CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		E SURVEY PLETED
		34G334	B. WING			04	/08/2021
NAME OF PF	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1	00/2021
IWRC-DO	SWOOD			:	2 ROSE STREET W		
					ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMI CFR(s): 483.440(d)(1		w	249			
	each client must rece treatment program co interventions and serv and frequency to sup	ndividual program plan, ive a continuous active					
	Based on observation interview the facility fa active treatment prog 2 sampled clients (#4 client (#5). The findin A. The facility failed t	ailed to ensure a continuous ram to address the needs of and #6) and 1 non-sampled og is: o ensure continuous active					
	treatment to address example:	the needs of client #4. For					
	AM revealed client #4 living room asleep. (7 7:08 AM revealed clie bedroom then walk ba go back to sleep on th Subsequent observat sleep until the qualifie profession (QIDP) cha you okay?" at 7:38 AM continued to sleep.	ack to the living room and ne living room couch. ion revealed clients #4 to ad intellectual disabilities ecked on the client with "Are M after which the client					
	QIDP to check on clie continued to sleep. C	n at 7:50 AM revealed the ent #4 after which the client Observation at 7:53 AM SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

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

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.

PRINTED: 04/19/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

	-	D HUMAN SERVICES			FOR	D: 04/19/2021 M APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE	D. 0938-0391 E SURVEY PLETED
		34G334	B. WING		04	/08/2021
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL)E	
IWRC-DO	GWOOD			DSE STREET W HEVILLE, 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 CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 249	revealed staff to verba the bathroom and have checked in preparation home. Subsequent of to then exit the living it the group home. Review of records for an individual support of client #4's ISP rever- relative to leisure cho Review of the leisure given a picture board, leisure activity to perfi- review of the 2/1/21 le revealed materials to "walk", "game", "musi- schedule frequency to Continued review of ri- a behavior support pla Review of the 9/2020 target behaviors of av- disrobing, dropping to mouthing, leaving the aggression, pouring h- spitting, taking other's and yelling. Further ri- prevention measures to include the need to with things she enjoys Interview with the QIE #4 should have been with active treatment observations on 4/8/2 the QIDP verified clief	ally prompt client #4 to use ve her blood pressure in for leaving the group bservation revealed client #4 room and prepare to leave client #4 on 4/8/21 revealed plan dated 10/5/20. Review valed a training objective ice implemented 2/1/21. objective revealed when , client #4 will choose a orm with staff. Continued eisure objective for client #4 include a picture board of c", "movie" or "toy" with o be implemented daily. ecords for client #4 revealed an (BSP) dated 9/23/20. BSP for client #4 revealed voiding task, crying, o the floor, hand/finger building, physical user drink out, self-injury, a things, throwing objects eview of the BSP revealed to support target behaviors vkeep client #4 engaged s. DP on 4/8/21 verified client engaged more frequently options during the morning 1. Continued interview with nt #4's leisure objective	W 249			

Facility ID: 956171

If continuation sheet Page 2 of 10

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/19/2021 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G334	B. WING			_	04/	08/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
IWRC-DO	GWOOD				ROSE STREET W ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	in a preferred leisure a B. The facility failed to treatment to address a example: Observation in the gro AM revealed client #5 asleep. Continued ob to wake up at various recliner of the living ro sleep. Subsequent of to sleep until the QIDF "Are you okay?" at 7:3 continued to sleep. Further observation at QIDP to check on clie client continued to slee of client #5 revealed to AM when staff began the group home. Review of records for an individual support of client #5's ISP rever relative to activity cho Review of the activity the need of client #5 to language by using a si wants and needs. Co activity choice objective client will push one of to request an activity. materials to include tw placed on a table in th "I want to play on the say "I want to look at	activity other than sleeping. to ensure continuous active the needs of client #5. For oup home on 4/8/21 at 7:05 to sit in the living room oservation revealed client #5 times, begin to rock in the bom and then go back to bservation revealed client #5 P checked on the client with 38 AM after which the client tt 7:50 AM revealed the ent #5 and after which the eep. Additional observation the client to sleep until 8:05 preparing the client to leave the client #5 on 4/8/21 revealed plan dated 10/9/20. Review ealed a training objective bice implemented 6/1/20. choice objective revealed to increase expressive switch to communicate ontinued review of the ve for client #5 revealed the t two voice output switches Further review revealed wo talking output switches the activity room: One will say computer." The other will	W	249				

Facility ID: 956171

If continuation sheet Page 3 of 10

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/19/2021 APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		34G334	B. WING			_	04/	08/2021
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
IWRC-DO	GWOOD				ROSE STREET W ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	Continued From page implemented daily.	: 3	w	249				
	a BSP dated 9/23/20. for client #5 revealed on the head and bites the BSP revealed pre support target behavior	ors to include the need to : #5, talk to him often. Help						
	#5 should have been with active treatment observations on 4/8/2 the QIDP verified clief objective could have b the morning of 4/8/21	OP on 4/8/21 verified client engaged more frequently options during the morning 1. Continued interview with nt #5's activity choice been implemented during to attempt to engage the ctivity choice other than						
	-	o ensure continuous active the needs of client #6. For						
	the living room and slithat was on and playin observation at 7:50 A check on client #6 after to sleep. Further obsite to sleep until 8:10 AM client to prepare to lear Review of records for dated 9/21/20. Revie	M revealed the QIDP to er which the client continued ervation revealed client #6 I when staff prompted the						
		g others, leaving building,						

Facility ID: 956171

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/19/2021 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G334	B. WING		04/	/08/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
IWRC-DOO	3WOOD			ROSE STREET W SHEVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 249 W 475	Continued From page slamming doors, spitt verbal aggression. For revealed prevention in behaviors to include t and keep a routine; H enjoys. Interview with the QID #6 should have been with active treatment observations on 4/8/2 the QIDP verified client should have been offer engage the client in a other than sleeping. MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served This STANDARD is in Based on observation interview the facility fa appropriate utensils w sampled clients (#3, # non-sampled client (# finding is: A. The facility failed t utensils to client #6. If Observation in the group PM revealed client #6 meal with a place sett sectional scoop dish, spoon. Continued ob	 A 4 ing, throwing objects and urther review of the BSP neasures to support target he need to provide structure lelp her do things she DP on 4/8/21 verified client engaged more frequently options during the morning 1. Continued interview with nt #6 needs structure and ered activity options to preferred activity choice (iv) with appropriate utensils. not met as evidenced by: n, record review and ailed to ensure all vere provided to 3 of 3 #4 and #6) and 1 for 2 of 2 meals. The o provide appropriate consisted of a sip cup and a regular servation revealed the 	W 249			
		servation revealed the e: Turkey tetrazini, zucchini				

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	S FOR MEDICARE &					<u>10. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
		34G334	B. WING		o	4/08/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	E	
IWRC-DO	GWOOD			ROSE STREET W SHEVILLE, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 475	Continued From page	e 5	W 475			
	and crushed pineapp	le. Subsequent observation use a spoon to eat all meal				
	Observation in the group home on 4/8/21 at 7:05 AM revealed client #6 to participate in the breakfast meal with a place setting that consisted of a sectional scoop dish, sip cup and a regular spoon. Continued observation revealed the breakfast meal for client #6 to include: pancakes, sausage and yogurt. Subsequent observation revealed client #6 to use a spoon to eat all meal items.					
	an individual support Review of the ISP for to include: Functional feed self, functional fi review of records for nutritional assessmen the 8/2020 nutritional #6 is able to eat indep utensils correctly. Co current nutritional ass	nt dated 8/2/20. Review of assessment revealed client pendently and uses all ontinued review of the sessment for client #6 ses a fork, spoon and high				
	disabilities profession revealed client #6 is of spoon at meals. Con QIDP verified client # meals. The QIDP ad	ility qualified intellectual al (QIDP) on 4/8/21 capable of using a fork and tinued interview with the 6 prefers to use a spoon at ditionally verified client #6 fork and spoon at all meals.				
	B. The facility failed to utensils to client #3.					

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		MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G		E SURVEY IPLETED
		34G334	B. WING		0	4/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IWRC-DO	GWOOD			2 ROSE STREET W 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)	OULD BE	(X5) COMPLETIO DATE
W 475		e 6 oup home on 4/7/21 at 5:45	W 47	75		
	PM revealed client #3 meal with a place set divided dish, weighte and straw. Continued dinner meal to include and crushed pineapp	B to participate in dinner ting that consisted of a d spoon, and a cup with a lid d observation revealed the e: Turkey tetrazzini, zucchini le. Subsequent observation use a weighted spoon to eat				
	AM revealed client #3 breakfast meal with a of a divided dish, wei straw. Continued obs breakfast meal to incl and applesauce. Sub	place setting that consisted ghted spoon and a cup with servation revealed the lude: Pancakes, sausage,				
	an ISP dated 8/27/20 records for client #3 r evaluation dated 8/26 nutritional evaluation to eat and assist with Continued review of r client #3 revealed the weighted handled for cup with a lid and stra records for client #3 c occupational therapy 8/17/21. Review of th	c client #3 on 4/8/21 revealed b. Continued review of revealed a nutritional 6/20. Review of the 8/26/20 revealed client #3 to be able some basic feeding skills. nutritional evaluation for e client uses a built up k, spoon, sectional plate and aw. Subsequent review of on 4/8/21 revealed an (OT)evaluation dated he 8/17/21 OT evaluation lds her fork and spoon in a				
	Interview with the QII #3 can use a fork and	DP on 4/8/21 revealed client d spoon at meals. with QIDP verified client #3				

Facility ID: 956171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/19/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	
		34G334	B. WING			04/	08/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
IWRC-DO	GWOOD				2 ROSE STREET W ASHEVILLE, NC 28803		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 475	prefers to use a spool QIDP confirmed client fork and spoon at all r C. The facility failed t utensils to client #4. I Observation in the gro PM revealed client #4 meal with a place sett divided dish, regular o observation revealed Turkey tetrazzini, zuc Subsequent observat a spoon to eat all mea Observation in the gro AM revealed client #4 with a place setting th dish, plastic cup and s observation revealed include: Pancakes, sa Subsequent observat a spoon to eat all mea Review of records for an ISP dated 10/5/20. records for client #4 rn procedure completed therapist dated 8/19/2 mealtime procedure for client uses her right h spoon. Continued rev for client #4 revealed #4 to pierce foods wit mealtime procedure for	n at meals. Additionally, the t #3 should be provided a meals. to provide appropriate For example. Dup home on 4/7/21 at 5:45 to participate in dinner ting that consisted of a cup and spoon. Continued the dinner meal to include: chini and crushed pineapple. ion revealed client #4 to use al items. Dup home on 4/8/21 at 5:30 to participate in breakfast nat consisted of a divided spoon. Continued the breakfast meal to ausage and applesauce. ion revealed client #4 to use al items. To client #4 on 4/8/21 revealed . Continued review of evealed a mealtime by the occupational 20. Review of the 8/19/20 or client #4 revealed the and to feed herself with a view of mealtime procedure staff are to encourage client th a fork. Further review of or client #4 verified client #4 high sided sectional plate,	W	475	5		

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/19/2021 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION		(X3) DATE	
		34G334	B. WING				04/	08/2021
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
IWRC-DO	GWOOD				2 ROSE STREET W ASHEVILLE, NC 28803	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	Interview with the QIE #4 can use a fork and Continued interview w #4 prefers to use a sp the QIDP confirmed of a full place setting of D. The facility failed to utensils for client #1. Observation in the gro PM revealed client #1 meal with a place setting observation revealed Turkey tetrazzini, zuc Subsequent observat a spoon to eat all mean Observation in the gro AM revealed client #1 with a place setting the plate, cup and spoon. revealed the breakfass and sausage. Subsecclient #1 to use a spo Review of records for dated 6/18/20. Contin client #1 revealed a n 6/11/20. Review of the evaluation revealed the plate and cup at mean	DP on 4/8/21 revealed client d spoon at meals. with the QIDP verified client boon at meals. Additionally, client #4 should be provided all utensils at all meals. to provide appropriate For example. oup home on 4/7/21 at 5:45 I to participate in dinner ting that consisted of a d spoon. Continued the dinner meal to include: schini and crushed pineapple. don revealed client #1 to use al items. oup home on 4/8/21 at 6:30 I to participate in breakfast hat consisted of a regular . Continued observation est meal to include: Pancakes quent observation revealed oon to eat all meal items. client #1 revealed an ISP nued review of records for nutritional evaluation dated he 6/11/20 nutritional client #1 remains ime using a regular fork. he nutritional evaluation for e client uses a fork, spoon, ls.	W	475				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/19/2021 1 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		34G334	B. WING		_	04/	08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
IWRC-DO	GWOOD			2 ROSE STREET W ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	#1 prefers to use a sp	vith the QIDP verified client boon at meals. Additionally, ilient #1 should be provided	W 475				

Facility ID: 956171

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