STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G089	A. BUILDING _____ B. WING _____	R-C 01/26/2022

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
{W 000}	INITIAL COMMENTS	{W 000}		
{W 331}	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 1 sampled clients (#1) with not ensuring appropriate monitoring and staff training after a medication change and a change in client health status. The finding is: Review of internal documents on 11/10/21 revealed an IRIS report completed 10/25/21. Review of the IRIS report revealed client #1 had developed bruising, discoloration and swelling of the scrotum area due to a fall. Continued review of the IRIS report revealed client #1 to have a diagnosis history of profound intellectual disability with unspecified behaviors and emotional disorders with onset in childhood. Interview with the facility administrator on 11/10/21 revealed client #1 was currently in a nursing facility due to the need for a higher level of care after a recent hospitalization. Continued interview with the administrator revealed client #1 was recently released from the hospital, after a change in health status, with a permanent catheter and currently required restraints to keep the client from pulling the catheter out. Further interview with the facility administrator revealed due to the need for a permanent catheter and client #1's need for restraints to prevent pulling the catheter out the team had made the decision	{W 331}		

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

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{W 331}	Continued From page 1	{W 331}		

the clients' needs could not be met internally and client #1 would need a different level of care upon hospital discharge.

A review of incident reports for client #1 from 10/22 through 10/25/21 revealed the following:

On 10/22/21 Client #1 experienced a fall without injury. Continued review of the 10/22/21 incident report revealed nursing assessed the client on 10/22/21 regarding the fall.

On 10/23/21 (5:00 PM) client #1 was sitting on the floor and staff assisted the client back to his feet and client #1 continued to walk around. Continued review of the 10/23/21 incident report revealed client #1 continued to fall several times over the next 30 to 40 minutes. Further review revealed staff tried to put shoes on client #1 thinking the client was having a traction issue and the client continued to fall. Subsequent review revealed staff was able to get client #1 to a recliner where the client sat waiting for his dinner meal. Additional review of the 10/23/21 incident report revealed staff contacted a supervisor at 5:30 PM although no notification of nursing was documented.

On 10/24/21 (5:30 AM) While changing client #1 in bed, the client would not stand and it was noticed his scrotum was purplish in color. Continued review of the 10/24/21 incident report revealed nursing was contacted and client #1 was sent out to the local emergency room. Further review revealed client #1 returned to the facility around 2:45 PM after going out for medical evaluation and had no new orders or diagnosis.

On 10/25/21 client #1 awoke at 2:05 AM and felt

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{W 331}	Continued From page 2	{W 331}		

warm. Staff called on call nursing and was directed to give the client a cool shower. When the client awoke his temperature was 102.6 and had a foul smell to his urine. Temperature went down to 101.3 with shower and continued to rise after shower and while getting dressed. Nursing was called and directed to call EMS; Client #1 was picked up at 3:55 AM and on call nurse would meet client at the hospital.

Review of an internal incident summary dated 10/28/21 revealed client #1 was taken into surgery with medical evaluation on 10/25/21 to evaluate needs due to significant swelling of the scrotum area. This resulted in the placement of a super pubic catheter. A review of conclusions from the internal incident summary revealed client #1 has experienced significant deterioration over the past year that has accelerated during the last few months. Continued review of conclusions revealed although there remains no definitive diagnosis, client #1's decline is consistent with a neurological condition caused by repeated head trauma. Client #1 has a lifetime history of head banging behavior. The currently witnessed balance issues indicate further decline. Further review of the internal incident summary revealed it is clear that the trauma to his bottom is likely a result of falls experienced on 10/23/21.

Review of records for client #1 on 11/10/21 revealed a person centered plan (PCP) dated 6/14/21. Review of client #1's PCP revealed the client to be non-verbal. Continued review of the PCP revealed a health service goal to monitor side effects of medications. A review of medication side effects listed in the health service goal revealed Risperdal to be associated with insomnia, dry mouth, headache, fatigue and

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{W 331}	Continued From page 3	{W 331}		

dizziness.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 11/10/21 verified client #1 was on general supervision and the facility had (3) staff on shift at the time of the incident of multiple falls on 10/23/21.

Interview with the facility QIDP and nursing on 11/10/21 revealed client #1 had been ordered a medication change on 10/22/21 that reduced the client #1's Resperidone dose from 6mg to 4mg daily. Continued interview with the QIDP and facility nurse verified prior to client #1's documented fall on 10/22/21 that the client was not known to have falls and neither the QIDP or nurse could recall the last fall client #1 had experienced prior to 10/22/21. Further interview with the facility nurse verified she had not conducted any additional training with staff after client #1's medication change or initial fall on 10/22/21 to support or monitor a change in health needs of the client.

A follow-up survey was conducted on 1/26/22. Review of internal records on 1/26/22 relative to the facility's Plan of Correction (POC) dated 12/3/21 revealed no evidence of in-service trainings related to nursing services, including incident review and response and timely reporting of changes in client condition.

Interview with the residential program administrator on 1/26/22 confirmed no in-service trainings relative to nursing services had been completed as indicated in the POC. Continued interview with the residential program administrator confirmed he would include a review process in the next POC to ensure all

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{W 331}	Continued From page 4 future correction plans are implemented in a timely manner.	{W 331}		
{W 340}	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on record review and staff interview, nursing failed to provide staff training relative to timely reporting and changing health needs. The finding is: Review of internal documents on 11/10/21 revealed an IRIS report completed 10/25/21. Review of the IRIS report revealed client #1 had developed bruising, discoloration and swelling of the scrotum area due to a fall. Continued review of the IRIS report revealed client #1 to have a diagnosis history of profound intellectual disability with unspecified behaviors and emotional disorders with onset in childhood. A review of incident reports for client #1 from 10/22 through 10/25/21 revealed the following: On 10/22/21 Client #1 experienced a fall without injury. Continued review of the 10/22/21 incident report revealed nursing assessed the client on 10/22/21 regarding the fall. On 10/23/21 (5:00 PM) client #1 was sitting on the floor and staff assisted the client back to his feet and client #1 continued to walk around.	{W 340}		

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{W 340}	Continued From page 5 Continued review of the 10/23/21 incident report revealed client #1 continued to fall several times over the next 30 to 40 minutes. Further review revealed staff tried to put shoes on client #1 thinking the client was having a traction issue and the client continued to fall. Subsequent review revealed staff was able to get client #1 to a recliner where the client sat waiting for his dinner meal. Additional review of the 10/23/21 incident report revealed staff contacted a supervisor at 5:30 PM although no notification of nursing was documented. On 10/24/21 (530 AM) While changing client #1 in bed, the client would not stand and it was noticed his scrotum was purplish in color. Continued review of the 10/24/21 incident report revealed nursing was contacted and client #1 was sent out to the local emergency room. Further review revealed client #1 returned to the facility around 2:45 PM after going out for medical evaluation and had no new orders or diagnosis. On 10/25/21 client #1 awoke at 2:05 AM and felt warm. Staff called on call nursing and was directed to give the client a cool shower. When the client awoke his temperature was 102.6 and had a foul smell to his urine. Temperature went down to 101.3 with shower and continued to rise after shower and while getting dressed. Nursing was called and directed to call EMS; Client #1 was picked up at 3:55 AM and on call nurse would meet client at the hospital. Interview with nursing on 11/10/21 verified there had been no call from staff on 10/23/21 relative to the multiple falls experienced by client #1. The facility nurse further confirmed staff did not call nursing until 10/24/21 due to concerns with client	{W 340}		

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{W 340}	Continued From page 6 #1's swollen area of the scrotum. Subsequent interview with the facility nurse verified nursing should have been called with the falls of client #1 on 10/23/21. Additional interview verified nursing had provided no additional training relative to timely reporting of a change in client health status since 10/23/21 when staff failed to report multiple falls of client #1. A follow-up survey was conducted on 1/26/22. Review of internal records on 1/26/22 relative to the facility's Plan of Correction (POC) dated 12/3/21 revealed no evidence of in-service trainings related to nursing services, including incident review and response and timely reporting of changes in client condition. Interview with the residential program administrator on 1/26/22 confirmed no in-service trainings relative to nursing services had been completed as indicated in the POC. Continued interview with the residential program administrator confirmed he would include a review process in the next POC to ensure all future corrections are implemented in a timely manner.	{W 340}		