

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G354	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806	
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W0104	<p>GOVERNING BODY</p> <p>CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the facility's governing body failed to exercise general policy, budget and operating direction over the facility with respect to maintenance and repair of the facility. The finding is:</p> <p>Observations in the group home on 5/12/26 and 5/13/26 revealed the following: client #2's bedroom was observed to have broken window handles, no closet door, a dirty adult disposable brief on the floor, and a strong odor of urine in the area of the bed; the door to client #3's bedroom was observed to be cracked across the middle; client #1's bedroom was observed to have large unpainted drywall patches on the walls, a hole in the wall behind the closet door, and paint peeling off of the wall around the door; the hallway and living areas were observed to have many areas of unpainted drywall patching; the living room furniture appeared extremely worn and the recliner functions were inoperable; the dining room chairs show extreme wear and the dining room table is unfinished and has been written on with permanent marker.</p> <p>Review of records revealed that some repairs were made prior to December, 2025, but no work orders have been submitted since December, 2025.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility is in need of repairs and maintenance as stated above.</p>	W0104		
W0130	<p>PROTECTION OF CLIENTS RIGHTS</p> <p>CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during</p>	W0130		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0130	Continued from page 1 treatment and care of personal needs. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for client #2 during personal care and treatment. The finding is: Observations in the group home on 5/13/26 revealed client #2 to enter the restroom at 7:11 am with staff A standing in the doorway and the bathroom door open to the hallway. Further observation revealed client #2 could be heard urinating while staff A gave directions to client #2 to continue urinating, to "point it down" and then to "put it back in your pants." Continued observation revealed client #2 to enter a different restroom with staff A at 7:40 am. Staff A again stood in the doorway with the door open and could be heard instructing client #2 to remove his clothing and enter the shower. Throughout client #2's shower, he was naked and visible from the hallway. Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that staff should ensure privacy for all clients during personal care and treatment.	W0130		
W0420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to provide client #2 with functional furniture in his bedroom. The finding is: Observations in the group home on 5/12/26 and 5/13/26 revealed client #2's bedroom to contain a bed and no other furniture. Further observation revealed there were no personal belongings in the room and the door of the closet was missing. Review of records on 5/13/26 revealed a behavior support plan (BSP) for client #2 dated 1/1/26 which states that client #2 should have furniture that is easily cleaned after toileting accidents and that he should have access to 2 of each clothing item in his dresser bin to support his desire to independent. Interview with the program manager (PM) on 5/13/26 confirmed that client #2 should have developmentally	W0420		

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W0420	Continued from page 2 appropriate furniture in his bedroom. Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed all clients should have developmentally appropriate bedroom furniture.	W0420		
W0440	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 record review and interview, the facility failed to ensure evacuation drills were conducted quarterly with each shift of personnel. The finding is: Review of records on 5/12/26 revealed that for the first quarter of the survey year, the facility conducted one drill, but it is unclear which shift was involved due to missing information on the record. Further review revealed that during the second quarter of the survey year, the facility conducted one drill during the first shift and another drill conducted during an unknown shift. Continued review revealed that during the third quarter of the survey year, the facility conducted three drills during unknown shifts. Additional review revealed that during the fourth quarter of the survey year, no drills were conducted. Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility could not produce evidence of additional fire drills and produced insufficient evidence to verify that drills were conducted quarterly for each shift of personnel.	W0440		
E0004	Develop EP Plan, Review and Update 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	E0004		

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E0004	<p>Continued from page 3 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> <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>.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to update the emergency preparedness plan (EPP) at least bi-annually. The finding is:</p> <p>Review of records on 5/12/26 revealed an EPP which was last reviewed in May, 2019.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility could not provide evidence of an EPP which was updated within the last 2 years.</p>	E0004		
E0015	<p>Subsistence Needs for Staff and Patients</p> <p>CFR(s): 483.475(b)(1)</p> <p>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1)</p>	E0015		

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E0015	<p>Continued from page 4</p> <p>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p>	E0015		

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E0015	Continued from page 5 (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that adequate provisions were present in the home for use in the event of emergencies. The finding is: Observations on 5/12/26 revealed a bin containing the facility's emergency provisions. Further observation revealed 5 dehydrated meals, 5 cans of vegetables and several cans of tuna. In addition, the bin contained several items of expired food. Further observation revealed several gallons of water which staff indicated were part of the emergency provisions. All water was expired and many jugs had missing lids. Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility lacked adequate provisions to use in the event of an emergency.	E0015		
E0037	EP Training Program CFR(s): 483.475(d)(1) §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 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.	E0037		

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E0037	<p>Continued from page 6</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> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF 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 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>	E0037		

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E0037	<p>Continued from page 7</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.</p> <p>(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 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,</p>	E0037		

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E0037	<p>Continued from page 8 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. 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</p>	E0037		

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E0037	Continued from page 9 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 that staff are adequately trained with respect to the emergency preparedness plan (EPP). The finding is: Review of records on 5/12/26 revealed no evidence of yearly staff training with respect to the EPP. Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility could not provide evidence of yearly staff training on the EPP since the last survey.	E0037		
E0039	EP Testing Requirements 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 functional	E0039		

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E0039	<p>Continued from page 10 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:</p> <p>(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 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>	E0039		

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(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
E0039	<p>Continued from page 11</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:</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 led by a facilitator that 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 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>	E0039		

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G354</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 05/13/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806</p>		
(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
E0039	<p>Continued from page 12</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 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</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806
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E0039	<p>Continued from page 13 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 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:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based</p>	E0039		
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G354</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 05/13/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806</p>		
(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
E0039	<p>Continued from page 14 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 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:</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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and</p>	E0039		

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G354</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 05/13/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806</p>		
(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
<p>E0039</p>	<p>Continued from page 15 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 to test the emergency plan at least annually. The HHA must do the following:</p> <p>(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]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p>	<p>E0039</p>		

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NAME OF PROVIDER OR SUPPLIER EMORY ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 20 EMORY ROAD , ASHEVILLE, North Carolina, 28806	
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E0039	<p>Continued from page 16</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.</p> <p>(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:</p> <p>Based on record review and interview, the facility failed to conduct testing of the emergency preparedness plan (EPP) within the last two years. The finding is:</p> <p>Record review on 5/12/26 revealed no evidence of annual testing of the emergency preparedness plan (EPP).</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that the facility could not provide evidence of annual testing of the EPP.</p>	E0039		

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W0460	<p>FOOD AND NUTRITION SERVICES</p> <p>CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record review and interview, the facility failed to ensure that 2 of 6 sampled clients (#4, #5) received their specially prescribed diet as ordered by the interdisciplinary team. The findings are:</p> <p>A. Observations in the group home on 5/12/26 at 4:30 PM revealed client #4 to participate in the dinner meal which included spaghetti and meatballs with sauce. Further observation revealed staff to serve client #4 a large plate of spaghetti and meatballs without measuring any of the food items. Continued observation revealed client #4 to request another serving of spaghetti and staff to tell her, "No, you're on a diet." Subsequent observations revealed that staff prepared a meal which was not on the menu and did not refer to any specific serving size to comply with differing diet needs of the clients served.</p> <p>Reviews of records on 5/13/26 revealed a person-centered plan (PCP) for client #4 dated 2/16/26 which states that client #4's current diet is, "Whole, diabetic, decaf, low to no calorie beverages, no grapefruit."</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that client #4's diet is current and that she should have all of her food measured to comply with the diabetic diet serving size for her health and safety.</p> <p>B. Observations in the group home on 5/12/26 at 4:30 PM revealed client #5 to participate in the dinner meal which included spaghetti and meatballs with sauce. Further observation revealed staff to serve client #5 a large plate of spaghetti and meatballs without measuring any of the food items. Continued observation revealed client #5 to request another serving of spaghetti and staff to serve client #5 a second large plate of spaghetti and meatballs. Subsequent observations revealed that staff prepared a meal which was not on the menu and did not refer to any specific serving size to comply with differing diet needs of the clients served.</p> <p>Reviews of records on 5/13/26 revealed a PCP for</p>	W0460		

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W0460	Continued from page 18 client #5 dated 2/27/25 which states that client #5's current diet is, "Whole, diabetic, decaf, low to no calorie beverages, no grapefruit." Interview with the QIDP on 5/13/26 confirmed that client #5's diet is current and that he should have all of her food measured to comply with the diabetic diet serving size for his health and safety.	W0460		
W0474	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 interview, the facility failed to ensure that 1 of 6 sampled clients (#2) received a diet which was consistent with their developmental level. The finding is: Observations in the group home on 5/12/26 at 4:30 PM revealed client #2 to participate in the dinner meal which included spaghetti and meatballs with sauce. Further observation revealed staff to serve client #2 a plate of spaghetti and meatballs in whole form and client #2 to begin to eat the food. Continued observations at 4:45 PM revealed staff to hand client #2 a butter knife and direct client #2 to cut up his spaghetti. Subsequent observation revealed client #2 to attempt to cut up the spaghetti but not the meatballs. Additional observation revealed client #2 to consume the entire plate of food without further modification. Observations in the group home on 5/13/26 at 7:30 AM revealed client #2 to participate in the breakfast meal which included waffles, scrambled eggs and bananas. Further observation revealed staff to serve client #2 waffles and bananas in whole form and client #2 to consume the entire plate of food without further modification. Review of records on 5/13/26 revealed an Annual Nutrition Assessment dated 11/30/25 which states that client #2's current diet is, "Heart Healthy (2000 Calorie Diet), Double Portions of Meats and Vegetables, 1/4" consistency." Interview with the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that client #2's diet is current and that he should have all of his food modified to 1/4" consistency for his health and safety.	W0474		

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W0488	<p>DINING AREAS AND SERVICE</p> <p>CFR(s): 483.480(d)(4)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record review and interview, the facility failed to ensure that 4 of 6 sampled clients (#1, #2, #4, #5) had the opportunity to eat in a manner consistent with their developmental level with respect to family style dining. The findings are:</p> <p>Observations in the group home on 5/12/26 at 4:30 PM revealed staff to lay 6 plates on the kitchen counter and to fill each plate with spaghetti and meatballs with sauce with no opportunity for clients to choose preferred foods. Further observation revealed staff to call the clients into the dining room for dinner and direct each client to take a plate from the counter and eat at the table. Continued observation revealed clients #1, #2, #4 and #5 to comply with staff's direction and clients #3 and #6 to prepare their own alternative meals.</p> <p>Observations in the group home on 5/13/26 at 7:30 AM revealed staff to lay 6 plates on the kitchen counter and to fill each plate with waffles, scrambled eggs and bananas with no opportunity for clients to choose preferred foods. Further observation revealed clients to enter the dining room as they were ready, take plates from the counter and eat at the table. Continued observation revealed clients #3 and #5 to prepare their own alternative meals.</p> <p>Review of records on 5/13/26 revealed Adaptive Behavior Inventories for client #1 dated 10/30/25, client #2 dated 10/30/25, client #4 dated 10/30/25, and client #5 dated 10/29/25. Further review of records revealed that all 4 clients are independent in all areas related to eating and family style dining.</p> <p>Interview with the program manager (PM) and the qualified intellectual disabilities professional (QIDP) on 5/13/26 confirmed that all 4 clients are independent in skills associated with eating and should be offered the opportunity to participate in family style dining.</p>	W0488		