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

PRINTED: 04/19/2021 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(40) 144		OMB	NO. 0938-039
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	ATE SURVEY
		34G334	B. WING			
IWRC-DO	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W ASHEVILLE, NC 28803		94/08/2021
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
t t t t t t t t t t t t t t t t t t t	CFR(s): 483.440(d)(1)  As soon as the interdiffermulated a client's interaction and service treatment program continterventions and service and frequency to supply objectives identified in plan.  This STANDARD is not assert the facility fail active treatment program 2 sampled clients (#4 active treatment program 2 sampled clients (#4 active treatment to address the facility failed to be active to address the facility failed to be active to address the facility failed to be active treatment to address the facility failed to be active to a facility failed to a faile	sciplinary team has idividual program plan, we a continuous active insisting of needed ices in sufficient number out the achievement of the the individual program.  It met as evidenced by: record review and ed to ensure a continuous in to address the needs of ind #6) and 1 non-sampled is:  In the individual program ensure continuous active in eneeds of client #4. For individual program is:  In the in	W 249		vior will eo be ry	
Q	ontinued to sleep. Obse	#4 after which the client				

ORATORY 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.

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

	STATEMENT	STATEMENT OF DEFICIENCIES  AND PLAN OF CORPECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039			
	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY OMPLETED
	NAME OF F	DDOL/IDED OF GUEST	34G334	B. WING				04/08/0004
IWRC-DOGWOOD  2 ROSE STREET W  ASHEVILLE, NC 28803  (X4) ID PREFIX (EACH DEFICIENCY MUST BE DEFCRED BY STREET)  PREFIX (EACH DEFICIENCY MUST BE DEFCRED BY STREET)  PROVIDER'S PL				04/08/2021				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE	(X5) COMPLETION DATE
	Ir # wool the st	the bathroom and have checked in preparation home. Subsequent obsto then exit the living rothe group home.  Review of records for can individual support plof client #4's ISP reveal relative to leisure choice. Review of the leisure obgiven a picture board, cleisure activity to perforreview of the 2/1/21 leis revealed materials to include frequency to be continued review of record behavior support plan Review of the 9/2020 BS arget behaviors of avoid disrobing, dropping to the potting, taking other's this individual. Further review of the need to keroith things she enjoys.  The continued review of record behaviors of avoid disrobing, dropping to the potting, taking other's this individual. Further review the prevention measures to so include the need to keroith things she enjoys.  The color of the province of the provinc	lly prompt client #4 to use e her blood pressure for leaving the group servation revealed client #4 som and prepare to leave lient #4 on 4/8/21 revealed an dated 10/5/20. Review led a training objective e implemented 2/1/21. Dejective revealed when lient #4 will choose a m with staff. Continued ure objective for client #4 clude a picture board of "movie" or "toy" with e implemented daily.  Dords for client #4 revealed (BSP) dated 9/23/20. SP for client #4 revealed ding task, crying, e floor, hand/finger ilding, physical drink out, self-injury, ings, throwing objects ew of the BSP revealed support target behaviors ep client #4 engaged  Don 4/8/21 verified client lagged more frequently ons during the morning Continued interview with 4's leisure objective	W	2249	DEFICIENCY)		

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(٧0) 1411	TID. C.		OMB	NO. 0938-0391
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		CONSTRUCTION		ATE SURVEY DMPLETED
NAME OF		34G334	B. WING				
	PROVIDER OR SUPPLIER		•	2 R	REET ADDRESS, CITY, STATE, ZIP CODE COSE STREET W HEVILLE, NC 28803		04/08/2021
(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 CROSS-REFERENCED TO THE APPROPRICIENCY)	DRE	(X5) COMPLETION DATE
t li li v s a c c t t c n p "'I s	in a preferred leisure a  B. The facility failed to treatment to address the treatment of the living room to sleep. Continued obstoned to sleep. Subsequent obstoned to sleep until the QIDP "Are you okay?" at 7:38 continued to sleep.  Further observation at "QIDP to check on client continued to sleep of client #5 revealed the AM when staff began put the group home.  Review of records for client and individual support plants of client #5's ISP revealed the activity choice of client #5 to it and any any and the activity choice of client will push one of two prequest an activity. Finaterials to include two plants and the correct want to play on the correct want to play the correct want to play the correct want to p	pensure continuous active the needs of client #5. For the needs of client #5 to sit in the living room servation revealed client #5 times, begin to rock in the new and then go back to servation revealed client #5. The checked on the client with the needs and after which the needs and after which the needs and after which the needs are to sleep until 8:05 to separing the client to leave the needs at training objective to the needs of the needs of the needs of the for client #5 revealed the needs of t	W	249			

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

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938 0301

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	RUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
		34G334	B. WNG_				
IWRC-DO	PROVIDER OR SUPPLIER			2 ROSE S	ADDRESS, CITY, STATE, ZIP CODE STREET W LLE, NC 28803	1 04	4/08/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RF	(X5) COMPLETION DATE
t t t t t t t t t t t t t t t t t t t	a BSP dated 9/23/20. for client #5 revealed on the head and bites the BSP revealed prevenue support target behavior spend time with client him do things he enjoy.  Interview with the QID #5 should have been ewith active treatment of observations on 4/8/21 the QIDP verified clien objective could have bethe morning of 4/8/21 the morning of 4/8/21 the QIDP verified clien objective could have bethe morning of 4/8/21 the QIDP verified clien objective could have bethe morning of 4/8/21 the QIDP verified clien objective could have bethe morning of 4/8/21 the QIDP verified clien objective could have bethe morning of 4/8/21 the property of the facility failed to treatment to address the example:  Observation at 7:35 AM the living room and playing observation at 7:50 AM where on sleep. Further observed on client #6 after on sleep. Further observed on sleep until 8:10 AM where on the property of the property	Review of the 9/2020 BSP target behaviors of hits self hand. Further review of vention measures to ors to include the need to #5, talk to him often. Help vs.  P on 4/8/21 verified client engaged more frequently entions during the morning. Continued interview with the #5's activity choice even implemented during to attempt to engage the divity choice other than the eneds of client #6. For the revealed client #6 to sit in the pin front of the television of music. Continued revealed the QIDP to which the client continued vertion revealed client #6 when staff prompted the television in the group home.  The revealed a BSP of the 9/2020 BSP for the behaviors of avoiding others, leaving building, thers, leaving building,	W2	49			

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MUUTIDUE O		OMB NO. 0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
NAME OF		34G334	B. WING		0.4/0.0/0.00
IWRC-DO	PROVIDER OR SUPPLIER		2 RC	EET ADDRESS, CITY, STATE, ZIP CODE  OSE STREET W  HEVILLE, NC 28803	04/08/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) RE COMPLETION
W 475	slamming doors, spitti verbal aggression. Furevealed prevention methaviors to include the and keep a routine; Heepigys.  Interview with the QIDI #6 should have been ewith active treatment of observations on 4/8/21 the QIDP verified client should have been offer engage the client in a pother than sleeping.  MEAL SERVICES  CFR(s): 483.480(b)(2)(	ng, throwing objects and urther review of the BSP reasures to support target are need to provide structure ple her do things she  P on 4/8/21 verified client engaged more frequently ptions during the morning. Continued interview with at #6 needs structure and red activity options to preferred activity choice	W 249		
i a s s r f f f f f f f f f f f f f f f f f	This STANDARD is not Based on observation, interview the facility faile appropriate utensils were sampled clients (#3, #4 non-sampled client (#1) finding is:  A. The facility failed to putensils to client #6. For Deservation in the group PM revealed client #6 to neal with a place setting ectional scoop dish, sip poon. Continued observation, interventional observation of the poon.	t met as evidenced by: record review and ed to ensure all re provided to 3 of 3 and #6) and 1 for 2 of 2 meals. The provide appropriate r example:  home on 4/7/21 at 5:45 participate in the dinner that consisted of a cup and a regular		Correction: Staff will have retrained and in-serviced on proper table settings for all residents. Picture place setting will be made available for staff training and reference.  Prevention: Random observations of meal times will be performed to ensure staff ar following the training.  Monitoring: Supervisors, Managers, and the Residential Coordinator will randomly monitor a meal at least once pe week and document their findings.  Date completed by 5/15/2021	е

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/19/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G334 B. WING NAME OF PROVIDER OR SUPPLIER 04/08/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W **IWRC-DOGWOOD** ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 475 | Continued From page 5 W 475 and crushed pineapple. Subsequent observation revealed client #6 to use a spoon to eat all meal items. 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. Review of records for client #6 on 4/8/21 revealed an individual support plan (ISP) dated 8/6/20. Review of the ISP for client #6 revealed strengths to include: Functional range of motion, able to feed self, functional fine motor skills. Continued review of records for client #6 revealed a nutritional assessment dated 8/2/20. Review of the 8/2020 nutritional assessment revealed client #6 is able to eat independently and uses all utensils correctly. Continued review of the current nutritional assessment for client #6 revealed the client uses a fork, spoon and high sided sectional scoop plate. Interview with the facility qualified intellectual disabilities professional (QIDP) on 4/8/21 revealed client #6 is capable of using a fork and spoon at meals. Continued interview with the

QIDP verified client #6 prefers to use a spoon at meals. The QIDP additionally verified client #6 should be provided a fork and spoon at all meals.

B. The facility failed to provide appropriate utensils to client #3. For example.

DEPAR*	TMENT OF HEALTH AN	ID HUMAN SERVICES			PRINT	ED: 04/19/202	
CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			FO	RM APPROVEI NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		34G334	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	4/08/2021	
IWRC-DO	GWOOD			2 ROSE STREET W ASHEVILLE, NC 28803			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D RE	(X5) COMPLETION DATE	
	Observation in the groph revealed client #3 meal with a place setting divided dish, weighted and straw. Continued dinner meal to include: and crushed pineapple revealed client #3 to use all meal items.  Observation in the group AM revealed client #3 to breakfast meal with a pof a divided dish, weighted straw. Continued observation in the group of a divided dish, weighted straw. Continued observed and applesauce. Subserve and applesauce. Subserve and applesauce. Subserve and applesauce and applesauce. Review of records for client #3 to use all meal items.  Review of records for client #3 revealed for client #3 revealed strain dated 8/26/20 nutritional evaluation review of eat and assist with so continued review of nutritient #3 revealed the client #	to participate in dinner on that consisted of a spoon, and a cup with a lid observation revealed the Turkey tetrazzini, zucchini and subsequent observation is a weighted spoon to eat spoon and a cup with real consisted the spoon to eat spoon and a cup with real consisted the spoon and a cup with real consisted the spoon and a cup with real consisted the spoon to eat spoon and a cup with real consisted the spoon and a cup with real consisted the spoon and a cup with real consisted the spoon to eat spoon and a cup with real consisted the spoon and a cup with rea	W 47				

Interview with the QIDP on 4/8/21 revealed client

Continued interview with QIDP verified client #3

#3 can use a fork and spoon at meals.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/19/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 34G334 B. WING NAME OF PROVIDER OR SUPPLIER 04/08/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W **IWRC-DOGWOOD** ASHEVILLE, NC 28803 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 7 W 475 prefers to use a spoon at meals. Additionally, the QIDP confirmed client #3 should be provided a fork and spoon at all meals. C. The facility failed to provide appropriate utensils to client #4. For example. Observation in the group home on 4/7/21 at 5:45 PM revealed client #4 to participate in dinner meal with a place setting that consisted of a divided dish, regular cup and spoon. Continued observation revealed the dinner meal to include:

Observation in the group home on 4/8/21 at 5:30 AM revealed client #4 to participate in breakfast with a place setting that consisted of a divided dish, plastic cup and spoon. Continued observation revealed the breakfast meal to include: Pancakes, sausage and applesauce. Subsequent observation revealed client #4 to use a spoon to eat all meal items.

Turkey tetrazzini, zucchini and crushed pineapple. Subsequent observation revealed client #4 to use

a spoon to eat all meal items.

Review of records for client #4 on 4/8/21 revealed an ISP dated 10/5/20. Continued review of records for client #4 revealed a mealtime procedure completed by the occupational therapist dated 8/19/20. Review of the 8/19/20 mealtime procedure for client #4 revealed the client uses her right hand to feed herself with a spoon. Continued review of mealtime procedure for client #4 revealed staff are to encourage client #4 to pierce foods with a fork. Further review of mealtime procedure for client #4 verified client #4 should be provided a high sided sectional plate, plastic cup, spoon, fork, and knife.

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CENT	ERS FOR MEDICARE &	MEDICAID SERVICES					RM APPROVE
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY IPLETED
		34G334	B. WING				
NAME OF	PROVIDER OR SUPPLIER	0.4004	B. WING_	STD	EET ADDRESS, CITY, STATE, ZIP CODE	04	1/08/2021
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					HEVILLE, NC 28803		
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W 47	Interview with the QID #4 can use a fork and Continued interview with 4 prefers to use a spot the QIDP confirmed clia a full place setting of a D. The facility failed to utensils for client #1. FO Observation in the group PM revealed client #1 to meal with a place setting regular plate, cup and sobservation revealed the Turkey tetrazzini, zucch Subsequent observation a spoon to eat all meal Observation in the group AM revealed client #1 to with a place setting that plate, cup and spoon. Or revealed the breakfast means the process of the pro	P on 4/8/21 revealed client spoon at meals. ith the QIDP verified client con at meals. Additionally, ient #4 should be provided II utensils at all meals.  In provide appropriate or example.  In phome on 4/7/21 at 5:45 to participate in dinner ag that consisted of a spoon. Continued the dinner meal to include: an initiand crushed pineapple. In revealed client #1 to use items.  In phome on 4/8/21 at 6:30 to participate in breakfast consisted of a regular continued observation and to include: Pancakes ent observation revealed to eat all meal items.  In the provided in th	W 47	75			

plate and cup at meals.

Interview with the QIDP on 4/8/21 revealed client

#1 can use a fork and spoon at meals.

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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA (X		TIDI E O	OMB	OMB NO. 0938-039	
AND PLAN OF CORRECTION  (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF		34G334	B. WING				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1WRC-DOGWOOD  2 ROSE STREET W  ASHEVILLE, NC 28803				(	04/08/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	) BE	(X5) COMPLETION DATE
W 475	Continued interview w	th the QIDP verified client on at meals. Additionally, ent #1 should be provided	W	475	DEPICIENCY		