STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G031	A. BUILDING _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEWEST OPPORTUNITIES-ORA HOUSE	**95 ORA STREET ASHEVILLE, NC 28801**

(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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) 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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) 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. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2	E 037		

policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) 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 role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) 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.

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[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.	E 037		
W 368	DRUG ADMINISTRATION 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:	W 368		

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W 368	Continued From page 5 Observation in the group home on 8/14/24 at 8:04 AM revealed staff to prompt client #1 to the medication room. Continued observations revealed staff to sanitize her hands and take client #1's blood pressure. Further observation revealed staff to educate, punch all medications, prepare solutions and powders, and pour the client's water. Subsequent observations at 8:09 AM revealed client #1 to take all morning medications and exit the medication room. Additional observations revealed client#1 to enter the kitchen and the staff to provide client #1 with his breakfast meal from the pantry for the second time which consisted of scrambled eggs, cream of wheat, juice, and milk. Client #1 refused to eat the breakfast meal. Review of records for client #1 on 8/14/24 revealed physician orders dated 6/1/24-8/31/24. Review of the physician orders revealed medications to administer at 8:00 AM to be Aripiprazole 5 MG tab, Calcium CIT 315 MG-Vitamin D3, COQ10 200 MG, Fexofenadine 180 MG tab, Fluoxetine 40 MG cap, Lactulose 10GM/15ML solution, Linzess 145 MCG cap, Omeprazole 20 MG cap, Vitamin D3 20000U tab, Metamucil powder, Ensure hi protein vanilla drink 1 bottle by mouth as needed if refuses a meal, and Propranolol 20 MG tab. Continue review of physician orders dated 6/11/24 revealed a discontinue order for client #1's Aripiprazole 5 MG and a start order for Aripiprazole 10 MG. Further observations revealed that client #1 was not administered the prescribed medication Aripiprazole 10 MG. Subsequent observations revealed that client #1 was not provided with	W 368		

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W 368	Continued From page 6 Ensure after refusing to eat the breakfast meal. Interview with the facility nurse and qualified 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 368		
W 474	MEAL SERVICES 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	W 474		

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W 474	Continued From page 7 observations revealed that client #1 consumed the toast only with no assistance from staff to ensure modified diet. Review of records for client #1 on 8/14/24 revealed a nutritional evaluation dated 3/4/24. Review of the nutritional evaluation for client #1 indicates the client is prescribed a regular chopped diet; may cut bread items into four quarters, and if client eats less than 50% offer Boost/Ensure. Interview on 8/14/24 with the qualified intellectual disabilities professional (QIDP) confirmed client #1's diet was current. Continued interview with the QIDP confirmed that staff should have assisted the client with their prescribed modified diet.	W 474		