STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G076	A. BUILDING _____ B. WING _____	C 04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IWC-ROSE STREET HOME	1 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 000	INITIAL COMMENTS	W 000		
	Intake #NC00187108			
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to assure its policies and procedures that prohibit abuse and neglect were implemented to assure client safety for 1 of 11 clients (#6). The finding is: Review of internal incident reports on 4/21/22 revealed an incident report dated 2/9/22 that indicated client #6 was being taken to bed from the shower and staff noticed a small bruise of unknown origin similar to a black eye on the client's left eye. Continued review of the internal incident report indicated staff will monitor area and report concerns to nursing. Review of internal incident report dated 2/12/22 indicated that staff witnessed client #10 hit client #6 in the face because the client was coughing. Continued review of the incident report indicated two staff moved client #10's belongings to the dining room so they could keep an eye on them. Further review of the incident report indicated client #6 did not require any medical treatment, no signs of pain or discomfort noted. Review of internal incident report dated 2/18/22 indicated that as staff walked past client #6's bedroom they noticed the client was bleeding from scratches of unknown origin to the right side of their face, including the corner of the right eye, cheek, and forehead. Continued review of the incident report	W 149		

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

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W 149	Continued From page 1	W 149		

indicated staff determined client #10 perpetrated the scratches as client #6 and client #10 are roommates and no one else was in the room at that time. Further review of the incident report indicated staff redirected client #10 to the activity room and client #6's wounds were cleaned and treated with triple antibiotic ointment. Review of internal incident report dated 2/24/22 revealed at 10:45 PM that staff observed a laceration of unknown origin above client #6's left eye during a bed check. Continued review of the incident report indicated that staff determined client was struck in the face. Further review of the incident report indicated that the facility nurse on duty treated the wound at the facility prior to transporting client #6 to the emergency room for additional treatment.

Review of internal records on 4/21/22 revealed an IRIS dated 2/28/22 completed by the quality assurance director (QAD). Review of the IRIS revealed client #6 is diagnosed with severe intellectual disability and neuromuscular scoliosis. Continued review of IRIS revealed an incident occurred on 2/24/22 when client #6 was asleep in bedroom and another resident who shared the bedroom, client #10, hit client #6 with an AFO causing a laceration to the left eye. Further review of IRIS revealed client #6 was taken to the ER however, after 3 or more hours and no service the facility nurse returned client #6 to the facility. Subsequent review revealed client #6 received care at home and was seen by primary care physician on 2/25/22 at 1:00 PM for assessment and treatment requiring glue and steri-strips. Additionally, the guardian was notified on 2/24/22 regarding the incident involving client #6.

Review of records on 4/21/22 for client #10

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W 149	Continued From page 2	W 149		

revealed an ISP dated 2/3/22. Review of the ISP for client #10 revealed a behavior support plan (BSP) dated 2/4/22. Review of client #10's BSP revealed target behaviors to reduce maladaptive behaviors and to improve social functioning skills. Continued review of the 2/4/22 BSP revealed behaviors of concern to include: gets into others beds, throws things, attempts to quiet noisy others, leaves safe areas and travels to unsafe areas with little safety awareness, push others, takes things from others, and disengages with activities which benefit him long-term but are not always preferred short-term.

Review of the facility abuse, neglect and exploitation policies and procedures on 4/21/22 indicated the definition of neglect as "any situation in which the staff do not carry out duties or responsibilities that in turn affect the health, safety, or well-being of a consumer. Neglect further refers to the failure of staff to act spontaneously in any situation that might adversely affect the health, safety, or well-being of a consumer." Continued review of the abuse, neglect and exploitation policies and procedures indicated "inadequate supervision" as one example of neglect.

Interview with the facility nurse on 4/21/22 confirmed that client #6 was transported to the ER on 2/24/22 due to laceration above eye. Continued interview with the facility nurse revealed that client #6 was returned to the facility after 3 or more hours of waiting at the ER without service due to needing tube feeding. Further interview with the facility nurse confirmed a follow-up appointment for client #6 was scheduled for 2/25/22 at 1:00 PM for assessment and treatment as needed.

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W 149	Continued From page 3 Interview with the facility qualified intellectual disabilities professional (QIDP) on 4/21/22 revealed client #10 moved to the facility on 1/5/22. Continued interview with the QIDP revealed the interdisciplinary team was initially informed that client #10 did not have a history of being aggressive to others and did not see many behavioral issues prior to the February incidents. Further interview with the QIDP revealed client #6 is non-ambulatory and client #10 was moved to another wing/room in the facility immediately after the 2/24/22 incident with a roommate that is ambulatory. Based on record reviews and interviews, the facility was aware that client #10 injured client #6 on 2/12/22 and 2/18/22 yet continued to allow the clients to reside in the same bedroom. The facility's neglect to take steps to protect client #6 from subsequent injury from client #10 led to a third incident on 2/24/22, which required client #6 to obtain emergency room treatment.	W 149		