STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G076	A. BUILDING _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IWC-ROSE STREET HOME	1 ROSE STREET W ASHEVILLE, NC 28803

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of a complaint survey conducted on 7/1/19 and 7/2/19 for Intake #'s NC152820 and NC152822.	W 000		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide recommended adaptive dining equipment for 1 of 3 sampled clients (#6). The finding is: Observations in the group home on 7/1/19 at 5:35 PM revealed client #6 to be seated at the dining table for the evening meal. The client was seated with his legs and feet crossed in the chair. The meal consisted of beef a roni and chopped, cooked carrots. The adaptive equipment for client #6 consisted of a regular large silver spoon, high sided sectional scoop plate, and a no spill rimmed cup. Further observations on 7/2/19 at 7:00 AM revealed client #6 to be seated at the dining table for the breakfast meal, and only the client's toes were reaching the floor. The meal consisted of scrambled eggs, grits and chopped toast. The adaptive equipment consisted of a small to medium sized maroon spoon, high sided sectional scoop plate and a no spill rimmed cup. Review of the record for client #6 on 7/2/19 revealed an individual service plan (ISP) dated	W 484		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G076	A. BUILDING _____ B. WING _____	07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IWC-ROSE STREET HOME	**1 ROSE STREET W ASHEVILLE, NC 28803**

(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 484	Continued From page 1 7/19/18. The ISP included a Mealtime Procedure document signed by the occupational therapist and dated 3/20/19, which included adaptive equipment recommendations for a built up handle youth spoon, sectional scoop plate, no spill rimmed cup. It also indicated the client's feet should be "propped on a table base for support". Interview with the qualified intellectual disabilities professional on 7/2/19 confirmed the Mealtime Procedure for client #6 was current and confirmed that staff should have assured client #6 was provided a built up handle youth spoon for both meals and should have assured a table base was provided to support the client's feet during both meals.	W 484		