PRINTED: 06/27/2018 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					E SURVEY PLETED
	34G031						06/	26/2018
				9	TREET ADDRES 5 ORA STREE ASHEVILLE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
E 015	PROVIDER OR SUPPLIER COUP HOME - ORA SUMMARY STATEMENT OF DEFICIENCIES			015	See	Hack Mount	igin WRO	8/17/8
LABORATOR		, medical, and pharmaceutical	MATURE			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.

Facility ID: 942816

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCT	ION	(X3) DATE SURVEY COMPLETED	
		34G031	B. WING			***************************************	06/2	26/2018
	ROVIDER OR SUPPLIER			95	REET ADDRES ORA STREE SHEVILLE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH	OVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
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 EP revealed the facility EP revealed the facility EP revealed the facility for clients and 2 staff for 3 days. Continued review of the facility EP revealed 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			015				
W 256	emergency food a per the facility's E PROGRAM MON CFR(s): 483.440(and water to address needs as P. ITORING & CHANGE	W	256	See	Attached		क्षामाङ ८ १८४ । ज

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

Event ID: DYDK11

Facility ID: 942816

If continuation sheet Page 2 of 8

Sude Cay, 210P

Program Administrator 0/26/18

PRINTED: 06/27/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	34G031					06/26/2018		
	PROVIDER OR SUPPLIER OUP HOME - ORA			95	REET ADDRESS, CITY, STATE, ZIP CODE ORA STREET SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 256	Continued From paleast by the qualification professional and reduction but not limited to safety regressing or losing. This STANDARD Based on record a qualified intellectual (QIDP) failed to result of the cobjectives listed on (ISP) for 1 of 3 safety revealed an ISP data an objective relative 9/23/17. Review of client will brush his less verbal promptor 3 consecutive objective revealed client #4's achieved less verbal promptom 2/18: 22%; 3/18: with the QIDP, verous election of the color of the	age 2 ed mental retardation evised as necessary, including, ituations in which the client is g skills already gained. is not met as evidenced by: review, verified by interview, the al disabilities professional view and revise 3 of 8 in the individual support plan impled clients (#4) when they ression. The findings are: int #4's record on 6/26/2018 ated 10/16/17 which contained ive to oral care (Morning) dated of the objective revealed the is teeth for 3 minutes, given 5 or its, 50% of all trials per month months. Further review of the all the following data relative to ement of the objective with 5 or its: 12/17: 38%; 1/18: 9%; 5% and 4/18: 0%. Interview rified by review of the record, ons had been made to the ral care objective despite	W	256	DEFICIENCY)			
	revealed an ISP d an objective relati dated 9/23/17. Ro after lunch the clie minutes, given 5 d all trials per montl Further review of	nt #4's record on 6/26/2018 lated 10/16/17 which contained we to oral care (after lunch) eview of the objective revealed ent will brush his teeth for 3 or less verbal prompts, 50% of a for 3 consecutive months. the objective revealed the ative to client #4's achievement						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DYDK11 Facility ID: 942816 If continuation sheet Page 3 of 8

Sude Cay, 2107 Program Administrator 0/28/18

PRINTED: 06/27/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WINC GROUP HOME - ORA SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG W 256 Continued From page 3 of the objective with 5 or less verbal prompts: 12/17-38%; 1/18: 16%; 2/18: 24%; 3/16: 18% and 4/18: 0%. Interview wifth the OIDP, verified by review of the record, revealed no revisions had been made to the objective verseled the following data relative to client #4* scord or 0.0000 and 11/18: 0.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE SO NA STREET ASHEVILLE, NC 28801 (PA) ID (PA)		34G031	B. WING _		06/2	6/2018	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 256 Continued From page 3 of the objective with 5 or less verbal prompts: 12/17: 38%; 11/18: 169%; 21/18: 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 affer funct oral an objective to wash hands (1st shiff) dated 6/23/17. Review of the objective revealed client #4's 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%; 17/17: 16%; 41/17: 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 shiff) objective date through the facility's electronic system. W 263 W 263 W 264 W 265 Continued From page 3 of the or less verbal prompts: 6/17: 32%; 17/17: 176%; 41/17: 0% and 1/18: 0%. Interview of the objective revealed client #4's achievement of the objective with independence/no prompts: 6/17: 32%; 17/17: 16%; 41/17: 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 shiff) 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. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3(iii) 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 effercy is laided to as the human rights committee (HRC): Jailed to		₹		95 ORA STREET			
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 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	PREFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	COMPLÉTION	
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DYDK11 Facility ID: 942816 If continuation sheet Page 4 of 6	of the objective w 12/17: 38%; 1/18 and 4/18: 0%. Int by review of the re had been made to care objective de C. Review of clies revealed an ISP of an objective to wo 6/23/17. Review #4 will follow the with soap and wa of all trials per mo Further review of following data rel of the objective w 6/17: 32%; 7/17: 10/17: 13%; 11/1 Interview with the record, revealed the client's wash despite a 7 mont and 4/18 could re date through the PROGRAM MON CFR(s): 483.440 The committee s are conducted or consent of the cl minor) or legal gr This STANDARE The specially co as the human rig ensure written in	ith 5 or less verbal prompts: 3: 16%; 2/18: 24%; 3/18: 18% terview with the QIDP, verified ecord, revealed no revisions of the client's after lunch oral spite regression since 12/2017. Int #4's record on 6/26/2018 dated 10/16/17 which contained ash hands (1st shift) dated of the objective revealed client steps to properly wash his hands atter, given gestural prompts 75% onth for 3 consecutive months. The objective revealed the ative to client #4's achievement with independence/no prompts: 16%; 8/17: 9%; 9/17: 11%; 7: 0%; 12/17: 0% and 1/18: 0%. A QIDP, verified by review of the no revisions had been made to hands (1st shift) objective heregression. Data for 2/18, 3/18 of be viewed as of the survey facility's electronic system. NITORING & CHANGE (f)(3)(ii) should insure that these programs only with the written informed itent, parents (if the client is a quardian.	W2	263 See Attached	If continuation she	8/12/18 C 28/18	

Huda J Cay 2008 Program Administrator 0/08/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G031	B. WING				06/2	26/2018
	ROVIDER OR SUPPLIER			95	REET ADDRESS, (ORA STREET SHEVILLE, NC	CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH COI	ER'S PLAN OF CORREC RRECTIVE ACTION SHO ERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 263	the use of medicati behaviors for 1 of 3 evidenced by interval. The finding is:	age 4 ions to control inappropriate 3 sampled clients (#1) as view and review of records. rds for client #1 revealed a blan (ISP) dated 9/14/17 which	W:	263				
	included a behavio incidents of inappro aggression, proper self-injurious behavious behavious, verified by intruse, revealed the Depakote, Guanfact	r support plan (BSP) to reduce opriate behaviors of ty destruction, agitation and viors. Continued review of the terviews with the QIDP and the e client is receiving sine (Adderall), Clonazepam, apine (Seroquel) to assist in						
	physician's orders orders verified the	cine (Adderall), Clonazepam,						
	revealed written in the records for the and Guanfacine (A review of the record the QIDP, revealed	of the records for client #1 formed consent was present in use of Depakote, Klonopin Adderall). However, further rds, verified by interview with d no written informed consent um or Quetiapine was present review.						
W 288	medication used to behaviors were us informed consent.	ility failed to show evidence o control inappropriate ed only with the written ROPRIATE CLIENT	w	288	See	Attached		814 8 6 28 8

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Event ID: DYDK11

Facility ID: 942816

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Sude | Cay 210P Program Administrator 0/28/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY	
	34G031		B. WING			06/26/2018		
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 5 ORA STREET SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 288	This STANDARD The team failed to inappropriate behas substitute for active active treatment proclients (#2) and 2 cand #6) as evidence and review of recomposition of the group home returned the pantry door. Or revealed the alarm pantry door was on the pantry door was to a would enter the pantry door the pantry	nage inappropriate client er be used as a substitute for t program. is not met as evidenced by: ensure techniques to manage aviors were not used as a etreatment or tied to a specific rogram for 1 of 3 sampled of 3 non-sampled clients (#5 ced by observations, interview ords. The findings are: Ing the 6/25-6/26/18 survey in evealed an alarm was placed on continued observations in would sound any time the		288				

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

Event ID: DYDK11

Facility ID: 942816

If continuation sheet Page 6 of 8

Huda / Coy QIDP Program Administrator 0/28/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			use vorces established	(X3) DATE SURVEY COMPLETED	
		34G031	B. WING				06/26/2018	
	PROVIDER OR SUPPLIER OUP HOME - ORA			9	TREET ADDRESS, CI 5 ORA STREET ASHEVILLE, NC 2	TY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORE	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULE RENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 288	technique to addresseeking identified a B. Review of the rean ISP dated 12/8/revealed a BSP to behaviors to zero pmonths. Continued target behaviors we self-injurious behave Additional review owith the QIDP, revepantry door was identified as a target C. Review of the rean ISP dated 7/17/revealed a BSP to edible/ consumable staff. Continued reinterview with the Consumable staff.	as a target behavior. ecords for client #6 revealed 17. Review of this ISP decrease incidents of target ber month for 12 consecutive d review of the BSP revealed ere defined as aggression, viors and property destruction. If the BSP, verified by interview ealed neither the alarm on the entified as a technique to ing nor was food seeking	W 2	288				
W 312	an alarm on the pa substitute for active active treatment pr DRUG USAGE CFR(s): 483.450(e Drugs used for cor must be used only client's individual p specifically towards	•	w:	312	See	Attacheel		क्षाचाह चित्र ।

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Event ID: DYDK11

Facility ID: 942816

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Kudel Cay Program Administrator

0 28/15

PRINTED: 06/27/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
	34G031					06/26/2018		
	PROVIDER OR SUPPLIER OUP HOME - ORA			95	REET ADDRESS, CITY, STATE, ZIP CODE 5 ORA STREET SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 312	Continued From pa	age 7	ws	312				
	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.							

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Event ID: DYDK11

Facility ID: 942816

If continuation sheet Page 8 of 8

Head Coy 21DP Program Administrator

Plan Of Correction Ora Street Annual Recertification Survey June 25-26, 2018

E 015 Subsistence Needs for Staff and Patients

- [(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:
 - (1) Food, water, medical and pharmaceutical supplies.

The facility will ensure that all emergency supplies are stocked and available in water resistant containers. Expiration dates will be checked and no less than 6 months from expiring. A checklist will be used and kept on file to ensure correct re-stocking.

This will be monitored by the Residential Services Coordinator and the QIDP/House Coordinator. Monitoring will occur at least every 6 months.

This will be completed by August 17, 2018



W256 Program Monitoring and Change

The Individual program plan must be reviewed at least by the QIDP and revised as necessary, including but not limited to situations in which the client is regressing or losing skills already gained.

A.,B., and C., All programs in the ISP for client #4 will be reviewed at a team meeting to review and retrain proper program implementation. Additionally, programs will be revised, as needed, to promote success independence.

This will be completed by the QIDP and the interdisciplinary team and monitored by the QIDP and Program Administrator. Monitoring will occur monthly and quarterly.

All revising and retraining will be completed by August 17, 2018

W263 Program Monitoring and Change

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.

The Nursing department will be responsible for all consents for medications used for behavioral control. These consents will be signed by all parties, including but not limited to the parent/guardian, Medical Director and the Human Rights Committee.

The Nursing department will be responsible for ensuring that any medication changes are both reflected in the MAR, and communicated to the QIDP and the Psychological Associate

The QIDP will be responsible for ensuring that any changes are reflected in the ARP/ISP documents in Therap. The Psychological Associate will ensure that all necessary changes are made to BSP documents.

This will be monitored by the Nursing Department, Psychological Associate and the QIDP.

Monitoring will occur quarterly at regularly scheduled Quarterly Medical Review meetings.

All consents will be signed and in place by August 17, 2018

W288 Management of inappropriate Client Behavior.

Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.

A., B., and C.: An interdisciplinary team meeting will be held to discuss ongoing food seeking with Clients #2, #5 and #6. Following the recommendations of the team, food seeking as a target behavior will be added to the Behavior Support Plans for the aforementioned clients. Re-training for all staff will occur to

reinforce the need for active supports and activities to re-direct any food seeking behaviors. Consent for all alarms will be obtained.

Retraining will be done by the QIDP. Consents for all alarms will be gotten by the QIDP and reviewed by the Human Rights Committee. Ongoing monitoring will be done monthly and quarterly by the QIDP and Program Administrator.

All revisions to Behavior Support Plans, necessary consents, and retraining of staff will be completed by August 17, 2018

W312 Drug Usage

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.

Cross referenced with W263

The Nursing department will be responsible for all consents for medications used for behavioral control. These consents will be signed by all parties, including but not limited to the parent/guardian, Medical Director and the Human Rights Committee.

The Nursing department will be responsible for ensuring that any medication changes are both reflected in the MAR, and communicated to the QIDP and the Psychological Associate

The QIDP will be responsible for ensuring that any changes are reflected in the ARP/ISP documents, as well as in the Behavior Support Plan in Therap.

This will be monitored by the Nursing Department, Psychological Associate and the QIDP.

Monitoring will occur quarterly at regularly scheduled Quarterly Medical Review meetings.

All consents will be signed and in place by August 17, 2018

Program Administrator