	-	ID HUMAN SERVICES				FORM	M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	34G321		B. WING			07/	/24/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
DAVOIDE	A 8 D			e	617 & 619 RAY AVENUE			
RAYSIDE	А & В			ŀ	HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE		
					DEFICIENCY)			
W 227	INDIVIDUAL PROGR CFR(s): 483.440(c)(4)	W	227				
	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.							
	The person centered residents of Rayside residents of Rayside objective training to a	ddress identified needs in by observations, interviews						
		21/18 for client #2, who failed to included objective eeds in privacy. For						
	7:16 AM revealed clie bedroom and change bedroom door open. passers by during this staff came by and not client was prompted t Continued observatio again revealed the cli bedroom and change open. Staff were aga prompt the client to cli	roup home on 7/24/18 at ent #2 to go to personal her shirt leaving the She was visible to any s time. It was noted when ticed the door open the o close the door for privacy. ns on 7/24/18 at 7:40 AM ent to go to her personal her shirt leaving the door in noted to come by and lose her door for privacy.						
	does have times she bathroom or her bedr	does not close the oom door for privacy while						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/25/2018 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION	(X3) DATE	
		34G321	B. WING			07/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
RAYSIDE	A & B				617 & 619 RAY AVENUE HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
W 227	dressing or using the the qualified intellectur (QIDP), substantiated PCP, revealed no obj this time to address c increase privacy skills B. The PCP dated 6/ resides in Rayside A, training to address ne example: Observations in the g 6:55 AM revealed clie bedroom, wearing on bathroom and then ba noted staff did not see bathroom and then ba noted staff did not see bathroom and then ba Interview with direct c does at times have di clothing or to close the QIDP, substantiated to PCP, revealed no obj this time to address c increase privacy skills C. The PCP dated 7/2 resides in Rayside B, training to address ne example: Observations in the g 8:22 AM revealed clie without closing the do to use the bathroom with Additional observation ask client #5 if she wa	bathroom. Interview with val disabilities professional d by review of the 5/21/18 ective training is in place at lient #2's identified need to s. '12/18 for client #7, who failed to include objective eeds in privacy. For roup home on 7/24/18 at ent #7 to exit her personal ly her panties, go the ack to her bedroom. It was e the client go to the ack to her bedroom. It was e the client go to the ack to her bedroom. care staff revealed the client fficulty remembering to wear e doors. Interview with the by review of the 6/12/18 ective training is in place at lient #7's identified need to s. 25/17 for client #5, who failed to included objective		227			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/25/2018 APPROVED). 0938-0391
. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	(X3) DATE COMP	SURVEY LETED
		34G321	B. WING			07/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
RAYSIDE A & B				617 & 619 RAY AVENUE HENDERSONVILLE, N	C 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 227	AM revealed client #5 without closing the do revealed client #1 to s hallway, in front on cli leave the group home change clothes with h open and client #1 sta bedroom door. Review of records for revealed a PCP dated PCP revealed no obje privacy. Continued re revealed a adaptive b assessment that was ABI revealed client #5 closing the bathroom training. Interview with the QIE assessment was curre had been completed of #5 was admitted to th QIDP further verified bathroom door open v interview with the QIE why client #5 did not 1 address privacy relati #5 could benefit from NURSING SERVICES CFR(s): 483.460(c)	ands. Observation at 9:02 5 to enter her bedroom area for. Continued observation stand in the group home ient #5's bedroom, waiting to e. Client #5 was observed to her bedroom door remaining anding in front of her client #5 on 7/24/18 d 7/25/17. Review of the ective training relative to eview of records for client #5 behavior inventory (ABI) not dated. Review of the 5 has no independence with door for privacy and needs OP verified client #5's ABI ent and although undated, it over the last year after client te facility on 7/25/2017. The client #5 often leaves the while toileting. Additional OP revealed she was unsure have a training objective to ve to closing doors as client privacy training. S	W 2				
L	L			I			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/25/2018 M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G321	B. WING			07/	/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
RAYSIDE	A & B				617 & 619 RAY AVENUE HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 331	The facility failed to ever were provided to resid accordance to their medication administra- interviews and review error reports. The fin Review of the medica Rayside A revealed th A. Review of the faci- reports revealed on 1 that client #2 received 10/11/17 at 7:30 AM. report revealed the medication discontinued on 10/6/ report revealed the er- physician until 10/13/ after the discovery of B. Review of the faci- reports revealed on 1 that client #2 received 10/11/17 at 8:00 PM. report revealed the er- physician until 10/16/ after the discovery of C. Review of the faci- reports revealed the er- physician until 10/16/ after the discovery of C. Review of the faci- reports revealed on 1 that client #2 received 10/12/17 at 8:00 PM. report revealed the er- physician until 10/16/ after the discovery of C. Review of the faci- reports revealed on 1 that client #2 received 10/12/17 at 8:00 PM. report revealed the er- discontinued on 10/6/ report revealed the er-	ensure nursing services dents of Rayside A in eeds in regard to sufficient g taken to address ation errors, as evidenced by of the facility medication ding is: thion error reports for ne following errors: lity's medication error 0/11/17 it was discovered d Nabumetane 500 mg. on Continued review of this redication had been 17. Further review of the tror was not reported to the 17. This is a delay of 2 days the error. continued review of this redication had been 17. This is a delay of 2 days the error. continued review of this redication had been 17. Further review of the tror was not reported to the 17. Further review of this redication had been 17. Further review of the the error. continued review of the tror was not reported to the 17. This is a delay of 2 days the error.		331				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/25/2018 1 APPROVED 0. 0938-0391	
· · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G321	B. WING			_	- 07/24/2018		
NAME OF PF	ROVIDER OR SUPPLIER		-	Ş	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
RAYSIDE A & B					617 & 619 RAY AVENUE HENDERSONVILLE, NC	28739			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)				(X5) COMPLETION DATE	
W 331	revealed on 10/14/17 #2 received Nabumet 8:00 PM. Continued revealed the medication on 10/6/17. Further medication 10/16/17. This is a dediscovery of the error Interview with the number at the time the medication is discontif document the MAR, or staff will pull the medication is discontif document the MAR, or staff will pull the medication is discontif document the MAR, or staff will pull the medication is discontif the physician as soon Further interview with the num- medication bubble paremoved after the firs 10/11/18 was discove additional error on 10 10/12/17 and 10/13/1 Therefore, the facility implemented sufficient address residents of the medications without enditional error on the medications without enditional error on the sufficient address residents of the medications without enditional error on the medications without enditional error enditiona	the error. ity's medication error reports it was discovered that client ane 500 mg. on 10/13/17 at review of this report on had been discontinued eview of the report revealed orted to the physician until elay of 2 days after the se, who was not employed ation errors occurred, cility system when a nued the nurse will call the group home, and cation bubble packs and sing office. Continued se substantiated the ould have been reported to a s they were discovered. the nurse revealed the cks should have been t medication error on red thus preventing the /11/17 and the errors for 7. failed to ensure nursing at corrective action to		331		DEFICIENCY)			
W 376	needs. DRUG ADMINISTRA CFR(s): 483.460(k)(8 The system for drug a		w	376	8				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 07/25/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	JLTIPLE CONSTRUCTION DING) DATE SURVEY COMPLETED
		34G321	B. WING				07/24/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
RAYSIDE	A & B			-	17 & 619 RAY AVENUE IENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 376	This STANDARD is r The facility failed to e errors were reported for 4 of 6 medication	e 5 on errors and adverse drug d immediately to a physician. not met as evidenced by: ensure drug administration to the physician immediately errors as evidenced by of facility reports. The	W	376			
	client #2 received Nat 10/11/17 at 7:30 AM. report revealed the m discontinued on 10/6/ report revealed the er	0/11/17 it was discovered bumetane 500 mg. on Continued review of this redication had been 17. Further review of the rror was not reported to the 17. This is a delay of 2 days					
	reports revealed on 1 client #2 received Nat 10/11/17 at 8:00 PM. report revealed the m discontinued on 10/6/ report revealed the er	'17. Further review of theror was not reported to the17. This is a delay of 2 days					
	reports revealed on 1 client #2 received Nat 10/12/17 at 8:00 PM. report revealed the m discontinued on 10/6/ report revealed the er	ility's medication error 0/14/17 it was discovered bumetane 500 mg. on Continued review of this redication had been (17. Further review of the ror was not reported to the 17. This is a delay of 2 days					

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/25/2018 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G321	B. WING				07/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (CODE		
RAYSIDE	A & B				617 & 619 RAY AVENUE HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
W 376	Continued From page after the discovery of D. Review of the facil revealed on 10/14/17 received Nabumetane 8:00 PM. Continued revealed the medicati on 10/6/17. Further re the error was not repo 10/16/17. This is a de discovery of the error Interview with the nur the facility at that time medications errors show	e 6 the error. ity's medication error reports it was discovered client #2 e 500 mg. on 10/13/17 at review of this report on had been discontinued eview of the report revealed orted to the physician until elay of 2 days after the se who was not employed at		376	DEFICIEN			

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