STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G321	A. BUILDING _____ B. WING _____	07/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) 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. This STANDARD is not met as evidenced by: The person centered plans (PCP's) for 2 of 4 residents of Rayside A (#2 and #7) and 1 of 4 residents of Rayside B (#5) failed to have objective training to address identified needs in privacy as evidenced by observations, interviews and review of records. The finding is: A. The PCP dated 5/21/18 for client #2, who resides in Rayside A, failed to included objective training to address needs in privacy. For example: Observations in the group home on 7/24/18 at 7:16 AM revealed client #2 to go to personal bedroom and change her shirt leaving the bedroom door open. She was visible to any passers by during this time. It was noted when staff came by and noticed the door open the client was prompted to close the door for privacy. Continued observations on 7/24/18 at 7:40 AM again revealed the client to go to her personal bedroom and change her shirt leaving the door open. Staff were again noted to come by and prompt the client to close her door for privacy. Interview with direct care staff revealed the client does have times she does not close the bathroom or her bedroom door for privacy while	W 227		

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

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W 227	Continued From page 1 dressing or using the bathroom. Interview with the qualified intellectual disabilities professional (QIDP), substantiated by review of the 5/21/18 PCP, revealed no objective training is in place at this time to address client #2's identified need to increase privacy skills. B. The PCP dated 6/12/18 for client #7, who resides in Rayside A, failed to include objective training to address needs in privacy. For example: Observations in the group home on 7/24/18 at 6:55 AM revealed client #7 to exit her personal bedroom, wearing only her panties, go the bathroom and then back to her bedroom. It was noted staff did not see the client go to the bathroom and then back to her bedroom. Interview with direct care staff revealed the client does at times have difficulty remembering to wear clothing or to close the doors. Interview with the QIDP, substantiated by review of the 6/12/18 PCP, revealed no objective training is in place at this time to address client #7's identified need to increase privacy skills. C. The PCP dated 7/25/17 for client #5, who resides in Rayside B, failed to included objective training to address needs in privacy. For example: Observations in the group home on 7/24/18 at 8:22 AM revealed client #5 to enter the bathroom without closing the door. Client #5 was observed to use the bathroom without closing the door and exit the bathroom without washing her hands. Additional observations revealed staff to verbally ask client #5 if she washed her hands after using the bathroom and verbally direct the client to the	W 227		

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W 227	Continued From page 2 kitchen to wash her hands. Observation at 9:02 AM revealed client #5 to enter her bedroom area without closing the door. Continued observation revealed client #1 to stand in the group home hallway, in front on client #5's bedroom, waiting to leave the group home. Client #5 was observed to change clothes with her bedroom door remaining open and client #1 standing in front of her bedroom door. Review of records for client #5 on 7/24/18 revealed a PCP dated 7/25/17. Review of the PCP revealed no objective training relative to privacy. Continued review of records for client #5 revealed a adaptive behavior inventory (ABI) assessment that was not dated. Review of the ABI revealed client #5 has no independence with closing the bathroom door for privacy and needs training. Interview with the QIDP verified client #5's ABI assessment was current and although undated, it had been completed over the last year after client #5 was admitted to the facility on 7/25/2017. The QIDP further verified client #5 often leaves the bathroom door open while toileting. Additional interview with the QIDP revealed she was unsure why client #5 did not have a training objective to address privacy relative to closing doors as client #5 could benefit from privacy training.	W 227		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331		

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W 331	Continued From page 3	W 331		

The facility failed to ensure nursing services were provided to residents of Rayside A in accordance to their needs in regard to sufficient corrective action being taken to address medication administration errors, as evidenced by interviews and review of the facility medication error reports. The finding is:

Review of the medication error reports for Rayside A revealed the following errors:

A. Review of the facility's medication error reports revealed on 10/11/17 it was discovered that client #2 received Nabumetane 500 mg. on 10/11/17 at 7:30 AM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/13/17. This is a delay of 2 days after the discovery of the error.

B. Review of the facility's medication error reports revealed on 10/14/17 it was discovered that client #2 received Nabumetane 500 mg. on 10/11/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days after the discovery of the error.

C. Review of the facility's medication error reports revealed on 10/14/17 it was discovered that client #2 received Nabumetane 500 mg. on 10/12/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days

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W 331	Continued From page 4 after the discovery of the error. D. Review of the facility's medication error reports revealed on 10/14/17 it was discovered that client #2 received Nabumetane 500 mg. on 10/13/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days after the discovery of the error. Interview with the nurse, who was not employed at the time the medication errors occurred, revealed it was the facility system when a medication is discontinued the nurse will document the MAR, call the group home, and staff will pull the medication bubble packs and bring them to the nursing office. Continued interview with the nurse substantiated the medications errors should have been reported to the physician as soon as they were discovered. Further interview with the nurse revealed the medication bubble packs should have been removed after the first medication error on 10/11/18 was discovered thus preventing the additional error on 10/11/17 and the errors for 10/12/17 and 10/13/17. Therefore, the facility failed to ensure nursing implemented sufficient corrective action to address residents of Rayside A to receive medications without errors in accordance to their needs.	W 331		
W 376	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure	W 376		

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W 376	Continued From page 5	W 376		

that drug administration errors and adverse drug reactions are reported immediately to a physician.

This STANDARD is not met as evidenced by:
The facility failed to ensure drug administration errors were reported to the physician immediately for 4 of 6 medication errors as evidenced by interview and review of facility reports. The findings are:

A. Review of the facility's medication error reports revealed on 10/11/17 it was discovered client #2 received Nabumetane 500 mg. on 10/11/17 at 7:30 AM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/13/17. This is a delay of 2 days after the discovery of the error.

B. Review of the facility's medication error reports revealed on 10/14/17 it was discovered client #2 received Nabumetane 500 mg. on 10/11/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days after the discovery of the error.

C. Review of the facility's medication error reports revealed on 10/14/17 it was discovered client #2 received Nabumetane 500 mg. on 10/12/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days

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W 376	Continued From page 6 after the discovery of the error. D. Review of the facility's medication error reports revealed on 10/14/17 it was discovered client #2 received Nabumetane 500 mg. on 10/13/17 at 8:00 PM. Continued review of this report revealed the medication had been discontinued on 10/6/17. Further review of the report revealed the error was not reported to the physician until 10/16/17. This is a delay of 2 days after the discovery of the error. Interview with the nurse who was not employed at the facility at that time substantiated the medications errors should have been report to the physician as soon as they were discovered.	W 376		