PRINTED: 11/01/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 004 Develop EP Plan, Review and Update E 004 Annually CFR(s): 483.475(a) §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). 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: (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: * [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 DHSR - Mental Health all-hazards approach.

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* [For LTC Facilities at §483.73(a):]

and updated at least annually.

Emergency Plan. The LTC facility must develop and maintain an emergency

preparedness plan that must be reviewed,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 34G075 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME **ASHEVILLE, NC 28803** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

E 004	Continued From page 1 * [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.	E 004	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.	11/22/2023
	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:			
	Review on 10/30/23 of the facility's EPP revealed that the facility does not have an EPP currently in place.			
E 037	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)	E 037		
	§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).			
	*[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:] (1) Training program. The [facility] must do all of the following:			
	(i) Initial training in emergency preparedness policies and procedures to all new and existing			

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staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (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. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (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. (v) Maintain documentation of all emergency preparedness training. vi) If the emergency preparedness policies and procedures are significantly updated, the nospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 3	E 037	
	*[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.		
	(ii) After initial training, provide emergency		
	preparedness training every 2 years.		
	(iii) Demonstrate staff knowledge of		
	emergency procedures. (iv) Maintain documentation of all		
	emergency preparedness training.		
	(v) If the emergency preparedness policies and		
	procedures are significantly updated, the PRTF		
	must conduct training on the updated policies		1
	and procedures.		
	*[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.		
	(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.		
	(iv) Maintain documentation of all training.(v) If the emergency preparedness policies and		
	procedures are significantly updated, the PACE		
	must conduct training on the updated policies		
	and procedures.		
	*[For LTC Facilities at §483.73(d):] (1) Training		
	[1 of LTO 1 definites at 9405.75(u).] (1) Training		

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E 037	Continued From page 4	E 037	
E 037	Program. The LTC facility 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (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. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding	E 037	
	emergency procedures. All new personnel must be oriented and assigned specific		
	of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting		
	equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.		
	*[For CAHs at §485.625(d):] (1) Training program.		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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E 037 Continued From page 5 E 037 The Executive Director will update the present 12/1/2023 hazard plan and training to reflect that it is for The CAH must do all of the following: (i) Initial training in emergency emergency preparedness. Staff will be preparedness policies and procedures. provided with training regarding the updated including prompt plan, contained procedures and protocols, its reporting and extinguishing of fires, location within the home, and drills overview. protection, and where necessary, Training will occur with all present staff by the evacuation of patients, personnel, and stated date, and annually thereafter. guests, fire prevention, and cooperation with firefighting and disaster Future employees will receive training at authorities, to all new and existing staff, orientation, instruction on plan location in the individuals providing services under home, annual training thereafter, and update arrangement, and volunteers, consistent with training as needed. their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[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. 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:

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Review on 10/30/23 of the facility's EPP revealed

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			ASHEVILLE, NC 28803	

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E 037	Continued From page 6 no evidence of initial or biennial training on the EPP. Interview on 10/31/23 with the executive director confirmed that initial training and	E 037		
E 039	biennial training for current staff were not completed. EP Testing Requirements CFR(s): 483.475(d)(2)	E 039		
	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §440.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §485.542(d)(2), §485.68(d)(2), §485.542(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[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]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (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			

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E 039	Continued From page 7 functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (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. (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. *[For Hospices at 418.113(d):] (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 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (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. (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	E 039			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
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scenario, and a set of problem statements,

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to challenge an emerginal to challenge an emerginal maintain documentain exercises, and emerginal the hospice's emerginal exercises, and emerginal exercises, and emerginal exercises, and emerginal exercises and emerginal exercises to twice per year. The [Formust do the following (i) Participate in an authat is community-back (A) When a community has exemply an actual natural or in that requires activated the [Facility] is exemply next required full-scalindividual, facility-based function (ii) Conduct an [a or and that may included following: (A) A second full-scalic community-based or in facility-based function (B) A mock did not exercises.	red questions designed ergency plan. sice's response to and tion of all drills, tabletop gency events and revise ency plan, as needed. 184(d), Hospitals at §485.625(d):] TF, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] g: nnual full-scale exercise is uct an annual sal exercise; or bital, CAH] experiences nan-made emergency plan, at from engaging in its le community based or sed functional exercise is the emergency event. Inditional annual exercise de, but is not limited to the exercise or workshop that is includes a group rrated, ergency scenario, and	E 039		

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E 039	maintain documental exercises, and emerging the [facility's] emerging the [facility's] emerging the [facility's] emerging the facility's] emerging the facility's] emerging the facility that is community-bated (A) When a community that is community-bated (A) When a community facility-based function (B) If the PACE experior man-made emerging activation of the emergency exercises the emergency of the emergency (ii) Conduct an activation onset of the emergency (iii) Conduct an activation of the emergency exercise unthis section is conductional exercise unthis section is conducted in the formal exercise unthis section is conducted	[facility's] response to and ion of all drills, tabletop gency events and revise ency plan, as needed. 34(d):] E organization must test the emergency plan e PACE organization must ency plan e PACE organization must ency that requires is uct an annual ency that requires regency plan, the PACE is go in its next required based or individual, all exercise following the cry event. Idditional exercise every 2 ear the full-scale or inder paragraph (d)(2)(i) of ited that may include, but exercise that is individual, a facility cise; or iill; or every or	E 03	9			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.400.000.000	TIPLE CONSTRUCTION ING		ATE SURVEY PLETED
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E 039	(iii) Analyze the PAC maintain documental exercises, and emerging the PACE's emerger *[For LTC Facilities a (2) The [LTC facility] to test the emergency year, including unant using the emergency facility, ICF/IID] must do the (i) Participate in an art that is community-based (A) When a community not accessible, conditionally facility-based function (B) If the [LTC facility] an actual natural or in that requires activation plan, the LTC facility engaging its next requommunity-based or individual, facility-based or individual, facility-based following the onset of (ii) Conduct an addition that may include, but following: (A) A secon that is community-based or a based functional exer (B) A mock disaster dr (C) A tabletop exercise by a facilitator include using a narrated, cliniscenario, and a set of directed messages, or prepared to challenge an emerging	te an emergency plan. E's response to and tion of all drills, tabletop gency events and revise ncy plan, as needed. It §483.73(d):] must conduct exercises by plan at least twice per nounced staff drills or procedures. The [LTC of following: nnual full-scale exercise is exercise as exercise is exercise. If acility experiences nan-made emergency on of the emergency on of the emergency is exempt from uired a full-scale exercise is not limited to the diffull-scale exercise. In individual, facility cise; or rill; or exercise or workshop that is led is a group discussion, cally-relevant emergency problem statements, acility] facility's response exercise depends on the designed gency plan. In individual designed gency plan. In individual facility's response	E 039			

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E 039	the [LTC facility] faci needed.	gency events, and revise ility's emergency plan, as	E 039			
	to test the emergency year. The ICF/IID mu (i) Participate in an athat is community-bat (A) When a community not accessible, condindividual, facility-based function (B) If the ICF/IID experor man-made emerging activation of the emerging full-scale community-based or in facility-based function the onset of the emerging (ii) Conduct an addition that may include, but following: (A) A second that is community-based or a facility-based function (B) A mock disaster did (C) A tabletop exercise by a facilitator and incodiscussion, using a native community and incodiscussion, using a native community and incodiscussion, using a native community and incommunity and	IID must conduct exercises y plan at least twice per ust do the following: nnual full-scale exercise ased; or ity-based exercise is uct an annual nal exercise; or. eriences an actual natural ency that requires ergency plan, the ICF/IID ging in its next required individual, nal exercise following regency event. onal annual exercise is not limited to the id full-scale exercise an individual, nal exercise; or rill; or e or workshop that is led cludes a group arrated, ergency scenario, and a ents, directed d questions an emergency plan. D's response to and				
	the ICF/IID's emergen *[For HHAs at §484.10 (d)(2) Testing. The HH.	* M				

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING _ 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 039 Continued From page 13 E 039 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 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (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. (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: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (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. (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.

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 039 Continued From page 14 E 039 The Executive Director and Facilities 12/1/2023 Coordinator will complete a revision of the drill to test the emergency plan. The OPO must do the following: training calendar to reflect monthly fire drills on a rotating shift basis, and monthly (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise emergency preparedness drill on a rotating is led by a facilitator and includes a group shift basis. These drills will include natural discussion, using a narrated, clinically disasters, evacuation procedures, full relevant emergency scenario, and a set of community scale evacuation, shelter in place, and other hazardous situations. The calendar statements, directed messages, or prepared will reflect that at least one full scale questions designed to challenge an community event drill and at least one table emergency plan. If the OPO experiences an top training exercise occur annually. Reviews actual natural or man-made emergency that of drills and exercises will occur at the requires activation of the emergency plan, the following management team meeting to OPO is exempt from engaging in its next identify, navigate, and implement solutions for required testing exercise following the onset any concerns experienced during the drills of the emergency event. (ii) Analyze the and exercises. Drill and exercise completion OPO's response to and maintain will be delegated to the house supervisory documentation of all tabletop exercises, and team (QP & Team Assistant) for assignment emergency events, and revise the [RNHCI's and monitoring compliance. One on one and OPO's] emergency plan, as needed. training will occur as needed by any member *[RNCHIs at §403.748]: of management. (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (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. (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. 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:

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E 039	Continued From pag	e 15	E 03	39			
W 130	a second full scale-c facility-based training tabletop exercise. PR CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensuctients. Therefore, the privacy during treatmeds. This STANDARD is not by: Based on observation and interview, the facility faprivacy was maintaineduring personal care. Observations in the grat 8:21 AM revealed of the toilet with his pant open. Continued obsessitting in the direct further observation revealed that tempt to check on the observation at 8:34 AM finish, leave the bathroagain sit with his pant open without staff interview.	ge of a full-scale ge, a second full acility-based training bletop exercise. B with the executive e facility has not or facility-based training, ommunity or g or mock drill, or a OTECTION OF In the rights of all e facility must ensure ent and care of personal of met as evidenced ation, record review alled to assure that ed for 1 of 6 clients (#4) The finding is: oup home on 10/31/23 client #4 to be sitting on is down and the door ervation revealed a staff om near the bathroom that the staff made no e client. Subsequent if revealed the client to own, then return and is down and the door	W 13	0			

PRINTED: 11/01/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 130 Continued From page 16 W 130 The supervisory team (QP & Team Assistant) will 12/1/2023 Centered Plan (PCP) dated 6/22/23 for client provide inservice training to staff regarding privacy standards and expectations. They will engage in #4. Continued review revealed the PCP to state that the client is blind and can toilet quality assurance and improvement via the use of observational assessment forms and as needed independently but additional 1:1 training and consultation with staff to needs help wiping. Further review revealed ensure understanding and compliance. The Clinical that the PCP does not contain a goal for Team (IDT, QP, Clinical Dir, Exec Dir) will coordinate client #4 to maintain privacy during personal and complete comprehensive skills evaluations. The QP will utilize these to update programmatic goals for individuals with identified need to address Interview with the Executive Director (ED) concerns surrounding privacy, as well as other on 10/31/23 confirmed that staff should be independence skills. The QP will provide inservice aware when client #4 enters the restroom training to the staff to ensure understanding of goal and should assist him with maintaining and methodology. privacy during toileting. Continued interview revealed the ED to confirm that client #4 would benefit from a W 371 program goal designed to assist him with W 371 independence in maintaining privacy during personal care. 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 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

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W 371	take the medications revealed that at no the education to client #1 medications nor did solient #1 to participate preparation of his medications on 10/3 accompany client #2 Continued observation revealed #2's morning medicate punch each pill into a applesauce, prepare powder, then hand the client with the water at take the medications. Further at no time did staff A #2 regarding his medications. Further at no time did staff A #2 regarding his medications on 10/3 accompany client #5 Continued observation revealed s #5's morning medicate punch one pill into a cowater then hand the medication of the preparation of pill into a cowater then hand the medication of the pill into a cowater then hand the medication of the pill into a cowater then hand the medication and the medication of the pill into a cowater then hand the medication of the pill into a cowater then hand the medication of the pill into a cowater then hand the medication of the pill into a cowater then hand the medication of the pill into a cowater then hand the medications of the preparation of the pill into a cowater then hand the medications of the pill into a cowater then hand the medications of the pill into a cowater then hand the medications of the pill into a cowater then hand the medications of the pill into a cowater the pill into a cowa	the medications to the and instruct the client to an instruct the client to a Further observation imedid staff A offer I regarding his staff A offer or encourage in the edications. Administration and a revealed staff A to to the medication room. Staff A to retrieve client tions from the closet, a cup, mix the pills with a cup of water with fiber is applesauce cup to the and instruct the client to a cobservation revealed that offer education to client dications nor did staff A ent #2 to participate in the closet, sup, prepare a cup of the clos	W 37	The clinical team will coordinate and corcomprehensive skills evaluations to ider skill level and need for each resident in to medication administration (knowledge participation scope). The QP will utilize information to develop and update programmatic goals for this domain. Stareceived person specific training regardi goals and methodology. The RN, Super Team, Clinical Dir, & Exec Dir. will monitoutcomes through intermittent assessme ensure staff understanding & compliance. The QP will also monitor goal progress through documentation of program trials determine if updates to the goal are need.	ntify regard e & this aff will ng visory or ents to e. to	12/1/2023

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W 474	#5 can participate in medica some level and show opportunities to participate. Continued clients should be pro about the medication this is staff's responsibility. MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served the developmental le This STANDARD is n Based on observation interviews, the facility form consistent with the and prescribed diets and #6). The findings A. The facility failed to diet for client #1. For	tecutive Director to #1, client #2, and client tion administration on ald have been afforded icipate to the extent interview confirmed that all ovided with education s they are taking and that (2)(iii) In a form consistent with vel of the client. ot met as evidenced by: as, record review, and failed to serve food in a ne developmental levels of 3 of 6 clients (#1, #2, are: are: a ensure the prescribed example: coup home on 10/30/23 the dinner meal to be cheese, cooked auce, and rolls. as revealed staff to lient #1, and client #1 thout staff cutting up any manner. The breakfast meal client #1 to be of and cheese toast. The everaled the cheese that to be in whole form.	W 474			

consume the		

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W 474	in in any way. Record review on 10 physician's order for stating that the clien chopped diet. Interview with the Ex 10/31/23 confirmed the following the current #1. Continued interview need for an updated be completed for the B. The facility failed to as prescribed. For expectations in the group 5:05 PM revealed the baked mac n cheese, applesauce, and dinrobservations at 5:15 eat mac n cheese, applesauce, and consistent #2 to provide a cutting up carrots. Observations in the group of the gro	/31/23 revealed a client #1 dated 6/6/23 t is currently prescribed a ecutive Director (ED) on that the staff should be prescribed diet for client liew revealed there is a nutritional evaluation to client. of follow client #2's diet cample: roup home on 10/30/23 at dinner meal to consist of carrots, peas, the rolls. Continued PM revealed client #2 to as, and dinner roll in the ency. At no time during that observed to assist modified diet other than roup home on 10/31/23 at breakfast meal to consist to ast. Continued diet client #2 to eat the cular whole consistency, observation was staff in t#2 to provide a ecord on 10/31/23 s order dated 6/6/23.	W 47-	All staff will receive training regarding m consistencies, dietary and menu guideli and person specific training in relation to these concepts and person specific diet consistency guidelines. All residents will receive evaluations to determine appropriate dietary and food consistency modifications needed, which include corroboration with physician, registered dietician, and additional ancill providers as needed. Individual evaluations will be completed determine programming needs for each person regarding participation in altering own food consistencies, with goals implemented where necessary. Staff will receive training regarding the implement of any goal programs. Compliance with training and prescribed diet/consistency will be monitored by the management team through meal/eating the assessments, with immediate training and disciplinary action occurring at any points which guidelines are not followed.	nes, o and hary to g their lation	12/31/2023

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

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moisten all solids, cuadded salt. Further in no nutritional assess surveyor to review for linear #2's physician! Further interview corshould have been properties assessment. C. The facility failed that as prescribed. For example, and dinional state of baked manapplesauce, and dinional state of the consistency. At no time was staff observed to provide a mechanical dinner meal.	ut meat wafer thin, and no review of the plan revealed sment was available for or client #2. Do on 10/31/23 confirmed sorders to be current. Infirmed that client #2 rovided a modified diet an updated nutritional so follow client #6's diet example: group home on 10/30/23 the dinner meal to concheese, carrots, peas, ner rolls. Continued PM revealed client #6 to regular whole the during the observation assist client #6 to soft dinner roll for the group home on 10/31/23 at	W 474			
8:12 AM revealed the of eggs, yogurt, chee Continued observation eat the cheese toast consistency. At no time was staff observed to provide a mechanical breakfast meal. Review of client #6's revealed a nutritional Continued review of the continu	breakfast meal to consist use toast, and milk. Ons revealed client #6 to in regular whole use during the observation assist client #6 to soft cheese toast for the record on 10/31/23 evaluation dated 1/2/23. The nutritional evaluation				
	Continued From page moisten all solids, cuadded salt. Further in no nutritional assess surveyor to review for linterview with the Electient #2's physician' Further interview corshould have been pland the client needs assessment. C. The facility failed the asprescribed. For election of the consist of baked manapplesauce, and din observations at 5:12 eather dinner roll in consistency. At no time was staff observed to provide a mechanical dinner meal. Observations in the grant observation of ergos, yogurt, cheek continued observations are the cheese toast consistency. At no time was staff observed to provide a mechanical breakfast meal. Review of client #6's revealed a nutritional continued review of the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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. 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. C. The facility failed to follow client #6's diet as prescribed. For example: 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. 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 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	DENTIFICATION NUMBER: 34G075 B. WING_ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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. 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. C. The facility failed to follow client #6's diet as prescribed. 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Continued review of the nutritional evaluation	TOP CORRECTION TO ENTIFICATION NUMBER: 34G075 **REPROVIDER OR SUPPLIER** A WENUE GROUP HOME **SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING MERCHANTION) Continued From page 20 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: 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. C. The facility failed to follow client #6's diet as prescribed. For example: Observations in the group home on 10/30/23 at 5:00 PM revealed the dinner meal to consist of baked mac in cheese, carrots, peas, applesauce, and dinner rolls. 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Review of client #6's record on 10/31/23 revealed an untrititional evaluation of the decire the first review of the nutritional evaluation of the provide a mechanical soft cheese toast for the provide a mechanical soft cheese toast for the preview of the nutritional evaluation of the provided and the provided and the provided the provided and the provided and the provided and the provided the provided the provided the provided the provided th	A BUILDING 346075 PROVIDER OR SUPPLIER AVENUE GROUP HOME SUMMARY STATEMENT OF DEPICIENCIES EACH DEPICIENCY MUST SE PRECEDED BY THE REQUESTION OF CASE REPORTED BY THE RECUESTION OF CASE RE

limited sugars (diabetic), low fat, and low salt, foods cut up in advance of being served mechanical soft.	7		
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	ROVIDER OR SUPPLIER VENUE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	

PRINTED: 11/01/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME **ASHEVILLE, NC 28803** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 004 Develop EP Plan, Review and Update E 004 Annually CFR(s): 483.475(a) §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). 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: (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: * [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.

* [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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	TE SURVEY .ETED	
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	PROVIDER OR SUPPLIER AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIF 22 CHILES AVENUE ASHEVILLE, NC 28803	CODE		
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E 004	Continued From page 1 * [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.	E 004	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.	11/22/2023
	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:			
	Review on 10/30/23 of the facility's EPP revealed that the facility does not have an EPP currently in place.			
E 037	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)	E 037		
	§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).			
	*[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:] (1) Training program. The [facility] must do all of the following:			
	(i) Initial training in emergency preparedness policies and procedures to all new and existing			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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p	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803		
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			DEFICIENCY)	
E 037	Continued From page 2 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (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. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (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. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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# (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. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency preparedness training on the updated policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. **[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 call new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness (iii) Demonstrate staff knowledge of emergency procedures it stanting at least every 2 years. (iii) Demonstrate staff knowledge of emergency preparedness ratining at least every 2 years. (iii) Demonstrate staff knowledge of emergency preparedness ratining in feast every 2 years. (iii) Olimital roll on the rollowing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies					
	E 037	*[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. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[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. (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. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.	E 037		
and procedures. *[For LTC Facilities at §483.73(d):] (1) Training		and procedures.			

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NAME OF PROVIDER OR SUPPLIER CHILES AVENUE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803		
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E 037	Continued From page 4 Program. The LTC facility must do all of the following:	E 037	
	(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. (ii) Provide emergency preparedness training		
	at least annually. (iii) Maintain documentation of all emergency preparedness training.		
	(iv) Demonstrate staff knowledge of emergency procedures.		
	*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (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.		
	(ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.		
	(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.		
	(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.		
	*[For CAHs at §485.625(d):] (1) Training program.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		34G075	B. WING	G	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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		

E 037 Continued From page 5 E 037 The Executive Director will update the present 12/1/2023 hazard plan and training to reflect that it is for The CAH must do all of the following: (i) Initial training in emergency emergency preparedness. Staff will be preparedness policies and procedures, provided with training regarding the updated including prompt plan, contained procedures and protocols, its reporting and extinguishing of fires, location within the home, and drills overview. protection, and where necessary, Training will occur with all present staff by the evacuation of patients, personnel, and stated date, and annually thereafter. guests, fire prevention, and cooperation with firefighting and disaster Future employees will receive training at authorities, to all new and existing staff, orientation, instruction on plan location in the individuals providing services under home, annual training thereafter, and update arrangement, and volunteers, consistent with training as needed. their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[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. 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:

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Review on 10/30/23 of the facility's EPP revealed

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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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E 037	Continued From page 6	E 037		
	no evidence of initial or biennial training on the EPP.			
E 039	Interview on 10/31/23 with the executive director confirmed that initial training and biennial training for current staff were not completed. EP Testing Requirements	E 039		
	CFR(s): 483.475(d)(2)			
	§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).			
	*[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]:			
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:			
	(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			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G075		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
		B. WING	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 039	Continued From page 7 functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (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. (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. *[For Hospices at 418.113(d):] (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 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (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. (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	EO	39			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE			
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E 039	Continued From page 8 is conducted, 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 (B) A mock disaster drill; or (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. (3) Testing for hospices that provide inpatient care directly. The hospice must	E 039				
	conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (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. (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 (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency					

directed

scenario, and a set of problem statements,

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
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E 039	to challenge an eme (iii) Analyze the hosp maintain documentat exercises, and emerg the hospice's emerg *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [F must do the following (i) Participate in an ar that is community-ba (A) When a communi not accessible, condi individual, facility-based function (B) If the [PRTF, Hosp an actual natural or in that requires activation the [facility] is exemp next required full-sca individual, facility-base following the onset of (ii) Conduct an [a or and that may include following: (A) A second full-scal community-based or in facility-based function (B) A mock described.	red questions designed regency plan. rice's response to and received and revise gency events and revise ency plan, as needed. 184(d), Hospitals at §485.625(d):] TF, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] g: nnual full-scale exercise sed; or ty-based exercise is uct an annual real exercise; or oital, CAH] experiences nan-made emergency plan, the from engaging in its le community based or red functional exercise the emergency event. Indiditional] annual exercise the emergency event. Indiditional] annual exercise de, but is not limited to the exercise or workshop that is includes a group reated, ergency scenario, and	E 039				

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E 039	maintain documental exercises, and emergency scenario, using a namergency scenario,	[facility's] response to and tion of all drills, tabletop gency events and revise ency plan, as needed. 34(d):] E organization must test the emergency plan e PACE organization must encual full-scale exercise is uct an annual exercise; or riences an actual natural ency that requires regency plan, the PACE is ency plan, the PACE is ency that required based or individual, all exercise following the coy event. Editional exercise every 2 are the full-scale or ender paragraph (d)(2)(i) of exect that may include, but exercise that is exercise that is exercise that is exercise; or riel; or events or every that is led cludes a group exercised, clinically-relevant	E 03	39			

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	F PROVIDER OR SUPPLIER S AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803		
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E 039	(iii) Analyze the PAC maintain documenta exercises, and emer the PACE's emerger *[For LTC Facilities a (2) The [LTC facility] to test the emergency year, including unan using the emergency facility, ICF/IID] must do the (i) Participate in an at that is community-based (A) When a community of accessible, condindividual, facility-based function (B) If the [LTC facility an actual natural or that requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requires activating plan, the LTC facility engaging its next requiremental community-based or individual, facility-base following the onset of (ii) Conduct an addition that may include, but following: (A) A second that is community-based or a based functional exercise by a facilitator included using a narrated, clinic scenario, and a set of directed messages, or prepare to challenge an emergence of the plane o	te an emergency plan. E's response to and tion of all drills, tabletop gency events and revise ncy plan, as needed. It §483.73(d):] must conduct exercises by plan at least twice per nounced staff drills y procedures. The [LTC of following: nnual full-scale exercise is uct an annual nal exercise. If facility experiences man-made emergency on of the emergency is exempt from uired a full-scale ed functional exercise is not limited to the diffull-scale exercise is not limited to the diffull-scale exercise an individual, facility roise; or rill; or e or workshop that is led as a group discussion, cally-relevant emergency for plan. acility] facility's response	E 039			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		DATE SURVEY PLETED
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CHILES	AVENUE GROUP HOME				22 CHILES AVENUE ASHEVILLE, NC 28803		
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E 039	Continued From page exercises, and emer the [LTC facility] fac needed. *[For ICF/IIDs at §48 (2) Testing. The ICF/ to test the emergency year. The ICF/IID mid (i) Participate in an at that is community-based function (B) If the ICF/IID export man-made emergency activation of the emergency is exempt from engated full-scale community-based or facility-based function the onset of the emergiactivation of the emergency is exempt from engated full-scale community-based or facility-based function the onset of the emergiactivation (B) Conduct an addition that may include, but following: (A) A secont that is community-based or facility-based function (B) A mock disaster decommunity-based function (B) A mock disaster decommunity-b	gency events, and revise illity's emergency plan, as 3.475(d)]: IID must conduct exercises y plan at least twice per ust do the following: nnual full-scale exercise ased; or ity-based exercise is luct an annual nal exercise; or. eriences an actual natural ency that requires argency plan, the ICF/IID ging in its next required individual, nal exercise following rency event. In al annual exercise is not limited to the ad full-scale exercise an individual, nal exercise; or rill; or e or workshop that is led cludes a group arrated, ergency scenario, and a	E 03	9			
	the ICF/IID's emerger *[For HHAs at §484.10	an emergency plan. D's response to and on of all drills, tabletop ency events, and revise ncy plan, as needed.					

PRINTED: 11/01/2023 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G075 B. WING_ 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 039 Continued From page 13 E 039 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 (A) When a community-based exercise is not accessible, conduct an annual individual. facility-based functional exercise every 2 years; or. (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. (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: (A) A second full-scale exercise that is community-based or an individual. facility-based functional exercise; or (B) A mock disaster drill; or (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. (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.

(d)(2) Testing. The OPO must conduct exercises

*[For OPOs at §486.360]

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 11/01/2023 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A BUILDING

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
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	PROVIDER OR SUPPLIER AVENUE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE ASHEVILLE, NC 28803			
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E 039	the following: (i) Conduct a paper-lyworkshop at least an is led by a facilitator discussion, using a nor relevant emergency problem statements, directed questions designed the emergency plan. If the actual natural or main requires activation of OPO is exempt from required testing exercing of the emergency events, and OPO's response to all documentation of all the emergency events, and OPO's emergency events, and emergency events, and emergency events, and emergency events, and least annually. A tagroup discussion led narrated, clinically-relevant exercises and a set of directed messages, or designed to challenge (ii) Analyze the RNHC maintain documentation exercises, and emergency the RNHCl's emerger This STANDARD is not Based on record review facility failed to conduct and the conduction of the conducti	py plan. The OPO must do pased, tabletop exercise or nually. A tabletop exercise and includes a group parrated, clinically scenario, and a set of messages, or prepared or challenge an ne OPO experiences and nemade emergency that the emergency plan, the engaging in its next bise following the onset ent. (ii) Analyze the nual maintain cabletop exercises, and and revise the [RNHCl's next plan, as needed. 8]: HHCl must conduct emergency plan. The collowing: ased, tabletop exercise abletop exercise abletop exercise is a by a facilitator, using a revant emergency plan. I's response to and on of all tabletop ency events, and revise next plan, as needed. It is needed.	E 039	The Executive Director and Facilities Coordinator will complete a revision of the training calendar to reflect monthly fire of on a rotating shift basis, and monthly emergency preparedness drill on a rotation shift basis. These drills will include nature disasters, evacuation procedures, full community scale evacuation, shelter in pand other hazardous situations. The cale will reflect that at least one full scale community event drill and at least one to top training exercise occur annually. Revor drills and exercises will occur at the following management team meeting to identify, navigate, and implement solution any concerns experienced during the drill and exercises. Drill and exercise comple will be delegated to the house supervisor team (QP & Team Assistant) for assignment and monitoring compliance. One on one training will occur as needed by any memor of management.	ing ral blace, endar ble riews ns for ls tion ry ent	12/1/2023	

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E 039	Continued From pag	e 15	E 0	39				
W 130	a second full scale-c facility-based training tabletop exercise. PR CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure clients. Therefore, the privacy during treatmeneds. This STANDARD is not by: Based on observational interview, the facility faprivacy was maintained during personal care. Observations in the grat 8:21 AM revealed of the toilet with his pant open. Continued obsessitting in the dining row who looked in the direct Further observation revealed that tempt to check on the observation at 8:34 AM finish, leave the bathro again sit with his pants open without staff interview.	g, a second full facility-based training pletop exercise. B with the executive refacility has not correctly facility-based training, community or g or mock drill, or a cottent of a facility must ensure rent and care of personal cottent and the door revealed a staff common cottent and the bathroom. The staff made not revealed the client to com, then return and adown and the door	W 13	60				

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 34G075 B. WING 10/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 22 CHILES AVENUE CHILES AVENUE GROUP HOME ASHEVILLE, NC 28803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 130 Continued From page 16 W 130 The supervisory team (QP & Team Assistant) will 12/1/2023 Centered Plan (PCP) dated 6/22/23 for client provide inservice training to staff regarding privacy standards and expectations. They will engage in #4. Continued review revealed the PCP to quality assurance and improvement via the use of state that the client is blind and can toilet observational assessment forms and as needed independently but additional 1:1 training and consultation with staff to needs help wiping. Further review revealed ensure understanding and compliance. The Clinical that the PCP does not contain a goal for Team (IDT, QP, Clinical Dir, Exec Dir) will coordinate client #4 to maintain privacy during personal and complete comprehensive skills evaluations. care The QP will utilize these to update programmatic goals for individuals with identified need to address Interview with the Executive Director (ED) concerns surrounding privacy, as well as other on 10/31/23 confirmed that staff should be independence skills. The QP will provide inservice aware when client #4 enters the restroom training to the staff to ensure understanding of goal and should assist him with maintaining and methodology. privacy during toileting. Continued interview revealed the ED Assessments will occur on each staff member at to confirm that client #4 would benefit from a least once per week. program goal designed to assist him with W 371 W 371 independence in maintaining privacy during personal care. 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 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

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W 371	take the medications revealed that at no tile education to client #1 medications nor did solient #1 to participate preparation of his medications on 10/3 accompany client #2 Continued observation revealed #2's morning medicate punch each pill into a applesauce, prepare powder, then hand the client with the water at take the medications. Further of at no time did staff A #2 regarding his med offer or encourage clithe preparation of his medications on 10/3 accompany client #5 to Continued observation revealed significant with the medication accompany client #5 to Continued observation revealed significant water then hand the medication to client with the medication accompany client #5 to Continued observation revealed significant water then hand the medication to client water then hand the medication to client water then hand the medication to client water then hand the medication accompany client #5 to Continued observation revealed significant water then hand the medications are provided to the preparation of the preparatio	the medications to the and instruct the client to an instruct the client to a Further observation and did staff A offer regarding his staff A offer or encourage in the dications. Indiministration and the closet of the medication room. In the dication room the closet, and the client to the medication room the client to the properties of the client to the properties of the client to the control of the client to the medication room. In the dication room the closet, and the closet of the closet	W 37	The clinical team will coordinate and concomprehensive skills evaluations to ider skill level and need for each resident in to medication administration (knowledge participation scope). The QP will utilize information to develop and update programmatic goals for this domain. Stareceived person specific training regarding goals and methodology. The RN, Super Team, Clinical Dir, & Exec Dir. will monito outcomes through ineraction assessment ensure staff understanding & compliance The QP will also monitor goal progress through documentation of program trials determine if updates to the goal are need. Assessment will occur once per week for "med tech" staff member during the training period, and then titrate to a periodic basis continued supervision purposes.	ntify regard e & this aff will ng rvisory or ats to e. to ded.	

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W 474	#5 can participate in medica some level and shou opportunities to parti possible. Continued clients should be pro about the medication this is staff's responsibility. MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served the developmental le This STANDARD is no Based on observation interviews, the facility form consistent with the and prescribed diets and and #6). The findings A. The facility failed to diet for client #1. For	tion administration on all have been afforded icipate to the extent interview confirmed that all ovided with education is they are taking and that (i)(iii) In a form consistent with vel of the client. Of the client in a sevidenced by: Is, record review, and failed to serve food in a interview developmental levels of 3 of 6 clients (#1, #2, are: I ensure the prescribed example: I coup home on 10/30/23 the dinner meal to be cheese, cooked auce, and rolls. In serve aled staff to lient #1, and client #1 thout staff cutting up any manner. I de breakfast meal client #1 to be in whole form.	W 47				

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W 474	in in any way. Record review on 10 physician's order for stating that the clien chopped diet. Interview with the Ex 10/31/23 confirmed the following the current #1. Continued intervinced for an updated be completed for the B. The facility failed to as prescribed. For ex Observations in the g 5:05 PM revealed the baked mac n cheese, applesauce, and dinn observations at 5:15 eat mac n cheese, peregular whole consiste the observation was sclient #2 to provide a routting up carrots. Observations in the gr 7:30 AM revealed the of eggs, and cheese to observations revealed.	staff cutting or modifying /31/23 revealed a client #1 dated 6/6/23 t is currently prescribed a ecutive Director (ED) on that the staff should be prescribed diet for client ew revealed there is a nutritional evaluation to client. of follow client #2's diet tample: roup home on 10/30/23 at dinner meal to consist of carrots, peas, ther rolls. Continued PM revealed client #2 to the as, and dinner roll in the ency. At no time during taff observed to assist modified diet other than oup home on 10/31/23 at breakfast meal to consist oast. Continued If client #2 to eat the ular whole consistency, observation was staff int #2 to provide a	W 47		All staff will receive training regarding meconsistencies, dietary and menu guidelir and person specific training in relation to these concepts and person specific diet consistency guidelines. All residents will receive evaluations to determine appropriate dietary and food consistency modifications needed, which include corroboration with physician, registered dietician, and additional ancilla providers as needed. Individual evaluations will be completed to determine programming needs for each person regarding participation in altering own food consistencies, with goals implemented where necessary. Staff will receive training regarding the implementation of any goal programs. Compliance with training and prescribed diet/consistency will be monitored by the management team through meal/eating times assessments, with immediate training and disciplinary action occurring at any points which guidelines are not followed. Assessment will occur no less than once pweek per meal time initially to ensure staff awareness and understanding of individual guidelines, and titrate to no less than once meal per month there after.	nes, o and o arry o their mes d/or in their in their mes d/or in their in their mes d/or in their in the interval in the in	12/31/2023

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

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W 474	added salt. Further in no nutritional assess surveyor to review for linterview with the ED client #2's physician's Further interview conshould have been proposed and the client needs assessment. C. The facility failed to as prescribed. For expending the same of the sam	at meat wafer thin, and no eview of the plan revealed sment was available for or client #2. O on 10/31/23 confirmed so orders to be current. firmed that client #2 ovided a modified diet an updated nutritional of follow client #6's diet cample: roup home on 10/30/23 the dinner meal to conclude the confirmed that client #6 to regular whole the during the observation assist client #6 to soft dinner roll for the coup home on 10/31/23 at breakfast meal to consist the se toast, and milk. The revealed client #6 to the regular whole the during the observation assist client #6 to the coup home on 10/31/23 at breakfast meal to consist the se toast, and milk. The revealed client #6 to the coup home on 10/31/25 at breakfast meal to consist the coup home on 10/31/25 at breakfast me	W 474			

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

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W 474	Continued From page 21	W 474	
	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.		