STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-MARS HILLS RESIDENTIAL SERV	BLUE RIDGE HOMES DRIVE #50 MARS HILL, NC 28754

(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 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: The facility failed to assure a continuous active treatment program consisting of needed interventions and services was provided for 2 of 2 sampled clients in Roan (#3 and #6) regarding communication objectives and needs as evidenced by observations, interviews and record verification. The findings are: A. For client #6, observations in the group home on 6/27/23 revealed client #6 to have a 1:1 staff person with him at all times. Interview with the group home manager revealed a 1:1 staff person is required to be within arms reach of the client at all times due to the client's behaviors particularly his biting behaviors. Further observations in the group home from 4:10 PM until supper at 6:10 PM, client #6 spent his afternoon in an agitated state in isolation time-out (ITO) as part of his behavior program, walking up and down the hallway, standing in the kitchen or running to the ITO room and placing himself in there for short amounts of time. Staff was observed to switch out 1:1 responsibility throughout the afternoon and each staff was	W 249	DHSR - Mental Health JUL 13 2023 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NICH DAUNIS	QIDP	10 July 2023

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
	34G092	A. BUILDING _____ B. WING _____	06/28/2023

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W 249	Continued From page 1 observed to verbally attempt to prompt the client without success. Continued observations at 5:05 PM revealed staff was able to use the client's communication board to prompt the client to briefly get a drink in the dining room. The client was also noted to take a quick bath at 5:45 PM for 10 minutes and put his plate on the table before supper at 6:05 PM. Further interview with the home manager revealed the client is agitated most afternoons and is more difficult to deal with behaviorally. Review of client #6's individual support plan (ISP) dated 10/5/22 revealed a communication objective for the client to use an object board to express his desires and needs. Review of the communication objective revealed the client to be training using objectives for food, drink, toileting and going outside. Further review of the communication objective revealed that prior to transitioning to the activity, staff should use a verbal cue for client #6 to touch the targeted object symbol for that event. Observations during the 6/27-28/23 survey revealed the client's communication symbol board to remain in the dining room during the survey and only used on one occasion. Opportunities were missed during the survey to use the food, toileting and going outside object cues. In addition, review of client #6's communication evaluation addendum dated 9/19/22 notes the need for client #6 to "increase his ability to to follow schedule/commands." Review of the client's psychological evaluation update dated 10/12/21 revealed the client "needs significant environmental control measures to lessen the	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G092	A. BUILDING _____ B. WING _____	06/28/2023

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W 249	Continued From page 2 opportunity for the occurrence of disruptive behavior including aggression directed at others, property and himself." The update also notes "he needs a prompt sequence to address those occasions where he does not want to participate in essential activities of daily living" and "the team will need to consider an array of distracting activities/objects for him to use to lessen the likelihood of problem behaviors, especially biting objects." Further review of the client's ISP revealed objective training for the client's four item communication board, wash hands, brush teeth, wiping, put dishes in the dishwasher, participate in an activity and cut food. Continued review revealed no training to assist the client with learning a schedule, choosing and participating in a variety of activities to assist with lessening the client's problem behaviors. B. For client #3, observations in the group on 6/27/23 revealed the client to be non-verbal and spend his afternoon sitting in the dining room participating in a leisure activity, outside sitting on the porch or walking with staff. Various staff were observed to verbally prompt the client to different activities including getting a drink, using the bathroom, walking, and prompts to go inside or outside. Further observations revealed the client was given a communication board at 5:50 PM while sitting at the table in preparation for supper but the communication board was removed from the table at 6:05 PM before supper started at 6:10 PM. Morning observations in the group home on 6/28/23 revealed the client to be up and ready at the beginning of observations at 6:45 AM, eat	W 249		

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W 249	Continued From page 3 breakfast at 7:05 PM, put dishes in the dishwasher and go brush teeth at 7:25 AM before laying back down on this bed. Staff were again observed to verbally prompt the client to each activity throughout the morning. Review of client #3's ISP dated 12/7/22 revealed the client to have a communication objective to utilize object symbols to express his desires and needs. Review of the communication objective revealed the client to be training on eat, drink, toilet and "back scratcher." Further review of the communication objective revealed that prior to the onset of the activity staff should present client #3 with the object board and prompt the client to choose the activity about to be completed. Observations throughout the 6/27-28/23 survey revealed the staff to verbally prompt the client to all activities and miss the opportunity to use the client's communication board except at 5:50 PM on 6/27/23 when the client was presented his communication board. However, the client was already noted to be sitting at the table waiting for supper to be served. The facility missed opportunities to train the client's communication objective and failed to train the objective as prescribed.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error.	W 369		

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 369	Continued From page 4 This affected 2 of 4 clients (#5, #7) observed receiving medications. The findings are: A. During observations in Snow Bird on 6/28/23 at 7:30am, Staff B was observed to assist client #7 with administering her mornign medications, which included one Cetrizine 10mg tablet. Review on 6/28/23 of client #7's physician's orders dated 5/17/23 reveled an order for Cetrizine 10mg, "Take 1 tablet at bedtime," ordered for 8:00pm. Interview on 6/28/23 with the facility nurse confirmed client #7 should have received her Cetrizine 10mg tablet at 8pm in accordance to her physician's orders. B. During observations in Spring Creek on 6/28/23 at 7:28 AM, staff A was observed to assist client #5 with administering her morning medications. Continued observations revealed staff A to administer Ear Wax Removal Ear Drops to client #5 by placing 2 drops in each ear. Review on 6/28/23 of client #5's physician orders dated 5/17/23 revealed an order for Ear Wax Removal 6.5% DR Debrox 6.5% Ear Drops to place 2 drops in each ear every day for 3 days then irrigate for cerumen buildup to be discontinued. Interview of 6/28/23 with the facility nurse confirmed that client #5 should not have received discontinued Ear Wax Removal 6.5% DR Debrox 6.5% Ear Drops.	W 369		

Blue West Opportunities – Mars Hill

Plan of Corrections

June 28th, 2023

W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)

The facility failed to assure a continuous active treatment program consisting of needed interventions and services was provided for 2 of 2 sampled clients in Roan (#3 and #6) regarding communication objectives and needs as evidenced by observations, interviews, and record verification.

A. The SLP and LPA will devise general interactions guidelines to cue utilization of an object board to aid in the client's (#6) choice making and to express their desires and needs. Staff training will include discussion of the importance and expectation of consistently encouraging the client (#6) to utilize the object board throughout the day to increase their ability to follow schedule/commands and prompt distracting or preferred activities to lessen the opportunity for the occurrences of disruptive behaviors.

   Regular assessment, chart reviews, and any follow-up thereby identified, will be conducted by the responsible persons to ensure the client (#6) receives a continuous active treatment program consisting of needed services and training regarding their communication objective and behavior supports.

   Responsible Person(s): QIDP, QIDP-A, SLP, CSS, LPA, BSS.

   Mechanism to ensure compliance: Regular Assessment.

   Frequency of Mechanism: At least monthly.

B. The CSS will conduct training with staff on the implementation of the client's (#3) communication objective to utilize object symbols to express their desires and needs.

   Regular assessment, chart reviews, and any follow-up thereby identified, will be conducted by the responsible persons to ensure the client (#3) receives a continuous active treatment program consisting of needed services in sufficient numbers and frequency to support the achievement of the objectives identified in the individual program.

   Responsible Person(s): QIDP, QIDP Assistant, CSS, SLP.

   Mechanism to ensure compliance: Regular assessment.

   Frequency of Mechanism: At least monthly.

W 369 DRUG ADMINISTRATION CFR(s): 483.460(k)(2)

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: W 369 Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 2 of 4 clients (#5 and #7) observed receiving medications.

A. The RN will conduct training with all certified medication technicians to ensure all medications are administered safely. The training will emphasize the completion of three checks prior to administering all medication. This includes comparing the MAR and the medication label three full times to ensure you have the correct resident, the correct medication, the correct dose, the correct date/time, and the correct route. In addition, ensuring that proper document is completed after each administration.

Regular assessments, chart (MAR) reviews, and any follow-up thereby identified will be conducted by the RN, LPN, and or MT-2 to ensure drug administration occurs without error.

Responsible Person(s): RN, LPN, MT-2, MT (certified).

Mechanism to ensure compliance: Regular assessment.

Frequency of Mechanism: As often as needed, at least monthly.