

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
--------------------	--	---------------	---	----------------------

E 004	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.475(a)</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p>	E 004	<p style="text-align: center;">DHSR - Mental Health</p> <p style="text-align: center;">NOV 14 2023</p> <p style="text-align: center;">Lic. & Cert. Section</p>	
-------	--	-------	--	--

Billy Spence

Executive Director

11/10/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: 921653 If continuation sheet Page 1 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 004	<p>Continued From page 1</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is:</p> <p>Review on 10/30/23 of the facility's EPP revealed that the facility does not have an EPP currently in place.</p>	E 004	<p>The Director will update the organizations present hazards plan to reflect that it is an emergency preparedness plan, with attention to protocols related to emergency events, preparedness, and procedures. The update will be reviewed with the MARF Board of Directors, and annually thereafter with revision and review dates noted.</p> <p>11/22/2023</p>
E 037	<p>Interview on 10/31/23 with the executive director confirmed that the facility does not have an EPP. EP Training Program CFR(s): 483.475(d)(1)</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing</p>	E 037	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 DATE)

			DEFICIENCY)	
E 037	<p>Continued From page 2</p> <p>staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p>	E 037		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 3</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training</p>	E 037		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 4</p> <p>Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program.</p>	E 037		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 5</p> <p>The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially. The finding is:</p> <p>Review on 10/30/23 of the facility's EPP revealed</p>	E 037	<p>The Executive Director will update the present hazard plan and training to reflect that it is for emergency preparedness. Staff will be provided with training regarding the updated plan, contained procedures and protocols, its location within the home, and drills overview. Training will occur with all present staff by the stated date, and annually thereafter.</p> <p>Future employees will receive training at orientation, instruction on plan location in the home, annual training thereafter, and update training as needed.</p>	12/1/2023
-------	--	-------	---	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 037	Continued From page 6 no evidence of initial or biennial training on the EPP.	E 037		
E 039	<p>Interview on 10/31/23 with the executive director confirmed that initial training and biennial training for current staff were not completed.</p> <p>EP Testing Requirements CFR(s): 483.475(d)(2)</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or</p>	E 039		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: 921653 If continuation sheet Page 7 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 7</p> <p>functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section</p>	E 039		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: 921653 If continuation sheet Page 8 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 8</p> <p>is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 9</p> <p>messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 10</p> <p>questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 11</p> <p>designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 12</p> <p>exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 13</p> <p>to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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	
E 039	<p>Continued From page 14</p> <p>to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is:</p>	E 039	<p>The Executive Director and Facilities Coordinator will complete a revision of the drill training calendar to reflect monthly fire drills on a rotating shift basis, and monthly emergency preparedness drill on a rotating shift basis. These drills will include natural disasters, evacuation procedures, full community scale evacuation, shelter in place, and other hazardous situations. The calendar will reflect that at least one full scale community event drill and at least one tabletop training exercise occur annually. Reviews of drills and exercises will occur at the following management team meeting to identify, navigate, and implement solutions for any concerns experienced during the drills and exercises. Drill and exercise completion will be delegated to the house supervisory team (QP & Team Assistant) for assignment and monitoring compliance. One on one training will occur as needed by any member of management.</p>	12/1/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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	
E 039	Continued From page 15	E 039			
W 130	<p>Review on 10/30/23 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise.</p> <p>Interview on 10/31/23 with the executive director confirmed the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>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, record review and interview, the facility failed to assure that privacy was maintained for 1 of 6 clients (#4) during personal care. The finding is:</p> <p>Observations in the group home on 10/31/23 at 8:21 AM revealed client #4 to be sitting on the toilet with his pants down and the door open. Continued observation revealed a staff sitting in the dining room near the bathroom who looked in the direction of the bathroom. Further observation revealed that the staff made no attempt to check on the client. Subsequent observation at 8:34 AM revealed the client to finish, leave the bathroom, then return and again sit with his pants down and the door open without staff intervention.</p> <p>Record review on 10/31/23 revealed an Person</p>	W 130			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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	<p>Continued From page 16</p> <p>Centered Plan (PCP) dated 6/22/23 for client #4. Continued review revealed the PCP to state that the client is blind and can toilet independently but needs help wiping. Further review revealed that the PCP does not contain a goal for client #4 to maintain privacy during personal care.</p> <p>Interview with the Executive Director (ED) on 10/31/23 confirmed that staff should be aware when client #4 enters the restroom and should assist him with maintaining privacy during toileting. Continued interview revealed the ED to confirm that client #4 would benefit from a program goal designed to assist him with independence in maintaining privacy during personal care.</p>	W 130	<p>The supervisory team (QP & Team Assistant) will provide inservice training to staff regarding privacy standards and expectations. They will engage in quality assurance and improvement via the use of observational assessment forms and as needed additional 1:1 training and consultation with staff to ensure understanding and compliance. The Clinical Team (IDT, QP, Clinical Dir, Exec Dir) will coordinate and complete comprehensive skills evaluations. The QP will utilize these to update programmatic goals for individuals with identified need to address concerns surrounding privacy, as well as other independence skills. The QP will provide inservice training to the staff to ensure understanding of goal and methodology.</p>	12/1/2023
W 371	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(4)</p> <p>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: Based on observations and interviews, the facility failed to provide opportunities for 3 of 6 clients (#1, #2, and #5) to participate in and receive education relative to medication administration. The finding is:</p> <p>Morning medication administration observations on 10/31/23 revealed staff A to accompany client #1 to the medication room. Continued observation revealed staff A to retrieve client #1's morning medications from the closet, punch each pill into a cup, prepare a cup of water with fiber</p>	W 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 371	<p>Continued From page 17</p> <p>powder, then hand the medications to the client with the water and instruct the client to take the medications. Further observation revealed that at no time did staff A offer education to client #1 regarding his medications nor did staff A offer or encourage client #1 to participate in the preparation of his medications.</p> <p>Morning medication administration observations on 10/31/23 revealed staff A to accompany client #2 to the medication room. Continued observation revealed staff A to retrieve client #2's morning medications from the closet, punch each pill into a cup, mix the pills with applesauce, prepare a cup of water with fiber powder, then hand the applesauce cup to the client with the water and instruct the client to take the medications. Further observation revealed that at no time did staff A offer education to client #2 regarding his medications nor did staff A offer or encourage client #2 to participate in the preparation of his medications.</p> <p>Morning medication administration observations on 10/31/23 revealed staff A to accompany client #5 to the medication room. Continued observation revealed staff A to retrieve client #5's morning medications from the closet, punch one pill into a cup, prepare a cup of water then hand the medications to client #5 with the water and instruct client #5 to take the medications. Further observation revealed staff A to administer drops in each of client #5's eyes. Subsequent observation revealed that at no time did staff A offer education to client #5 regarding his medications nor did staff A offer or encourage client #5 to participate in the preparation of his medications.</p>	W 371	<p>The clinical team will coordinate and complete comprehensive skills evaluations to identify skill level and need for each resident in regard to medication administration (knowledge & participation scope). The QP will utilize this information to develop and update programmatic goals for this domain. Staff will receive person specific training regarding goals and methodology. The RN, Supervisory Team, Clinical Dir, & Exec Dir. will monitor outcomes through intermittent assessments to ensure staff understanding & compliance. The QP will also monitor goal progress through documentation of program trials to determine if updates to the goal are needed.</p>	12/1/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 371	Continued From page 18 Interview with the Executive Director confirmed that client #1, client #2, and client #5 can participate in medication administration on some level and should have been afforded opportunities to participate to the extent possible. Continued interview confirmed that all clients should be provided with education about the medications they are taking and that this is staff's responsibility.	W 371			
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets of 3 of 6 clients (#1, #2, and #6). The findings are: A. The facility failed to ensure the prescribed diet for client #1. For example: Observations in the group home on 10/30/23 at 5:30 PM revealed the dinner meal to be baked macaroni and cheese, cooked carrots, peas, applesauce, and rolls. Continued observations revealed staff to serve a whole roll to client #1, and client #1 to consume the roll without staff cutting up or modifying the roll in any manner. Observations during the breakfast meal on 10/31/23 revealed client #1 to be served scrambled eggs, yogurt and cheese toast. Continued observation revealed the cheese toast served to client #1 to be in whole form. Further observation revealed client #1 to	W 474			

consume the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474	<p>Continued From page 19</p> <p>cheese toast without staff cutting or modifying in in any way.</p> <p>Record review on 10/31/23 revealed a physician's order for client #1 dated 6/6/23 stating that the client is currently prescribed a chopped diet.</p> <p>Interview with the Executive Director (ED) on 10/31/23 confirmed that the staff should be following the current prescribed diet for client #1. Continued interview revealed there is a need for an updated nutritional evaluation to be completed for the client.</p> <p>B. The facility failed to follow client #2's diet as prescribed. For example:</p> <p>Observations in the group home on 10/30/23 at 5:05 PM revealed the dinner meal to consist of baked mac n cheese, carrots, peas, applesauce, and dinner rolls. Continued observations at 5:15 PM revealed client #2 to eat mac n cheese, peas, and dinner roll in regular whole consistency. At no time during the observation was staff observed to assist client #2 to provide a modified diet other than cutting up carrots.</p> <p>Observations in the group home on 10/31/23 at 7:30 AM revealed the breakfast meal to consist of eggs, and cheese toast. Continued observations revealed client #2 to eat the breakfast meal in regular whole consistency. At no time during the observation was staff observed to assist client #2 to provide a modified diet.</p> <p>Review of client #2's record on 10/31/23 revealed a physician's order dated 6/6/23. Continued review of the physician's orders</p>	W 474	<p>All staff will receive training regarding modified consistencies, dietary and menu guidelines, and person specific training in relation to these concepts and person specific diet and consistency guidelines.</p> <p>All residents will receive evaluations to determine appropriate dietary and food consistency modifications needed, which include corroboration with physician, registered dietician, and additional ancillary providers as needed.</p> <p>Individual evaluations will be completed to determine programming needs for each person regarding participation in altering their own food consistencies, with goals implemented where necessary. Staff will receive training regarding the implementation of any goal programs.</p> <p>Compliance with training and prescribed diet/consistency will be monitored by the management team through meal/eating times assessments, with immediate training and/or disciplinary action occurring at any points in which guidelines are not followed.</p>	12/31/2023

revealed that client #2's prescribed diet is modified regular,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474	<p>Continued From page 20</p> <p>moisten all solids, cut meat wafer thin, and no added salt. Further review of the plan revealed no nutritional assessment was available for surveyor to review for client #2.</p> <p>Interview with the ED on 10/31/23 confirmed client #2's physician's orders to be current. Further interview confirmed that client #2 should have been provided a modified diet and the client needs an updated nutritional assessment.</p> <p>C. The facility failed to follow client #6's diet as prescribed. For example:</p> <p>Observations in the group home on 10/30/23 at 5:00 PM revealed the dinner meal to consist of baked mac n cheese, carrots, peas, applesauce, and dinner rolls. Continued observations at 5:12 PM revealed client #6 to eat her dinner roll in regular whole consistency. At no time during the observation was staff observed to assist client #6 to provide a mechanical soft dinner roll for the dinner meal.</p> <p>Observations in the group home on 10/31/23 at 8:12 AM revealed the breakfast meal to consist of eggs, yogurt, cheese toast, and milk. Continued observations revealed client #6 to eat the cheese toast in regular whole consistency. At no time during the observation was staff observed to assist client #6 to provide a mechanical soft cheese toast for the breakfast meal.</p> <p>Review of client #6's record on 10/31/23 revealed a nutritional evaluation dated 1/2/23. Continued review of the nutritional evaluation revealed that client #6's prescribed diet to be</p>	W 474		
-------	--	-------	--	--

	limited sugars (diabetic), low fat, and low salt, foods cut up in advance of being served mechanical soft.			
--	--	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474	Continued From page 21 Interview with the ED on 10/31/23 confirmed client #6's nutritional evaluation. Further interview confirmed that client #6 should have been provided with a mechanical soft diet.	W 474		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
--------------------	--	---------------	---	----------------------

E 004	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.475(a)</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p>	E 004		
-------	--	-------	--	--

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: ⁹²¹⁶⁵³ If continuation sheet Page 1 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 004	<p>Continued From page 1</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is:</p> <p>Review on 10/30/23 of the facility's EPP revealed that the facility does not have an EPP currently in place.</p>	E 004	<p>The Director will update the organization's present hazards plan to reflect that it is an emergency preparedness plan, with attention to protocols related to emergency events, preparedness, and procedures. The update will be reviewed with the MARF Board of Directors, and annually thereafter with revision and review dates noted.</p>	11/22/2023
E 037	<p>Interview on 10/31/23 with the executive director confirmed that the facility does not have an EPP. EP Training Program CFR(s): 483.475(d)(1)</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing</p>	E 037		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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	(X5) COMPLETION DATE

		DEFICIENCY)	
E 037	<p>Continued From page 2</p> <p>staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p>	E 037	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 3</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training</p>	E 037		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 4</p> <p>Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program.</p>	E 037		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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

E 037	<p>Continued From page 5</p> <p>The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially. The finding is:</p> <p>Review on 10/30/23 of the facility's EPP revealed</p>	E 037	<p>The Executive Director will update the present hazard plan and training to reflect that it is for emergency preparedness. Staff will be provided with training regarding the updated plan, contained procedures and protocols, its location within the home, and drills overview. Training will occur with all present staff by the stated date, and annually thereafter.</p> <p>Future employees will receive training at orientation, instruction on plan location in the home, annual training thereafter, and update training as needed.</p>	12/1/2023
-------	--	-------	---	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 037	<p>Continued From page 6</p> <p>no evidence of initial or biennial training on the EPP.</p> <p>Interview on 10/31/23 with the executive director confirmed that initial training and biennial training for current staff were not completed.</p> <p>EP Testing Requirements CFR(s): 483.475(d)(2)</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or</p>	E 037		
E 039		E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 7</p> <p>functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section</p>	E 039		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: ⁹²¹⁶⁵³ If continuation sheet Page 8 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 8</p> <p>is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 9</p> <p>messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 10</p> <p>questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 11</p> <p>designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 12</p> <p>exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 13</p> <p>to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises</p>	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	<p>Continued From page 14</p> <p>to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's emergency preparedness plan (EPP). The finding is:</p>	E 039	<p>The Executive Director and Facilities Coordinator will complete a revision of the drill training calendar to reflect monthly fire drills on a rotating shift basis, and monthly emergency preparedness drill on a rotating shift basis. These drills will include natural disasters, evacuation procedures, full community scale evacuation, shelter in place, and other hazardous situations. The calendar will reflect that at least one full scale community event drill and at least one tabletop training exercise occur annually. Reviews of drills and exercises will occur at the following management team meeting to identify, navigate, and implement solutions for any concerns experienced during the drills and exercises. Drill and exercise completion will be delegated to the house supervisory team (QP & Team Assistant) for assignment and monitoring compliance. One on one training will occur as needed by any member of management.</p>	12/1/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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
E 039	Continued From page 15	E 039		
W 130	<p>Review on 10/30/23 of the facility's EPP revealed no evidence of a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise.</p> <p>Interview on 10/31/23 with the executive director confirmed the facility has not conducted a full-scale community or facility-based training, a second full scale-community or facility-based training or mock drill, or a tabletop exercise. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>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, record review and interview, the facility failed to assure that privacy was maintained for 1 of 6 clients (#4) during personal care. The finding is:</p> <p>Observations in the group home on 10/31/23 at 8:21 AM revealed client #4 to be sitting on the toilet with his pants down and the door open. Continued observation revealed a staff sitting in the dining room near the bathroom who looked in the direction of the bathroom. Further observation revealed that the staff made no attempt to check on the client. Subsequent observation at 8:34 AM revealed the client to finish, leave the bathroom, then return and again sit with his pants down and the door open without staff intervention.</p> <p>Record review on 10/31/23 revealed an Person</p>	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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	Continued From page 16 Centered Plan (PCP) dated 6/22/23 for client #4. Continued review revealed the PCP to state that the client is blind and can toilet independently but needs help wiping. Further review revealed that the PCP does not contain a goal for client #4 to maintain privacy during personal care. Interview with the Executive Director (ED) on 10/31/23 confirmed that staff should be aware when client #4 enters the restroom and should assist him with maintaining privacy during toileting. Continued interview revealed the ED to confirm that client #4 would benefit from a program goal designed to assist him with independence in maintaining privacy during personal care.	W 130	The supervisory team (QP & Team Assistant) will provide inservice training to staff regarding privacy standards and expectations. They will engage in quality assurance and improvement via the use of observational assessment forms and as needed additional 1:1 training and consultation with staff to ensure understanding and compliance. The Clinical Team (IDT, QP, Clinical Dir, Exec Dir) will coordinate and complete comprehensive skills evaluations. The QP will utilize these to update programmatic goals for individuals with identified need to address concerns surrounding privacy, as well as other independence skills. The QP will provide inservice training to the staff to ensure understanding of goal and methodology.	12/1/2023
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: Based on observations and interviews, the facility failed to provide opportunities for 3 of 6 clients (#1, #2, and #5) to participate in and receive education relative to medication administration. The finding is: Morning medication administration observations on 10/31/23 revealed staff A to accompany client #1 to the medication room. Continued observation revealed staff A to retrieve client #1's morning medications from the closet, punch each pill into a cup, prepare a cup of water with fiber	W 371	Assessments will occur on each staff member at least once per week.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 371	<p>Continued From page 17</p> <p>powder, then hand the medications to the client with the water and instruct the client to take the medications. Further observation revealed that at no time did staff A offer education to client #1 regarding his medications nor did staff A offer or encourage client #1 to participate in the preparation of his medications.</p> <p>Morning medication administration observations on 10/31/23 revealed staff A to accompany client #2 to the medication room. Continued observation revealed staff A to retrieve client #2's morning medications from the closet, punch each pill into a cup, mix the pills with applesauce, prepare a cup of water with fiber powder, then hand the applesauce cup to the client with the water and instruct the client to take the medications. Further observation revealed that at no time did staff A offer education to client #2 regarding his medications nor did staff A offer or encourage client #2 to participate in the preparation of his medications.</p> <p>Morning medication administration observations on 10/31/23 revealed staff A to accompany client #5 to the medication room. Continued observation revealed staff A to retrieve client #5's morning medications from the closet, punch one pill into a cup, prepare a cup of water then hand the medications to client #5 with the water and instruct client #5 to take the medications. Further observation revealed staff A to administer drops in each of client #5's eyes. Subsequent observation revealed that at no time did staff A offer education to client #5 regarding his medications nor did staff A offer or encourage client #5 to participate in the preparation of his medications.</p>	W 371	<p>The clinical team will coordinate and complete comprehensive skills evaluations to identify skill level and need for each resident in regard to medication administration (knowledge & participation scope). The QP will utilize this information to develop and update programmatic goals for this domain. Staff will receive person specific training regarding goals and methodology. The RN, Supervisory Team, Clinical Dir, & Exec Dir. will monitor outcomes through interaction assessments to ensure staff understanding & compliance. The QP will also monitor goal progress through documentation of program trials to determine if updates to the goal are needed.</p> <p>Assessment will occur once per week for each "med tech" staff member during the training period, and then titrate to a periodic basis for continued supervision purposes</p>	12/1/2023	

consume the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474	<p>Continued From page 19</p> <p>cheese toast without staff cutting or modifying in in any way.</p> <p>Record review on 10/31/23 revealed a physician's order for client #1 dated 6/6/23 stating that the client is currently prescribed a chopped diet.</p> <p>Interview with the Executive Director (ED) on 10/31/23 confirmed that the staff should be following the current prescribed diet for client #1. Continued interview revealed there is a need for an updated nutritional evaluation to be completed for the client.</p> <p>B. The facility failed to follow client #2's diet as prescribed. For example:</p> <p>Observations in the group home on 10/30/23 at 5:05 PM revealed the dinner meal to consist of baked mac n cheese, carrots, peas, applesauce, and dinner rolls. Continued observations at 5:15 PM revealed client #2 to eat mac n cheese, peas, and dinner roll in regular whole consistency. At no time during the observation was staff observed to assist client #2 to provide a modified diet other than cutting up carrots.</p> <p>Observations in the group home on 10/31/23 at 7:30 AM revealed the breakfast meal to consist of eggs, and cheese toast. Continued observations revealed client #2 to eat the breakfast meal in regular whole consistency. At no time during the observation was staff observed to assist client #2 to provide a modified diet.</p> <p>Review of client #2's record on 10/31/23 revealed a physician's order dated 6/6/23. Continued review of the physician's orders</p>	W 474	<p>All staff will receive training regarding modified consistencies, dietary and menu guidelines, and person specific training in relation to these concepts and person specific diet and consistency guidelines.</p> <p>All residents will receive evaluations to determine appropriate dietary and food consistency modifications needed, which include corroboration with physician, registered dietician, and additional ancillary providers as needed.</p> <p>Individual evaluations will be completed to determine programming needs for each person regarding participation in altering their own food consistencies, with goals implemented where necessary. Staff will receive training regarding the implementation of any goal programs.</p> <p>Compliance with training and prescribed diet/consistency will be monitored by the management team through meal/eating times assessments, with immediate training and/or disciplinary action occurring at any points in which guidelines are not followed. Assessment will occur no less than once per week per meal time initially to ensure staff awareness and understanding of individual guidelines, and titrate to no less than once per meal per month there after.</p>	12/31/2023
-------	--	-------	--	------------

revealed that client #2's prescribed diet is modified regular,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474	<p>Continued From page 20</p> <p>moisten all solids, cut meat wafer thin, and no added salt. Further review of the plan revealed no nutritional assessment was available for surveyor to review for client #2.</p> <p>Interview with the ED on 10/31/23 confirmed client #2's physician's orders to be current. Further interview confirmed that client #2 should have been provided a modified diet and the client needs an updated nutritional assessment.</p> <p>C. The facility failed to follow client #6's diet as prescribed. For example:</p> <p>Observations in the group home on 10/30/23 at 5:00 PM revealed the dinner meal to consist of baked mac n cheese, carrots, peas, applesauce, and dinner rolls. Continued observations at 5:12 PM revealed client #6 to eat her dinner roll in regular whole consistency. At no time during the observation was staff observed to assist client #6 to provide a mechanical soft dinner roll for the dinner meal.</p> <p>Observations in the group home on 10/31/23 at 8:12 AM revealed the breakfast meal to consist of eggs, yogurt, cheese toast, and milk. Continued observations revealed client #6 to eat the cheese toast in regular whole consistency. At no time during the observation was staff observed to assist client #6 to provide a mechanical soft cheese toast for the breakfast meal.</p> <p>Review of client #6's record on 10/31/23 revealed a nutritional evaluation dated 1/2/23. Continued review of the nutritional evaluation revealed that client #6's prescribed diet to be</p>	W 474		
-------	--	-------	--	--

limited sugars (diabetic), low fat, and low salt, foods cut up in advance of being served mechanical soft.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:A21V11 Facility ID: 921653 If continuation sheet Page 21 of 22

PRINTED: 11/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE 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 474

Continued From page 21

Interview with the ED on 10/31/23 confirmed client #6's nutritional evaluation. Further interview confirmed that client #6 should have been provided with a mechanical soft diet.

W 474