STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G209	A. BUILDING ______ B. WING ______	10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-PISGAH HOUSE	28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803

(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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the individual support plan (ISP) failed to address identified needs for 1 of 3 sampled clients (#5) relative to assuring client privacy. The finding is: Morning observations in the group home on 10/26/21 at 7:49 AM revealed client #5 to walk into the bathroom and leave the door half open. Continued observation revealed client #5 to remain in bathroom and stand in front of toilet using the bathroom. Further observation revealed client #5 to exit the bathroom and to go to his bedroom. Observations did not reveal staff to prompt client #5 to close the bathroom door for privacy. Review of records for client #5 on 10/26/21 revealed an individual support plan (ISP) dated 4/26/21 with training objectives to clean glasses, to wear a robe for privacy, to brush all around his mouth, to soap and wash entire body, to eat meals at a safe rate, to exercise, and to complete an education work task. Interview with the qualified intellectual disabilities professional (QIDP) and clinical director on 10/26/21 verified staff should have prompted client #5 to close the bathroom door for privacy. Continued interview with the QIDP confirmed staff need training to ensure privacy and new guidelines will be implemented.	W 227	DHSR-Mental Health NOV 2 4 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sari A. Rovinsky
TITLE: QIDP
(X6) DATE: Nov. 18, 2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6) were provided opportunities for choice and self management relative to meal preparation. The finding is: Observations in the group home on 10/25/21 from 4:30 PM to 6:30 PM revealed staff member B to get items from the refrigerator, freezer, pantry and cabinets. Further observation revealed staff to prepare chicken stuffing bake, broccoli, pumpkin pie for dinner. Continued review revealed staff A to set the table, pour milk and juice in all cups. Subsequent review revealed staff A to fix all clients plates and staff B to place them on the table. No clients were observed to assist with meal preparation or set their place settings. Morning observations in the group home on 10/26/21 from 6:30 AM to 8:30 AM revealed staff member C to get items from the refrigerator, pantry, and cabinets. Further observations revealed Staff C to prepare waffle, sausages, mandarin oranges, and coffee for breakfast. Continued review revealed staff C to fix all clients plates and place them on the table. No clients were observed assisting with meal preparation. Review of the record for client #1 on 10/26/21 revealed an individual support plan (ISP) dated 11/21/20. The ISP included a current	W 247		

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	34G209	A. BUILDING ______ B. WING ______	10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-PISGAH HOUSE	28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803

(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 247	Continued From page 2	W 247		

Comprehensive Functional Assessment (CFA) which indicated the client enjoys heating up items in the microwave and making sandwiches.

Review of the record for client #2 revealed an ISP dated 1/16/21. The ISP included a current CFA which indicated the client enjoys helping in the kitchen.

Review of the record for client #3 revealed an ISP dated 6/2/21. The ISP included a current CFA which indicated the client is able to do many things independently in the kitchen such as making his own sandwiches. Further review of the CFA revealed client #3 needs monitoring to ensure he uses appropriate portions.

Review of the record for client #4 revealed an ISP dated 8/19/20. The ISP included a current CFA which indicated client #4 to have cooking capabilities but is somewhat anxious and requires verbal, gestural and eyes on support mostly due to his anxiety.

Review of the record for client #5 revealed an ISP dated 4/26/21. The ISP indicated a current CFA which indicated the client enjoys helping in the kitchen but needs to be monitored to prevent food seeking.

Review of the record for client #6 revealed an ISP dated 4/13/21. The ISP included a current CFA which indicated the client enjoys helping in the kitchen.

Interview with the clinical director on 10/26/21 confirmed all clients in the home are capable of participating in meal preparation at some capacity. Continued interview with the clinical

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

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	34G209	A. BUILDING ______ B. WING ______	10/26/2021

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BLUEWEST OPPORTUNITIES-PISGAH HOUSE	**28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803**

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W 247	Continued From page 3 director revealed because of COVID the facility continues to follow protcols relative to meal preparation and clients should have been offered and prompted by staff to set their place settings to assist during meals. Further interview with the qualified intellectual disability professional (QIDP) confirmed staff should have offered all clients the opportunity to set their place at the table.	W 247		
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, record reviews and interviews, the facility failed to assure the privacy objective contained in the individual support plan (ISP) for 1 of 3 sampled clients (#6) was implemented as prescribed. The finding is: Morning observations in the group home on 10/26/21 at 7:41 AM revealed client #6 to pour shampoo and body wash in a medicine cup while in the laundry room area. Continued observation at 7:45 AM revealed client #6 to be in the bathroom with the door open preparing to shower. Further observations revealed client #6 to walk from the bathroom and open client #5's bedroom door and close the bedroom door	W 249		

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	34G209	A. BUILDING ______ B. WING ______	10/26/2021

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W 249	Continued From page 4 returning to bathroom. Subsequent observations at 8:08 AM revealed client #6 to exit the bathroom wearing only a t-shirt and walk down the hallway and return to the bathroom. Observations did not reveal staff to prompt client #6 to wear a robe and close bathroom door for privacy. Review of records for client #6 revealed an individual support plan (ISP) dated 4/13/21 with training objectives to support independent living skills, for toileting, for clothing, for oral hygiene, for flatware sorting, for privacy and for washing hands. Continued review of objective goals revealed a privacy goal implemented 3/18/20 for client #6 to be given one gestural prompt and his cue card to wear his robe when going to the bathroom and leaving the bathroom. Interview with the qualified intellectual disabilities professional (QIDP) and clinical director on 10/26/21 verified staff should have prompted client #6 to wear a robe and close the bathroom door for privacy. Continued interview with QIDP confirmed staff need training to ensure privacy and new guidelines will be implemented.	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, record review and interviews, the facility failed to provide training relative to eyeglasses for 1 of 3 sampled clients	W 436		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 436	Continued From page 5	W 436		

(#5). The finding is:

Observations in the group home on 10/25/21 from 4:30 PM to 6:30 PM revealed client #5 to participate in various activities such as walking in and out of the kitchen area, attempting to grab snacks from the pantry and refrigerator, wash hands and participate in the dinner meal, rinse his dishes and place them in the dishwasher, then take the trash to the outside bin. At no time during observation was client #5 prompt to wear his eyeglasses.

Observations on 10/26/21 from 6:30 AM to 8:30 AM revealed client #5 to enter the medication room for administration of morning medications, participate in breakfast meal, put his dishes in the dishwasher, write the date and day on the white board and to then to his room. Additional observation during survey revealed at no time was client #5 prompt to wear glasses.

Review of records for client #5 on 10/26/21 revealed an individual support plan (ISP) dated 4/26/21. Review of the ISP for client #5 revealed adaptive equipment to include glasses and a training objective to keep his glasses clean. Continued review of records for client #5 revealed a vision consult dated 7/29/20. Review of the facility nursing note, verified by interview, revealed the client must wear his eye glasses and can remove for near work activities or while eating.

Interview with the facility nurse and clinical director on 10/26/21 verified client #5 has prescribed glasses kept in his bedroom and does not like to wear them. Continued interview with the facility nurse verified client #5 should be

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W 436	Continued From page 6 encouraged to wear his glasses as prescribed. Interview with the qualified intellectual disabilities professional (QIDP) verified client #5 did not have a current program to address training relative to the use and wearing of his eyeglasses.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to show evidence that quarterly fire drills were conducted with each shift of personnel relative to first/second shifts. The finding is: Review of the facility fire drill reports from 11/20 through 10/21 revealed missing drills for 11/20, 12/20, 1/21, 2/21, and 3/21. Further review of the fire drill reports revealed a first shift drill conducted on 6/4/21 and 9/24/21 with a second shift drill completed on 5/13/21 and 8/12/21. The facility had no additional documentation available conducting first/second shift drills during the review year. Interview with the facility site supervisor on 10/26/21 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview with the site supervisor revealed that they have a client who will remove documents with dates on them and possibly that client removed the missing drills. Further interview with site supervisor confirmed there was no additional documentation to reflect the missing drills were conducted during the review year.	W 440		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 8, 2021

Tina Woody, Interim CEO
BlueWest Opportunities, Inc
PO Box 1250
Asheville, NC 28802

Re: Recertification Completed October 26, 2021
Blue West Opportunities- Pisgah House
28 Pisaghview Avenue, Asheville, NC 28803
Provider Number 34G209
MHL# 011-047
E-mail Address: twoody@bluewestopportunities.org

Dear Ms.Woody :

Thank you for the cooperation and courtesy extended during the recertification survey completed October 26, 2021. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is December 25, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at (828) 750-2702.

Sincerely,

Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
dhhs@vayahealth.com

Plan of Correction

Pisgah View Group Home

Annual Recertification Survey

October 26-27, 2021

W 227 Individual Program Plan. The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.

The client (#5) will be supported with a new goal to address the need of preserving privacy. The new goal will be implemented and trained by the QIDP by November 25, 2021.

Regular assessments, chart reviews, and any follow-up thereby identified will be conducted by the QIDP or designee to ensure that client (#5) has an individual program plan which states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.

Responsible Person(s): QIDP

Mechanism to ensure compliance: Regular assessment and review

Frequency of Mechanism: At least quarterly

W 247 Individual program Plan. The individual program plan must include opportunities for client choice and self-management.

Staff will be in-serviced by the Dietary Manager on client meal participation and family-style dining by November 25, 2021. Additionally, the QIDP will implement meal participation goals for all clients who are currently lacking such formal programs. These programs will be written and trained by November 25, 2021. The QIDP and site supervisors will provide ongoing observations and additional training as needed on client meal participation.

Regular assessments, chart reviews, and any follow-up thereby identified will be conducted by members of the clinical and management teams to ensure that clients continue to enjoy opportunities for choice and self-management during mealtimes.

Responsible Person(s): Dietary Manager, QIDP

Mechanism to ensure compliance: Regular assessment and review

Frequency of Mechanism: At least quarterly

W 249 Program Implementation. 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.

The client (#6) will be supported with new guidelines to address the need for preserving privacy. The new guidelines will be implemented and trained by the QIDP by November 25, 2021. The QIDP and site supervisors will provide ongoing observations and additional training as needed on program implementation.

Responsible Person(s): QIDP

Mechanism to ensure compliance: Regular assessment and review

Frequency of Mechanism: At least quarterly

W 436 Space and Equipment. 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.

The client (#5) will be supported with a new goal to address engagement with and toleration of the client's prescribed eyeglasses. The new goal will be implemented and trained by the QIDP by November 25, 2021.

Regular assessments, chart reviews, and any follow-up thereby identified will be conducted by the QIDP to ensure that the facility will 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.

Responsible Person(s): QIDP

Mechanism to ensure compliance: Regular assessment and review

Frequency of Mechanism: At least quarterly

W 440 Evacuation drills. The facility must hold evacuation drills at least quarterly for each shift of personnel.

The site management team will in-service staff to ensure each shift conducts, documents, and successfully preserves the documentation of evacuation drills conducted quarterly for each shift of personnel.

Responsible Person(s): Site director, maintenance supervisor

Mechanism to ensure compliance: Regular assessment and review

Frequency of Mechanism: At least quarterly