		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G031	B. WING			08/14/2024	
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
BLUEWEST OPPORTUNITIES-ORA HOUSE					95 ORA STREET ASHEVILLE, NC 28801		
PREFIX (EACH DEFIC		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037 EP Training P CFR(s): 483.4 §403.748(d)(1) §441.184(d)(1) §483.73(d)(1), §485.68(d)(1), §485.68(d)(1), §485.727(d)(1) §491.12(d)(1), *[For RNCHIs Hospitals at §4 at §484.102, F under §485.72 RHC/FQHCs at (1) Training p the following: (i) Initial trainir policies and p staff, individua arrangement, expected roles (ii) Provide em least every 2 y (iii) Maintain d preparedness (iv) Demonstra procedures. (v) If the emer procedures ar must conduct procedures. *[For Hospice hospice must (i) Initial trainir policies and p	rogra 75(d)), §46 , §48 ,	m (1) 16.54(d)(1), §418.113(d)(1), 50.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §485.625(d)(1), 35.920(d)(1), §486.360(d)(1), 03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at entation of all emergency	E 0	937			

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 08/16/2024

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.

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		34G031	B. WING _		08	/14/2024	
	PROVIDER OR SUPPLIER	-ORA HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 95 ORA STREET ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
E 037	procedures. (iii) Provide emerge least every 2 years. (iv) Periodically revi emergency prepare employees (includir special emphasis p procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergence procedures are sign must conduct trainin procedures. *[For PRTFs at §44 program. The PRTF (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial trainin preparedness traini (iii) Demonstrate sta procedures. (iv) Maintain docum preparedness traini (v) If the emergence procedures are sign must conduct trainin procedures. *[For PACE at §460 organization must of	aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency ng. by preparedness policies and hificantly updated, the hospice ng on the updated policies and enter the following: emergency preparedness lures to all of the following: emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their ng, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency	E 03	37			

If continuation sheet Page 2 of 8

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) D	O. 0938-039 ATE SURVEY OMPLETED		
		34G031	B. WING _			0	08/14/2024	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CO			
BLUEWI	EST OPPORTUNITIES	-ORA HOUSE			RA STREET IEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
E 037	policies and proced staff, individuals pro- arrangement, contra- volunteers, consiste (ii) Provide emerger least every 2 years. (iii) Demonstrate sta procedures, includir what to do, where to case of an emerger (iv) Maintain docum (v) If the emergence procedures are sign must conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro- arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all co (i) Provide initial tra preparedness polici and existing staff, in	Jures to all new and existing poiding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ing informing participants of o go, and whom to contact in ncy. The tation of all training. By preparedness policies and hificantly updated, the PACE ing on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing poiding services under volunteers, consistent with their incy preparedness training at tentation of all emergency ing. aff knowledge of emergency as and procedures to all new ining in emergency ies and procedures to all new individuals providing services , and volunteers, consistent	EO	37				

If continuation sheet Page 3 of 8

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		34G031	B. WING	00/44/0004	
	PROVIDER OR SUPPLIER	546051	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	08/14/2024
		-ORA HOUSE		95 ORA STREET ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLET
E 037	 (ii) Provide emerge least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned speci the CORF's emerge their first workday. include instruction i alarm systems and equipment. (v) If the emergen procedures are sign must conduct trainin procedures. *[For CAHs at §485 The CAH must do a (i) Initial training in o policies and proced reporting and exting and where necessa personnel, and gue cooperation with fira authorities, to all ne individuals providin and volunteers, cor roles. (ii) Provide emerge least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign 	ncy preparedness training at nentation of the training. aff knowledge of emergency v personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must n the location and use of signals and firefighting cy preparedness policies and nificantly updated, the CORF ng on the updated policies and 5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at	E 03	37	

If continuation sheet Page 4 of 8

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G031 B. WING 08/14/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 95 ORA STREET **BLUEWEST OPPORTUNITIES-ORA HOUSE** ASHEVILLE, NC 28801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 4 E 037 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness Plan (EPP) at least biennially. The finding is: Review of the facility's EPP on 8/13/24 revealed it was reviewed by the facility administrator on 10/2023. Continued review revealed no evidence of initial or biennial staff training on the EPP. Interview with the qualified intellectual disability professional (QIDP) on 8/14/24 confirmed that initial and biennial training for current staff has not been completed. W 368 DRUG ADMINISTRATION W 368 CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered in compliance with physician's orders for 1 of 5 clients (#1). The finding is:

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 5 of 8

PRINTED: 08/16/2024

		AND HUMAN SERVICES				FORM	08/16/2024 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE SURVEY COMPLETED		
		34G031	B. WING			08/ [,]	14/2024	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BLUEWEST OPPORTUNITIES-ORA HOUSE					5 ORA STREET SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 368	Continued From pa	ige 5	W 3	368				
	AM revealed staff to medication room. C revealed staff to sat client #1's blood pre revealed staff to ed prepare solutions a client's water. Subsequent observ client #1 to take all the medication roor revealed client#1 to staff to provide client from the pantry for consisted of scram	group home on 8/14/24 at 8:04 o prompt client #1 to the Continued observations nitize her hands and take essure. Further observation ucate, punch all medications, ind powders, and pour the vations at 8:09 AM revealed morning medications and exit m. Additional observations o enter the kitchen and the nt #1 with his breakfast meal the second time which bled eggs, cream of wheat, ent #1 refused to eat the						
	revealed physician Review of the physi medications to adm Aripiprazole 5 MG t MG-Vitamin D3, CC 180 MG tab, Fluoxe 10GM/15ML solutio Omeprazole 20 MG Metamucil powder, 1 bottle by mouth a and Propranolol 20 physician orders da discontinue order for and a start order for observations reveal administered the pr Aripiprazole 10 MG	for client #1 on 8/14/24 orders dated 6/1/24-8/31/24. ician orders revealed inister at 8:00 AM to be tab, Calcium CIT 315 DQ10 200 MG, Fexofenadine etine 40 MG cap, Lactulose on, Linzess 145 MCG cap, 6 cap, Vitamin D3 20000U tab, Ensure hi protein vanilla drink s needed if refuses a meal, MG tab. Continue review of ated 6/11/24 revealed a or client #1's Aripiprazole 5 MG r Aripiprazole 10 MG. Further led that client #1 was not rescribed medication a. Subsequent observations #1 was not provided with						

Facility ID: 942816

If continuation sheet Page 6 of 8

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G031 B. WING 08/14/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 95 ORA STREET **BLUEWEST OPPORTUNITIES-ORA HOUSE** ASHEVILLE, NC 28801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 368 Continued From page 6 W 368 Ensure after refusing to eat the breakfast meal. Interview with the facility nurse and gualified intellectual disabilities professional (QIDP) on 8/14/24 confirmed the physician orders for client #1 to be current. Continued interview with the facility nurse revealed that staff should administer all medications as prescribed and client #1 should be offered Ensure if less than 50 percent of the meal is consumed, or if the meal is refused. W 474 MEAL SERVICES W 474 CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 1 of 5 clients (#1). The finding is: Observation in the group home on 8/13/24 at 5:51 PM revealed client #1 to participate in the dinner meal which included squash casserole, wax beans, beets, apple parfait, milk, and juice. Continued observations revealed staff to assist client #1 to put the dinner items on his plate. Further observations revealed client #1 consumed his dinner meal with no further assistance from staff to ensure a modified diet. Observation in the group home on 8/14/24 at 7:59 AM revealed client #1 to walk out of the pantry with staff carrying the breakfast meal. Continued observations revealed the breakfast meal included a whole piece of toast, cream of wheat, scrambled eggs, milk, and juice. Further

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 7 of 8

PRINTED: 08/16/2024

		AND HUMAN SERVICES				FORM	08/16/2024 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·			(X3) DATE SURVEY COMPLETED		
		34G031	B. WING	;		08/	14/2024
NAME OF	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BLUEW		-ORA HOUSE			95 ORA STREET ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 474	observations revea the toast only with r ensure modified did Review of records to revealed a nutrition Review of the nutrition Review of the nutrition indicates the client chopped diet; may quarters, and if clie Boost/Ensure. Interview on 8/14/2 disabilities professi #1's diet was current the QIDP confirmed	led that client #1 consumed no assistance from staff to	W.	474			

If continuation sheet Page 8 of 8