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 _____	12/11/2024

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 000	INITIAL COMMENTS A recertification survey and complaint survey for intake #NC00224373 was completed on 12/11/24. The allegation for the complaint survey was unsubstantiated and no deficiencies were cited. However, deficiencies were cited related to the recertification survey.	W 000		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) 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. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 1 of 8 clients (#5) observed during medication administration was provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medications administered. The findings is: Observation in Rayside A on 12/11/24 at 7:56 AM revealed client #5 to receive a prompt to get a glass of water and enter the medication room. Continued observation revealed staff to hand client #5 a medication cup containing all her morning medications. Further observation revealed client #5 to place all medications from the cup in her mouth and swallow all with her water. Client #5 was not observed to receive any training during the medication pass or to participate beyond taking her medications from staff and getting her water.	W 371		

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

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.

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 _____	12/11/2024

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W 371	Continued From page 1 Review of records for client #5 on 12/11/24 revealed a person-centered plan (PCP) dated 10/29/2024. Continued review of the PCP revealed client #5 has a diagnosis of SOTOS Syndrome and Schizoaffective DO. Further review of client #5's PCP revealed she can fully participate in medication administration. Interview with the staff on 12/11/24 revealed that staff would typically prepare all clients' medications before they enter the medication room. Continued interview with staff revealed she was trained to administer medication without explanation to the type of medication, reason for the medication or side effects of the medication. Interview with the facility nurse (RN) on 12/11/24 verified staff are not trained to provide education during medication administration. Continued interview with the RN revealed that staff will receive further training to educate clients during medication.	W 371		