STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G334	A. BUILDING _____ B. WING _____	05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IWRC-DOGWOOD	2 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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that privacy was maintained for 2 of 6 clients (#1 and #2) during personal care. The findings are: A. The facility failed to assure that privacy for client #1 was maintained during personal care. For example: Observation in the group home on 5/31/23 at 7:53 AM revealed staff A to prompt client #1 to go and use the bathroom. Continued observation revealed client #1 to exit the living room and to go to the bathroom with staff A. Further observation at 7:58 AM revealed client #1 entered the dining room wearing only a pull-up with clothes and shoes in his hands. Subsequent observation revealed the surveyor notified the home manager (HM) that client #1 was exposed and the HM assisted client #1 to the bathroom to get dressed. Interview with the qualified intellectual disabilities professional (QIDP) on 5/31/23 verified that staff should be observing privacy during personal care. Continued interview with the QIDP revealed that staff should have remained with client #1 until completely dressed. B. The facility failed to assure that privacy for client #2 was maintained during personal care. For example: Observation in the group home on 5/31/23 at 6:31	W 130	Correction: Staff will be retrained and in-serviced on resident's rights regarding privacy during treatment and care of personal needs. Staff should be observing privacy during personal care. Prevention: At next house meeting, when staff is present, review clients' privacy rights during personal care. Ensure doors remain closed during changing times and that clients are completely dressed before leaving room. Monitoring: Shift supervisor will monitor shift for clients' privacy during personal care and throughout. QIDP will monitor for privacy of clients during monthly observations. Date of Completion: At next house meeting, 6/30/23 RECEIVED JUN 23 2023 DHSR-MH Licensure Sect	6/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President & CEO | (X6) DATE: 6/20/2023

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.

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W 130	Continued From page 1 AM revealed staff C to enter client #2's bedroom. Continued observation revealed the client to be wearing underwear and pulling a shirt over her head. Further observation revealed staff C left the bedroom door open while client #2 continued to get dressed. Subsequent observation revealed staff C to exit the bedroom and to not close the door for privacy. Interview with the QIDP on 5/31/23 verified that staff should be observing privacy during personal care by closing the client's bedroom door.	W 130		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: The facility failed to assure 1 of 3 sampled clients (#4) observed during medication administration were provided teaching related to name, purpose, and side effects of medication. The finding is: Morning observations in the group home on 5/31/23 at 6:10 AM revealed staff A to offer client #4 a cup of yogurt containing the client's medications. Continued observation revealed staff A to feed client #4 the contents of the cup. Further observation revealed client #4 to consume the entire contents of the cup and to exit the medication room. Subsequent observation revealed that staff did not provide medication education during the medication	W 371	Correction: An In-service for medication education and a medpasser observation will be conducted by Nurse. Prevention: Nurse will attend monthly house meetings and answer and questions about medpassing the staff may have. Monitoring: House manager and shift supervisor will monitor on their shifts that medpassers are giving clients' medication education during medication administration Date of Completion: 7/28/23	7/28/23

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W 371	Continued From page 2 administration. Review of records on 5/31/23 revealed an individual service plan (ISP) dated 7/13/22. Continue review of the ISP revealed that client #4 can hold items. Further review of records on 5/31/23 revealed an occupational therapy assessment dated 6/7/22 that indicates client #4 can maintain grip of his built-up handle spoon during feeding and activate devices via a switch. Interview with staff A on 5/31/23 revealed that client #4's medications were dispensed, crushed, and applied to yogurt before he entered the medication room. Continued interview with staff A revealed client #4 typically will just receive his medications with no participation or education because of his physical limitations. Interview with the facility nurse revealed all clients are to receive education and be actively engaged in their medication administration regardless of their physical or intellectual disabilities. A subsequent interview with the facility nurse revealed that staff A was trained to provide education and engage clients in their medication administration and staff will be retrained.	W 371	Correction: An In-service for drug storage and a medpasser observation will be conducted by Nurse. Prevention: Nurse will attend monthly house meetings and answer and questions about medpassing the staff may have. They will also remind medpassers about proper medication storage. Monitoring: House manager and shift supervisor will monitor on their shifts that medpassers are practicing proper storage of medications. Date of Completion: 7/28/23	7/28/23
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews the facility failed to assure medications were properly stored during medication administration. The finding is:	W 382		

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W 382	Continued From page 3 Observation in the group home on 5/31/23 at 7:08 AM revealed staff to approach client #1 with two blue cups that contained his liquid medication in one and plain water in the other to be administered via his g-tube site. Continued observation revealed staff noticing the liquids were in the wrong-colored cups. Obserations revealed staff to place the cups above client #1's head on the counter above where he sat on the floor and to walk to the kitchen to retrieve two small clear cups, leaving the medications unattended. Further observation revealed staff to return with two small clear cups, exchange the contents and to administer the medication to client #1 via his g-tube sites. Interviews on 5/31/23 with the qualified intellectual disabilities professional (QIDP) and the facility nurse revealed staff are to secure, store and lock medication up anytime they need to leave the medication room or medication administration area to ensure the safety of all clients and individuals in the home. Continued interviews with the facility nurse revealed that staff are trained in the proper storage of medications.	W 382	Correction: Staff will be retrained and in-serviced on using the proper mealtime equipment for all residents at each meal. During monthly house meeting, staff will be reminded that all clients are to provide clients with other adaptive equipment, such as glasses and gait belts as stated in their plans.	6/30/23
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 observations, record review and interview, the facility failed to furnish adaptive	W 436	Prevention: QIDP printed index cards with each clients' adaptive equipment to be used during mealtimes and will review with staff. Review annual IPP and Programs, including evaluations and procedures from consultants at monthly house meeting one week after the plan is complete. Monitoring: During monthly observations, the QIDP will monitor for clients and shift supervisor with monitor to ensure adaptive equipment is being used. Date of Completion: 6/30/23	

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W 436	Continued From page 4 equipment and prescribed eyeglasses for 2 of 6 clients (#3 and #4). The findings are: A. The facility failed to provide prescribed eyeglasses and gait belt for client #3. For Example: Observation in the group home on 5/31/23 during 90 minutes of observations revealed client #3 to participate in various activities to include the breakfast meal, taking dishes to the kitchen, watching television, and to participate in medication administration. At no time throughout the observation was staff observed to prompt client #3 to wear prescribed eyeglasses. Subsequent observation on 5/31/23 at 8:04 AM revealed client #3 to exit the group home with staff to walk to Adult Day Activity (ADA) and to not wear a gait belt. Continued observation revealed that staff was not observed to prompt client #3 to wear a gait belt prior to leaving the group home. Review of records on 5/31/23 for client #3 revealed an individual support plan (ISP) dated 7/13/22. Continued review of record for client #3 revealed a vision consult dated 6/8/22 with a diagnosis of mild cataracts in both eyes. Further review of the vision consults revealed client #3 to have new prescribed glasses to wear full-time. Subsequent review of records revealed a physical therapy evaluation dated 5/12/22 that client #3 requires gait belt assistance with a staff member when ambulating outdoors on uneven surfaces. Interview on 5/31/23 with the qualified intellectual disabilities professional (QIDP) confirmed that client #3 should be wearing prescribed eyeglasses. Continued interview with the QIDP	W 436		

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W 436	Continued From page 5 confirmed that client #3 should be wearing prescribed gait belt when walking to ADA. B. The facility failed to provide prescribed scoop plate and dycem mat for client #4 during mealtimes. For example: Observation in the group home on 5/30/23 during the dinner meal revealed client #4 to not have his prescribed dycem mat. Continued observation in the group home on 5/31/23 during the breakfast meal revealed client #4 to participate in the breakfast meal without his dycem mat and scoop plate. Review of records on 5/31/23 revealed an individual support plan (ISP) dated 6/9/22. Continued review of the ISP revealed nutritional guidance for client #4 as follows: needs to be assisted by staff to feed himself using adaptive equipment and client #4 uses a wrist splint on the left hand, a large built-up angled spoon, scoop dish, nosey cup and dycem mat. Continued review of records on 5/31/23 for client #4 revealed a nutritional assessment dated 6/8/22 with recommendations as follows: client #4 needs to be fed by staff with use of adaptive equipment as follows: uses wrist support splint, large built-up angled spoon, scoop dish, dycem mat, and he needs his 3' tray above the table with his belt secured and slightly tipped back. Interview on 5/31/23 with the QIDP confirmed that client #4 should have all his adaptive equipment during breakfast and dinner meals as prescribed in his nutritional assessment.	W 436		