|   | -   | ID HUMAN SERVICES   |           |  |   | FORM   | APPROVED                   |
|---|---|---|-----------|--|---|--|----------------------------|
| CENTERS FOR MEDICARE & M<br>STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,       |  | CONSTRUCTION                                    | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |
|   |   | 34G321  | B. WING _ |  |   | 08/31/2021   |                            |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |           |  | TREET ADDRESS, CITY, STATE, ZIP CODE            |  |                            |
| RAYSIDE   | A & B   |   |           |  | 17 & 619 RAY AVENUE<br>IENDERSONVILLE, NC 28739 |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |           | PROVIDER'S PLAN OF CORRECTION           FIX         (EACH CORRECTIVE ACTION SHOULD BE           G         CROSS-REFERENCED TO THE APPROPRIATE           DEFICIENCY)         DEFICIENCY |   |  | (X5)<br>COMPLETION<br>DATE |
| W 227   | objectives necessary as identified by the co  |   | W 2       | 227  |   |  |                            |
|   | This STANDARD is not met as evidenced by:<br>Based on observation, review of records and<br>interview, the person centered plan (PCP) failed<br>to have training to meet identified client needs<br>relative to communication for 1 of 4 sampled<br>clients (#5). The finding is:   |   |           |  |   |  |                            |
|   | Observations in the group home throughout the<br>8/30-31 survey revealed client #5 to communicate<br>wants and needs with pointing and minimal words<br>such as "baby, hi, bye, bubbles and thank you."<br>Continued observation revealed staff to<br>communicate with client #5 with the use of<br>objects or verbally acknowledging words the<br>client used. |   |           |  |   |  |                            |
|   | 2/2/16. Review of the<br>assessment revealed<br>and needs through pu-<br>independent in obtain<br>an object (hands rem<br>and a few verbalizatio<br>2016 communication<br>to include increased of<br>interactions and incre<br>communicator. Furth<br>communication assess  | ation assessment dated<br>e 2016 communication<br>client #5 indicates wants<br>ulling staff, being<br>ning a desired object, using<br>ote to staff to request TV)<br>ons. Continued review of the<br>assessment revealed needs<br>consistency in responding to<br>ease in effectiveness as a<br>er review of the 2016 |           |  |   |  |                            |

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

TITLE

(X6) DATE

PRINTED: 09/08/2021

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.

|   | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |  |   |                               |  | FORM       | D: 09/08/2021<br>MAPPROVED<br>D. 0938-0391 |  |
|---|---|---|--|---|-------------------------------|--|------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING           |   |                               | (X3) DATE SURVEY<br>COMPLETED  |            |  |  |
| 34G321  |   |   | B. WING  |   |                               | _  | 08/31/2021 |  |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   |   |  |   | REET ADDRESS, CITY, ST        | ATE, ZIP CODE  |            |  |  |
| RAYSIDE   | A & B   |   | 617 & 619 RAY AVENUE<br>HENDERSONVILLE, NC 28739 |   |                               |  |            |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                              | ( | (EACH CORREC<br>CROSS-REFEREN | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD B<br>NCED TO THE APPROPRI<br>DEFICIENCY) |            | (X5)<br>COMPLETION<br>DATE                 |  |
| W 227   | format of the presenta<br>in a photograph book<br>did not respond appro-<br>picture schedule on the<br>Continued review of r<br>a communication prog<br>5/1/17 for lack of prog<br>the past communication<br>revealed the program<br>will comply with movin<br>when shown a TEAC<br>independence. Furth<br>client #5 revealed no<br>or current communicat<br>Subsequent review of<br>revealed no updated<br>since the 2/2/16 evalu<br>Interview with the faci<br>disabilities profession<br>verified client #5 has<br>had no current comm<br>Continued interview v<br>#5 had not had an up<br>assessment since 2/2<br>MGMT OF INAPPRO<br>BEHAVIOR<br>CFR(s): 483.450(b)(3)<br>Techniques to manag<br>behavior must never 1<br>of staff. | ed at home and at the<br>TEACCH picture schedule<br>ation of one picture at a time<br>should be tried as client #5<br>opriately to a TEACCH<br>ne wall.<br>ecords for client #5 revealed<br>gram that was discontinued<br>gress. Continued review of<br>on program for client #5<br>objective to read: Client #5<br>ng to the appropriate area<br>CH card with 90%<br>er review of records for<br>revised communication goal<br>ation objective since 5/1/17.<br>f records for client #5<br>communication evaluation<br>uation.<br>ility qualified intellectual<br>al (QIDP) on 8/31/21<br>communication deficits and<br>unication program.<br>vith the QIDP verified client<br>dated communication<br>2/2016.<br>PRIATE CLIENT | W 2  |   |                               |  |            |  |  |
|   | This STANDARD is r  | not met as evidenced by:  |  |   |                               |  |            |  |  |

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|                                    | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |  |  |  | FORM                          | D: 09/08/2021<br>APPROVED<br>D. 0938-0391 |  |  |  |
|------------------------------------|--|--|--|--|--|-------------------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PRO |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |   |  |  |  |
|                                    |  | 34G321   | B. WING                                |  |  | 08/                           | 31/2021                                   |  |  |  |
| NAME OF PI                         | ROVIDER OR SUPPLIER  |  |  | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |   |  |  |  |
| RAYSIDE A & B                      |  |  |  | 617 & 619 RAY AVENUE<br>HENDERSONVILLE, NC 28739 |  |                               |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG           | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE                |  |  |  |
| W 287                              | Based on observation<br>interviews, the team fit<br>techniques to manage<br>was not used as a con-<br>clients (#2, #4, #5 and<br>television remote accor<br>Observations in the g<br>8/30-31/21 survey rev-<br>various times to sit in<br>home and the televisi-<br>turned on with staff as<br>observed for the telev-<br>in the living room of th<br>Subsequent observati-<br>remote to sit on top of<br>group home kitchen.<br>Observation in the gro<br>AM revealed client #4<br>facing the television the<br>At to tell the client "one<br>you." Continued obse-<br>enter the kitchen, accor<br>the top of the refrigera-<br>room to assist client #<br>channel. Further obs-<br>return the television re-<br>refrigerator after assis<br>Interview with staff A of<br>television remote for the<br>kept on top of the refri-<br>#5 will lose it or hide i<br>qualified intellectual d<br>(QIDP) on 8/31/21 rev<br>group home need assist<br>television remote whill | ns, record review and<br>ailed to assure restrictive<br>e inappropriate behavior<br>nvenience for staff for 4 of 4<br>d #8) in Rayside B relative to<br>ess. The finding is:<br>roup home throughout the<br>vealed various clients at<br>the living room of the group<br>on to be turned off or to be<br>asistance. At no time was it<br>rision remote to be present<br>ne group home.<br>ion revealed the television<br>f the refrigerator of the<br>bup home on 8/31/21 at 7:45<br>to sit in the living room<br>hat was turned off and staff<br>e minute, and I will help<br>ervation revealed staff to<br>tess the television remote off<br>ator and return to the living<br>t4 with finding a preferred<br>ervation revealed staff A to<br>emote to the top of the<br>sting client #4. | W                                      | 287  |  |                               |   |  |  |  |

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|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |  |  | FOR                           | D: 09/08/2021<br>M APPROVED<br>D. 0938-0391 |  |  |  |  |
|--------------------------|---|--|--|--|-------------------------------|---|--|--|--|--|
|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING           |  | (X3) DATE SURVEY<br>COMPLETED |   |  |  |  |  |
| 34G321                   |   | 34G321   | B. WING  |  | 08/31/2021                    |   |  |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER                           |  |  | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |   |  |  |  |  |
| RAYSIDE                  | A & B   |  | 617 & 619 RAY AVENUE<br>HENDERSONVILLE, NC 28739 |  |                               |   |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)            | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE                  |  |  |  |  |
| W 287                    | interview with the QIE client in the group ho | e 3<br>DP on 8/31/21 verified no<br>me had a restriction in their<br>ve to the television remote | W 287  |  |                               |   |  |  |  |  |

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