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BLUEWEST OPPORTUNITIES-SWANNANOA RESIDENTIAL	**91 POPLAR CIRCLE SWANNANOA, NC 28778**

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W 000	INITIAL COMMENTS Complaint Intake#: NC00179341, NC00179668	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body failed to exercise general policy and operating direction over the facility by failing to assure facility furniture was in good repair in Beaucatcher. The finding is: Observation conducted of the group home furniture in the main day room of Beaucatcher on 7/27/21 revealed a recliner to slightly lean to the left side. Continued observation revealed the foot rest of the chair to protrude outward from the chair and staff I to attempt to recline the chair. Upon staff I's attempt to recline the chair, the wooden leg came out from under the chair and the foot rest was observed to be broken. Staff I, then placed the chair back into an unreclined position. Further observation revealed from 9:10 AM to 9:30 AM for client #11 to sit in the recliner with the recliner leaning to the left side. Interview with client #19 revealed she enjoys sitting in the recliner and had not done so for a while as the recliner was broken and had been broke for a while. Further interview confirmed client #6 also enjoys sitting in the recliner. Interview with staff I on 7/27/21 revealed she had previously requested repairs for the recliner and	W 104		

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 104	Continued From page 1 was assured the repairs were completed. Further interview with staff J verified client #6 and #19 prefer to sit in the recliner while in the dayroom. Additional interview with staff J revealed a work order should be completed to address the need for furniture repairs. Interview with the clinical director on 7/27/21 revealed all furniture should be in good repair and without safety concerns to clients in the home. Continued interview with the clinical director revealed furniture should also be arranged or removed after an observation of a safety issue to provide safety to the clients in the facility until maintenance can conduct necessary repairs.	W 104		
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: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149) and failed to provide evidence that all alleged violations were thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of Client Protection for it's clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written	W 149		

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W 149	Continued From page 2	W 149		

policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on observation, record/document review and interview, the facility failed to assure it's policies and procedures that prohibit abuse and neglect were implemented to prevent peer to peer abuse for 1 of 6 sampled clients (#4). The finding is:

Review of internal facility documents on 7/26/21 revealed an incident report dated 7/14/21. Review of the 7/14/21 incident report revealed staff A had observed client #16 to exit and close the bedroom door of clients #4 and #23, two females that resided in the group home, after client #16 had informed staff A he was going to bed (10:20 PM). Continued review of documentation from the 7/14/21 incident revealed staff A to indicate abuse was suspected during the incident.

Interview with the clinical director on 7/26/21 revealed he had interviewed staff A after the 7/14/21 incident and had confirmed staff A had not observed any direct physical contact between client #16 and client #4 or #23 during the 7/14/21 incident. Continued interview with the clinical director revealed the incident was immediately reported to the site supervisor and an observation of client #4 after the incident revealed the client's brief to be opened up and pulled down. Further interview with the clinical director revealed a nursing evaluation was conducted on client #4 and #23 on 7/15/21 to assess for sexual abuse.

Subsequent interview with the clinical director on

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7/26/21 revealed an in-service training was conducted with all staff that work with client #16 on 7/16/21 relative to the bedroom alarm for the client. Interview with the clinical director verified no additional protective measures had been implemented with the 7/14/21 incident other than a nursing evaluation for client #4 and #23, an in-service regarding client #16's bedroom door alarm and consideration of the clinical team as to the appropriateness of keeping client #4 and #23 in the same home as #16. Additional interview with the clinical director verified the facility had not initiated a formal investigation regarding the 7/14/21 incident although the facility had interviewed staff A and reviewed camera footage in the group home from 7/14/21. The clinical director further confirmed a current facility inquiry had started 7/25/21 due to a report of information that was different from the information reported in the 7/14/21 incident by staff A.

Review of records for client #16 on 7/26/21 revealed a person centered plan (PCP) dated 5/9/21. Continued review of the PCP for client #16 revealed a behavior support plan dated 9/24/20. Review of the current behavior plan for client #16 revealed target behaviors of non-compliance, intrusive attention seeking, inappropriate contact, verbal aggression, PICA, physical aggression, property destruction, AWOL, verbally threatening self injurious behavior, self injury, making untrue statements, inappropriate sexual self stimulation, invading the privacy of other persons bedrooms and taking inappropriate foods. Additional record review for client #16 revealed a diagnosis history of mild intellectual disability, pervasive developmental disorder, bi-polar disorder and oppositional defiant disorder.

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Continued From page 4

Interview with clinical director on 7/26/21, after the initial interview, verified client #16 has had a history of involvement in allegations regarding sexual behavior towards other clients although no allegation of sexual abuse had ever been substantiated. The clinical director further confirmed clients #4 and #23 would be moved, on the current day, to another residence on the facility site, outside the residence of client #16.

Observation in the group home on 7/26/21 verified client #4 and #23 had been moved to another residence on the facility site. Observation of client #4 and #23, at their relocated residence in Sunset, revealed both clients to be non-verbal and client #4 to ambulate in a wheelchair with staff assistance.

Interview with staff A on 7/26/21 verified he had observed client #16 to exit the bedroom and close the door of client #4 and #23 on 7/14/21. Continued interview with staff A revealed while he did not observe direct physical contact of client #16 with client #4 or #23 he was concerned with what did happen. Further interview with staff A verified he immediately reported the incident to the site supervisor.

Interview with the site supervisor, staff B, on 7/26/21 revealed he was informed by staff A of the incident on 7/14/21 involving client #16. Continued interview with staff B revealed he conducted an immediate observation of clients #4 and #23 with the report received by staff A and observed the blanket for client #4 to be pulled back, the brief of client #4 to be undone and the brief to be folded down between the client's legs. Subsequent interview with staff B revealed he

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W 149	Continued From page 5 reported the observation to the clinical director. Additional interview with staff B revealed the observation of client #4 after the incident was not consistent with the client's physical abilities to pull back her own bed linens, undue her brief or fold it down. Interview with the clinical director and facility administrator on 7/27/21 revealed, after a review of camera footage during the survey process, that client #16 had entered the bedroom of client #4 and #23 for approximately 8 minutes on 7/20/21 and it could not be determined what occurred while client #16 was in the bedroom. Continued interview revealed the clinical director and the facility director to verify it had also been discovered, with video review, that client #16 had sexually abused client #4 on 7/23/21. Further interview with administration staff verified client #16 had sexually abused client #4 in the common room of the group home with (2) staff on shift. Subsequent interview with administration confirmed the staff on shift were not supervising clients as (1) staff was in the medication room and the other staff had left the group home to conduct medication administration in another residence on the site. Review on 7/27/21 of the facility's abuse and neglect policy titled "Abuse, Neglect and Exploitation" dated 7/1/2019 revealed all individuals served by the organization are to be protected from abuse, neglect, exploitation and mistreatment. Continued review of the facility's abuse and neglect policy revealed allegations of abuse, neglect or exploitation are to be investigated thoroughly. Interview with administration staff verified they	W 149		

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W 149	Continued From page 6 had neglected to protect client #4 from peer to peer abuse and failed to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Subsequent interview with administration staff verified client #16's supervision guidelines would be increased to 1:1 as of the current survey date with additional training for any staff providing supervision to the client.	W 149		
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 review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 6 sampled clients (#4). The finding is: Review of internal facility documents on 7/26/21 revealed an incident report dated 7/14/21. Review of the 7/14/21 incident report revealed staff A had observed client #16 to close the bedroom door of clients #4 and #23, two females that resided in the group home, after client #16 had informed staff A he was going to bed (10:20 PM). Continued review of documentation from the 7/14/21 incident revealed staff A to indicate abuse was suspected during the incident. Interview with the clinical director on 7/26/21 revealed he had interviewed staff A after the 7/14/21 incident and had confirmed staff A had	W 154		

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not observed any direct physical contact between client #16 and client #4 or #23 during the 7/14/21 incident. Continued interview with the clinical director revealed the incident was immediately reported to the site supervisor and an observation of client #4 after the incident revealed the client's brief to be opened up and pulled down. Further interview with the clinical director revealed a nursing evaluation was conducted on client #4 and #23 on 7/15/21 to assess for sexual abuse. Subsequent interview with the clinical director revealed an in-service training was conducted on 7/16/21 with all staff that work with client #16 relative to the bedroom alarm for the client.

Interview with the clinical director on 7/26/21 verified no additional protective measures had been implemented since 7/14/21 other than a nursing evaluation for client #4 and #23, and in-service regarding client #16's bedroom alarm. Interview with the clinical director also revealed the clinical team was reviewing the appropriateness of keeping client #4 and #23 in the same home as #16, while at the time of interview, all clients resided together. Additional interview with the clinical director verified the facility had not initiated a formal investigation regarding the 7/14/21 incident although the facility had interviewed staff A and reviewed camera footage in the group home from 7/14/21. The clinical director further confirmed a current facility inquiry had started 7/25/21 due to a report of information that was different from the information reported in the 7/14/21 incident by staff A.

Review of records for client #16 on 7/26/21 revealed a person centered plan (PCP) dated 5/9/21. Continued review of the PCP for client #16 revealed a behavior support plan dated

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9/24/20. Review of the current behavior plan for client #16 revealed target behaviors of non-compliance, intrusive attention seeking, inappropriate contact, verbal aggression, PICA, physical aggression, property destruction, AWOL, verbally threatening self injurious behavior, self injury, making untrue statements, inappropriate sexual self stimulation, invading the privacy of other persons bedrooms and taking inappropriate foods. Additional record review for client #16 revealed a diagnosis history of mild intellectual disability, pervasive developmental disorder, bi-polar disorder and oppositional defiant disorder.

Interview with clinical director on 7/26/21, after the initial interview, verified client #16 has had a history of involvement in allegations regarding sexual behavior towards other clients although no allegation of sexual abuse had ever been substantiated. The clinical director further confirmed clients #4 and #23 would be moved on the current day to another residence on the facility site, outside the residence of client #16.

Observation in the group home on 7/26/21 verified client #4 and #23 had been moved to another residence on the facility site. Observation of client #4 and #23, at their relocated residence in Sunset, revealed both clients to be non-verbal and client #4 to ambulate in a wheelchair with staff assistance.

Interview with staff A on 7/26/21 verified he had observed client #16 to exit the bedroom and close the bedroom door of client #4 and #23 on 7/14/21. Continued interview with staff A revealed while he did not observe direct physical contact of client #16 with client #4 or #23 he was concerned

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with what did happen. Further interview with staff A verified he immediately reported the incident to the site supervisor.

Interview with the site supervisor, staff B, on 7/26/21 revealed he was informed by staff A of the incident on 7/14/21 involving client #16. Continued interview with staff B revealed he conducted an immediate observation of clients #4 and #23 with the report received by staff A and observed the blanket for client #4 to be pulled back, the brief of client #4 to be undone and the brief to be folded down between the client's legs. Subsequent interview with staff B revealed he reported the observation immediately to the clinical director. Additional interview with staff B revealed the observation of client #4 after the incident was not consistent with the client's physical abilities to pull back her own bed linens, undue her brief or fold it down.

Interview with the clinical director and facility administrator on 7/27/21 revealed, after a review of camera footage during the survey process, that client #16 had entered the bedroom of client #4 and #23 for approximately 8 minutes on 7/20/21 and it could not be determined what occurred while client #16 was in the bedroom. Continued interview revealed the clinical director and the facility administrator to verify it had also been discovered, with video review during the survey process, that client #16 had sexually abused client #4 on 7/23/21. Further interview with administration staff verified client #16 had sexually abused client #4 in the common room of the group home with (2) staff on shift. Subsequent interview with administration confirmed the staff on shift were not supervising clients as (1) staff was in the medication room

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W 154	Continued From page 10 and the other staff had left the group home to conduct medication administration in another residence on the site. Interview with administration staff verified they had failed to protect client #4 from abuse and failed to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Additional interview verified if a thorough investigation had been conducted relative to the 7/14/21 incident, findings could have prevented further incidents that occurred between client #16 and client #4.	W 154		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interviews and record verification the facility failed to provide sufficient direct care staff to manage and supervise clients appropriately. The finding is: Interview on 7/27/21 with the clinical director and facility director revealed, after a review of group home camera video on 7/26/21 and 7/27/21 by administration staff, it was discovered on 7/20/21 that client #16 had entered the bedroom of client	W 186		

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W 186	Continued From page 11 #4 and #23 for approximately 8 minutes. Continued interview with administration revealed it could not be determined what occurred on 7/20/21 while client #16 was in the bedroom of client #4 and #23. Further interview revealed the clinical director and the facility director to verify it had also been discovered, with video review, that client #16 had sexually abused client #4 on 7/23/21. Subsequent interview with administration staff verified client #16 had sexually abused client #4 in the common room of the group home with (2) staff on shift. Interview with administration additionally verified the staff on shift were not supervising clients as (1) staff was in the medication room and the other staff had left the group home to conduct medication administration in another residence on the site. Review of records for client #16 on 7/26/21 revealed a person centered plan (PCP) dated 5/9/21. Continued review of the PCP for client #16 revealed a behavior support plan dated 9/24/20. Review of the current behavior plan for client #16 revealed target behaviors of non-compliance, intrusive attention seeking, inappropriate contact, verbal aggression, PICA, physical aggression, property destruction, AWOL, verbally threatening self injurious behavior, self injury, making untrue statements, inappropriate sexual self stimulation, invading the privacy of other persons bedrooms and taking inappropriate foods. Additional record review for client #16 revealed a diagnosis history of mild intellectual disability, pervasive developmental disorder, bi-polar disorder and oppositional defiant disorder. Additional interview with clinical director during the 7/26-27/2021 survey verified client #16 had a	W 186		

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W 186	Continued From page 12 history of involvement in allegations regarding inappropriate sexual behavior towards other clients although no allegation of sexual abuse had ever been substantiated. The clinical director and facility administrator further verified, with interview on 7/27/21, the facility had failed to provide appropriate supervision on 7/23/21 during a time period that a substantiated incident of sexual abuse had occurred between client #16 and client #4.	W 186		
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 plan. 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 person centered plans (PCP's) were implemented as prescribed for 1 of 6 clients in Hawksbill (#16), 4 of 7 clients in Pisgah (#2, #7, #10 and #17) and 4 of 8 clients in Beaucatcher(#1,#5, #6 and #21). The findings are: A. The facility failed to ensure a behavior support plan (BSP) was implemented as prescribed for client #16. For example:	W 249		

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1. The facility failed to implement a silent alarm as prescribed for client #16.

Observation in the facility on 7/26/21 during afternoon observations revealed an alarm to be attached to the bedroom door of client #16 bedroom door. Continued observation in the facility on 7/27/21 at 6:50 AM revealed client #16 to be in his bedroom with the door closed. Further observation revealed client #16 to exit his bedroom and walk the hallway of the facility. Subsequent observation throughout the morning observation period revealed the alarm control box to client #16's door alarm to sit on a table in the common area, unattended by staff until observations ended at 9:15 AM.

Review of records for client #16 on 7/27/21 revealed a PCP dated 5/9/21 that reflected a diagnosis history to include Mild Intellectual Disability, Pervasive Developmental Disorder and Bi-polar Disorder. Review of client #16's PCP revealed a BSP dated 7/14/20. Review of the current BSP for client #16 revealed target behaviors of noncompliance, intrusive attention seeking behavior, inappropriate contact (spitting, touching people in private-sexual areas of the body; possibly escalating to aggressive grabbing, pulling or inappropriate "horse play"), verbal aggression, pica, physical aggression, property destruction, AWOL, verbally threatening self-injury, self-injury, taking items inappropriately (stealing), making untrue statements, inappropriate sexual self stimulation, and invading the privacy of other persons room (going into the the bedroom of another client without permission or approval).

Continued review of client #16's BSP revealed

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W 249	Continued From page 14 prevention strategies that include: a silent alarm on the exits from his bedroom during team designated times due to client #16 leaving his room at night on second and third shift and going into the bedroom of others. Further review of guidelines relative to the silent alarm for client #16 revealed when staff are aware the alarm is activated they will observe and monitor the client to ensure he does not enter the room of another home resident. Review on 7/27/21 of internal training revealed an in-service training with staff on 7/16/21 specific to client #16's room alarm. Review of the 7/16/21 training revealed in the event client #16 is in his room, staff must have his "buzzer" (alarm) on their person at all times; when the buzzer vibrates this means that staff must go and check on client #16 and see what he is doing immediately. The charger for the buzzer is in the Hawksbill front office, put it in there if not in use. Interview with staff A on 7/26/21 revealed the silent alarm for client #16 is used at night only after the client goes to bed. Continued interview with staff A revealed after client #16 goes to bed, staff use the alarm control box to monitor client #16 by keeping the control box on the staff and monitoring the box for any vibration that would indicate the client has opened his bedroom door. It should be noted this surveyor had staff A to set off the alarm to ensure working order of the control box. Further interview with staff A revealed the alarm control box is kept in a locked area when not in use as client #16 is capable of accessing the alarm box and tampering with the controls. Interview with the clinical director on 7/27/21	W 249		

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revealed the alarm control box should not have been sitting on a table unattended in the common area of the group home during morning observations of survey of 7/27/21. Continued interview with facility clinical director verified guidelines regarding the silent alarm for client #16 should be more specific than to be used "during team designated times".

2. The facility failed to implement supervision as prescribed for client #16. For example:

Interview on 7/27/21 with the clinical director and facility director revealed, after a review of group home camera video on 7/26/21 and 7/27/21 by administration staff, it was discovered on 7/20/21 that client #16 had entered the bedroom of client #4 and #23 for approximately 8 minutes. Continued interview with administration revealed it could not be determined what occurred on 7/20/21 while client #16 was in the bedroom of client #4 and #23. Further interview revealed the clinical director and the facility director to verify it had also been discovered, with video review, that client #16 had sexually abused client #4 on 7/23/21. Subsequent interview with administration staff verified client #16 had sexually abused client #4 in the common room of the group home with (2) staff on shift. Interview with administration additionally verified the staff on shift were not supervising clients as (1) staff was in the medication room and the other staff had left the group home to conduct medication administration in another residence on the site.

Review of records for client #16 on 7/26/21 revealed a person centered plan (PCP) dated 5/9/21. Continued review of the PCP for client #16 revealed a behavior support plan dated

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9/24/20. Review of the current behavior plan for client #16 revealed target behaviors of non-compliance, intrusive attention seeking, inappropriate contact, verbal aggression, PICA, physical aggression, property destruction, AWOL, verbally threatening self injurious behavior, self injury, making untrue statements, inappropriate sexual self stimulation, invading the privacy of other persons bedrooms and taking inappropriate foods. Additional record review for client #16 revealed a diagnosis history of mild intellectual disability, pervasive developmental disorder, bi-polar disorder and oppositional defiant disorder.

Additional interview with clinical director during the 7/26-27/2021 survey verified client #16 had a history of involvement in allegations regarding inappropriate sexual behavior towards other clients and needed close supervision although no allegation of sexual abuse had ever been substantiated. The clinical director and facility administrator further verified, with interview on 7/27/21, client #16 needs eyesight supervision and the facility had failed to provide appropriate supervision which had resulted in a substantiated incident of sexual abuse between client #16 and client #4.

3. The facility failed to address non-compliance behaviors as prescribed for client #16.

Observation in Hawksbill, during survey observations on 7/26/21 revealed client #16 to be dressed in a pair of shorts and a t-shirt. Continued observation on 7/27/21 during morning observations revealed client #16 to exit his room wearing the same clothing as observed on 7/26/21. Further observation throughout the

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W 249	Continued From page 17 7/26-27/21 survey revealed client #16 to have a set of clothes ,folded on the floor, outside his bedroom door. Review of records for client #16 on 7/26/21 revealed a person centered plan (PCP) dated 5/9/21. Continued record review for client #16 revealed a diagnosis history of mild intellectual disability, pervasive developmental disorder, bi-polar disorder and oppositional defiant disorder. Review of the PCP for client #16 revealed a behavior support plan (BSP) dated 9/24/20. Review of the current behavior plan for client #16 revealed target behaviors of non-compliance, intrusive attention seeking, inappropriate contact, verbal aggression, PICA, physical aggression, property destruction, AWOL, verbally threatening self injurious behavior, self injury, making untrue statements, inappropriate sexual self stimulation, invading the privacy of other persons bedrooms and taking inappropriate foods. Subsequent review of the BSP for client #16 revealed non-compliance behaviors to include refusing to cooperate with activities necessary for his health, hygiene or habilitation and refusing to follow or participate in his schedule of activities. A review of data related to client #16's hygiene revealed (3) days of data for 4/2021 with no data for shower, (3) days of data for 5/2021 with no data for shower and (13) days of data collection for 7/2021. Data collection for 6/2021 was not provided to the surveyor. Additional review of the BSP for client #16 revealed prevention strategies for non-compliance to include: A) Ask once, if client #16 refuses walk away and go reinforce someone	W 249		

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else for cooperating with the same or similar task. B) If necessary, ask again after a few minutes and help him remember what reinforcers he gets for getting his jobs done; remind him he earns outings for being cooperative. C) If after two prompts he still does not cooperate then wait about 5-10 minutes then try again or have another staff to try again. D) Notify the supervisor if after 1 hour client #16 cannot be encouraged to complete any necessary habilitation activities (self care activities such as bathing, chores, goal programs, etc).

Interview with staff C on 7/27/21 revealed client #16 has non-compliance behaviors and should have taken a shower the evening of 7/26 and refused. Continued interview with staff C revealed client #16's clothing in the hallway outside his bedroom was in the hallway for the client to either put away or use when he showers. Interview with the clinical director on 7/27/21 revealed client #16 takes showers regularly and all staff should support the client with prescribed interventions of the clients BSP. Continued interview with the clinical director verified staff need additional training relative to supporting client #16 with hygiene tasks.
B. The team failed to implement handwashing objectives for 4 of 7 clients (#2, #7, #10, and #17) in Pisgah. For example:

1. The team failed to implement handwashing for client #2.

Surveyor arrived at the group home on 7/27/21 at 6:50 AM. Observation in the group home at 7:50 AM revealed client #2 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #2 prior to

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breakfast did the client wash his hands or receive a prompt from staff to wash his hands.

Review of client #2's record revealed a PCP dated 6/14/21. Continued review of client #2's PCP revealed a handwashing objective with an implementation date of 8/20/20. Further review revealed client #2 will wash his hands independently 80% of the time for 3 consecutive review periods.

2. The team failed to implement handwashing for client #7.

Observation in the group home at 7:50 AM revealed client #7 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #7 prior to breakfast did the client wash her hands or receive a prompt from staff to wash her hands.

Review of client #7's record revealed a PCP dated 8/11/20. Continued review of client #7's PCP revealed a handwashing objective with an implementation date of 5/19/20. Further review revealed client #7 will wash her right hand with a verbal prompt 70% of the time for 3 consecutive review periods.

3. The team failed to implement handwashing for client #10.

Observation in the group home at 7:50 AM revealed client #10 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #10 prior to breakfast did the client wash her hands or receive a prompt from staff to wash her hands.

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Review of client #10's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 5/26/21. Further review revealed the client will wash her hands with a gestural prompt 70% of the time for 3 consecutive review periods.

4. The team failed to implement handwashing for client #17.

Observation in the group home at 7:50 AM revealed client #17 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #17 prior to breakfast did she wash her hands or receive a prompt from staff to wash her hands.

Review of client #17's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 8/18/20. Further review revealed the client will wash her hands with a partial physical prompt 80% of the time for 3 consecutive review periods.

Interview with the clinical director on 7/27/21 confirmed all client's should be prompted to wash their hands prior to meal participation. Continued interview with the clinical director verified all program objectives should be trained at every opportunity and implemented as prescribed.
C. The team failed to implement handwashing objectives for 4 of 8 clients (#1, #5, #6, and #22) in Beaucatcher. For example:

Observation in the group home on 7/26/21 from 4:15 PM - 6:30 PM revealed all clients to participate in leisure activities, snack time, the

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W 249	Continued From page 21 dinner meal, clean up tasks, and to take dishes to the kitchen after the meal. At no time during observations were clients prompted to wash their hands. Observation in the group home on 7/27/21 from 6:50 AM - 9:30 AM revealed all clients to get dressed, to participate in the breakfast meal, to take dishes to the kitchen, to participate in medication administration and to leave the group home for thier vocational setting. At no time during observations were clients prompted to wash their hands. 1. Review of client #1's record on 7/27/21 revealed a PCP dated 4/29/21. Continued review of client #1's PCP revealed a handwashing objective. Further review revealed client #1 will wash her hands thoroughly with gestural prompts 80% of the time for 3 consecutive review periods. 2. Review of client #5's record on 7/27/21 revealed a PCP dated 8/17/20. Continued review of client #5's PCP revealed a handwashing objective. Further review revealed client #5 will wash his hands thoroughly with gestural prompts 80% of the time for 3 consecutive review periods. 3. Review of client #6's record on 7/27/21 revealed a PCP dated 9/23/20. Continued review of client #6's PCP revealed a handwashing objective. Further review revealed client #6 will wash her hands with gestural prompts 80% of the time for 3 consecutive review periods. 4. Review of client #22's record on 7/27/21 revealed a PCP dated 7/22/20. Continued review of client #22's PCP revealed a handwashing objective. Further review revealed client #22 will	W 249		

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W 249	Continued From page 22 wash her hands with verbal prompts 80% of the time for 3 consecutive review periods. Interview with the clinical director on 7/27/21 revealed all handwashing objectives should be implemented as prescribed and all clients should be encouraged to wash their hands throughout activity transitions. Continued interview with the clinical director confirmed all clients should be prompted to wash their hands before meals.	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. This STANDARD is not met as evidenced by: Based on observations, review of records and staff interviews, the facility failed to ensure adaptive devices were kept clean for 3 of 6 clients in Hawksbill (#3, #9, and #15) and 2 of 8 clients in Beaucatcher(#6 and #14). The findings are: A. The facility failed to ensure adaptive equipment was clean for 4 of 6 clients in Hawksbill. For example: 1. The facility failed to ensure adaptive equipment relative to a face shield was clean for client #3. Observation in the facility during the 7/26-27	W 436		

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W 436	Continued From page 23 survey observations revealed client #3 to ambulate with a helmet. Observation of client #3's helmet revealed a face shield to be attached that covered the clients full facial area. Continued observation throughout the 7/26-27/21 survey revealed the face shield of client #3 to appear dirty with accumulated debris on the inside of the shield. Review of records for client #3 on 7/26-27/21 revealed a person-centered plan (PCP) dated 6/1/21. Review of the PCP for client #3 revealed adaptive equipment to include a helmet. Continued review of adaptive equipment for client #3 revealed a physical therapy note to indicate the client's helmet includes a face shield to prevent facial injury. Interview with the clinical director on 7/27/21 revealed all adaptive equipment should be kept clean for all clients. Continued interview with the clinical director revealed staff on third shift are responsible for cleaning adaptive equipment while all staff should be monitoring adaptive devices to ensure cleanliness. 2. The facility failed to ensure adaptive equipment relative to a wheelchair and gait belt were clean for client #9. Observation in the facility during the 7/26-27 survey observations revealed client #9 to ambulate in a wheelchair with a gait belt around the clients waist. Observation of client #9's wheelchair lap belt revealed dried food and debris to be accumulated across the belt. Continued observation throughout the 7/26-27/21 survey revealed the gait belt that client #9 was observed to wear also appeared to have dried debris and	W 436		

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W 436	Continued From page 24 food stains along the front of the belt. Review of records for client #9 on 7/27/21 revealed a person-centered plan (PCP) dated 12/1/20. Review of the PCP for client #9 revealed adaptive equipment to include a wheelchair and large padded gait belt. Interview with the clinical director on 7/27/21 revealed all adaptive equipment should be kept clean for all clients. Continued interview with the clinical director revealed staff on third shift are responsible for cleaning adaptive equipment while all staff should be monitoring adaptive devices to ensure cleanliness. 3. The facility failed to ensure adaptive equipment relative to a wheelchair was clean for client #15. Observation in the facility during the 7/26-27 survey observations revealed client #15 to ambulate in a wheelchair. Observation of client #15's wheelchair lap belt revealed dried food and debris to be accumulated across the belt. Review of records for client #15 on 7/27/21 revealed a person-centered plan (PCP) dated 10/1/20. Review of the PCP for client #15 revealed adaptive equipment to include a wheelchair. Interview with the clinical director on 7/27/21 verified client #15 had a new wheelchair on order due to multiple wear and tear concerns with the client's current wheelchair. Continued interview with the clinical director revealed all adaptive equipment should be kept clean for all clients. Further interview with the clinical director	W 436		

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W 436	Continued From page 25 revealed staff on third shift are responsible for cleaning adaptive equipment while all staff should be monitoring adaptive devices to ensure equipment is clean. B. The facility failed to ensure adaptive equipment was clean for 2 of 8 clients in Beaucatcher: For example: 1. The facility failed to ensure adaptive equipment relative to a wheelchair was clean for client #6. Observation in the facility during the 7/26/21 and 7/27/21 survey observations revealed client #6 to ambulate in a wheelchair. Observation of client #6's wheelchair revealed dried food and debris to be accumulated beneath the seat cushion and on both sides between the wheelchair frame and wheels. Review of records for client #6 on 7/27/21 revealed a person-centered plan (PCP) dated 9/23/20. Review of the PCP for client #6 revealed adaptive equipment to include a wheelchair. Interview with the clinical director on 7/27/21 revealed all adaptive equipment should be kept clean for all clients. Further interview with the clinical director revealed staff on third shift are responsible for cleaning adaptive equipment while all staff should be monitoring adaptive devices to ensure equipment is clean. 2. The facility failed to ensure adaptive equipment relative to a helmet strap was clean for client #14. Observation in the facility during the 7/26/21 and	W 436		

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W 436	Continued From page 26 7/27/21 survey observations revealed client #14 to ambulate throughout the home wearing a helmet. Observation of client #6's helmet strap revealed dried food and debris to be accumulated across the strap. Review of records for client #6 on 7/27/21 revealed a person-centered plan (PCP) dated 12/11/20. Review of the PCP for client #14 revealed adaptive equipment to include a helmet. Interview with the clinical director on 7/27/21 revealed all adaptive equipment should be kept clean for all clients. Further interview with the clinical director revealed staff on third shift are responsible for cleaning adaptive equipment while all staff should be monitoring adaptive devices to ensure equipment is clean.	W 436		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at the appropriate temperature for 8 of 8 clients (#1, #5, #6, #11, #14, #18, #19, and #22) in Beaucatcher. The finding is: Observation in the group home on 7/27/21 at 7:10 AM revealed staff I to place breakfast items on the table to include waffles, juice and milk. Continued observations at 7:30 AM revealed clients (#1, #5, #6, #11, #14, #18, #19 and #22) to be seated at the dining table.	W 473		

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	34G089	A. BUILDING ______ B. WING ______	C 07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
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Further observation at 7:45 AM revealed staff I to assist client #11, #14, #19 and #22 to fix their plates and to pour milk from the pitcher into a cup for each client. Observation at 7:45 AM revealed the milk to sit out of the refrigerator for over 30 minutes. Subsequent observation at 7:50 AM revealed all clients to engage in eating and drinking breakfast items. Additional observation at 8:15 AM revealed staff I to return the drink items to the kitchen, including the milk which was placed back into the refrigerator.

Interview with the facility dietician on 7/27/21 at 8:15 AM revealed that milk should not sit outside of refrigeration for more than 15 minutes. Continued interview revealed food temperature should be checked with a thermometer to ensure appropriate serving temperature after food has been on the table an extended period of time.

Interview with the clinical director on 7/27/21 confirmed milk should not have been allowed to remain outside of refrigeration for more than 15 minutes. The clinical director further confirmed the milk remaining in the pitcher after the breakfast meal should have been discarded.