preferred activities of in a rocking chair, pla toys and playing with activities). Further review of the offer activity choices t assist until the client fe engaged. Subsequer to continue communic symbols and manual what will be happenin the BSP for client #20 does pull down his pa assist him in pulling th appropriate leisure ac prosocial form of stim Interview with the facil disabilities profession has a mobile communit that should be used w activity transitions and interview with the QIE have been offered pa preferred activities ab support active engage	client's upper leg gently mmediately after provide a opriate sensory object the a BSP revealed the client attention span for most for constructive involvement iew revealed a staff person o monitor active SP for client #20 identified the client to include: sitting ying with preferred fuzzy water toys (or water BSP revealed the need to to the client and continue to becomes constructively int review revealed the need cation attempts using object signs to let the client know ag next. Additional review of D revealed when the client ants, staff will immediately nem back up and re-direct to ctivity to provide a more fulation. ility qualified intellectual ial (QIDP) verified client #20 nication board with objects with client #20 to support d engagement. Continued DP verified client #20 should rticipation in various pout every 15 minutes to	W 24	49					

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Facility ID: 922427

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	· · ·	PLETED			
		34G092	B. WING		04/	04/27/2021		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1			
BLUEWE	ST OPPORTUNITIES-MA	RS HILLS RESIDENTIAL SERV		BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 249		e 4 n staff should have offered a	W 249					
M 050	preferred object to the appropriate activity e	e client to encourage ngagement.	W 252					
W 252	PROGRAM DOCUM CFR(s): 483.440(e)(1		W 252					
	specified in client ind	nplishment of the criteria ividual program plan ocumented in measurable						
	Based on review of r team failed to ensure management program support plan (ISP) for	not met as evidenced by: records and interview, the data for a behavior n listed in the individual r 1 of 2 clients (#20) in ed as prescribed. The						
	revealed client #20 in various times, to pull his pants back up. C revealed client #20 a up with verbal direction with no direction as s	but the 4/26-27/21 survey Snowbird to stand up at down his pants then to pull ontinued observations t times pulled his pants back on from staff and other times taff were observed to just he pulled up his pants.						
	Observation of staff r various times when c down for staff to touc time the client pulled staff supervision of cl times to monitor the c	edirection revealed at lient #20 pulled his pants h the clients leg at which his pants up. Observation of ient #20 revealed staff at client closely with physical ent while at other times client						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/06/2021 APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G092	B. WING		_	04/27/2021		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST				
BLUEWE	ST OPPORTUNITIES-MAI	RS HILLS RESIDENTIAL SERV		LUE RIDGE HOMES DRIV ARS HILL, NC 28754	′E #50			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 252	Review of records for revealed an ISP date ISP for client #20 reve plan (BSP) dated 7/20 BSP revealed target to physical aggression, self-injurious behavior Continued review of to #20 revealed clothing removing or starting to location. Further revies frequency of data coll to be as the target be A review of internal do client #20's behavior during survey observa 4/27/21 revealed no of the behavior. Interview with the fact disabilities profession verified the target beh be documented as the QIDP further verified of client #20's behavior during survey observa by staff. Continued in revealed client #20's is not always docume	c client #20 on 4/27/21 d 3/27/21. Review of the ealed a behavior support 6/19. Review of the 7/2019 behavior of clothing removal, property destruction, r and sleep disturbance. he current BSP for client removal to be defined as: o remove clothing in a public ew of the BSP revealed the lection for target behaviors havior occurs.	W 252					

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