STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G354	A. BUILDING _____ B. WING _____	R 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMORY ROAD HOME	**20 EMORY ROAD ASHEVILLE, NC 28806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A revisit was conducted on 7/24/25 for all previous deficiencies cited on 5/7/25. The facility was unable to provide full documentation to support the Plan of Correction. Deficiencies were recited and the facility remains out of compliance.	W 000		
{W 260}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the person-centered plan (PCP) was revised at least annually for 3 of 5 audited clients (#2, #3, and #6). The findings are: Review of records on 5/7/25 for client #2 revealed a PCP dated 6/22/22. There was no additional documentation provided to show evidence that client #2's PCP meeting had taken place and updated since 6/22/22. Review of records on 5/7/25 for client #3 revealed a PCP dated 3/13/24. There was no additional documentation provided to show evidence that client #3's PCP meeting had taken place and updated since 3/13/24. Review of records on 5/7/25 for client #6 revealed a PCP dated 4/16/24. There was no additional documentation provided to show evidence that client #6's PCP meeting had taken place and updated since 4/16/24. Interview on 5/7/25 with the qualified intellectual disabilities professional (QIDP) confirmed that	{W 260}		

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

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{W 260}	Continued From page 1 client #2's, #3's, and #6's PCPs were current. Continued interview with the QIDP revealed that the PCP meetings had not taken place. During the follow-up survey completed on 7/24/25, the facility was unable to provide evidence of updated person-centered plans for clients #2, #3, and #6. The deficiency remains out of compliance.	{W 260}		
{W 440}	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to first, second, and third shift. The finding is: Review of the facility fire drill reports from 6/24 through 5/25 revealed missing fire drills for 9/24, 10/24, 11/24, and 12/24. Further review of the fire drill reports revealed first shift drills conducted on 7/11/24, 1/28/25, and 4/8/25; second shift drills conducted on 8/6/24, 2/11/25, and 5/5/25; and third shift drills completed on 6/11/24 and 3/13/25. There was no additional documentation available about conducting the missing fire drills during the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 5/7/25 confirmed facility fire drills should have been conducted quarterly for each shift. Continued interview QIDP confirmed that all requested documentation for fire drills conducted 6/24 through 5/25 were provided to the surveyor.	{W 440}		

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	34G354	A. BUILDING _____ B. WING _____	R 07/24/2025

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{W 440}	Continued From page 2 During the follow-up survey completed on 7/24/25, the facility was unable to provide evidence of staff training on conducting fire drills. The deficiency remains out of compliance.	{W 440}		