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 _____	11/18/2025

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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039	E 039: QP will complete a Tabletop Exercise at Rayside A and Rayside B. All staff and managers will participate in the Tabletop Exercise according to the EOP requirements. The QP and Home Manager will receive an in-service regarding EOP regulatory requirements to maintain appropriate required documentation and meet regulatory requirements for implementation of annual testing of the EOP.	12/30/25

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

JM Stoddard, Executive Director 12/11/25

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.

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E 039	Continued From page 1 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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E 039	Continued From page 2 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.	E 039		

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 5 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

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E 039	Continued From page 6 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 7 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 8 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to show evidence of exercises to verify testing of the emergency preparedness plan (EPP). The findings are: A. The facility failed to show evidence of full-scale community/facility-based exercises, mock drill, or tabletop exercises to verify testing of the EPP. This affected all clients residing in Rayside B. For example: Review of facility documentation on 11/18/25	E 039		

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E 039	Continued From page 9 revealed an EPP dated 10/20/25. Further review of the facility's EPP did not reveal evidence of a mock drill, tabletop exercise, or full-scale community-based exercise to test the facility's EPP. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed that evidence of a tabletop exercise, mock drill, or full-scale exercise could not be found during the survey. Further interview with the QIDP revealed a live event was discussed, however, the documentation could not be found. B. The facility failed to show evidence of full-scale community/facility-based exercises, mock drill, or tabletop exercises to verify testing of the EPP. This affected clients residing in Rayside A. For example: Review of facility documentation on 11/18/25 revealed an EPP dated 4/25/25. Further review of the facility's EPP did not reveal evidence of a mock drill, tabletop exercise, or full-scale community-based exercise to test the facility's EPP. Interview with the interim QIDP on 11/18/25 revealed that evidence of a tabletop exercise, mock drill, or full-scale exercise could not be found during the survey. Further interview with the interim QIDP revealed a live event was discussed, however, the documentation was not available during the survey. Continued interview with the interim QIDP verified that staff and management should complete all emergency preparedness exercises to test the EPP as required.	E 039		

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W 129 W 129	Continued From page 10 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure clients have a right to personal privacy for 2 of 5 audited clients (#2 and #3) during personal care and medication administration. This affected clients residing in Rayside A. The findings are: A. The facility failed to respect the privacy of client #2 during personal care. For example: Observations on 11/18/25 at 8:30AM revealed client #2 to lay in her bed while staff prepare the client for personal care. Further observations at 8:46AM revealed staff to transition client #2 to the hoyer lift with her bedroom door remaining open. Continued observations at 9:18AM revealed staff to again transition client #2 to her bed with no clothes on with the client's rear end exposed which could be seen from the hallway. Subsequent observations at 9:30AM revealed staff to again provide personal care to client #2 and change her adult briefs with the door remaining open and rear end exposed no clothes on as various staff and management came in and out of the facility. At no point during the observations did staff close the bedroom door to ensure client #2 received privacy during personal care. Interview with the facility nurse and interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff have been	W 129 W 129	W129: IDT will in-service all staff regarding privacy rights and staff responsibilities to ensure client privacy during personal care. IDT will in-service all staff regarding privacy rights and staff responsibilities to ensure client privacy during medication administration. Privacy will be reviewed at the staff meeting held in December and January to ensure understanding by all DSP's. IDT will complete 2 Interaction Assessments each week for 6 weeks to monitor for proper implementation of privacy practices during personal care and medication administration and continued education, if needed.	1/15/25

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W 129	Continued From page 11 trained to respect the privacy of clients during personal care. B. The facility failed to ensure privacy for client #2 and #3 during medication administration. For example: Observations on 11/18/25 at 7:50AM revealed the medication technician to prepare client #3's medications for administration. Further observations at 7:54AM revealed the medication technician to administer medications in her room while client #2 remained in the room. Continued observations also revealed client #3 to receive her medications with the bedroom door remaining open which could be seen from the hallway by other staff and clients. Observations on 11/18/25 at 8:15AM revealed staff to prepare medication administration for client #2. Further observations at 8:20AM revealed the medication technician to administer medications to client #2 in the bedroom as client #3 remained in the room. Continued observations revealed the residential team lead (RTL) to enter the bedroom and share with the medication technician that medications should be administered in the medication room. Observations did not reveal medication technician to ensure the privacy of client #2 during medication administration. Interview with the facility nurse on 11/18/25 verified staff have been trained to ensure the privacy of clients during medication administration. Interview with the facility nurse and interim QIDP on 11/18/25 verified that medications should be administered in the medication room to ensure privacy during	W 129		

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W 129	Continued From page 12 administration.	W 129		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 5 audited clients (#3) were provided opportunities for choice and self-management during mealtimes in Rayside A. The finding is: Observations on 11/18/25 at 6:55AM revealed staff to provide personal care and get another client dressed (#2) while client #3 remained in her bed. Further observations revealed client #3 to remain in her room from 7:30AM to 10:00AM while staff provided personal care to client #2 in their shared bedroom. Continued observations at 8:20AM revealed staff to enter the kitchen and prepare the breakfast meal. Subsequent observations at 10:00AM revealed staff to transport client #3 to the dining area to prepare for the breakfast meal. Observations did not reveal a staff member to escort client #3 to the dining table for breakfast meal after 100 minutes of unstructured time in her room. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed that staff should have escorted client #3 to the dining room after the breakfast meal was prepared to feed her. Further interview with the interim QIDP verified that client #3 did not have to wait for 100 minutes in order to participate in the breakfast meal. Continued interview with the	W 247	W247: IDT will in-service all staff regarding opportunity for choice, implementation of the Resident Schedule, active treatment, and PIRT to ensure client choice, engagement, and meal times are adhered to. Interaction Assessments will be completed by the IDT 2 times each week for 6 weeks to monitor for client choice, active treatment, PIRT, and appropriate meal time.	1/15/25

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 _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 247	Continued From page 13 interim QIDP verified it was not a requirement for client #3 to wait until client #2 was dressed in order for the two clients to eat breakfast together.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure continuous active treatment programs were implemented as identified in person centered plans (PCP's) for 2 of 5 audited clients (#4 and #6) in Rayside B. The findings are: A. The facility failed to ensure program and training objectives were implemented as required for client #4. For example: Observations throughout the recertification survey from 11/17/25 to 11/18/25 revealed client #4 to participate in medication administration, converse with staff and other peers, participate in dinner and breakfast meals, take dishes to the sink (dinner meal), and watch her favorite tv show "Martin" in the livingroom. Continued observations did not reveal staff to prompt client #4 to review her visual schedule or follow her gum schedule.	W 249	W249: Hab Spec will in-service staff regarding programs developed for each individual, reviewing how to reference, implement, and document individual-specific programs. Program implementation, program documentation, active treatment, and PIRT will be monitored by the IDT through Interaction Assessments completed 2 times each week for 6 weeks.	1/15/25

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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W 249	Continued From page 14 Review of the record for client #4 on 11/18/25 revealed a PCP dated 2/20/25 with six program and service objectives. Continued review of the training objectives for client #4 included the following: 1) Dancing with Music Videos; 2) Music Step; 3) Community Integration; 4) Gum Schedule; 5)Visual Schedule and 6) Calendar Step. Further review of the training objectives for the visual schedule revealed, client #4 will follow her visual schedule daily. Subsequent review of the gum schedule revealed client #4 will be offered by staff gum pieces every two hours beginning at 8am. Interview with the agency's habilitation specialist (HS) on 11/18/25 revealed that client #4 training objectives are current. Continued interview with the HS confirmed staff should review client #4's visual schedule with her throughout the day. Further interview with the HS also confirmed client #4 should be offered a piece of gum every two hours as outlined in her training objective. B. The facility failed to ensure program and training objectives were implemented as required for client #6. For example: Observations throughout the recertification survey from 11/17/25 to 11/18/25 revealed client #6 to engage with a musical instrument in hand, attempt communication with staff and other peers, participate in dinner and breakfast meals, participate in medication administration and display a few targeted behaviors in the morning. Continued observations did not reveal staff to prompt or offer client #6 to pour her drinks during meals.	W 249		

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 15 Review of the record for client #6 on 11/18/25 revealed a PCP dated 8/14/25 with six program and service objectives. Continued review of the training objectives for client #6 included the following: 1) Shampoo Hair; 2) Toileting Schedule; 3) Time on Task; 4) Exercise For 30 Minutes; 5)Verbalize Colors and 6) Pour Drink. Further review of the training objectives for the visual schedule revealed client #6 will pour her drinks during meals. Interview with the HS on 11/18/25 revealed that client #3 training objectives are current. Further interview with the HS confirmed clients should receive training objectives as outlined in their PCP's and staff should provide and encourage participation in order to determine progress towards training and behavior objectives.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.45(c)(2) 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: Based on observations, record reviews and interviews, the facility failed to assure all drugs were administered without error for 2 of 5 audited clients (#3 and #5). The findings are: A. The facility failed to assure drugs were administered without error for client #3 residing in Rayside A. For example: Observations on 11/18/25 at 7:45AM revealed the medication technician to enter the medication room to prepare for medication administration for client #3. The following medications were placed	W 369	W369, W371, W382: Clinical nursing team will in-service staff regarding proper medication administration. Clinical nursing team will work with the PMD and Tarrytown to ensure QuickMar reflects appropriate administration times and procedures to include administration times, safeguarding of the medications, administration procedures, and opportunity for education. Nursing will monitor medication administration by conducting a medication observation 1 time each week for 6 weeks.	1/15/25

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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W 369	Continued From page 16 in the cup for administration: Levothyroxine 50 mcg, Vitamin D3 2000IU, Levocarnitine 330mg, Carbamazepine 200mg ER, Polyethylene Glycol 3350, Levetiracetam 250mg, Carbamazepine 300mg ER, Calcium + D Tab 315-500, Certavite Tab, Valproic Acid 20ml, Lactulose Solution 5ml, Acetaminochen 2, 325mg, and Calcitonin Salmon Nasal Spray (1 spray in left nostril). Further observations at 8:03AM revealed staff to administer medications to client #3 in her room. Review of the record for client #3 on 11/18/25 revealed a physician's order dated 10/23/25 which indicated Levothyroxine 50 mcg should be taken on an empty stomach at 6:00AM. Review of the QuickMAR report dated 11/18/25 verified the Levothyroxine 50 mcg for client #3 was administered at 8:08AM. Interview with the facility nurse on 11/18/25 revealed the medication Levothyroxine 50mcg for client #3 should have been administered at 6:00AM as prescribed. Further interview with the facility nurse verified the physician's order for client #3 was current. Continued interview with the facility nurse revealed medication technician staff should report a late dosage or any problems relative to medications to nursing. Subsequent interview with the facility nurse verified that client #3's medications should be administered as prescribed. B. The facility failed to assure drugs were administered without error for client #5 residing in Rayside B. For example: Observations in the group home on 11/17/25 at 4:58PM revealed client #5 to enter the medication room. Further observations revealed the	W 369		

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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RAYSIDE A & B	617 & 619 RAY AVENUE HENDERSONVILLE, NC 28739

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W 369	Continued From page 17 residential team lead (RTL) to retrieve client #5's medication bin from the closet, scan the medication Carvedilol 6.25mg (1 tab) blister pack, then dispense into a medication cup. Continued observations revealed the RTL to hand client #5 the medication cup. Subsequent observations revealed client #5 to swallow the medication followed by a cup of water and exit the medication room. Additional observations at 5:00PM revealed client #5 to engage in activities, place serving bowls on the dining table and at 5:55PM participate in the dinner meal. Review of record for client #5 on 11/18/25 revealed a physician's order to include the medication Carvedilol Tab 6.25mg (1 tab), to be taken with meals. Interview with the facility nurse on 11/18/25 revealed client #5's physician order is current. Further interview with the facility nurse revealed client #5's Carvedilol 6.25mg should have been administered with a meal as prescribed.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.45(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 observations and interviews, the system for drug administration failed to assure 4 of 5 audited clients (#2, #3, #4, and #5) observed during medication administration were provided education. The findings are:	W 371		

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 _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 371	Continued From page 18 A. The facility failed to provide medication education for client #5 during medication administration in Rayside B. For example: During a medication administration observation on 11/17/25 at 5:30PM revealed the residential team lead (RTL) to call client #5 to the medication room to receive medications. Further observations revealed the RTL to retrieve client #5's medication bin from the closet, scan medication carvedilol 6.25mg (1 tab) blister pack, then dispense into a medication cup. Continued observations revealed the RTL to hand client #5 the medication cup. Subsequent observations revealed client #5 to swallow the medication followed by a cup of water, then exit the medication room. Additional observations did not reveal client #5 to receive any education related to name, purpose and side effects of medications administered. Interview with the facility nurse on 11/18/25 revealed staff have been trained to provide education to all clients while administering medication. Continued interview with the facility nurse revealed all clients should be provided same and all education relative to the medications administered. B. The facility failed to provide medication education for client #4 during medication administration in Rayside B. For example: During a medication administration observation on 11/18/25 at 7:15AM revealed the residential team lead (RTL) to call client #4 to the medication room to receive medications. Further	W 371		

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 371	Continued From page 19 observations revealed the RTL to retrieve client #4's medication from the closet, scan medication blister packs, then dispense into a medication cup. Continued observations revealed the RTL to crush client #4's medications, open the capsules and empty the sprinkles into the cup. Further observations revealed the RTL to mix the crushed medications with vanilla pudding and feed to client #4. Subsequent observations did not reveal client #4 to receive any education related to name, purpose and side effects of medications administered. Interview with facility nurse on 11/18/25 revealed staff have been trained to provide education to all clients while administering medications. Continued interview with the facility nurse revealed all clients should be provided some sort of education relative to the medications administered. C. The facility failed to provide medication education to clients #2 and #3 during medication administration observation. For example: Observations on 11/19/25 at 7:50AM revealed the medication technician to pop the medications from a blister pack and add Ensure to the cup and mash to form. Further observations reveal the medication technician to enter client #2's room and administer the medication. Continued observations did not reveal the medication technician to provide client #2 with the medication name, usage, and the potential side effects. Subsequent observations at 8:20AM revealed the medication technician to prepare client #3's medications by crushing the pills in a cup and adding applesauce. Additional observations	W 371		

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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W 371	Continued From page 20 revealed the medication technician to walk to enter client #3's bedroom and administer the medication to the client while she sat in bed. Continued observations did not reveal the medication technician to provide client #3 with the medication name, usage, and potential side effects. Interview with the facility nurse on 11/18/25 revealed the medication technician should have administered the medication to clients with a description of the medication usage and potential side effects. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff were trained to provide medication education to clients during medication administration.	W 371		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.45(d)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained secured except when preparing for medication administration for 3 of 3 audited clients (#2, #3). This affected all those living in Rayside A. The findings are: A. The facility failed to secure topicals when they are not being administered for client #2. For example: Observations in the facility from	W 382		

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 _____	11/18/2025

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RAYSIDE A & B	617 & 619 RAY AVENUE HENDERSONVILLE, NC 28739

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W 382	Continued From page 21 11/17/25-11/18/25 revealed two bottles of topicals on top of client #2's dresser. At no point during the observation did staff remove and secure the topicals in the medication room when they were not being used. Interview with the facility nurse on 11/18/25 verified the prescribed topicals should be locked in the medication cart/cabinet in the medication room when they were not being used. Interview with the Interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed staff have been trained to secure medications and topicals in the medication cabinet when they are not being used. B. The facility failed to secure medications when they did not belong to/were not being administered for clients #2 and #3. The findings include: Observation of the facility on 11/18/25 at 8:23AM revealed the medication technician and the surveyor entered the medication room to record and check medications. Further observation revealed the medication technician to unlock the medication cabinet and remove clients #2 and #3 medications/cups placing them on the desk. Observation revealed this surveyor to tell the medication technician "please don't leave me in here." Continued observations revealed the medication technician to acknowledge the surveyor's statement by stating "ok, I won't". Subsequent observation at 8:25AM revealed the medication technician to exit the medication area, leaving the medication cabinet unlocked, medications/cups remaining on the desk, and to leave the surveyor in the medication room unattended. Continued observations revealed medication technician to again exit the medication	W 382		

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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W 382	Continued from page 22 room at 6:30AM and 6:37AM. Interview with the facility nurse on 11/18/25 verified that medications should not be left unattended and the medication cabinet should be locked when the medications are not being administered. Interview with the human qualified intellectual disabilities professional (QIDP) on 11/18/25 verified staff have been trained to not leave client medications unattended when medications are not being administered.	W 382		
W 436	483.470(g)(2) EQUIPMENT CFR(s): 483.470(g)(2) The facility must maintain in good repair, and in a safe manner for use and to make informed choices about dentures, eyeglasses, hearing and communications aids, braces, and prosthetic devices ordered by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that clients were provided adaptive equipment and used appropriately as prescribed for 2 of 5 audited clients (#3 and #5) who affected clients residing in Rayside A. The findings are: A. The facility failed to use the gait belt for client #3 as ordered. For example: Observation on 11/17/25 from 1:30PM to 1:40PM revealed client #3 to sit in the living room area in the recliner. Further observation revealed client #3's gait belt to sit on a side table next to the recliner. Continued	W 436	W 436: Hab Spec will in-service staff regarding orders for and proper use of adaptive equipment. The IDT team will monitor implementation of adaptive equipment through Appearance Checklist completion for 30 days.	1/15/25

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	34G321	A. BUILDING _____ B. WING _____	11/18/2025

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W 436	Continued from page 23 observ… revealed staff A to assist client #… of the recliner by holding the client's… Subsequent observations revealed staff A to assist client #3 to the dining room t… her hands. Additional observ… staff A to position client #3 in … by holding onto the client's hands. … the observation did staff … assist client #3 with an bul… provided. Mo… on 11/18/25 at 9:50AM reveal… client #3's gait belt and tra… fe… her bed to the wheelchair by … hands. Further observation at 10:… to transition client #3 from the wh… dining room table by holding onto the … handles. At no point during the obs… the gait belt as pre… Re… client #3 on 11/18/25 revealed a … (PT) assessment dated … stated client #3 should wear … during waking hours with con… e. Review of the Occ… OT Assessment dated 8/6/… #3 "must wear a gait belt or ve… for … mobility. Use wheelchair for … Int… with qualified intellectual dis… (QIDP) on 11/18/25 ver… should wear her gait belt du… with contact guard as… observed with the interim QI… have been trained to use the ge… #3 during transfers and m…	W 436		

STATEMENT OF DEFICIE AND PLAN OF CORRE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 436	Con [illegible] B. The [illegible] harness for client #2 as [illegible] for example: Observation conducted [illegible] certification survey from 11/17/25-11/18/25 revealed client #2 to participate in [illegible] activities without access to her [illegible] harness. At no point during the observation was client #2's harness to ensure [illegible] distribution. Review of [illegible] for client #2 on 11/18/25 revealed a physician's order dated 9/25/25 and a physical therapy (PT) assessment dated 8/16/25 which identified client #2 has the following adaptive equipment: safety harness, shower chair, [illegible], Hoyer lift, bilateral bunny hooks, [illegible] mat, and high sided dish. Further review of the record for client #2 revealed a person-centered plan (PCP) dated 8/13/25 indicating client #2 to be assessed for a new seat [illegible]. Interview with [illegible] on 11/18/25 verified client #2's physician's order and interdisciplinary assessment. Further interview with the [illegible] staff should use client #2 [illegible] harness.	W 436		
W 440	EVACUATION DRILLS CFR(s) [illegible] at least quarterly for each shift of personnel. This [illegible] was evidenced by: Based on record review and interview, the facility failed to ensure quarterly fire drills were conducted for each shift of personnel relative to fire [illegible] on the night shift in Rayside B. The findings [illegible]	W 440	W 440, W448: IDT will in-service staff regarding the Fire Drill Book, procedures, fire drill report completion, and regulatory requirements for drill completion. Fire drills will be completed to bring each site into compliance. The QP will monitor drill completion each month to ensure compliance utilizing the PowerApp report.	1/15/25

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W 440	Continued from page 25 Review of the facility fire drill reports from 11/24 through 11/[illegible] revealed missing fire drills for 2/25, 3/25, 4/[illegible]/25. Further review of the fire drill reports revealed 1st shift drills conducted on 1/22/25 and 7/[illegible]/25, second shift drills conducted on 7/[illegible]/25 and 8/[illegible]/25, and third shift drills completed on 7/[illegible]/25 and 8/13/25. There was no additional information available for conducting the missing drills during the review year. Interview with the qualified intellectual disabilities professional (QIDP) on 11/18/25 confirmed that drills should have been conducted for each shift. Further interview with the QIDP confirmed that all required documentation for fire drills conducted 11/24 through 11/25 were provided to the surveyor.	W 440		
W 448	EVACUATION DRILLS CFR(s): [illegible] The facility had [illegible] problems with evacuation during incidents. This STANDARD PLUS is not met as evidenced by: Based on record review and interview, the facility failed to conduct timeframes of fire evacuation drills [illegible] evacuation for evacuation problems during [illegible] evacuation for Rayside A. The findings are: Review of facility documentation on 11/17/25 revealed fire evacuation drill reports covering the last [illegible] 11/2024-10/2025. Further review revealed the fire drill reports did not include documentation for the following evacuation drills: [illegible]/25, 5/14/25, 8/[illegible]/25, and 8/27/25.	W 448		

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 ________	11/18/2025

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 448	Continued From page 26 Review of facility fire evacuation drill reports revealed several fire evacuation drill dates with problems during facility evacuation drills. Further review of the fire evacuation drill reports revealed the following dates with areas of concern: 6/5/25 and [illegible] "[illegible] people supported evacuate appropriately? No". Review of evacuation drill reports on [illegible] and 11/[illegible]/25 stated "if a sprinkler system is in the home, is an inspection form on file within 12 months? No". Continued review of facility fire evacuation drills did not note [illegible] why clients were not evacuated [illegible] and why the sprinkler inspection report was not provided within 12 months. Interview with the interim qualified intellectual disabilities professional (QIDP) on 11/18/25 revealed [illegible] what problems occurred [illegible] of concern according to the fire evacuation drill reports. Further interview with the interim QIDP revealed staff should share fire drill [illegible] with management and ensure [illegible] are filled out appropriately. [illegible] interview with the interim QIDP [illegible] with fire drill evacuation drills [illegible] the facility safety committee [illegible].	W 448		