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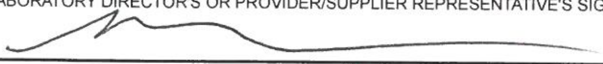
	34G334	A. BUILDING ______ B. WING ______	06/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IWRC-DOGWOOD	2 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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clothing fit properly for 1 of 3 sampled clients (#5) relative to pant size. The finding is: Observations in the group home on 6/26/2019 at 6:12 AM, revealed staff E to pull up the pants of client #5 in the kitchen. Further observation revealed client #5 did not have on a belt. Observation from 6:12 AM to 6:27 AM revealed client #5's pants continued to slide down exposing her backside as the client ambulated in the group home. At 6:27 AM, this surveyor alerted the qualified intellectual disabilities professional (QIDP) on site to the observation of client #5's pants consistently falling from her waist. Further observation at 6:35 AM revealed the QIDP prompted client #5 to her room to assist the client with pulling up her pants and putting on a belt. Review on 6/26/19 of client #5's record revealed a habilitation plan (HP) dated 8/30/18. Review of the 8/30/18 habilitation plan revealed documentation that client #5 requires cues to use both hands to pull up pants completely and for straightening her clothing. Interview with the qualified intellectual disabilities professional (QIDP) on 6/26/19 revealed staff	W 137	**Correction:** Staff will be in serviced and retrained to ensure that consumers are wearing proper fitting clothes or accessories. **Prevention:** On 1st shift morning assignments, a staff will be assigned to ensure that clients clothing fit properly. A quarterly clothing Inventory will be done to ensure clothing is fitting properly and appropriately sized. **Monitoring** and how often: Assigned staff will monitor daily to ensure clients are wearing proper fitting clothing. House Manager, shift supervisor and client advocate will do clothing inventories once a quarter to ensure that clothing is sized appropriately. RECEIVED JUL 1 $ 2019 DHSR NH L & C Black Mountain / WRO	8/9/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE President & CEO

(X6) DATE 7/12/19

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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W 137	Continued From page 1 failed to appropriately prompt client #5 to keep her pants pulled up and to ensure that the client's clothing fit appropriately.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure staff were appropriately trained relative to the use of a gait belt for 1 of 3 sampled clients (#6). The finding is: Observations in the facility on 6/25/19 at 5:06 PM revealed staff A and staff D to transfer client #6 from a wheelchair to a recliner in the living room of the group home. Further observations of the transfer revealed staff A holding client #6 around the waist with both hands while staff D grabbed the client by the back of his pants and transferred the client. Further observations did not reveal the use of the gait belt the client was wearing during the transfer. Continued observations at 6:00 PM revealed staff D to transfer client #6 from a wheelchair to a chair at the kitchen table by grabbing the back of the client's shirt and physically guiding the client into the chair. Staff D was further observed to not use the gait belt that was visually fastened around the client's waist during the transfer. Review of the records for client #6 on 6/26/19	W 189	**Correction:** Staff will be retrained and in serviced on the proper use of gait belts and which clients are to use them. **Prevention:** Staff on first shift will be assigned to check each consumer who has a gait belt to ensure the belt is on and properly secured. **Monitoring and how often:** The Shift Supervisor will monitor staff and clients Daily to ensure their gait belts are being used properly. House Manager and QIDP will randomly monitor clients that use gait belts to ensure they have them on and are being used properly.	8/9/2019

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W 189	Continued From page 2 revealed a individual habilitation plan (IHP) dated 9/13/18. Review of the 9/13/18 IHP revealed documentation that the gait belt for client #6 is necessary equipment needed for transfers. Further record review for client #6 revealed an occupational therapy (OT) evaluation dated 9/12/18. Review of the current OT evaluation revealed that client #6 must wear a gait belt when ambulating with staff assistance. Review of the physical therapy (PT) evaluation dated 9/10/18 revealed that caregiver contact assistance guarding with a gait belt will continue to be necessary. Interview with the qualified intellectual disabilities professional (QIDP) on 6/26/19 revealed that a two-person transfer is needed with client #6 while also using the client's gait belt. The QIDP further confirmed that staff should have used the client's gait belt during all transfers as recommended in current evaluations.	W 189		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) 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. This STANDARD is not met as evidenced by: Based on observation, review of records and interview the individual habilitation plan (IHP) failed to have sufficient interventions to address identified needs in communication skills for 1 of 3 sampled clients (#3). The finding is:	W 227	**Correction:** QIDP will discuss with Speech consultant the implementation of a communication device program to use a big Mac Switch at meals for client #3. QIDP and/ or Speech therapist will in service and train staff on use of communication devices at meal time for client #3. **Prevention:** QIDP will ensure that meal guidelines are updated, include all Adaptive equipment and are placed so that staff can reference them easily. House Manager and QIPD will randomly complete meal assessments to ensure proper equipment is being used. **Monitoring and how often:** Shift Supervisor will monitor daily to ensure proper equipment is being used. House Manager and QIDP will randomly complete assessments of meal time.	**8/9/2019**

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W 227	Continued From page 3 Observations during the 6/25-26/19 survey revealed client #3 to be mostly non-verbal and to use a wheelchair for ambulation. Client #3 was observed to use gestures and vocalizations to communicate with staff. Continued observations revealed staff to use verbal prompts and physical assistance to transition the client to various activities such as leisure activities, time in room, meal participation and medication administration. Further observations of client #3's meals revealed the client's place setting to consist of adaptive equipment that included a lap tray, high sided scoop plate, built up angled spoon, nosey cup, shirt protector, hand splint and dycem mat. At no time was it observed during meals or any other time of the survey for client #3 to use big mack switches to communicate wants or needs with staff. Review of records for client #3 on 6/26/19 revealed a individual habilitation plan (IHP) dated 6/19/19. Review of the IHP revealed a communication evaluation dated 6/10/19 that revealed client #3 is unable to express wants/needs verbally. Further review of the 6/10/19 communication evaluation revealed to increase client #3's control over his environment, the use of big mack switches to communicate basic wants/needs during mealtime is recommended. Interview with the qualified intellectual disabilities professional (QIDP) on 6/26/19 verified client #3 did not currently have a communication objective relative to utilizing a big mack switch. Further interview with the QIDP verified a communication objective relative to the recommendations of the current communication evaluation should have been implemented for client #3.	W 227		

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W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, review of records and interview the facility failed to ensure sufficient interventions were implemented as prescribed in the behavior support plan for 1 of 3 sampled clients (#5). The finding is: Observations in the group home on the morning of 6/26/2019 at 7:16 AM revealed client (#5) to be verbally prompted by staff G to the medication room. Further observation revealed client #5 to scream, hit herself in the face, and pace the floor in the hallway and kitchen while staff G physically guided client #5 to the medication room. Continued observation at 7:18 AM revealed client #5 entering the medication room, pushing items off the table to the floor until staff G closed the door to the medication room. Subsequent observation at 7:22 AM revealed staff to open the door to the medication room and numerous items were observed on the medication room floor. Additional observation revealed client #5 to appear calm, exit the medication room and walk to the living room of the group home. Observation at 7:25 revealed staff G to clean up the medication room, removing items from the	W 249	**Correction:** Staff will be in serviced and retrained on client #5's Behavior Plan and interventions during a behavior by Psychologist. **Prevention:** Staff will be in serviced as needed to ensure that behavior plans continue to be accurately implemented and evaluated. **Monitoring and How Often:** Psychologist and QIDP will review Behavior Plans quarterly. House Manager and QIDP will do random assessments and training with staff to ensure knowledge of behavior programs are current.	**8/9/2019**

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W 249	Continued From page 5 floor. Review of record for client #5 on 6/26/19 revealed a behavior support plan (BSP) dated 3/16/18. Review of the 3/16/18 BSP revealed target behaviors that included yelling, screaming, self-injurious behaviors, and AWOL. Further review of the 3/16/18 BSP revealed prevention measures to target behaviors include staff redirecting unsafe behaviors, to move away from client when aggressive and to give time/space to calm, and to direct the client to clean up any mess she makes. Interview with staff G on 6/26/19 at 7:22 AM revealed that client #5 had a behavior in the medication room and threw items in the floor. Interview with the facility qualified intellectual disabilities professional (QIDP) on 6/26/19 verified client #5's BSP to be current. Further interview with the QIDP verified staff should have given client #5 time and space to calm when the client became aggressive and staff should have supported client #5 with providing the opportunity to clean up any mess that was the result of a behavior. Further interview with the QIDP verified staff did not implement the behavior plan for client #5 as written and prescribed.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.	W 340	**Correction:** A new hands free trash can will be purchased by House Manager. Staff will also be trained and in serviced on general hygiene practice and proper hand washing technique. **Prevention:** The duty rosters will be revised to ensure that the trash can is cleaned during the shift and at the end of the shift to ensure proper sanitation. **Monitoring and How often:** House Manger and QIDP will do random environmental assessments. Third shift observations will also include general checks for sanitation.	**8/9/2019**

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W 340	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the interdisciplinary team failed to provide staff training of appropriate hygiene practices relative to meal preparation and client care. The finding is: Observations in the group home on 6/25-26/19 revealed the dinner and breakfast meals to be prepared in the kitchen of the group home. Observation of the kitchen trash can revealed residue from multiple meals and a flip top lid that required touching the trash can lid to throw away trash during meal preparation. Observation on 6/26/19 revealed staff E to clean the kitchen area after the breakfast meal and to throw trash into the trash can, touching the top of the trash can without gloves. Further observation revealed staff G to enter the living room to engage in client care without washing her hands. Interview with the home manager (HM) on 6/26/19 verified the kitchen trash can in the group home was dirty and had residue from various past meals indicating the trash can had not been cleaned for an undetermined amount of time. Interview with the qualified intellectual disabilities professional (QIDP) on 6/26/19 confirmed staff should have washed their hands after cleaning in the kitchen before engaging in client care. Additional interview with the HM and QIDP confirmed the condition of the kitchen trash can was not acceptable and created hygiene concerns for the group home.	W 340		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1)	W 435		

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W 435	Continued From page 7 The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide sufficient space in dining for 2 of 3 sampled clients (#3 and #4) relative to wheelchair needs. The finding is: Observation on 6/25/19 at 5:55 PM revealed staff to assist client #4 with entering the dining area as the client sat in her wheelchair. Continued observation revealed staff to angle client #4 around large bins placed in the kitchen along the wall to allow the client to get to the kitchen table. Client #4's wheelchair was observed to get caught on the edge of a bin that staff had to readjust the client around. Interview with the home manager on 6/25/19 revealed the bins in the kitchen area contained the emergency supplies for the group home to include the food supply and the group home was limited with storage options. Further interview with the HM verified the bins get in the way of mobility for client's in the home and need to be moved. Observation on 6/26/19 at 5:50 AM of the dining area of the group home revealed the large bins with emergency supplies for the group home had been moved to an opposing wall of the dining room after observation and interview with the HM	W 435	**Correction:** All Non-essential items will be removed from the client activity spaces to ensure that clients have ample space to maneuver. **Prevention:** Third Shift observations will have a section to be added to ensure client activity spaces are unobstructed. **Monitoring and How Often:** Monitoring will take place on 3rd shift observations done by House Managers, QIDP Program Director and Quality Assurance Director twice monthly.	**8/9/2019**

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W 435	Continued From page 8 on 6/25/19. Further observation on 6/26/19 at 6:00 AM revealed staff to assist client #3 with ambulating to the dining table as the client sat in his wheelchair. Subsequent observation revealed staff to have limited space to get client #3 to his place setting due to the new location of the kitchen storage bins. The qualified intellectual disabilities professional (QIDP) was observed to enter the dining area and assist with moving the kitchen table further from the bins to allow client #3 more space to access his place setting. Subsequent observation revealed staff to angle client #3 at his place setting to further support the client with needed space at the table. Interview with the QIDP on 6/26/19 verified the storage bins in the dining room of the group home impeded ambulation space needed for clients #3 and #4 at the dining table. Further interview with the QIDP revealed the storage bins would be moved to ensure space for ambulation of all clients.	W 435		
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, record review and interview, the facility failed to provide recommended adaptive dining equipment for 1 of 3 sampled clients (#3). The finding is: Observations in the group home on 6/25/19 at	W 484	**Correction:** QIDP will in service and train staff on use of adaptive equipment at meal times. **Prevention:** QIDP will ensure that meal time guidelines are updated, include all Adaptive equipment and are placed so staff can reference them easily. House Manager and QIPD will randomly complete meal assessments to ensure proper equipment is being used. **Monitoring and how often:** Shift Supervisor will monitor daily to ensure proper equipment is being used. House Manager and QIDP will randomly complete assessments.	**8/9/2019**

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W 484	Continued From page 9 5:55 PM revealed client #3 to be seated in a wheelchair at the dining table for the evening meal. The meal consisted of baked chicken, mashed potatoes, mixed vegetables and peaches. The adaptive equipment for client #3 consisted of a lap tray, high sided scoop plate, built up angled spoon, nosey cup, shirt protector, hand splint and dycem mat. Further observations on 6/26/19 at 6:25 AM revealed client #3 to be assisted by staff to the dining table for the breakfast meal. The meal consisted of toast, a banana and almond milk. Observation of adaptive equipment at the breakfast meal included a high sided scoop dish, nosey cup, dycem mat, built up angled spoon and shirt protector. Subsequent observation at the breakfast meal revealed staff F to assist with feeding client #3 while placing the client's plate in the client's lap and allowing spillage from the meal to spill on the client and into the client's chair. Observation at 6:40 AM revealed staff F to apply client #3's hand splint and to interrupt the client's meal to apply the lap tray to the client's wheelchair after prompting from the home manager. Continued observation revealed staff to place the client's dish on the client's lap try and for client #3 to complete his breakfast meal with staff assistance. Review of the record for client #3 on 6/26/19 revealed an individual habilitation plan (IHP) dated 6/19/19. The IHP included a nutritional assessment dated 6/10/19 that documented when client #3 is eating he needs his lap tray 3" above the table with the wheelchair belt secure and the chair slightly tipped back. Further review of the 6/10/19 nutritional assessment revealed adaptive equipment to include a wrist support splint, large built up angled spoon, scoop dish	W 484		

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W 484	Continued From page 10 and dycem mat. Continued record review for client #3 revealed a occupational therapy (OT) assessment dated 6/10/19 that documented client #3 is dependent on staff for self feeding. Interview with staff F on 6/26/19 revealed client #3's wrist splint and lap tray were not initially utilized with the client's breakfast meal as she forgot to use them. Interview with the qualified intellectual disabilities professional on 6/26/19 verified a lap tray and wrist splint should be utilized with client #3 at all meals and the client's meal should never be placed directly into the client's lap.	W 484		