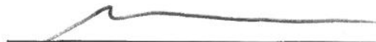
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G076	A. BUILDING ______ B. WING ______	C 01/06/2022

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 Intake #NC00183670	W 000		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to show evidence of the completion of timely corrective action related to an internal investigation involving an allegation of neglect. The finding is: Review of internal records on 1/6/22 revealed an internal investigation dated 11/23/21. Review of the internal investigation revealed on 11/23/21 staff A alleged staff B had failed to provide meals or conduct hygiene needs of client #1 during shift on 11/23/21. Continued review of the internal investigation revealed Staff B was placed on administrative leave pending investigation of the allegation, interviews were conducted with all appropriate staff and facility camera footage was reviewed for the date of the allegation. Further review of the internal investigation revealed an outcome summary that indicated an unsubstantiated finding based on insufficient evidence. Continued review of the investigation summary revealed recommendations that the qualified intellectual disabilities professional (QIDP) would provide staff training on proper use of time and offering choices to residents of activities balanced with completing health and safety tasks like preparing meals, cleaning, laundry and timely documentation.	W 157	Correction: All staff will be in-serviced and retrained on daily schedule, offering residents choices and documentation. Prevention: Routine monitoring and observations will be done monthly. Monitoring: Observations and monitoring will be done by House Manager and Residential Coordinator	2/15/2022

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



TITLE: President & CEO

(X6) DATE: 1/25/2022

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.

DHSR - Mental Health
FEB 04 2022
Lic. & Cert. Section

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W 157	Continued From page 1 Interview with the clinical director and quality assurance director on 1/6/22 revealed no evidence was available to review regarding the in-service training recommended by the internal investigation dated 11/23/21. Continued interview with administration revealed it was unknown if the trainings were completed. Further interview with the clinical director and quality assurance director revealed the alleged staff in the internal investigation continues to be employed on a PRN basis at the facility.	W 157		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to address the identified needs of 1 of 1 client (#1) relative to meal refusals. The finding is: Observations in the facility on 1/6/22 at 11:55 AM revealed client #1 to participate in the lunch meal. Continued observation revealed staff A to assist client #1 with eating due limited hand dexterity. Further observation revealed the lunch meal to include 8 ounces of a nutritional supplement (Ensure), applesauce, yogurt, and a peanut butter and jelly sandwich served with ground consistency. Subsequent observation revealed client #1's adaptive equipment to include a shirt protector, high sided divided dish, and a cup with lid and straw. Additional observation revealed client #1 to consume about 15% of the meal before refusing the rest.	W 227	Correction: All staff will be in-serviced and retrained to [redacted] Meal guidelines. All Guidelines will be put into EHR Therap to ensure staff has access. Prevention: Routine observations of mealtimes will be done monthly. All guidelines will be placed in Therap within 5 days of IPP. Monitoring: Observations and monitoring will be conducted by House Manager and Residential Coordinator. Program Director will review all guidelines within 5 days of IPP to ensure they are current.	2/15/2022

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W 227	Continued From page 2 Review of records for client #1 on 1/6/22 revealed an admission date of 6/28/21. Review of client #1's behavior plan on 1/6/22 revealed a target behavior of avoiding tasks, with prevention strategies to include: alternate staff, prompt to complete task, reinforce appropriate behaviors, and provide time and space to calm. Review of internal documentation reflecting meal intake for client #1 from 10/2021 through 12/2021 revealed the following: September 2021 revealed client #1 had 4 days with no meal intake, October 2021 revealed client #1 had 2 days with no meal intake and December 2021 revealed client #1 had 7 days with no meal intake. Interview with staff A on 1/6/22 revealed client #1 has a history of meal refusal and client #1's compliance is often related to staff preference. Continued interview with staff A revealed when client #1 refuses a meal, staff should try and switch off with another staff to allow a different staff to offer the meal. Interview with the clinical director and quality assurance director on 1/6/22 revealed client #1 had no current guidelines to address meal refusals. Continued interview with administration staff revealed there had been no guidelines or prevention strategies implemented to address client #1's identified history of meal refusals after the 11/23/21 internal investigation.	W 227		