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 _____	06/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WNC GROUP HOME - ORA	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 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical	E 015		

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 015	Continued From page 1 supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: The facility failed to ensure sufficient food and water were available as per the facility emergency plan (EP) as evidenced by observations, interview and policy review. The finding is: Review of the facility EP revealed the facility should have food supplies for 6 clients and 2 staff for 3 days. Continued review of the facility EP revealed the facility should also have 24 gallons of water in the facility for clients and staff. Observations in the group home, verified by interview with the qualified intellectual disabilities professional (QIDP), revealed 4 gallons of water and no food identified as emergency supplies was present in the home. Continued interview with the QIDP revealed the additional water and food should have been purchased and placed in the pantry. Therefore, the facility failed to have insufficient emergency food and water to address needs as per the facility's EP.	E 015		
W 256	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(ii) The individual program plan must be reviewed at	W 256		

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W 256	Continued From page 2 least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. This STANDARD is not met as evidenced by: Based on record review, verified by interview, the qualified intellectual disabilities professional (QIDP) failed to review and revise 3 of 8 objectives listed on the individual support plan (ISP) for 1 of 3 sampled clients (#4) when they were showing regression. The findings are: A. Review of client #4's record on 6/26/2018 revealed an ISP dated 10/16/17 which contained an objective relative to oral care (Morning) dated 9/23/17. Review of the objective revealed the client will brush his teeth for 3 minutes, given 5 or less verbal prompts, 50% of all trials per month for 3 consecutive months. Further review of the objective revealed the following data relative to client #4's achievement of the objective with 5 or less verbal prompts: 12/17: 38%; 1/18: 9%; 2/18: 22%; 3/18: 5% and 4/18: 0%. Interview with the QIDP, verified by review of the record, revealed no revisions had been made to the client's morning oral care objective despite regression since 12/2017. B. Review of client #4's record on 6/26/2018 revealed an ISP dated 10/16/17 which contained an objective relative to oral care (after lunch) dated 9/23/17. Review of the objective revealed after lunch the client will brush his teeth for 3 minutes, given 5 or less verbal prompts, 50% of all trials per month for 3 consecutive months. Further review of the objective revealed the following data relative to client #4's achievement	W 256		

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W 256	Continued From page 3 of the objective with 5 or less verbal prompts: 12/17: 38%; 1/18: 16%; 2/18: 24%; 3/18: 18% and 4/18: 0%. Interview with the QIDP, verified by review of the record, revealed no revisions had been made to the client's after lunch oral care objective despite regression since 12/2017. C. Review of client #4's record on 6/26/2018 revealed an ISP dated 10/16/17 which contained an objective to wash hands (1st shift) dated 6/23/17. Review of the objective revealed client #4 will follow the steps to properly wash his hands with soap and water, given gestural prompts 75% of all trials per month for 3 consecutive months. Further review of the objective revealed the following data relative to client #4's achievement of the objective with independence/no prompts: 6/17: 32%; 7/17: 16%; 8/17: 9%; 9/17: 11%; 10/17: 13%; 11/17: 0%; 12/17: 0% and 1/18: 0%. Interview with the QIDP, verified by review of the record, revealed no revisions had been made to the client's wash hands (1st shift) objective despite a 7 month regression. Data for 2/18, 3/18 and 4/18 could not be viewed as of the survey date through the facility's electronic system.	W 256		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: The specially constituted committee referred to as the human rights committee (HRC) failed to ensure written informed consent was obtained for	W 263		

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W 263	Continued From page 4 the use of medications to control inappropriate behaviors for 1 of 3 sampled clients (#1) as evidenced by interview and review of records. The finding is: Review of the records for client #1 revealed a individual support plan (ISP) dated 9/14/17 which included a behavior support plan (BSP) to reduce incidents of inappropriate behaviors of aggression, property destruction, agitation and self-injurious behaviors. Continued review of the BSP, verified by interviews with the QIDP and the nurse, revealed the client is receiving Depakote,Guanfacine (Adderall), Clonazepam, Lithium, and Quetiapine (Seroquel) to assist in controlling inappropriate behaviors. Review of the records for client #1 revealed physician's orders dated 5/1/18. Review of these orders verified the client is receiving Depakote,Guanfacine (Adderall), Clonazepam, Lithium, and Quetiapine (Seroquel). Continued review of the records for client #1 revealed written informed consent was present in the records for the use of Depakote, Klonopin and Guanfacine (Adderall). However, further review of the records, verified by interview with the QIDP, revealed no written informed consent for the use of Lithium or Quetiapine was present in the records for review. Therefore, the facility failed to show evidence medication used to control inappropriate behaviors were used only with the written informed consent.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 288		

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W 288	Continued From page 5 CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: The team failed to ensure techniques to manage inappropriate behaviors were not used as a substitute for active treatment or tied to a specific active treatment program for 1 of 3 sampled clients (#2) and 2 of 3 non-sampled clients (#5 and #6) as evidenced by observations, interview and review of records. The findings are: Observations during the 6/25-6/26/18 survey in the group home revealed an alarm was placed on the pantry door. Continued observations revealed the alarm would sound any time the pantry door was opened. Interview with direct care staff and the qualified intellectual disabilities professional (QIDP) stated the alarm was to alert staff when food seekers would enter the pantry. Additional interviews with the QIDP identified the food seekers as clients #2 and #6. A. Review of the records for client #2 revealed an individual support plan (ISP) dated 6/8/17. Review of this ISP revealed a behavior support plan (BSP) to decrease incidents of target behaviors to zero per month for 12 consecutive months. Continued review of the BSP revealed target behaviors were defined as aggression and agitation. Additional review of the BSP, verified by interview with the QIDP, revealed neither the alarm on the pantry door was identified as a	W 288		

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W 288	Continued From page 6 technique to address food seeking nor was food seeking identified as a target behavior. B. Review of the records for client #6 revealed an ISP dated 12/8/17. Review of this ISP revealed a BSP to decrease incidents of target behaviors to zero per month for 12 consecutive months. Continued review of the BSP revealed target behaviors were defined as aggression, self-injurious behaviors and property destruction. Additional review of the BSP, verified by interview with the QIDP, revealed neither the alarm on the pantry door was identified as a technique to address food seeking nor was food seeking identified as a target behavior. C. Review of the records for client #5 revealed an ISP dated 7/17/17. Review of this ISP revealed a BSP to decrease attempts to grab any edible/ consumable item unless given to him by a staff. Continued review of the BSP, verified by interview with the QIDP, revealed the alarm on the pantry door was not addressed in the BSP for client #5. Therefore, the facility failed to ensure the use of an alarm on the pantry door was not used as a substitute for active treatment or tied to a specific active treatment program.	W 288		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	W 312		

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W 312	Continued From page 7 This STANDARD is not met as evidenced by: The team failed to ensure drugs used to assist in controlling inappropriate behaviors were used only as an integral part of the individual support plan (ISP) for 1 of 3 sampled clients (#2) as evidenced by interview and review of records. The finding is: Review of the records for client #2 revealed physician's orders dated 5/1/18. Review of these orders, substantiated by interviews with the qualified intellectual disabilities professional (QIDP), revealed the client is receiving Risperdal, Clonidine and Prozac. Continued review of the records for client #2 revealed an ISP dated 6/8/17. Review of this ISP for client #2 revealed a behavior support plan (BSP) to decrease the number of target behaviors to zero per month for 12 consecutive months with the target behaviors defined as aggression and agitation. Continued review of this BSP revealed the client is receiving Risperdal and Clonidine to assist in reducing these target behaviors. Additional review of the BSP verified by interview with the QIDP, revealed the BSP did not include the use of Prozac in the control or reduction of the target behaviors. Therefore, the team failed to ensure the use of Prozac was used only as an integral part of the ISP in the reduction or elimination of the inappropriate behaviors for which it is used. .	W 312		