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 _____	C 09/03/2025

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 An unannounced visit was conducted on 9/3/25 for CINV Intake No. NC00232640. One allegation was substantiated and three allegations were unsubstantiated due to insufficient evidence. One deficiency was cited.	W 000		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered in accordance with physician ' s orders. This affected 6 of 8 sampled clients (#2, #3, #4, #5, #6, #7). The finding is: During record review on 9/3/25, the facility produced Medication Administration Records (MARs) for all clients in the home for the months of July and August, 2025. Review of the MARs revealed that the facility had failed to administer 5 prescribed medication doses to client #2, 27 medication doses to client #3, 70 medication doses to client #4, 6 medication doses to client #5, 13 medication doses to client #6 and 31 medication doses to client #7 during the period reviewed. Interview with the facility nurse confirmed that the medication doses were not documented, indicating that the medications had not been administered as prescribed.	W 368		

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