STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G354	A. BUILDING _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMORY ROAD HOME	**20 EMORY ROAD ASHEVILLE, NC 28806**

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted timely. The finding is: Observations in the group home on 2/23-2/24/21 revealed the bedroom door of client #1 to have a large crack to run across the entire middle of the door. Continued observation of client #1's bedroom door revealed the door frame to be broken with missing wood and the hinge at the bottom of the door to be unattached from the frame with exposed screws protruding from the hinge. Review of internal facility records on 2/24/21 revealed a work order dated 3/16/20 that indicated client #1's door needed to be replaced. Continued internal record review revealed a safety check list dated 2/5/21 that indicated client #1's bedroom door was damaged. Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #1's door had been in need of replacement since 3/2020. Continued interview with the QIDP revealed she was unaware damage to client #1's door involved the frame or an unattached hinge with exposed screws. Interview with the QIDP and administration staff revealed in 3/2020 all	W 104		

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

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W 104	Continued From page 1 bedroom doors in the group home were approved to be replaced with metal doors and the health pandemic had prevented doors from getting replaced. Additional interview with administration staff and the QIDP on 2/24/21 revealed maintenance staff would be replacing client #1's door on the current date. Subsequent interview with the QIDP verified client #1's door should have been replaced more timely due to the extent of the damage to the door with broken wood in the frame, an unattached hinge and exposed screws.	W 104		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain adaptive equipment in good repair relative to a helmet for 1 of 4 sampled clients (#1). The finding is: Observation in the group home throughout the 2/23-24/21 survey revealed client #1 to wear a helmet. Observation in the group home on 2/24/21 at 7:35 AM revealed client #1 to participate in his morning medication administration. Continued observation of client #1's medication administration revealed the client	W 436		

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W 436	Continued From page 2 to take off his helmet to apply a topical to his facial area. Further observation revealed the helmet of client #1 to have internal padding that was worn with damage and a piece of padding in the top of the helmet to be broken off with a small piece remaining. Review of records for client #1 on 2/24/21 revealed physician orders dated 12/17/20 that reflected adaptive equipment to include a helmet for safety during awake hours. Continued record review for client #1 revealed a diagnosis history of autism, moderate intellectual disability and seizure disorder. Review of internal facility records revealed an assessment of adaptive equipment for the facility dated 1/8/21, 1/15/21, 1/22/21 and 1/29/21 to reflect adaptive equipment was not applicable in the group home. Interview with nursing staff confirmed client #1's helmet is considered adaptive equipment and is needed due to seizures. Continued interview with nursing staff verified a foam pad was placed in the inside, top of client #1's helmet to address proper fit with client #1's glasses. Further interview with nursing and the facility qualified intellectual disabilities professional (QIDP) verified all adaptive equipment should be assessed with in home assessments to ensure all adaptive equipment is clean and in good condition. Additional interview with the QIDP verified it was unknown when the last time client #1's helmet had been assessed for repair needs.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to show evidence quarterly drills were conducted with each shift of personnel relative to third shift. The finding is: Review of the facility fire drill reports from 2/20 through 1/21 revealed one 3rd shift fire drill was conducted on 6/8/20 (2nd quarter). Further review of the fire drill reports revealed no evidence 3rd shift fire drills were conducted during the 1st, 3rd or 4th quarters of the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 2/23/21 confirmed 3rd shift fire drills should have been conducted quarterly over the review year. Continued interview with the QIDP confirmed there was no additional documentation to reflect 3rd shift drills were conducted during the 1st, 3rd or 4th quarters of the year reviewed.	W 440		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to to ensure food was served at the appropriate temperature for 1 of 1 sampled client (#1). The finding is: Observations in the group home on 2/23/21 at 4:40 PM revealed client's #2, #3 and #4 seated at	W 473		

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W 473	Continued From page 4 the dining table eating dinner. The food items on the table at that time consisted of salmon stir fry and three pitchers of drink items including milk, juice and water. Continued observations at 5:00 PM revealed client #1 to sit at the dining table for his dinner meal. The items on the table at that time included the drink items, consisting of the same pitchers of milk, juice and water. Further observations at 5:05 PM revealed client #1 to pour milk from the pitcher into a cup. Client #1 was observed to drink the milk at 5:15PM. At that time, the milk had been out of the refrigerator for at least 35 minutes. Continued observations at 5:30PM revealed client #5 to return the drink items to the kitchen, including the milk which was placed back into the refrigerator. Review of facility policy and procedures on 2/24/21 revealed a meal time staff training/assessment tool. Review of the internal training tool indicated that milk should not sit outside of refrigeration for more than 15 minutes, as well as indicating leftovers should be stored properly within appropriate time frames. Interview with the qualified intellectual disabilities professional on 2/24/21 confirmed milk should not have been allowed to remain un-cooled for more than 15 minutes and further confirmed the remaining milk in the pitcher should have been discarded.	W 473		