

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

PRINTED: 02/04/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/26/2022
NAME OF PROVIDER OR SUPPLIER BLUEWEST OPPORTUNITIES-SWANNANOVA RESIDENTIAL			STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOVA, 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}	*see attached for corrections	2/25/22	
{W 331}	<p>NURSING SERVICES CFR(s): 483.460(c)</p> <p>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:</p> <p>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.</p> <p>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</p>	{W 331}			

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FEB 23 2022

DHSR-MH Licensure Sect

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

TITLE

(X6) DATE

Perek Briscoe, Residential Program Administrator

[Signature]

2/13/22

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.

Derek Briscoe, Program Administrator

BlueWest Opportunities

43 College Place Suite 306

Asheville, NC 28803

2/13/2021

To the DHHS survey team:

On behalf of all the clients and the entire support team at BlueWest Opportunities, thank you for the time and energy you spent with us on November 11, 2021, and on January 26, 2022, helping us to improve our services. Following, you will find our plan to correct the issues cited during the survey and follow-up survey. We look forward to the improved outcomes you have helped us to identify.

We will be prepared by February 25, 2022 to review corrections for both deficiencies cited.

Thank you again.

Sincerely,

A handwritten signature in black ink, appearing to read 'Derek Briscoe', with a stylized flourish at the end.

Derek Briscoe

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.

Responsible persons: Residential Program Administrator, Quality Assurance Manager

Mechanism to ensure compliance: Regular review of incident reports

Frequency of mechanism: At least weekly