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 ______	C 08/07/2024

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 000	INITIAL COMMENTS A complaint survey was completed on 8/7/24 for intake #NC00219891. The allegation was substantiated and a deficiency was cited.	W 000		
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 review of records and interviews, the facility failed to ensure sufficient direct care staff were available to manage 4 of 5 clients in the home (#1, #2, #3, and #4). Review on 8/7/24 of internal investigation summary completed on 8/17/24 revealed the investigator to look into the incident that occurred on 7/17/24 with client #1 falling through a hole in the group home's bathroom floor during a subfloor replacement. There were two facility maintenance staff working at the BWO-Pisgah house facility replacing a rotten subfloor in one of the bathrooms located to the left exiting client #1's bedroom slightly down the hall on the right. Maintenance staff had the bathroom door completely sealed off with signage stating and warning that the bathroom was closed and sealed off due to construction/repairs. The following were notified of incident/investigation: DSS, guardian, CIRT committee members, Human Rights committee chair, and a 24-hour IRIS report to include HCPR report.	W 186		

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 186	Continued From page 1 Review on 8/7/of the facility's summary of surveillance evidence began review of video footage from 7/17/24 at approximately 2:30 PM which revealed that the facility maintenance crew were observed replacing the subflooring in the resident restroom at the Pisgah House group home. Client #2 was in his bedroom, client #3 was seen in the hallway curious to what the maintenance crew was doing and then exits the home and goes outside in the backyard. Client #4 was in his bedroom and client #1 was in the main room of the house. Staff A was monitoring the clients and walked outside returning with client #3. Saff B exits the facility for training. Client #5 was not at home during the incident. Subsequently at approximately 2:40 PM maintenance #1 and maintenance #2 stepped away from the bathroom project to make a cut to a board for the subfloor. The bathroom door was closed and both maintenance workers were away for approximately 1 minute and 15 seconds. Client #1 walked from the main room (medication room area) with some papers in his hand around the corner and went to the bathroom. The camera showed the door to the bathroom closed and then a crash could be heard. In a few second both maintenance crew members return to the bathroom with the board they cut and opened the door and they both could be heard screaming "oh my God" repeatedly. Staff A can be seen running around the corner and yelling. Staff A and maintenance #2 ran down to the basement and maintenance #1 remained back at the bathroom. Review on 8/7/24 of the summary of incident revealed that the facility nurse was in the basement office when client #1 came crashing	W 186		

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W 186	Continued From page 2 down from the hole in the subfloor. Continued review revealed that another facility nurse entered the nursing office at that time and both nurses aided in the care for client #1. Client #1 was then taken by ambulance to the emergency room on 7/1/7/24 at approximately 2:50 PM. Client #1 was admitted on 7/18/24 at 3:00 AM with 6 pelvic fractures and a fractured sacrum. The client went into surgery on 7/18/24 at 8:00 AM and surgery went well. Additionally, client #1 will need a wheelchair 100% of the time with stand-transfer only and zero weight on his left leg for 6 weeks or more. Client #1 will be at a rehabilitation facility for some of the time. Review on 8/7/24 of statement from maintenance #2 revealed that on 7/17/24 the maintenance worker engaged in bathroom renovations at the Pisgah House. Maintenance #2 stepped outside to make a precise cut on a board that needed maintenance #1's assistance to hold for approximately 1 minute and 30 seconds. When both crew members walked back in client #1 had just fallen through the hole that was cut out in order to replace the floor. The client fell through the ceiling of the basement approximately 8ft. to the basement floor. Review on 8/7/24 of statement from maintenance #1 revealed that maintenance #1 was assisting with renovations occurring at Pisgah House group home. Continued review revealed that maintenance #1 left the bathroom to assist with a saw cut and while outside with maintenance #2 that's when client #1 snuck into the work area falling through the drywall into the floor below. Review on 8/7/24 of statement from staff A revealed that staff A was in the main communal	W 186		

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W 186	Continued From page 3	W 186		

area of the home. Staff A noted that shortly before the incident staff A had come inside from being outdoors with client #3. Staff B had been assisting staff A until exiting to go to a training. Staff A stated that client #5 had not arrived from work, client #3 had gone to his room, client #2 was in his bedroom, client #4 was in his bedroom, and client #1 had been in the living room in the recliner but was going back to his bedroom. In just an instant later staff A heard noises and ran back towards the bathroom/hallway and learned what happened. Staff A immediately ran downstairs with maintenance #2 to client #1's aid.

Review on 8/7/24 of the general events reports revealed that on 7/17/24 staff A was the only staff in the house sitting on the couch while work was being done in the bathroom next to client #3's bedroom. Staff A did not realize neither maintenance was in the house and that the bathroom was not secure, so staff A was surprised when it was discovered that client #1 fell through the floor of the bathroom.

Review of records on 8/7/24 for client #1 revealed the client to be diagnosed with Severe IDD, Autistic Disorder, Obsessive-Compulsive Personality Disorder, history of Tinea Crusis, Hypothyroidism, Vitamin D deficiency, Overweight and obesity, Vascular dementia, unspecified severity, Secondary parkinsonism, unspecified, Transient cerebral ischemic attack, unspecified, Cerebral cysts left anterior arachnoid cyst.

Interview with the Site Supervisor on 8/7/24 confirmed that an incident occurred on 7/17/24 where client #1 entered an unsecured bathroom in the facility that was being renovated where the client fell through a hole landing in the basement

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W 186	Continued From page 4 causing injury to the client. Continued interview confirmed that staff B left the group home to attend a training leaving staff A with 4 clients. Further interviews confirmed that management was not aware of staff B leaving the facility and no coverage for staff was provided.	W 186		