

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

PRINTED: 08/14/2025
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 08/13/2025
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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 1 of 5 audit clients (#2) at Beaucatcher was afforded privacy during personal care. The findings is: Observations in the home on 11/13/25 at 6:27 AM revealed client #2 standing in her bedroom naked, trying to fasten her bra for approximately three minutes and visible from the hallway. Continued observation revealed staff A to enter client #2's room to ask if she needed any assistance. Further observation revealed client #2 to decline assistance and staff A to exit her room leaving the door wide open. Subsequent observation revealed client #2 to step out of sight from the hallway but to continue dressing with the door wide open. Interview on 11/13/25 with the RN/Qualified Intellectual Disabilities Professional (RN/QIDP) revealed staff should close the door for client #2 during personal care to ensure her privacy.	W 130			
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.¹	W 249			

RECEIVED

DHSR-MH Licensure Sect

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

TITLE

(X6) DATE

Christine R. Wellingham, QIDP

08/19/25

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 249	Continued From page 1	W 249			
	This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 5 audit clients (#5) at Hawksbill received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The finding is: Observations in the group home on 8/12/25 revealed client #5 to wear a gait belt and for staff to ambulate client around the home utilizing his gait belt. Continued observation at 4:22 PM revealed staff to ambulate client #5 next door to Beaucatcher utilizing their gait belt only. Further observations at 5:15 PM revealed staff to ambulate client #5 back to Hawksbill utilizing their gait belt only. Additional observations in the group home revealed a walker to be sitting in the hallway corner. Review of client #5's record on 8/13/25 revealed a PCP dated 8/7/25 which indicated a habilitation program for physical therapy exercise, to include gait training, seated exercises, and standing exercises. Continued review of client #5's record revealed a physical therapy (PT) evaluation dated 7/10/25. Review of the PT evaluation indicated client #5 is prescribed a gait belt, walker, and wheelchair for long distances. Continued review of the PT evaluation indicated client #5 ambulates with a walker and gait belt with standby to minimal assistance. Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/25 confirmed client #5's PCP and PT recommendations are current.				

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W 249 Continued From page 2
Continued interview with the QIDP revealed client #5 has made progress with ambulation and the walker is not always needed while in the home. Further interview with the QIDP revealed staff are supposed to support client #5 with ambulation utilizing his walker anytime he leaves the home.

W 249

W 474 MEAL SERVICES
CFR(s): 483.480(b)(2)(iii)

W 474

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 of 1 of 5 audit clients (#5) at Hawksbill. The finding is:

Observations in the group home on 8/12/25 at 4:00 PM revealed client #5 to participate in group snack. Continued observations revealed client #5 to choose Cheeto Puffs and for staff to serve them cut in half. Observation of the dinner meal at 5:34 PM revealed it to include Greek pasta, marinated cucumbers and onions, green beans, sliced orange and pineapple, milk and water. Additional observation revealed client #5 to be served the dinner meal in whole form and to participate independently in the dinner meal.

Observations in the group home on 8/13/25 at 7:06 AM revealed the breakfast meal to include scrambled eggs, grits, Greek yogurt, mixed berries, milk and coffee. Continued observations revealed client #5 to be served the breakfast meal in whole form and to participate independently in the breakfast meal.

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W 474	Continued From page 3 Review of client #5's records on 8/13/25 revealed a nutritional assessment dated 8/1/24 which indicated their diet order to be regular, finely chopped. Interview with qualified intellectual disabilities professional (QIDP) on 8/13/25 confirmed the diet order for client #5 is current. Continued interview with the QIDP verified finely chopped consistency should be less than one quarter inch with certain foods minimally processed in a food processor, depending on texture. Further interview with the QIDP confirmed staff are responsible for ensuring clients receive their diet orders as prescribed.	W 474			

Blue West Opportunities – Swannanoa

Plan of Correction

Survey 08/12/25 – 08/13/2025

W130

The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.

This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 1 of 5 audit clients (#2) at Beaucatcher was afforded privacy during personal care.

Staff will be trained on Client Rights by the QIDP and support instruction to ensure the client's safety and optimize support for privacy. Standard training, routine monitoring, and any follow-ups thereby identified, will be conducted by the person responsible to ensure the client is provided privacy.

Responsible Person(s): QIDP, QIDP Assistant, Site Director

Mechanism to ensure compliance: Standard training, visual monitoring, Administrative Quick View Assessments

Frequency of Mechanism: ongoing as needed, monthly as assigned.

W249

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program plan consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program.

This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 5 audit clients (#5) at Hawksbill received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP).

Motoric Specialist and PT will review the recommendations for safe ambulation and transfers of each SW resident. Training will be offered at each group home. Weekly assessments will be completed in each home for compliance. Any discrepancies found in the assessments will be discussed with the appropriate staff and any follow-ups will be sent to the appropriate supervisor.

Responsible Person: QIDP, Site Director, Motoric Clinical Specialist

Mechanism to ensure compliance: Assessments and observation of transfers and ambulation, Administrative Quick View Assessments, Transfer and Ambulation Sheet.

Frequency of mechanism: monthly, on going

W474

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 of 1 of 5 audit clients (#5) at Hawksbill.

The Dietary Manager/Clinical Support Specialist will conduct training with staff about the importance of adhering to a client's prescribed diet, nutritional needs, and where individual dietary information is located within the group home.

Routine in-home monitoring and observations are made by the Site Director, Shift Supervisors, Assistant QIDP and QIDP. In addition, the Dietary Manager/Clinical Support Specialist and Site Director delegates responsibility to the Supervisors to conduct two observation-based Mealtime Assessments each month.

Responsible Person(s): Dietary Manager/Clinical Support Specialist, Site Director, QIDP, Supervisors: TE and MB.

Mechanism to ensure compliance: Visual monitoring, corrections as needed, Mealtime Assessments.

Frequency of Mechanism: As often as needed on a case-to-case basis, two Mealtime Assessments each month.