PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED	
	•	34G267	B. WING				07/	10/2018
	ROVIDER OR SUPPLIER	1		1	TREET ADDRESS, CITY, S KENMORE STREET SHEVILLE, NC 2880:			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD I ENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	3	W	000				સીઓલ
W 195	Complaint Intake: No ACTIVE TREATMEN CFR(s): 483.440		w	195	See AH	scheel		110/18
	The facility must ens treatment services re	ure that specific active equirements are met.						
LABORATORY	The facility failed to: received a continuous which includes aggre implementation of a generic training, trea related services described toward the pregression or loss of status (W196); assuraccomplishment of the client individual services documented in measuremented in measuremented by the quaprofessional and that prescribed to assure revised as necessar (W257); assure compassessments were upon assessments were up	program of specialized and tment, health services and cribed in the subpart, that is prevention or deceleration of current optimal functional re data relative to the ne criteria specified in the ide plan objectives was surable terms to enable of the client's progress andividual service plan was lified intellectual disabilities at data was documented as a program objectives were by to assure client progress prehensive functional apdated as needed (W259); citives were developed to as a identified by the essment (W227).	E		тіт	Received Sur 2 5 20 by:	Nountain .	(X6) DATE

And 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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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		34G267	B. WING			7/10/2018
	ROVIDER OR SUPPLIER DUP HOME - KENMORE		11	REET ADDRESS, CITY, STATE, ZIP CO KENMORE STREET SHEVILLE, NC 28803	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 195	treatment program, veconsistent implement specialized and general services and related subpart, that is direction to the client to function determination and in (ii) The prevention or loss of current open that services that active treatment programs and the control of the client to function or loss of current open that services that active treatment programs and general services and g	eive a continuous active which includes aggressive, ntation of a program of eric training, treatment, health services described in this ted toward: of the behaviors necessary for	W 195			* sale
	assure data relative criteria specified in t plan objectives was terms to enable qua client's progress (#1 B. Cross-reference assure the individua by the qualified intel professional and that	W257. The facility failed to a service plans were reviewed lectual disabilities at objective data was scribed to assure revisions as				

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Event ID; 36Y511

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Takel Cay Program Administrator 7/18/15

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G267	B. WING	B. WING		7/10/2018
	ROVIDER OR SUPPLIER UP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1 KENMORE STREET ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 196	C. Cross-reference \(\) assure comprehensivere updated as need clients (#1, #2 and #3) D. Cross-reference \(\) assure training object meet the needs identified by the collectives necessary as identified by the collectives of the collective of	N259. The facility failed to be functional assessments ded for 3 of 3 sampled 3). N227. The facility failed to tives were developed to diffied by the comprehensive 3 sampled clients (#2).	W 19			7/18/18
	Based on record reversalled to ensure the infor 1 of 3 sampled clitraining to address in academic/vocational. Review of the record revealed an ISP date. #2's ISP revealed ob cooking, oral hygiene. Additional record reveducational/pre-vocadated 2/28/18. Reviews assessment revealed. #2 with telling time, retraining, assembling appropriate material.	not met as evidenced by: riew and interview, the facility individual service plan (ISP) ients (#2) included objective ientified needs relative to skills. The finding is: If or client #2 on 7/10/18 ad 5/7/18. Review of client ijective training in areas of a and chore participation. riew for client #2 revealed an ational/vocational assessment assessment ational/vocational assessment actional/vocational dacademic deficits for client remaining seated during objects, selecting for a task and math deficits. client #2's training objectives				

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Event ID: 36Y511

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Xula Cay Program Administrator

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	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G267	B. WING		07	7/10/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1 KENMORE STREET ASHEVILLE, NC 28803	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 227	Interview with the quaprofessional (QIDP) of had no current training identified vocational with the QIDP reveal client #2 would benestructure in his daily verified vocational of developed to support identified in the 2/28/although none had be PROGRAM DOCUM CFR(s): 483.440(e)().	alified intellectual disabilities on 7/10/18 revealed client #2 ng objectives relative to deficits. Further interview ed additional training for fit the client's need for schedule. The QIDP further objectives should have been to client #2 with deficits 1/18 vocational assessment, een implemented.	W 227			324B
	Based on record reversalled to ensure data on the individual service (#1, #2 and #3). The A. The team failed to acquisition objective #2 was collected as 1. Review of client #1 revealed an ISP date	o ensure data for 3 of 3 skill s listed on the ISP for client				

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Event ID: 36Y511

Facility ID: 932083

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Lude Cuy Program Administrator 7/18/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		34G267	B. WING		(7/10/2018
	ROVIDER OR SUPPLIER DUP HOME - KENMOR	E	1	TREET ADDRESS, CITY, STATE, ZIP COD KENMORE STREET SHEVILLE, NC 28803	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
W 252	80% of trials over 6 10/10/17. The prowas to be collected Continued review 6 data collection for 30 days; 12/17, days; 2/18, 0 of 28 7 of 30 days; 5/18, 30 days with only 6/14-6/30/2018. 2. Review of clien revealed an ISP days objective to address bedroom with 90% month by 6/1/19, in program direction collected daily. Crevealed monthly for the past year a 9/17, 3 of 30 days; of 30 days; 12/17, days; 2/18, 0 of 28 11 of 30 days; 5/18 30 days. 3. Review of clien revealed an ISP dobjective to address of each step of prompt for each stimplemented 9/22 indicated data was Continued review data collection for as follows: 8/17, 1 days; 10/17, 11 of	age 4 6 consecutive months, revised gram direction indicated data of three times per week. of the record revealed monthly this objective, since its revised 0/17, only 3 of 31 days; 11/17, 1 0 of 31 days; 1/18, 0 of 31 days; 3/18, 1 of 31 days; 4/18, 1 of 31 days and 6/18, 15 of two data points from It #2's record on 7/10/18 ated 5/7/18 which included an eschore participation-clean of of opportunities presented per emplemented 6/22/17. The indicated data was to be ontinued review of the record data collection for this objective is follows: 8/17, 3 of 31 days; 1/17, 7 of 31 days; 1/18, 0 of 31 days; 3/18, 6 of 31 days; 4/18, 8, 2 of 31 days and 6/18, 7 of 1 days; 3/18 which included an escoral hygiene with completion of the record revealed monthly this objective for the past year 4 of 31 days; 9/17, 13 of 30 days; 11/17, 10 of 30 days; 11/18, 3 of 31 days; 2/18, 15	W 252			

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Leda Cay Program Administrator 7/18/18

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SÜRVEY COMPLETED	
		34G267	B. WING_			07	/10/2018
	ROVIDER OR SUPPLIER DUP HOME - KENMORE			1 K	REET ADDRESS, CITY, STATE, ZIP CODE ENMORE STREET HEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETION DATE	
W 252	of 28 days; 3/18, 9 of days; 5/18, 15 of 31 days. Interview with the queprofessional (QIDP) data collection for the completed as prescriwith the QIDP verifier for all objectives prevenecessary. B. The team failed to acquisition objectives #3 was collected as 1. Review of client revealed an ISP data objective to adjust the showering 90% of trimonths, implemented direction indicated days Continued review of data collection for the as follows: 8/17, 8 of 10/17, 2 of 31 days; of 31 days; 1/18, 0 of 31 days; 4 31 days and 6/18, 0 2. Review of client revealed an ISP data	alified intellectual disabilities on 7/10/18 confirmed that use objectives was not bed. Additional interview do the lack of data collection wented the ability to revise as on the lack of data collection wented the ability to revise as on the lack of data collection wented the ability to revise as on the lack of data collection wented the ability to revise as on the lack of data collection wented the ability to revise as on the lack of data collection wented the ability to revise as on the lack of 5 of 5 skill as listed on the ISP for client prescribed. #3's record on 7/10/18 and 9/6/17 which included an elementary when also for three consecutive do 7/5/17. The program ata was to be collected daily. The record revealed monthly is objective for the past year and 13 days; 9/17, 7 of 30 days; 11/17, 7 of 30 days; 11/17, 4 f 31 days; 2/18, 0 of 28 days; 1/18, 0 of 30 days; 5/18, 0 of	W	252	DEFIGIENCY)		
	months, implemente direction indicated d Continued review of data collection for th	se for three consecutive d 9/12/17. The program ata was to be collected daily. the record revealed monthly is objective for the past year f 30 days; 10/17, 3 of 31		A CONTRACTOR OF THE PROPERTY O			

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Event ID: 36Y511

Facility ID: 932083

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Lade Cary Program Administrator 7/18/16

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G267	B. WING		C	07/10/2018	
	ROVIDER OR SUPPLIER PUP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP CO 1 KENMORE STREET ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 252	days; 11/17, 6 of 30 1/18, 0 of 31 days; 2 31 days; 4/18, 0 of 3 and 6/18, 1 of 30 days. 3. Review of client: revealed an ISP date objective to wash haby 6/11/18, impleme direction indicated d. Continued review of data collection for thas follows: 8/17, 4 of 10/17, 4 of 31 days; of 31 days; 1/18, 0 of 31 days; 1/18, 0 of 31 days; and 6/18, 3 4. Review of client frevealed an ISP date objective to make be independence by 8/17 the program directic collected daily. Correvealed monthly dafor the past year as 9/17, 2 of 30; 10/17, days; 12/17, 2 of 31 2/18, 0 of 28 days; 330 days; 5/18, 0 of 3 days. 5. Review of client frevealed an ISP date objective to brush his 90% independence implemented 1/1/18 indicated data was to several to the	days; 12/17, 2 of 31 days; /18, 0 of 28 days; 3/18, 2 of 0 days; 5/18, 0 of 31 days /s. #3's record on 7/10/18 ed 9/6/17 which included an inds with 90% independence inted 8/18/17. The program ata was to be collected daily. The record revealed monthly is objective for the past year is 31 days; 9/17, 3 of 30 days; 11/17, 7 of 30 days; 12/17, 3 of 31 days; 2/18, 0 of 28 days; /18, 0 of 30 days; 5/18, 1 of of 30 days. #3's record on 7/10/18 ed 9/6/17 which included an indicated data was to be intinued review of the record ta collection for this objective follows: 8/17, 1 of 31 days; 2 of 31 days; 11/17, 4 of 30 days; 1/18, 0 of 31 days; 2 of 31 days; 11/17, 4 of 30 days; 1/18, 0 of 31 days; 1/18, 1 of 31 days and 6/18, 2 of 30 #3's record on 7/10/18 ed 9/6/17 which included an is teeth for 3 minutes with for 6 consecutive months, The program direction	W 2	52			

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Facility ID: 932083

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Theda | Cong Program Administrator 7/18/16

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COMPLETED
- 07/10/2018
ATE, ZIP CODE
PLAN OF CORRECTION (X5) CTIVE ACTION SHOULD BE COMPLETION NCED TO THE APPROPRIATE DATE DEFICIENCY)
73 R'S REG

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Event ID: 36Y511

Facility ID: 932083

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Sidal Cary Program Administrator 7/18/16

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	1'''	(X3) DATE SURVEY COMPLETED	
		34G267	B. WING			07/10/2018
	ROVIDER OR SUPPLIER PUP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP C 1 KENMORE STREET ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF K (EACH CORRECTIVE ACT CROSS-REFERENCED TO I DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 252	6/18 revealed data w 0 of 31 days; 9/17, 1 days; 11/17; 3 of 30 of 1/18, 0 of 31 days; 2. 31 days; 4/18, 4 of 30 and 6/18, 2 of 30 day 3. Review of client # revealed an ISP date objective to dry uppe independence for 6 of directions indicated of taken daily. Review collections summary 6/18 revealed data w 10 of 31 days; 9/17 of days; 11/17, 13 of 30 1/18, 1 of 31 days; 2 31 days; 4/18, 6 of 3 and 6/18, 14 of 30 day 4. Review of client # revealed an ISP date objective to complete 70% for 3 months re directions indicated of taken daily. Review collections summary 6/18 revealed data w 9 of 31 days; 9/17, 1 days; 11/17, 11 of 30 1/18, 2 of 31 days; 2 31 days; 4/18, 14 of and 6/18, 21 of 30 d 5. Review of client # revealed an ISP date dining objective for u 6/18 revealed an ISP date dining objective for u	ras collected as follows: 8/17, of 30 days; 10/17; 1 of 31 days; 12/17; 2 of 31 days; /18, 0 of 28 days; 3/18, 4 of 0 days; 5/18, 1 of 31 days /s. Part of 30 days; 5/18, 1 of 31 days /s. Part of 30 days; 5/18, 1 of 31 days /s. Part of 30 days; 10/18 Part of 30 days; 10/17, 8 of 31 of 30 days; 10/17, 9 of 31 days; 12/17, 9 of 31 days; 12/17, 9 of 30 days; 3/18, 1 of 0 days; 5/18, 2 of 30 days ays. Part of 30 days; 10/17, 8 of 31 of 30 days; 10/17, 8 of 31 of 30 days; 10/17, 8 of 31 of 30 days; 10/17, 1 of 30 days; 10/17, 12 of 31 of 30 days; 10/17, 12 of 31 of 30 days; 12/17, 8 of 31 days; 1/18, 17 of 28 days; 3/18, 7 of 30 days; 5/18, 11 of 31 days	W	252		

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Sudal Cary Program Administrator 7/18/16

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G267	B. WING			07/10/2018
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COI KENMORE STREET ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 257	supposed to be taker monthly data collection revealed data was do for 6/18 was docume. Interview with the QII data collection for the completed as prescri with the QIDP verified for all objectives prevaccurately review and necessary. PROGRAM MONITO CFR(s): 483.440(f)(1). The individual progral least by the qualified professional and revibut not limited to situ failing to progress to after reasonable efform. This STANDARD is Based on record revialled to ensure that prescribed for prograindividual service place clients (#1, #2 and #12 of 13 objectives or reviewed and assession. The team failed to acquisition objectives.	ns indicated data was in daily. Review of the consummary sheet for 5/18 ocumented 4 of 31 days and inted for 17 of 30 days. OP on 7/10/18 confirmed that ese objectives was not bed. Additional interview do the lack of data collection rented the ability to do revise programs as ORING & CHANGE ()(iii) In plan must be reviewed at mental retardation sed as necessary, including, ations in which the client is ward identified objectives rts have been made. Inot met as evidenced by: In with the client is ward interview, the team data was collected a sem objectives listed on the lass (ISPs) for 3 of 3 sampled (ISPs) for 3 of 3 skill (ISPs) for client (ISP	W 252			

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Event ID: 36Y511

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Sala Cay Program Administrator 7/18/16

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G267	B. WING	B. WING		07/1	10/2018
	ROVIDER OR SUPPLIER DUP HOME - KENMORE			1 K	REET ADDRESS, CITY, STATE, ZIP CODE ENMORE STREET HEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 257	objective to prepare a 80% of trials over 6 d 10/10/17. The prograwas to be collected the Continued review of data collection for this date, as follows: 10/10 of 30 days; 12/17, 0 days; 2/18, 0 of 28 days; 2/18, 0 of 28 days; 2/18, 0 of 28 days; 3/18, 1 30 days with only two 6/14-6/30/2018. Further evidence of revision 2. Review of client # revealed an ISP date objective to address bedroom with 90% of month by 6/1/19, improgram direction indicollected daily. Concrevealed monthly day for the past year as f 9/17, 3 of 30 days; 1 of 30 days; 12/17, 1 days; 2/18, 0 of 28 days; 2/18, 0 of 28 days. Further revof revision to this objective to address of each step of program to reach step of pro	d's record on 7/10/18 d 5/7/18 which included an a vegetable or side item at consecutive months, revised am direction indicated data aree times per week. The record revealed monthly is objective, since its revised 7, only 3 of 31 days; 11/17, 1 of 31 days; 1/18, 0 of 31 days; 3/18, 1 of 31 days; 4/18, of 31 days and 6/18, 15 of 50 data points from their review did not reveal to this objective in 9 months. 2's record on 7/10/18 and 5/7/18 which included an chore participation-clean of opportunities presented per olemented 6/22/17. The dicated data was to be tinued review of the record that collection for this objective follows: 8/17, 3 of 31 days; 0/17, 2 of 31 days; 11/17, 7 of 31 days; 1/18, 0 of 31 days; 3/18, 6 of 31 days; 4/18, 2 of 31 days and 6/18, 7 of 1 days and 6/18, 7 of	W	257			

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Event ID: 36Y511

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Huda / Cong Program Administrator 7/18/18

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED
		34G267	B. WING	*******************************	0	7/10/2018
	ROVIDER OR SUPPLIER DUP HOME - KENMORE		1 KE	EET ADDRESS, CITY, STATE, ZIP CODE NMORE STREET IEVILLE, NC 28803	<u>i</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 257	data collection for thi as follows: 8/17, 14 of days; 10/17, 11 of 31 12/17, 7 of 31 days; of 28 days; 3/18, 9 of days; 5/18, 15 of 31 days. Further review revision to this objection for these of days as prescribed. Additiverified the lack of daysified the lack of	the record revealed monthly sobjective for the past year of 31 days; 9/17, 13 of 30 days; 11/18, 3 of 31 days; 2/18, 15 of 31 days; 4/18, 21 of 30 days and 6/18, 21 of 30 days and 6/18, 21 of 30 did not reveal evidence of a tive over the review year. alified intellectual disabilities confirmed that data objectives was not completed cional interview with the QIDP eta collection for all at the ability to review for se as necessary. The ability to review for se as necessary, and thus year example of the ISP for client as necessary, and thus year example of the ISP for client as necessary. The program at a was to be collected daily, the record revealed monthly is objective for the past year for 31 days; 9/17, 7 of 30 days; 11/17, 7 of 30 days; 12/17, 4 of 31 days; 2/18, 0 of 28 days; 1/18, 0 of 30 days. Further review noe of revision to this	W 257			

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Land Coy Program Administrator 7/18/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G267	B. WING _			07/10/2018
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP CO 1 KENMORE STREET ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 257	revealed an ISP date communication objet 90% correct responsion months, implemente direction indicated date Continued review of data collection for the as follows: 9/17, 0 of days; 11/17, 6 of 30 1/18, 0 of 31 days; 2 31 days; 4/18, 0 of 31 and 6/18, 1 of 30 day reveal evidence of responsive to wash has be solved an ISP date objective to wash has be solved and collection indicated data collection for the as follows: 8/17, 4 of 31 days; of 31 days; 1/18, 0 of 31 days; of 31 days; of 31 days; of 31 days; 1/18, 0 of 31 days; of 31 days; 1/18, 0 of 31 days; of 31 days; 1/18, 0 of 31 days	ed 9/6/17 which included a ctive to read sight words for the for three consecutive d 9/12/17. The program at a was to be collected daily. The record revealed monthly is objective for the past year of 30 days; 10/17, 3 of 31 days; 12/17, 2 of 31 days; 18, 0 of 28 days; 3/18, 2 of 0 days; 5/18, 0 of 31 days of 32 days of 31 days; 31				

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Hadal Cey Program Administrator 7/18/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED		
		34G267	B. WING			07/10/2018		
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE				STREET ADDRESS, CITY, STA 1 KENMORE STREET ASHEVILLE, NC 28803	NTE, ZIP CODE	•		
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W 257	9/17, 2 of 30; 10/17 days; 12/17, 2 of 37 2/18, 0 of 28 days; 30 days; 5/18, 0 of days. Further revirerevision to this objective to brush it 90% independence implemented 1/1/18 indicated data was Continued review of data collection for it implementation, as 2/18, 12 of 28 days of 30 days; 5/18, 14 days. Further rev revision to this objective implementation. Interview with the opposessional (QIDF collection for these as prescribed. Adverified the lack of objectives prevente progression and re C. The team failed acquisition objective #2 was documente program revision of 1. Review of clien revealed an ISP da communication objection object	ge 13 7, 2 of 31 days; 11/17, 4 of 30 8 days; 1/18, 0 of 31 days; 3/18, 0 of 31 days; 4/18, 1 of 31 days and 6/18, 2 of 30 8 did not reveal evidence of active over the review year. #3's record on 7/10/18 8 ted 9/6/17 which included an anis teeth for 3 minutes with a for 6 consecutive months, and the record revealed monthly his objective, since follows: 1/18, 0 of 31 days; s; 3/18, 9 of 31 days; 4/18, 11 8 of 31 days and 6/18, 13 of 30 item did not reveal evidence of active in the 6 months since follows: 1/18, 0 of 31 days; and 6/18, 13 of 30 item did not reveal evidence of active in the 6 months since follows: 1/18, 0 of 31 days; and 6/18, 13 of 30 item did not reveal evidence of active in the 6 months since follows: 1/18 of 30 item did not reveal evidence of active in the 1/18 of 3 of 5 skill are the ability to review for a for all and the ability to review for a for a for 3 of 5 skill are the ability to review for a for 3 of 5 skill are as prescribed, and thus completed as necessary. 1 the 1/2/18 which included a for 3 of 3 months. The	W	257				

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La Coy Program Administrator 7/18/18

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G267	B. WING				07/10/2018
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE			1 KEN	ET ADDRESS, CITY, STATE, ZIP CODE NMORE STREET EVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	i	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 257	to be taken daily. R collection data colle 8/17 through 6/18 re follows: 8/17, 0 of 3 10/17, 1 of 31 days; of 31 days; 1/18, 0 of 3/18, 4 of 31 days; 4/31 days and 6/18, 1 2. Review of client revealed an ISP data communication objewith independence program directions to be taken daily. R collection summary 6/18 revealed data 0 of 31 days; 9/17, days; 11/17; 3 of 30 1/18, 0 of 31 days; 3/148, 4 of 30 of 30. 3. Review of client revealed an ISP data objective to dry upp independence for 6 directions indicated taken daily. Review collections summar 6/18 revealed data 10 of 31 days; 9/17 days; 11/17, 13 of 31 1/18, 1 of 31 days; 31 days; 4/18, 6 of and 6/18, 14 of 30 of and 6/	eview of the monthly data ction summary sheets from evealed data was collected as at days; 9/17, 0 of 30 days; 11/17, 1 of 31 days; 12/17, 2 of 31 days; 2/18, 0 of 28 days; 14/18, 4 of 30 days; 5/18, 1 of of 31 days. #1's record on 7/10/18 and 1/2/18 which included a active to use table top games at 90% for 3 months. The indicated data was supposed deview of the monthly data sheets from 8/17 through was collected as follows: 8/17, 1 of 30 days; 10/17; 1 of 31 and 30; 5/18, 1 of 31 and 6/18, 2 #1's record on 7/10/18 and 6/18, 2	W	257			

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Sull Coy Program Administrator 7/16/18

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ION	(X3) DATE SURVEY COMPLETED	
		34G267	B. WING			07/	/10/2018
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE			STREET ADDRE 1 KENMORE S ASHEVILLE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 259	objective to complete 70% for 3 months, redirections indicated of taken daily. Review collections summary 6/18 revealed data w 9 of 31 days; 9/17, 11 days; 11/17, 11 of 30 1/18, 2 of 31 days; 2/31 days; 4/18, 14 of 3 and 6/18, 21 of 30 da Interview with the quiprofessional (QIDP) collection for these of as prescribed. Additiverified the lack of day objectives prevented progression and review PROGRAM MONITO CFR(s): 483.440(f)(2) At least annually, the assessment of each the interdisciplinary the interd	d 1/2/18 which included an esteps for oral hygiene at vised in 4/18. The program lata was supposed to be of the monthly data sheets from 8/17 through as collected as follows: 8/17, 1 of 30 days; 10/17, 12 of 31 days; 12/17, 8 of 31 days; 18, 17 of 28 days; 3/18, 7 of 30 days; 5/18, 11 of 31 days ays. alified intellectual disabilities confirmed that data bjectives was not completed ional interview with the QIDP lata collection for all the ability to review for se as necessary. PRING & CHANGE Comprehensive functional client must be reviewed by eam for relevancy and not met as evidenced by: view and interview, the facility update the Comprehensive ent (CFA) for 3 of 3 sampled	W 25		Attached		8/24/18 110/18

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Kudel Ceny Program Administrator 7/18/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G267	B. WING _	B. WING		07/10/2018	
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1 KENMORE STREET ASHEVILLE, NC 28803				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 259	5/7/18. Further record comprehensive asses 6/21/16. Review of the assessment form revareas of daily living of identified needs. Addrevealed a vocational Review of the vocational Collent deficits in acadionly. Interview with the quaprofessional (QIDP) is have a current CFA to daily living skills. Further sealed she did not full CFA was completed clients current skill or areas of daily living. QIDP confirmed the form complete a CFA annual B. The facility failed #3 relative to daily living revealed an ISP date review revealed an ISP date review revealed a conform completed 9/6/10 comprehensive assessment in the arrocational skills to in Further record review assessment dated 2/1/10/20 vocational assessment academic and vocational assessment academic and vocational assessment academic and vocational skills assessment academic and vocational assessment academic and vocational assessment academic and vocational academic academi	al service plan (ISP) dated de review revealed a sement form completed ne 6/21/16 comprehensive ealed no assessment in the revocational skills to indicate ditional record review assessment dated 2/28/18. It is in assessment revealed emic and vocational skills alified intellectual disabilities revealed client #2 did not perflect skills or deficits in or reflect the reflect or updated to reflect the functioning level related to Further interview with the facility's procedure was to ually. It is update the CFA for client region of the sement form revealed no reas of daily living or dicate identified needs. It is revealed a vocational 28/18. Review of the sement revealed client deficits in	W 2				

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Hede Cay Program Administrator 7/18/18

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DEPARTMENT OF HEALTH AND HOWAN SERVICES	FORM APPROVEL
CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G267	B. WING		0	7/10/2018	
NAME OF PROVIDER OR SUPPLIER WNC GROUP HOME - KENMORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1 KENMORE STREET ASHEVILLE, NC 28803				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 259	deficits in daily living the QIDP revealed shad ever had an assigned skills or functioning the client's admission further interview with admission and annual control of the facility's procedure shadmission and annual control of the facility failed facility failed the facility failed facility faile	re a current CFA to reflect g skills. Further interview with she did not know if client #3 sessment to reflect current level in daily living skills since on to the facility in 8/2017. It the QIDP confirmed the was to complete a CFA uponually. It to update the CFA for client of daily living. For example: If of client #1 on 7/10/18 and 1/29/18. Further record comprehensive functional last completed on 6/27/16. It did not reveal assessment in ving or vocational/educational ecord review revealed only a nall assessment completed on 1/20/18 revealed client #1 ent CFA to reflect skills or g skills. Further interview with it the facility's procedure was	W 259				

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Land Coy Program Administrator 7/18/15

Plan Of Correction Kenmore Annual Recertification Survey July 9-10, 2018

W 195 Active Treatment Services

The facility must ensure that specific active treatment services requirements are met.

The Facility will ensure that all areas of Active Treatment are fully in compliance as referenced in each subsequent area W 227, W252, W257 and 259.

The Facility will ensure that all areas of Active Treatment are fully in compliance as referenced in each subsequent area W 227, W252, W257 and 259.

This will be monitored by the Program Administrator, and the QIDP.

W 196 Active Treatment

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:

- (i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and
- (ii) The prevention or deceleration of regression of loss of current optimal functional status.

The Facility will ensure that all areas of Active Treatment are fully in compliance as referenced in each subsequent area W 227, W252, W257 and 259.

This will be monitored by the Program Administrator, and the QIDP.

This will be completed by August 24, 2018



W 227 Individual Program Plan

The Individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

The facility will ensure that an updated CFA is completed for all residents. Goals and objectives will be written and implemented based on the needs identified and prioritized by the IDT. The facility will further ensure that academic/vocational needs identified in the CFA will be also be prioritized and goals written to compliment skills worked on in the IEP for each individual.

This will be completed, monitored and updated annually by the QIDP

This correction will be completed by August 24, 2018

W 252 Program Documentation

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

The facility will ensure that all data is collected according to the frequency listed in each program for all residents. A data collection checklist will be utilized and initialed by each DSP as data collection is completed. A data collection "Buddy Check" will be completed daily to ensure that a second staff member is looking at all programs scheduled for any given shift. Retraining on the importance of accurate data collection will be done with all DSP staff.

A review of data collection will be done weekly by the QIDP

This correction will be implemented by August 24, 2018

W 257 Program Monitoring and Change

The individual program plan must be reviewed at least by the QP and revised as necessary, including but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.

The facility will ensure that programs and data collection are reviewed monthly with a progress note. Additionally, programs will be reviewed quarterly again with a progress note, and annually with the Annual Review plan process. Revisions will be made if there is 3 months of decline or lack of progress noted, or if criterion has been met on any given goal.

This will be completed by the QIDP, and further reviewed by the Program Administrator.

This correction will be implemented by August 24, 2018

W 259 Program Monitoring and Change

At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.

The facility will ensure that the Comprehensive Functional Assessment will be updated annually. Additionally, any needs identified in the CFA will be discussed with the team as part of the Annual Review Process, goals/needs prioritized and included as part of the completed plan.

This will be completed by the QIDP with input from the Interdisciplinary team.

This correction will be implemented by August 24, 2018

Fuda / Cary Program Administrator 7/18/18