| 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 _____ | 10/10/2023 |

| 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 |
|---|---|---|---|---|
| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>§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).<br><br>*[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:]<br>(1) Training program. The [facility] must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(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. | E 037 | | |

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

| 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 _____ | 10/10/2023 |

| 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 |
|---|---|---|---|---|
| E 037 | Continued From page 1<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(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.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness | E 037 | | |

| 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 _____ | 10/10/2023 |

| 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 |
|---|---|---|---|---|
| E 037 | Continued From page 2<br>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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) 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. | E 037 | | |

| 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 _____ | 10/10/2023 |

| 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 |
|---|---|---|---|---|
| E 037 | Continued From page 3<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. | E 037 | | |

| 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 _____ | 10/10/2023 |

| 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 |
|---|---|---|---|---|
| E 037 | Continued From page 4<br>*[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 CMHC must provide emergency preparedness training at least every 2 years.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure direct care staff were trained on the facility's emergency preparedness plan (EPP) at least biennially for Rayside A & B. The finding is:<br><br>Review on 10/9/23 of the facility's EPP revealed no evidence of initial or biennial training on the EPP.<br><br>Interview on 10/10/23 with the facility administrator verified that initial and biennial trainings for current staff were completed; however, there was no documentation provided to surveyor to show evidence of training. | E 037 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. | W 249 | | |

| 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 _____ | 10/10/2023 |

| 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 249 | Continued From page 5 | W 249 | | |

This STANDARD is not met as evidenced by:
Based on observations, record review and interview, the facility failed to ensure clients received continuous active treatment program consisting of needed interventions and services identified in the Person-Centered Plan (PCP) for 2 of 4 sampled clients (#2, #7) and client (#1) relative to wearing prescribed eyeglasses, communicaton, and daily living. The findings are:

A. The facility failed to ensure continuous active treatment for client #2 relative to prescribed eyeglasses. For example:

Observation in the group home throughout the 10/9-10/10/23 survey revealed client #2 to participate in various activities to include setting the table with dinner mats and glasses with drink, to participate in the dinner and breakfast meal and to participate in medication administration. Continued observation on 10/9/23 at 4:40 PM revealed client #2 to place her prescription eyeglasses on her head and at no time throughout the survey was staff observed to prompt client #2 to wear her eyeglasses.

Review of records for client #2 revealed a person-centered plan (PCP) dated 3/16/23. Continued review of record for client #2 revealed a vision consult dated 4/13/21 with a diagnosis of vitreous degeneration, right eye oculus dexter. Review of the vision consult also revealed posterior vitrecus detachment. Further review of the vision consult revealed client #2 to have a new prescription for eyeglasses.

| 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 _____ | 10/10/2023 |

| 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 249 | Continued From page 6<br>Interview on 6/30/22 with the facility administrator verifid that client #2's PCP is current. Continued interview with the facility administrator verified that client #2 should be wearing prescribed eyeglasses.<br><br>B. The facility failed to ensure that client #7 received a continuous active treatment plan relative to communication goals. For example:<br><br>Afternoon observations in the group home on 10/9/23 revealed client #7 to sit in a wheelchair in her bedroom watching a movie. Continued observation revealed this client to receive a tube feeding in the bedroom, then move to the living room where she watched television. Further observation revealed a Dynavox communication device to be present in the living room of the home where it was unplugged and was not turned on. Client #7 is not able to use the device without assistance and no staff offered client #7 an opportunity to use the device during the observation period from 4:00 PM until 5:25 PM.<br><br>Morning observations in the group home on 10/10/23 revealed client #7 to watch television in her room from 7:00 AM until 8:00 AM. Continued observation revealed this client to be dressed and in her wheelchair at 8:10 AM. Further observation revealed client #7 to receive a receive a tube feeding in her bedroom, then move to the living room at 8:38 AM, where she remained, watching television until the end of the observation at 9:15 AM. Subsequent observation revealed that no staff offered client #7 an opportunity to use the communication device during the observation period from 7:00 AM until 9:15 AM.<br><br>Record review on 10/9/23 revealed a Person | W 249 | | |

| 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 _____ | 10/10/2023 |

| 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 249 | Continued From page 7 | W 249 | | |

Centered Plan (PCP) dated 11/28/22 for client #7. Continued review revealed a goal for this client to interact with her Dynavox for 30 minutes with 90% accuracy. Further review of the PCP revealed that the Dynavox goal is to be successfully performed at least 3 times per week at the home.

Interview with staff A on 10/10/23 revealed they had not been trained on use of the Dynavox device and have never run this program with client #7. Interview with staff B on 10/10/23 revealed they had not seen client #7 use the Dynavox device since they have been working in the home, about 1 month.

Interview with the Facility Administrator, the Qualified Intellectual Disability Professional (QIDP) and the Program Manager on 10/10/23 revealed that the Dyynavox program objective is current and that staff should all be trained on its use and should run the goal with the client as indicated.

C. The facility failed to ensure that client #1 received a continuous active treatment plan relative to activities of daily living. For example:

Morning observations in the group home on 10/10/23 revealed client #1 to be in bed watching television from 7:00 AM until 7:45 AM. Continued observation revealed client #1 to then move to the dining room table while staff prepared their morning medications in the medication closet and administer the medications, mixed with pudding, to client #1 at the dining room table.

Record review on 10/10/23 revealed a Person Centered Plan (PCP) dated 11/7/22 for client #1

| 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 _____ | 10/10/2023 |

| 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 249 | Continued From page 8<br>which states that the client is able to assist with the administration of her own medications by obtaining her own water from the sink and bringing it to the med closet. The PCP further states that the client can pop the pills into her cup.<br><br>Interview with the Facility Administrator, the Qualified Intellectual Disability Professional (QIDP) and the Program Manager on 10/10/23 revealed that, although this client has lost some skills recently, she is still capable of participating in medication administration and should have been given the opportunity to participate. | W 249 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure that all drugs, including those that are self-administered, were administered without error for 1 of 6 clients (#1). The finding is:<br><br>Observation in the home on 10/10/23 at 7:52 AM revealed staff C to retrieve a packet of Cholestrymine, 4 grams, from the medication closet, mix the contents with a juice drink and thickener, hand it to client #1 and instruct client #1 to drink it. Continued observation revealed client #1 to drink the contents of the glass.<br><br>Record review on 10/10/23 revealed a medication administration record which states: Cholestyram POW 4 gm: Mix 1 packet and give by mouth once | W 369 | | |

| 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 _____ | 10/10/2023 |

| 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 369 | Continued From page 9<br>every day (10AM).<br><br>Interview with the Facility Administrator confirmed that client #1 should have received the Cholestyramine medication no earlier than 9:00 AM and that admistering it at 7:52 AM amounted to a medication error. | W 369 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure adaptive equipment was furnished for client #8. The finding is:<br><br>Evening observation in the facility on 10/9/23 at 5:03 PM revealed client #8 to participate in the dinner meal. Continued observation revealed client #8 to be provided the following adaptive equipment for the dinner meal to include a shirt protector and divided dish. At no time during the survey was staff observed to furnish client #8 with her dycem mat.<br><br>Morning observation in the facility on 10/10/23 at 7:35 AM revealed #8 to participate in the breakfast meal. Continued observation revealed client #8 to be provided the following adaptive equipment for the breakfast meal to include a shirt protector and divided dish. At no time during the survey was staff observed to furnish client #8 | W 436 | | |

| 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 _____ | 10/10/2023 |

| 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 436 | Continued From page 10<br>with her dycem mat.<br><br>Review of the records for client #8 on 10/10/23 revealed a Person-Centered Plan (PCP) dated 3/6/23. Continued review of the PCP revealed that client #8 is prescribed a high sided dish, dycem mat, and shirt protector. Further review of PCP revealed an occupational therapy evaluation dated 12/3/23. Further review of client #8's occupational therapy evaluation revealed that client #8's adaptive equipment includes a high sided dish, non-skid mat, and shirt protectors during meals.<br><br>Interview with facility administrator confirmed the 3/6/23 PCP for client #8 was current. Continued interview with the facility administrator confirmed that client #8 should have been provided with her dycem mat as prescribed. | W 436 | | |
| W 440 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1)<br><br>at least quarterly for each shift of personnel.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is:<br><br>A review of the facility fire drill reports on 10/9/23 revealed the second and third quarter fire drills for the annual review period to be incomplete. Continued review revealed that documentation of first and third shift drills for the second quarter, and second and third shift drills for the third quarter was not completed as required.<br><br>Interview with the Faclity Administrator, Qualified | W 440 | | |

| 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 _____ | 10/10/2023 |

| 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 440 | Continued From page 11<br>Intellectual Disability Professinal (QIDP) and the Program Manager on 10/10/23 confirmed fire drills should have been conducted quarterly for each shift of personnel, and the drills are required to be properly documented. | W 440 | | |
| W 474 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iii)<br><br>Food must be served in a form consistent with the developmental level of the client.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to serve food in a form consistent with the developmental level of 3 of 8 clients (#1, #2, #3) relative to prescribed diets. The finding is:<br><br>A. The facility failed to follow client #1's diet as ordered. For example:<br><br>Observation during the evening meal on 10/9/23 revealed the meal to consist of fish sticks, tater tots, and green peas. Continued observation revealed that client #1 was served whole tater tots, fish sticks cut into 1/2" - 1" pieces, and whole peas. Further observation revealed client #1 to eat the entire meal.<br><br>Observation during the morning meal on 10/10/23 revealed the meal to consist of oatmeal and fruit cups. Continued observations revealed that the fruit was cut into approximately 1/2" pieces. Further observation revealed client #1 to eat the entire meal.<br><br>Record review revealed a Person Centered Plan dated 11/7/22 for client #1 which indicates client #1 has a history of dysphagia. Continued record | W 474 | | |

| 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 _____ | 10/10/2023 |

| 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 474 | Continued From page 12 | W 474 | | |

review revealed a nutritional evaluation for client #1 dated 9/21/22 indicating the client's diet order to be 1800 calories, pureed consistency with honey thick liquids, no grapefruit juice and 1/2 cup of prune mix every morning. Further record review revealed client #1 to have undergone a swallow study on 8/28/23 which recommended that client #1's diet be changed to 1/4" consistency.

Interview with the Facility Administrator, Qualified Intellectual Disability Professional (QIDP) and Program Manager confirmed that client #1 should have been provided with a 1/4" consistency diet.

B. The facility failed to follow client #3's diet as ordered. For example:

Observation during the evening meal on 10/9/23 revealed the meal to consist of fish sticks, tater tots, and green peas. Continued observation revealed that client #3 was served whole tater tots, fish sticks cut into 1/2" - 1" pieces, and whole peas. Further observation revealed client #3 to eat the entire meal.

Observation during the morning meal on 10/10/23 revealed the meal to consist of a sausage link wrapped in a pancake. Continued observations revealed that the item was cut into approximately 1" - 1 1/2" pieces. Further observation revealed client #3 to eat some of the meal.

Record review revealed a nutritional evaluation for client #3 dated 7/22/22 indicating the client's diet order to be heart healthy, 1/4" consistency with honey thick liquids. Further record review revealed client #3 to have undergone a swallow study on 8/28/23 which recommended that client

| 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 _____ | 10/10/2023 |

| 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 474 | Continued From page 13<br>#3's diet continue to be 1/4" consistency.<br><br>Interview with the Facility Administrator, Qualified Intellectual Disability Professional (QIDP) and Program Manager confirmed that client #3 should have been provided with a 1/4" consistency diet as prescribed.<br><br>C. The facility failed to follow client #2's diet as prescribed. For example:<br><br>Observations in the group home on 10/9/23 at 5:09 PM revealed the dinner meal to consist of biscuits, chicken, and vegetables. Continued observations at 5:12 PM revealed client #2 to eat the dinner meal in regular whole consistency. At no time during the observation was staff observed to assist client #2 to provide a mechanical soft dinner meal.<br><br>Observations in the group home on 10/10/23 at 8:35 AM revealed the breakfast meal to consist of two waffles, breakfast steak and a bottled juice. Continued observations revealed client #2 to eat the breakfast meal in regular whole consistency. Further observation revealed client #2 to eat the breakfast meal without her prescribed dentures. At no time during the observation was staff observed to assist client #2 to provide a mechanical soft breakfast.<br><br>Review of client #2's record on 10/10/23 revealed a PCP dated 3/16/23. Continued review of the PCP revealed that client #2's prescribed diet to be a mechanical soft consistency. Further review of the plan revealed no nutritional assessment was available for surveyor to review for client #2 during the survey. | W 474 | | |

| 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 _____ | 10/10/2023 |

| 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 474 | Continued From page 14<br>Interview with the facility administrator on 10/10/23 verified client #2's PCP to be current. Further interview with the facility administrator confirmed that client #2 should have been provided a mechanical soft diet as prescribed. | W 474 | | |
| W 475 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iv)<br><br>Food must be served with appropriate utensils. This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure all appropriate utensils were provided to 1 of 4 sampled clients (#2) for 2 of 2 meals. The finding is:<br><br>Observation in the group home on 10/9/23 at 5:00 PM revealed client #2 to participate in the dinner meal with a place setting that consisted of a plate, mat, cup, and spoon. Continued observation revealed the dinner meal to include biscuits, chicken, and vegetables served in whole consistency. Subsequent observation revealed staff at no time provided a fork and knife for the dinner meal.<br><br>Observation in the group home on 10/10/23 at 8:35 AM revealed client #2 to participate in the breakfast meal with a place setting that consisted of a plate and spoon. Continued observation revealed the breakfast meal to include two waffles and breakfast steak served in whole consistency. Further observation revealed client #2 to cut her waffles with a spoon. At no time during observation did staff provide a fork and knife for the breakfast meal.<br><br>Review of record for client #2 on 10/10/23 | W 475 | | |

| 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 _____ | 10/10/2023 |

| 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 475 | Continued From page 15<br>revealed a Person-Centered Plan (PCP) dated 3/16/23. Continued review of the PCP for client #2 revealed an occupational therapy evaluation for the client to use a regular spoon, fork, and knife at mealtimes.<br><br>Interview with the facility administrator on 10/10/22 revealed that client #2's PCP is current. Continued interview with the facility administrator verified that all meals for client #2 should be provided a full place setting consisting of utensils (fork, spoon, and knife). | W 475 | | |