DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W ASHEVILLE, NC 28803 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 12/15/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W ASHEVILLE, NC 28803 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE		OF DEFICIENCIES F CORRECTION	IENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		E SURVEY		
NAME OF PROVIDER OR SUPPLIER 12/15/2020							С
INTRC-DOGWOOD WRC-DOGWOOD SIMMARY STATEMENT OF DEFICIENCIES PRETA GRAPH EPROGRAPH REGULATORY OR LSC IDENTIFYING INFORMATION) PRETA REGULATORY OR LSC IDENTIFYING INFORMATION) W 331 NURSING SERVICES CFR(s): 483.480(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in socordance with the needs of client (#1) relative to dental care. The finding is: A review of records for client #1 revealed a diagnosis history to include severe intellectual disability and Lennox-Cestaut syndrome. Further review of records for client #1 revealed an individual support plan dated 86/20. Review of dental records for client #1 revealed on individual support plan dated 86/20. Review of dental records for client #1 revealed on soulds acted: 11/15/18, 3/27/19, 5/20/19, 6/20/19, 7/9/19, 1/27/20, 7/4/20, 10/22/20 and 10/29/20. Review of the 11/15/18 commendation. Review of the 3/27/19 consult revealed the consults revealed no evidence of a follow-up with the 11/15/18 recommendation. Review of the 3/27/19 consult revealed the client was unable to be seen today at the dental office due to not being at the home for pick up this moming. Review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued			34G334	B. WING		12	-
ASHEVILLE, NC 28803 PROVIDERS PLAN OF CORRECTION PREFIX (PACH DEPTICIENCY MUST BE PRECODED BY PULL PREFIX (PACH DEPTICIENCY MUST BE PRECODED BY PULL PREFIX (PACH DEPTICIENCY MUST BE PRECODED BY PULL PREFIX TAG NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in accordance with the needs of client (#1) relative to dental care. The finding is: care. The finding is: A review of records for client #1 revealed a diagnosis history to include severe intellectual disability and Lennox-Gestaut syndrome. Further review of records for client #1 revealed an individual support plan dated 8/5/20. Review of dental records for client #1 revealed consults dated: 111/5/18, 327/19, 5/20/19, 8/20/19, 7/3/19, 1/27/20, 7/14/20, 10/22/20 and 10/29/20. Review of the 111/5/18 consult revealed the patient presented after a fall, unable to diagnose #8 and #9 at this time: follow up in 4 weeks after healing. Continued review of medical consults revealed no evidence of a follow-up with the 111/15/18 recommendation. Review of the 3/27/19 consult revealed the client was unable to be seen today at the dental office due to not being at her home for jok up this morning. Review of electronic communication between the guardian to report client #1 was assessed by a dentation of 16/19 due to a fall on 4/14/19. Continued review of deetcronic communication revealed the guardian to report a ASHEVILLE, NC 28808 PROVIDENCE CORRECTION PROUDED STOULD BE CROSS-REFERENCENT TO THE APPROPRIATE SIGNATION PREFIX PREFIX PREFIX PREVICE CORRECTION PROVIDENCY PREFIX PREFIXENCY PREFIX PREVICE CORRECTION PROVIDENCY PREFIX PREVICE CORRECTION CORRECTION CORRECTION PREFIX PREVILE TO CORRECTION PROVIDENCY PREFIX PREVILE TO CORRECTION PROVIDENCY PREFIX PREVILE TO CORRECTION PROVIDENCY PREFIX PREVILE TO CORRECTION PROV	NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	71012020
W 331 NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in accordance with the needs of client (#1) relative to dental care. The finding is: A review of records for client #1 on 12/15/20 revealed an admit date of 7/12/1/18. Continued review of records for client #1 revealed a diagnosis history to include severe intellectual disability and Lennox. Gestaut syndrome. Further review of records for client #1 revealed an individual support plan dated 6/5/20. Review of dental records for client #1 revealed consults dated: 11/15/18, 3/27/19, 5/20/19, 6/20/19, 7/8/19, 1/27/20, 7/14/20, 10/22/20 and 10/29/20. Review of the 11/15/18 consult revealed the patient presented after a fall, unable to diagnose #8 and #9 at this time; follow up in 4 weeks after healing. Continued review of medical consults revealed no evidence of a follow-up with the 11/15/18 recommendation. Review of the 3/27/19 consult revealed the client was unable to be seen today at the dental office due to not being at the home for jok up this morning. Review of electronic communication revealed the guardian to report client #1 was assessed by a dentation of 4/15/19 trevealed the guardian to report client #1 was assessed by a dentation of 4/15/19 trevealed the guardian to report client #1 was assessed by a dentation of 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report client #1 was assessed by a dentation of 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a fall in the fall of the factor of the fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a fall on 4/14/19. Continued review of electronic c	IWRC-DO	GWOOD					
W 331 NURSING SERVICES CFR(s): 483.480(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services in accordance with their needs. A review of records for client #1 or 12/15/20 revealed an admit date of 7/27/18. Continued review of records for client #1 revealed a diagnosis history to include severe intellectual disability and Lennox. Gestaut syndrome. Further review of records for client #1 revealed a nindividual support plan dated 8/6/20. Review of dental records for client #1 revealed consults deted: 11/15/18, 3/27/19, 6/20/19, 1/37/20, 7/14/20, 1/0/22/20 and 1/0/29/20. Review of the 1/115/18 consult revealed the patient presented after a fall, unable to diagnose #3 and #9 at this time; follow up in 4 weeks after healing. Continued review of medical consults revealed on evidence of a follow-up with the 11/15/18 recommendation. Review of the 3/27/19 consult revealed the client was unable to be seen today at the dental office due to not being at the home for jok up this morning. Review of electronic communication revealed the guardian to report client #1 was assessed by a dentation of reflection of the cord. Afford revealed the guardian to report client #1 was assessed by a dentation of reflectionic communication revealed the guardian to report client #1 was assessed by a dentation of reflectionic communication revealed the guardian to report client #1 was assessed by a dentation of reflectionic communication revealed the guardian to report client #1 was assessed by a dentation of reflectionic communication revealed the guardian to report client #1 was assessed by a dentation of report client #1 was assessed by a dentation of reflectionic communication revealed the guardian to report client #1 was assessed by a dentation of report client #1 was assessed by a dentation of report client #1 was assessed by a dentation of report client #1 was assessed					ASHEVILLE, NC 28803		
CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility falled to provide nursing services in accordance with the needs of client (#1) relative to dental care. The finding is: A review of records for client #1 on 12/15/20 revealed an admit date of 7/27/18. Confinued review of records for client #1 revealed a diagnosis history to include severe intellectual disability and Lennox-Gestaut syndrome. Further review of records for client #1 revealed an individual support plan dated 8/6/20. Review of dental records for client #1 revealed consults dated: 11/15/18, 3/27/19, 5/20/19, 6/20/19, 7/9/19, 1/27/20, 7/14/20, 10/22/20 and 10/29/20. Review of the 11/15/18 consult revealed the patient presented after a fall, unable to diagnose #8 and #9 at this time; follow up in 4 weeks after healing. Continued review of medical consults revealed no evidence of a follow-up with the 11/15/18 recommendation. Review of the 3/27/19 consult revealed the client was unable to be seen today at the dental office due to not being at her home for pick up this moming. Review of electronic communication revealed the guardian to report client #1 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a lent #4 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a lent #4 was assessed by a dentist on 4/15/19 due to a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a lent #4 fall be a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a lent #4 fall be a fall on 4/14/19. Continued review of electronic communication revealed the guardian to report a lent #4 fall be a fall on 4/14/19. Continued review of electronic communication revealed the gua	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
communication revealed the guardian to report a RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	t v c c n b 4 w	CFR(s): 483.460(c) The facility must proservices in accordance of the facility must proservices in accordance of the facility must proservice of the facility must proservice of the facility of the facility of the facility and	and met as evidenced by: wiew and interview, the facility sing services in accordance ent (#1) relative to dental: for client #1 on 12/15/20 ate of 7/27/18. Continued a client #1 revealed a include severe intellectual acceptatus syndrome. Further and dated 8/6/20. Fords for client #1 revealed an endated 8/6/20. Fords for client #1 revealed for client #1 revealed and the 11/15/18 consult presented after a fall, unable go at this time; follow up in 4. Continued review of medical evidence of a follow-up with endation. For consult revealed the client in today at the dental office er home for pick up this electronic communication and the facility nurse dated guardian to report client #1 entist on 4/15/19 due to a fall		Measure to Correct: Nurs staff will contact the guidocumentation for client's medical/dental services on the facility and enter their client's medical record. Nursing Dept staff will do the scheduling of dental a and/or attempts to scheduling and/or attempts to scheduling the event the dentist is waccept the client or scheduling Dept will ensure to staff know there is an appear to be at the at least one day before and least one day before and for the client to be at the to leave for the appointment house staff will make sure is ready to go. Nursing Dept staff will be on how to document appoint and follow-ups in the election and follow-ups in the elections.	ardian for eceived atside of a into occurrent oppointment of edental we date/come in mable to whether the chief the clief trained thereof	
RATORT DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					_	44	
	RATORY DIR	ECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		VDATE /

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 the program participation.

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

Event ID: WU3311

Facility ID: 956171

If continuation sheet Page 1 of 4

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		34G334	B. WING_		С
IWRC-DC (X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W ASHEVILLE, NC 28803 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
i i i i i i i i i i i i i i i i i i i	dental appointment for for 5/24/19 for a clean additional work and appre-op physical. Reviewerevealed: Dental pre-o (for surgery). Subsequest treatment revealed no appointment on 5/24/2 occurred. Review of the 6/20/19 treatment for a fall, cliefell face forward on the related to the 6/20/19 opain with Tylenol/Ibuprodentist. If tooth falls out to ER. Review of a 7/9 revealed client #1 prese evaluation. Limited exa comprehensive exam we completed. Patient is a comprehensive treatment (OR). Return appointment of the consultation of the consultation of the revealed no evidence of 7/9/19 consult and no as were available until 1/27/20 direvealed the recomment exam and cleaning as occurred. Review of fucilient #1 revealed no evidence of fucilient	r client #1 was scheduled ing, filling and any opointment would require a sew of the 5/20/19 consult p due to epilepsy; cleared unt review of dental documented evidence the 0 for client #1 had medical consult revealed int #1 had a seizure and floor. Review of orders consult included: control of and try to get into the put tooth in milk and go interest for a dental memoral consult included: consult included: control of and try to get into the put tooth in milk and go interest for a dental memoral consult included for a dental memoral for a dental memoral for a dental memoral for a dental memoral for client #1 for a follow-up from the diditional dental consults for client #1 for a follow-up from the diditional dental consults for client #1 dation for referral for full inly a partial exam was rither dental records for idence of a full exam as 17/20 dental consult. No is were available for	W 33	Measures to Prevent: Nursing Care for each client. Who will Monitor: The Q Nursing Coordinator will reach all dental ments. How Often: The Mursing Ca will monitor this schedule monthly basis.	rough y of all indicated, dental IDP + nonitor for each appoint

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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	
		34G334	B. WNG		_	١	C
NAME OF PROVIDER OR SUPPLIER IWRC-DOGWOOD			STREET ADDRESS, CITY, STA 2 ROSE STREET W ASHEVILLE, NC 28803	ATE, ZIP CODE	1 12	/15/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC) CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	E TE	(X5) COMPLETION DATE
W 33	evaluation was for a for Continued review reverse probable fracture of the damage to anterior may problems unable to be Subsequent review of revealed physician ord sustained. Trauma to require treatment. Pat Other dental needs we due to poor cooperation to touch her mouth. Resunder general anesthest consults or documental 10/22/20. Review of dental records a pre-op appointment for comprehensive dental edit of dental records for clied dental operation. Review procedure for client #1 regeneralized decalcificating generalized decalcificating generalized gingivitis and Further review of the 10 revealed involved proce extractions, prophy and Subsequent review reverse extracted due to an in #26 and a luxated #9. Interview with the facility disabilities professional (has seizures and has ha admission that resulted in Interview with the facility	ollow-up with a dental injury. Italed a diagnosis of e anterior maxilla or exillary teeth, other determined at this visit. Ithe 7/14/20 dental consult ers to reflect: Patient is maxillary anterior teeth that ient appears to be in pain. It unable to be assessed In, she will not allow anyone commend treatment in OR Isia. No additional dental ition was available until Is dated 10/22/20 revealed or client #1 relative to a exam. Continued review ent #1 revealed a 10/29/20 ew of the 10/29/20 dental revealed findings of: ue and calculus, ion, missing #8 and #23, id periodontal disease. //2020 dental operation dures to include: dental fluoride varnish. aled (2) teeth needed to infection associated with qualified intellectual QIDP) verified client #1 d a couple of falls since in dental injuries. Inurse on 12/15/20 Ithe position and started	W	331			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G334	B. WING		1	Ç
NAME OF PROVIDER OR SUPPLIER IWRC-DOGWOOD			STF 2 R	REET ADDRESS, CITY, STATE, ZIP CODE OSE STREET W HEVILLE, NC 28803	12/	15/2020
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE !	(X5) COMPLETION DATE
1	going to the emergene 7/14/20. Further inter revealed she was una treatment client #1 ha beginning her position how to look up dental documentation system. Interview with adminis were present in address care. Further interview verified the inability to documentation if client comprehensive dental prior to 10/29/20. Sub	d assisted client #1 with cy room after a fall on view with the facility nurse ware of any dental d received prior to and she was unaware of history in the n used by the facility. tration staff verified gaps ssing client #1's dental v with administration staff determine in #1 had received a evaluation since admission sequent interview with nursing services had failed	W 331			