

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G334	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026
NAME OF PROVIDER OR SUPPLIER IWRC-DOGWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 2 ROSE STREET W , ASHEVILLE, North Carolina, 28803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 treatment and care of personal needs.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interviews, the facility failed to ensure client rights relative to privacy for 1 of 3 audit clients (#6). The findings are:</p> <p>Observation in the group on 5/29/26 from 6:20 AM to 6:28 AM revealed client #6 to be sitting in the bathroom with the door wide open in view of any person traveling the back hallway. Further observation revealed the home's Qualified Intellectual Disabilities Profession (QIDP) and staff B to find client #6 in the bathroom on the toilet while making rounds. Continued observations revealed client #6 had entered the bathroom independently to use the restroom leaving the door wide open. Subsequent review revealed the QIPD to close the door.</p> <p>Interview on 5/19/26 with the QIDP confirmed client #6 requires assistance during personal care</p>	W0130		
W0371	<p>DRUG ADMINISTRATION</p> <p>CFR(s): 483.460(k)(4)</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the system for drug administration failed to assure 2 of 2 audited clients (#4 and #6) observed during medication administration were provided the opportunity to participate in medication</p>	W0371		

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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W0371	<p>Continued from page 1 self-administration or provided teaching related to name, purpose and side effects of medication administrated. The findings are:</p> <p>A. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example:</p> <p>Observation in the group home 5/19/26 at 5:56 AM revealed client #4 to sit in his bedroom with a preferred item and watch the television. Further observation revealed staff C to remove medication packet for the medication closet and prepare medications for administration by pouring them into the medication cup mixing them with applesauce. Continued observation revealed staff C to walk to client #4, announce "here's your medications" and feed them to him until all were consumed. Additional observation revealed staff C to thank client #4 for consuming his medications and wiping his mouth. Client #4 was not observed to receive any training during medication pass or to participate beyond taking medications from staff C.</p> <p>Review of records for client #4 revealed a person-centered plan (PCP) dated 6/19/25. Review of the PCP revealed client #4 requires assistance with all areas of activities of daily living.</p> <p>Interview with the QIDP on 5/19/26 revealed client #4 should receive education during medication relative to medication benefits and side effects.</p> <p>B. The system for drug administration failed to assure client #6 was provided the opportunity to participate in medication self-administration. For example:</p> <p>Observation in the group home 5/19/26 at 6:00 AM revealed client #6 to sit at the dining room table with a preferred item and watch staff C in the medication room prepare all her medications. Further observation revealed staff C to remove medication packet from the medication closet and prepare medications for administration by pouring them into the medication cup, crushing some and mixing with water during medication administration via client #6's G-Tube.. Continued observation revealed staff C to walk to client #6, announce "let's go to the medication room for your medications," and prepare her G-Tube sight for medication administration until all were administered. Additional observation revealed staff C to thank client #6 for being patient with her medication administration. Client #6 was not observed to receive any training during medication</p>	W0371		

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W0371	Continued from page 2 pass or to participate beyond taking medications from staff C. Review of records for client #6 revealed a person-centered plan (PCP) dated 6/19/25. Review of the PCP revealed client #4 requires assistance with all activities of daily living. Interview with the QIDP on 5/19/26 revealed client #6 should receive education during medication relative to medication benefits and side effects.	W0371		