DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES					MB NO. 0938-0391	
DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X	3) DATE SURVEY COMPLETED	
	34G076	B. WING _			C 07/18/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
IWC-ROSE STREET HOME			1 ROSE STREET W			
			ASHEVILLE, NC 28803			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5)		COMPLETION	
INITIAL COMMENTS		wo	000			
Complaint Intake #: NC00140575						
No deficient practices were identified as a result of this complaint survey.						
					(X6) DATE	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E STREET HOME SUMMARY STI (EACH DEFICIENC' REGULATORY OR L INITIAL COMMENTS Complaint Intake #: N No deficient practices of this complaint surve	S FOR MEDICARE & MEDICAID SERVICES Deficiencies CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G076 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint Intake #: NC00140575 No deficient practices were identified as a result of this complaint survey.	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 34G076 B. WING_ ROVIDER OR SUPPLIER B. WING_ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG INITIAL COMMENTS W 1 Complaint Intake #: NC00140575 W 1 No deficient practices were identified as a result Interfed as a result	S FOR MEDICARE & MEDICAID SERVICES 9° DEFIDENCIES (X1) PROVIDENSUPPLIERCLIA (X2) MULTIPLE CONSTRUCTION 34G076 B. WING TODER OR SUPPLIER INSEET ADDRESS, CITY, STATE, ZIP CONSTRUCTION STREET HOME INSEET TO DEFIDIENCIES SUMMARY STATEMENT OF DEFIDIENCIES INSEET ADDRESS, CITY, STATE, ZIP CONSTRUCTION OF CONSTRUCTION AND CONSTRUCTI	MENT OF HEALTH AND HUMAN SERVICES OI SFOR MEDICARE & MEDICALD SERVICES OI PERCENCISS (X1) PROVIDER SUPPLIER SERVICES OF SUPPLIER STREET HOME STREET HOME STREET HOME STREET HOME SUMMARY STATEMENT OF DEFICIENCIES (CACH DEPICIENCY ON USE THE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INTIAL COMMENTS Complaint Intake #: NC00140575 No deficient practices were identified as a result of this complaint survey.	

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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