Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF	
74457 2744	or contraction	ISENTI IO/TIOTATOMISEIT.	A. BUILDING: _		JOHN EET	
		HAL011375	B. WING		06/02/	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		ND HILL ROA E, NC 28806	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	annual survey with ar 05/26/21-05/28/21 an	d desk review from th an exit conference via				
D 131	10A NCAC 13F .0406	S(a) Test For Tuberculosis	D 131			
	(a) Upon employment home, the administration any live-in non-reside tuberculosis disease imeasures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis	Test For Tuberculosis at or living in an adult care tor and all other staff and ents shall be tested for in compliance with control of the Commission for Health in 10A NCAC 41A .0205 amendments and editions. It available at no charge by ement of Health and Human is Control Program, 1902 Raleigh, NC 27699-1902.				
	facility failed to ensure	as evidenced by: ews and interviews the e 3 of 3 sampled staff (Staff ed for tuberculosis (TB)				
	The findings are:					
	personnel record revershe was hired on 06There was document negative results was a -There was no document skin test having been	/23/20 as a MA. tation of a TB skin test with read on 6/19/20. nentation of a second TB				

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

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL011375	B. WING		06/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DICHMON	ID HILL REST HOME # 2	95 RICHMO	OND HILL ROA	D		
KICHWICK	ID HILL REST HOWE # 2	ASHEVILL	E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE
D 131	Continued From page	÷ 1	D 131			
	revealed she could no second TB test.	ot remember if she had a				
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	revealed:	, MA, personnel record				
	-She was hired on 01 -There was no docum been completed.	/19/21 as a PCA. nentation a TB skin test had				
	Attempted telephone on 05/28/21 at 1:15pr	interview with Staff B, MA, n was unsuccessful.				
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	Personnel record reve					
		/31/21 as a housekeeper. nentation of any TB skin test				
	Interview with Staff C 2:15pm revealed: -She was hired as a h	, PCA on 05/27/21 at nousekeeper then became a				
		est completed when she was w where the documentation				
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	3:30pm revealed: -The staff were told w	ministrator on 05/27/21 at when they were hired they sted TB test from the health				

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department.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/0	2/2021
RICHMON	D HILL REST HOME # 2		ND HILL ROA E, NC 28806	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 131	Continued From page	e 2 y there were no TB tests in	D 131			
	the staff records.	ess of "getting the staff				
D 137	10A NCAC 13F .0407 Qualifications	(a)(5) Other Staff	D 137			
	(a) Each staff person shall:(5) have no substant	Other Staff Qualifications at an adult care home lated findings listed on the Care Personnel Registry				
	This Rule is not met a Based on interviews a facility failed to ensure A, B and C) had no si	as evidenced by: and record reviews, the e 3 of 3 sampled staff (Staff ubstantiated findings listed Health Care Personnel				
	The findings are:					
	personnel record rever- The date of hire was	06/23/20. nentation a HCPR check				
		CPR check dated 05/17/21 o substantiated findings.				
	revealed:	MA on 05/28/21 at 1:10pm				
	2020.	ne facility since June of HCPR check had been				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
ANDIEAN	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING: _		J GOWII E	LILD
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA	ND .		
	QUILLEN/ QT		E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 137	Continued From page	2 3	D 137			
		lity when she was hired. / substantiated findings on				
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	Refer to interview with 05/27/21 at 3:00pm.	n the Property Manager on				
	Review of Staff B's revealed: The date of hire was	, MA, personnel record				
		nentation a HCPR check				
		CPR check dated 02/15/21 o substantiated findings.				
	Attempted telephone on 05/28/21 at 1:15pr	interview with Staff B, MA, m was unsuccessful.				
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	Refer to interview with 05/27/21 at 3:00pm.	n the Property Manager on				
	3. Review of Staff C's personnel record reversity. The date of hire was					
		nentation a HCPR check				
		CPR check dated 05/25/21 o substantiated findings.				
	Interview with Staff C 2:15pm revealed: -She was hired as a h					

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BIOLOGI		95 RICHM	OND HILL ROA	.D	
RICHMON	ID HILL REST HOME # 2		E, NC 28806		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 137	Continued From page	e 4	D 137		
	-"I was made a PCA by weeks after I was hire	by the Administrator several ed".			
		ministrator on 05/27/21 at had noticed that Staff C did she ran a check on			
	Refer to interview with 05/27/21 at 3:30pm.	h the Administrator on			
	Refer to interview with 05/27/21 at 3:00pm.	h the Property Manager on			
	at 3:00pm revealed: -Prior to the new man was responsible for m checks were complete workStaff A and B had stamanagement and sho completed since it was managementShe did not currently recordsThe new administrate employee recordsThe previous administrate previous administrate records.	ould have had a HCPR			
	3:30pm revealed: -The staff had been h the facilityShe had been trying staffing records in ord	ministrator on 05/27/21 at sired before she had come to to organize getting the der.			

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staffing records were missing "lots" of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF B	ROVIDER OR SUPPLIER		DESS CITY STA	TE ZID CODE	1 00/02/2021
NAME OF F	ROVIDER OR SUFFLIER		RESS, CITY, STA OND HILL ROA		
RICHMON	ID HILL REST HOME # 2		E, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 137	Continued From page	e 5	D 137		
	documentation.	for ensuring all staffing			
D 150	.0501 Personal Care	Training And Competency	D 150		
	10A NCAC 13F .0501 And Competency	Personal Care Training			
	who provide or directly provide personal care complete an 80-hour competency evaluation the Department. Directly performance of staff (80-hour training and opprogram are available mailing by contacting Services, Adult Care Mail Service Center, (b) The facility shall a in Paragraph (a) of the completed within six is hired after Septembe the successful completed and competency evaluation.	e to residents successfully personal care training and on program established by ectly supervise means being to oversee or direct the			
	facility failed to ensur A) who provided pers	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff onal care to residents had ecessful completion of an			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
			B WING			
		HAL011375	B. WING		06/02	2/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
RICHMON	D HILL REST HOME # 2		OND HILL ROA E, NC 28806	U		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 150	Continued From page		D 150			
	80-hour personal care evaluation program.	e training and competency				
	The findings are:					
		, medication aide (MA),				
	personnel record reversible was hired on 06.					
	-There was no docum					
	completed an 80 hour	r personal care training and on program.				
	Interview with Staff A, revealed:	MA on 05/28/21 at 1:10pm				
	-She was a Medicatio					
	 She had the Persona past. 	al Care Aide Training in the				
	-She had given a cop	y of the 80-hour training to				
	the facility when she was steed the resi	was hired. idents when they needed				
	assistance with perso	-				
	Interview with the Pro at 3:00pm revealed:	perty Manager on 05/27/21				
	-She had been respon	nsible for the staff records in				
		e new Administrator had he new administrator was				
	now responsible for th	ne staff records.				
	-She did not know wh documentation was.	ere the missing				
	Interview with the Adr 3:30pm revealed:	ninistrator on 05/27/21 at				
	-She did not know if a					
	previously had PCA tr	aining. the facility long enough to				
	get the records in ord					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/0	72/2021
RICHMON	D HILL REST HOME # 2		OND HILL ROA E, NC 28806	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 162	Continued From page	÷ 7	D 162			
D 162	10A NCAC 13F .0504 For LHPS Tasks	(b) Competency Validation	D 162			
		Competency Validation For essional Support Task				
	the following licensed (1) A registered nurs competency of staff we tasks specified in Sub (28) of Rule .0903 of (2) In lieu of a registroare practitioner licen 38, may validate the operform personal care Subparagraphs (a)(6) (19) and (a)(21) of Ru (3) In lieu of a registropharmacist may validate who perform the pers Subparagraph (a)(8) Subchapter. (4) In lieu of a registropharmacist or physical transport of staff we competency of	who perform personal care oparagraphs (a)(1) through this Subchapter. ered nurse, a respiratory sed under G.S. 90, Article competency of staff who e tasks specified in (a) (a)(11), (a)(16), (a)(18), (a) ale .0903 of this Subchapter. ered nurse, a registered ate the competency of staff onal care task specified in of Rule .0903 of this ered nurse, an occupational herapist may validate the who perform personal care oparagraphs (a)(17) and (a)				
	facility failed to ensure professional support (validation had been c	ews and interviews, the e a licensed health (LHPS) competency ompleted for tasks including istive devices that requires nd transferring				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		1101 044075	B. WING		004	00/0004
		HAL011375	B. W. C		06/0	02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		95 RICHM	OND HILL ROA	AD.		
RICHMON	D HILL REST HOME # 2	ASHEVILL	E, NC 28806			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ı.	PROVIDER'S PLAN OF CORRI		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SH		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API	PROPRIATE	DATE
				DEFICIENCY)		
D 162	Continued From page	e 8	D 162			
	. •					
	sampled (staff B and	C).				
	T. C					
	The findings are:					
	1 Paview of Staff R's	, medication aide (MA),				
	personnel record reve					
		/19/21 as a personal care				
	aide (PCA).	119/21 as a personal care				
		nentation LHPS competency				
	validation for Staff B					
	validation for Otali B i	nad been completed.				
	Attempted telephone	interview with Staff B, MA,				
	on 05/28/21 at 1:15pr					
	o oo, <u>_</u> , aop.					
	Refer to interview with	h the Property Manager on				
	05/27/21 at 3:00pm.	, , ,				
	·					
	Refer to interview with	h the Administrator on				
	05/27/21 at 3:30pm.					
		s, personal care aide (PCA),				
	Personnel record reve	= =:: = =::				
		/31/21 as a housekeeper.				
		nentation LHPS competency				
	validation for Staff C I	had been completed.				
		DOA 05/07/04 1				
	Interview with Staff C	, PCA on 05/27/21 at				
	2:15pm revealed:					
	-She was hired as a h	oy the Administrator several				
	weeks after I was hire					
		a "private sitter" for residents				
	before coming to the					
	•	ven any training at the				
	facility.	ton any danning at the				
	-	idents with bathing and				
	transferring when nee					
	g					
	Refer to interview with	h the Property Manager on				

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05/27/21 at 3:00pm.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU COMPLET	
		HAL011375	B. WING		06/02	/2024
NAME OF D					1 06/02	12021
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA OND HILL ROA			
RICHMON	D HILL REST HOME # 2		.E, NC 28806	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 162	Continued From page	9	D 162			
	Refer to interview with 05/27/21 at 3:30pm.	n the Administrator on				
	at 3:00pm revealed: -The previous Admini recordsShe had been responshe past, but since the April 2021 she was not recordsShe did not know who documentation was. Interview with the Adm 3:30pm revealed: -She had not been at get the records in ord -There was not currer who done licensed her (LHPS).	ninistrator on 05/27/21 at the facility long enough to				
	tasks. -"Technically" Staff C a PCA.	was a housekeeper and not				
D 167	10A NCAC 13F .0507 Cardio-Pulmonary Re		D 167			
	staff person on the pr completed within the cardio-pulmonary res management, includir provided by the Amer					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
RICHMON	D HILL REST HOME # 2		OND HILL ROA E, NC 28806	AD.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 167	First Aid, or by a train certification as a train from one of these org person trained accord access at all times in valve pocket mask for cardio-pulmonary resulting. This Rule is not met a TYPE B VIOLATION Based on observation reviews, the facility fastaff was on the premise completed a course in resuscitation (CPR) a within the last 24 more (Staff B and C) who, a residents residing in the considered full resulting. The findings are: 1. Review of Staff B's—She was a medication—The hire date for Stata—There was no docume completed training on management. Attempted telephone on 05/28/21 at 1:15pr. Refer to Interview with 05/27/21 at 3:30pm.	Health Institute or Medic er with documented er on these procedures anizations. The staff ding to this Rule shall have the facility to a one-way ruse in performing uscitation. as evidenced by: as, interviews and record illed to ensure at least one dises at all times who had no cardio-pulmonary and choking management and this for 2 of 3 sampled staff alone, cared for the 11 he building who were citate code status. personnel record revealed: an aide (MA). ff B was 01/19/21. anentation Staff B had and CPR and choking interview with Staff B, MA,	D 167		
	personnel record reve				

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 95 RICHMOND HILL ROAD	
95 RICHMOND HILL ROAD	
95 RICHMOND HILL ROAD	NAME OF PROVID
RICHMOND HILL REST HOME # 2 ASHEVILLE, NC 28806	RICHMOND HIL
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COINTING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
D 167 Continued From page 11 -She was hired on 03/31/21There was no documentation Staff C had completed training on CPR and choking management. Interview with Staff C, PCA on 05/27/21 at 2:15pm revealed: -She was hired as a housekeeperSeveral weeks after she was hired she was made a PCA by the AdministratorShe worked by herself in the buildingShe had not had any training at the facility on CPRShe had previous CPR training, but did not remember whenShe thought she was still certified, but did not have any documentation of CPR. Refer to Interview with the Administrator on 05/27/21 at 3:30pm revealed: -She did not know that the staff did not have CPR trainingShe was responsible for making sure staff records were up-to-date and completeShe was responsible for making sure staff records were up-to-date and completeShe was responsible for making sure staff had completed all required trainingShe was responsible for the total operations of the facilityShe had not taken the CPR training into consideration when scheduling staff to workShe did not have CPR trainingShe did not have CPR trainingShe did not have CPR trainingShe did not have a formal schedule for the staffing "The staff knew when they were supposed to work"She thought there was some staff who had CPR	-Sh -The comman lnte 2:15 -Sh -Se mad -Sh -Sh -Sh -Sh -Sh hav Ref 05/2 Inte 3:30 -Sh train -Sh com -Sh the -Sh con -Sh staf sup

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-She did not know when CPR was last done in

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
RICHMON	ID HILL REST HOME # 2		OND HILL ROA E, NC 28806	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 167	on the premises at all a course in cardio-pul and choking manager C being the only emp without CPR and sup failure was detrimentated welfare of the resident Violation. The facility provided a accordance with G.S. this violation.	ensure at least one staff was times, who had completed lmonary resuscitation (CPR) ment related to Staff B and loyees on the premises ervising residents. This all to the health, safety, and its and constitutes a Type B a plan of protection in 131D-34 on 05/29/21 for DATE FOR THIS TYPE B IOT EXCEED JULY 17,	D 167			
D 176	With a Capacity or Car Residents (a) An adult care hor responsible for the to home and shall also be Division of Health Sel county department of and maintaining the re The co-administrator, share equal responsible for the operation of the	Management of Facilities ensus of Seven to Thirty me administrator shall be tal operation of an adult care be responsible to the rvice Regulation and the social services for meeting tales of this Subchapter. when there is one, shall boility with the administrator to the home and for meeting tales of this Subchapter. or also refers to	D 176			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011375	B. WING		06/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DICHMON	D HILL REST HOME # 2	95 RICHM	OND HILL ROA	AD	
KICIIWIOI	D HILL REST HOWL # 2	ASHEVILL	E, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
D 176	Continued From page	e 13	D 176		
	Subchapter.				
	Subchapter.				
	This Rule is not met	as evidenced by:			
	TYPE A1 VIOLATION				
	111 2711 1102/11011	•			
	Based on observation	ns, interviews, and record			
		rator failed to ensure the			
		al operations of the facility			
		ed to compliance with health			
	care, ensuring reside	•			
	unsupervised, medica				
		and control program, and			
	staff qualifications.	1 3 ,			
	'				
	The findings are:				
	Interview with the Adr	ministrator on 05/26/21 at			
	10:50am revealed:				
	-She screened all sta	ff and residents "about every			
	6 weeks" with a COV				
	-Visitors were require	d to sign a visitor log located			
	at the main office buil	ding but were not asked			
	screening questions of	or temperatures were not			
		ple of weeks due to verbal			
	guidance she had rec				
		nber who she had received			
	_	rom for no longer screening			
		was either the NC DHHS or			
	the local health depar				
		for the overall operations of			
	the facility.				
	L-4	dia dia dia dia (NAA)			
		dication aide (MA) on			
	05/26/21 at 11:30am				
	-one was the MA for a	a sister facility but was also	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE S		
			A. BUILDING: _	A. BUILDING:		
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA	,D		
	OLIMANA DV. OT		E, NC 28806	DROVIDERIO DI ANI OF CORRECTI	ON.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETE DATE
D 176	Continued From page		D 176			
	administering medica 05/26/21 for this facili	ty because there was not a				
	MA assigned to work.					
	•	n "short staffed" so she had tions at this facility and a				
	sister facility.	none at this racinty and a				
		tered a resident's scheduled				
	morning medications insulin.	including his pills and				
	-She did not know wh	o or when they had left a				
	cup of 10 unidentified pills in a resident's room					
	took the pills.	r that the resident found and				
		ith the Administrator on				
	05/26/21 at 4:43pm re	evealed: r leave medications with				
	residents to self-admi					
		y a MA had left medications				
		'I have no answer for that". so the medications belonged				
	to that were left in a re					
		esident had swallowed the				
		n medicine cup in his room. Thad "problems" because				
	she did not have enough					
	-The MA was respons	sible for notifying the PCP				
		medications, medication vsician's orders for health				
		ameters when the result				
	was outside of those	parameters.				
	3	for the overall operations of				
	the facility.					
	Interview with the Adr 3:26pm revealed:	ministrator on 05/27/21 at				
	-She had been "short member per each fac	" on staff and had one staff				
		//////////////////////////////////////				
		ave to "switch out" for the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06	6/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
DICUMON	ID UILL BEST HOME # 2	95 RICH	MOND HILL ROAD				
KICHWON	ID HILL REST HOME # 2	ASHEVIL	LE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 176	Continued From page	e 15	D 176				
	-She expected staff to residents and not lear -She was ultimately rothe facilityShe had just found obeen leaving the facil residents alone for all PCA arrived for day some -She had been working records in order since facility the first week of -She could not find a the record "should be -When she started as staffing records were documentationShe was responsible requirements were considered.	esponsible for the staffing of out the night shift PCA had ity at 8:00am and left the root 5-10 minutes until the hift. Ing on getting the staffing a she started working at the of April 2021. In record for one resident and in the facility. In the Administrator the missing "lots" of the for assuring all staffing ompleted.					
	11:08am revealed: -She had been emplorations and the first week or -She was responsible. There were other stated staff schedules, paper on physician's orders her responsibility to ewere completedIt was her responsibility doing what they were -She was not aware ralone, medications wor left in resident roor physician orders were implemented, record not being completed,	e for staff training. Iff who were responsible for rwork, audits, following up and other duties but it was nsure their assigned duties lity to ensure staff were "supposed to do". esidents were being left ere not being administered ms in medication cups, e not being followed up on or and medication audits were visitors needed to be					
		d symptoms, one resident ted/offered the vaccination					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
			71. 501251110.			
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		OND HILL ROA E, NC 28806	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 176	available and accessing -The overall daily open her responsibility. Noncompliance was in areas: 1. Based on observating review, the facility fail free from neglect relations the facility and wounder of days while whereabouts (Reside residents alone in the 10A NCAC 13F .0909 Violation)]. 2. Based on observating reviews, the facility	cords not being readily ble. Frations of the facility were dentified in the following rule ions, interviews, and record ed to ensure residents were ted to a resident who eloped vas gone for an unknown not knowing the residents nt #5), and staff leaving facility. [Refer to Tag D0338 of Resident Rights (Type A1 ions, interviews, and record	D 176			
	reviews, the facility fa were administered as residents related to a scheduled a slow acti [Refer to Tag D0358,	ions, interviews and record iled to ensure medications ordered for 1 of 3 sampled fast acting insulin and a ng insulin. 10A NCAC 13F .1004(a) ation (Type B Violation)].				
	reviews, the facility fa care provider (PCP) f related to one resider sliding scale (a fast a slow acting insulin) ar	ions, interviews and record iled to notify the primary or 2 of 3 sampled residents, at who missed doses of cting insulin), scheduled (a and swallowed 10 unidentified to left in the residents room				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		I ` '	(X3) DATE SURVEY COMPLETED	
			/ 20122to. <u>-</u>				
		HAL011375	B. WING		06	/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
RICHMON	ID HILL REST HOME # 2		OND HILL ROA E, NC 28806	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 176	notify the primary care weight gain of 3 or me [Refer to Tag D0273, Health Care (Type B 5. Based on observat reviews, the facility fa staff was on the prem completed a course in resuscitation (CPR) a within the last 24 mor (Staff B and C) who, a residents residing in t considered full resusci	resident who had an order to e provider (PCP) for a daily ore pounds (Resident #2). 10A NCAC 13F .0902(b) Violation)]. ions, interviews and record illed to ensure at least one hises at all times who had in cardio-pulmonary and choking management on this for 2 of 3 sampled staff alone, cared for the 11 the building who were citate code status. [Refer to IC 13F .0507 Training on	D 176				
	reviews the facility fairecommendations and for Disease Control (Coperatment of Health (NCDHHS) were implied to the facility failed to ensure Administrator or Admitted to the facility failed to the facility	d guidance by the Centers CDC) and the North Carolina and Human Services lemented when caring for 11 global Coronavirus c as related to the screening d visitors and wearing the stective equipment (PPE). 0A NCAC 13F .1801(c) ection Prevention and be B Violation)]. sions and interviews, the e there was always one inistrator-In-Charge (AIC) in ng that at no time a resident t a staff member in the					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPL	
		HAL011375	B. WING		06/0)2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		OND HILL ROA .E, NC 28806	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 176	(Type B Violation)]. 8. Based on observat interviews, the facility records were maintain 4 of 5 sampled reside and #5). [Refer to Tag Records].	ions, record reviews and failed to ensure resident ned in an orderly manner for ints (Residents #1, #2, #3 g 0433, .1201(a) Resident	D 176			
	facility were implement necessary to maintain mental health were professed failure to maintain constatutes governing and responsibility of the A Administrator failed to the overall operations meet and monitor rule failing to notify the prifor a residents weight parameters, failing to dose of insulin to a retook medications left knowing if the medications left knowing if the medications care and sureloped from the facilit law enforcement or the (AHS), infection prevents for not screening visit. This failure resulted in constitutes a Type A1	ons, and policies of the need to ensure the services in the residents physical and rovided as evidenced by the impliance with the rules and ult care homes, which is the impliance with the rules and ult care homes, which is the impliance with the rules and ult care homes, which is the impliance with the rules and ult care homes, which is the impliance with the management of the facility by failing to be related to health care by mary care provider (PCP) again outside of ordered administer a scheduled sident, and a resident who in a cup in the his room not action belonged to him, pervision for a resident who by and failing to notify local the Adult Home Specialist ention and control program ors, and staff qualifications.				
	accordance with G.S. this violation.	vided a Plan of Protection in 131D-34 on 05/29/21 for				
	CORRECTION DATE	EOD THE TVDE A1	1			1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
RICHMON	D HILL REST HOME # 2		MOND HILL ROA LLE, NC 28806	D	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 176	Continued From page	: 19	D 176		
	VIOLATION SHALL N	OT EXCEED JULY 2, 2019			
D 177	10A NCAC 13F .0601 Facilities With A Capa		D 177		
		Management Of Facilities ensus Of Seven To Thirty			
	or administrator-in-ch- responsible for assuri are carried out in the at no time is a resider without a staff membe in Paragraph (c) of thi arrangements shall be with a capacity or cen	ng that all required duties home and for assuring that all left alone in the home er. Except for the provisions is Rule, one of the following e used to manage a facility sus of 7 to 30 residents:			
	500 feet of the home telecommunication wi (2) An administratorwithin 500 feet of the	r is in the home or within with a means of two-way th the home at all times; in-charge is in the home or home with a means of cation with the home at all			
	each with a capacity of adjacently on the same least one staff member basis in each of these shall be at least one a				
	each home with a me telecommunication wi and directly responsib	ge who is within 500 feet of ans of two-way th each home at all times ble for assuring that all arried out in each home.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	I \ /	SURVEY PLETED	
			A. BUILDING:			
		HAL011375	B. WING		06	3/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
		95 RICHI	MOND HILL ROAD			
RICHMON	ID HILL REST HOME # 2		LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 177	Continued From page	e 20	D 177			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	failed to ensure there Administrator or Admi the home and ensurir	ns and interviews, the facility was always one inistrator-In-Charge (AIC) in ng that at no time a resident it a staff member in the				
	The findings are:					
	9:15am revealed the out of the office appro	of the facility on 05/26/21 at Administrator had walked eximately 50 yards away up lea between buildings #1,				
	9:15am revealed: -She was responsible (approximately 150 fe	went to this facility to				
	-The facility did not ha in the building. -The facility had a pel	rsonal care aide (PCA) ne building, "actually she's				
	-There was supposed facility at all times.	I to be someone in the ed anything, the residents er.				
	revealed:	A on 05/26/21 at 9:53am ents who lived in the facility.				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		IOND HILL ROAD LE, NC 28806			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE	
D 177	Continued From page	21	D 177			
	facility before she arri	d recently been leaving the ved if she was running a d left the residents alone				
	until she arrived.					
		ht shift PCA "last week" to eaving the residents alone				
	revealed:	CA on 05/26/21 at 12:42pm				
	-The residents were le	find the Property Manager. eft unattended with no other hile eating lunch in the				
	revealed she left the t	CA on 05/27/21 at 3:21pm facility with no other staff g to find the Administrator alone for 5 minutes.				
	Interview with the PC	A on 05/27/21 at 3:25pm				
	_	off member working at the and 05/27/21 from 8:00am				
	-She would go to a sign the MA came to admit residents.	nts alone in the facility. ster facility to "cover" when nister medications to the				
	come from a sister fa	ave a MA and a MA would cility (up to approximately				
	medications.	property to administer s unattended on 05/26/21				
	and 05/27/21 because staff on the property.	e she was locating other				
	Interview with the Adr 3:26pm revealed:	ministrator on 05/27/21 at				
		" on staff and had one staff				

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STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/02	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		MOND HILL ROAL)		
	CLIMMADY CT		LE, NC 28806	DROVIDERIO DI ANI OF CODDECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 177	Continued From page	22	D 177			
	and the staff would had for the MA to administ residentsStaff were allowed to go to retrieve items froutside the facilityShe expected staff to residents and not leaven alone on 05/26/21 and the property instead of the facilityShe did not know the facilityShe did not know the leaving the facility at the facility at the facility at the facility and the shift.	by the PCA left the residents d 05/27/21 to find staff on of calling staff on the phone. esponsible for the staffing of e night shift PCA had been 3:00am and left the he PCA had arrived for day				
	Administrator or Openitor or School or Administrator or Openitor or Administrator or Openitor or Administrator or Openitor or Administrator or Openitor or O	Violation.				

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VIOLATION SHALL NOT EXCEED JULY 17,

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
RICHMON	ID HILL REST HOME # 2	95 RICHM	OND HILL ROA	AD.	
		ASHEVILL	.E, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 177	Continued From page	e 23	D 177		
	2021.				
D 234	10A NCAC 13F .0703 Medical Exam & Imm	• •	D 234		
	Examination & Immur (a) Upon admission tresident shall be tested in compliance with the by the Commission for specified in 10A NCA subsequent amendmenter rule are available the Department of He Tuberculosis Control	to an adult care home, each ed for tuberculosis disease e control measures adopted			
	facility failed to ensure (Resident #5) had con testing upon admission	as evidenced by: and record reviews, the e 1 of 4 sampled residents mpleted tuberculosis (TB) on in compliance with the the Commission for Health			
	The findings are:				
	06/29/20 revealed dia schizoaffective disord	5's current FL-2 dated agnoses included ler, intellectual disability, disorder, depression.			
		5's record on 06/01/21 o documentation of a TB			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S			
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	ILD
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2	95 RICHMO	ND HILL ROA	D		
_			E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 234	Continued From page	24	D 234			
	skin test completed for admission.	or Resident #5 upon				
	revealed:	nt #5 on 05/28/21 at 3:49pm				
	-He had resided in thi 2021.	s facility since January				
	-He did not know if he admission.	was tested for TB upon				
	06/01/21 at 3:26pm re -She had worked for t Administrator for abou	he facility as the				
	recordShe did not know if F	Resident #5 had been tested				
	for TBShe was responsible the facility.	for the overall operations of				
D 259	10A NCAC 13F .0802	e(a) Resident Care Plan	D 259			
	developed for each re the resident assessm 30 days following adn .0801 of this Section.	ne shall assure a care plan is esident in conjunction with ent to be completed within hission according to Rule				
	facility failed to ensure	and record reviews, the e a care plan was developed sidents (Resident #1) within				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA E, NC 28806	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 259	Continued From page The findings are: Review of Resident # 04/05/21 revealed: -Diagnoses included of schizophrenia and more. The resident was seriof a walker. Review of Resident # revealed an admission Review of Resident # was no care plan. Interview with the Profest at 3:10pm revealed: -The resident had been to have had multiple of the serious o	e 25 calculated diabetes, bipolar disorder, porbid obesity. mi-ambulatory with the use calculated diabetes, bipolar disorder, porbid obesity. mi-ambulatory with the use calculated diabetes	D 259			
	3:30pm revealed: -She did not know wh the resident's recordThe care plan would before she started to -There had been an is	have been completed				

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started at the facility.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIG: 11401		95 RICHM	OND HILL ROA	.D	
RICHMON	D HILL REST HOME # 2	ASHEVIL	LE, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	10A NCAC 13F .0902		D 273		
	` '	nd acute health care needs			
	This Rule is not met a TYPE B VIOLATION	as evidenced by:			
	reviews, the facility facare provider (PCP) for related to one resident sliding scale (a fast acts slow acting insulin) arpills in a medicine cup (Resident #4), and a notify the primary care	is, interviews and record iled to notify the primary or 2 of 3 sampled residents, it who missed doses of cting insulin), scheduled (and swallowed 10 unidentified or left in the residents room resident who had an order to be provider (PCP) for a daily ore pounds (Resident #2).			
	The findings are:				
	06/29/20 revealed: -Diagnosis included T -The medications incl insulin sliding scale for and at bedtime (a fast blood glucose levels)The sliding scale blood (0) units; 151-200 (2) 251-300 (6) units; 301 units; call provider if let 500The medications includits twice a day at 8:	uded Novolog Flexpen our times per day with meals acting insulin used to lower			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL011375	B. WING		06	6/02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMO	ND HILL REST HOME # 2	95 RICHI	MOND HILL ROAD			
	THE REOT HOME # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 273	Observation of the no 05/26/21 at 11:55am -The medication aide and said she was the morning blood sugar because she had foryThe pharmacy nurse checking the medica and told the MA "You morning insulin now" a. Review of Resider Medication Administr revealed: -There was an entry sliding scale, 0-150=201-250=4 units, 251 units, 351-500=10 ur -There was an entry (FSBS) 4 times a day -There was no docur obtained on 04/02/21 8:00am; 04/14/21 at and 12:00pm. Review of Resident # 05/12/21 -05/26/21 re -There was an entry sliding scale, 0-150=201-250=4 units, 251 units, 351-500=10 ur -There was no docur being obtained on 058:00pm; 05/13/21 at 12:00pm; 05/26/21 at 12:00pm; 05/26/21 at b. Review of Resider Medication Administr revealed:	con medication pass on revealed: (MA) came into the building pare to obtain Resident #4's and administer his insuling gotten to do it that morning. It was in the building tions on the medication cart are not going to do the are not going flexpen per 0 units, 151-200=2 units, 1-300=6 units, 151-200=2 units, 1-300=6 units, 151-200=2 units, 1-300=6 units, 301-350=8 units. In the total distribution of the parent of the pare	D 273			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING: _			
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA E, NC 28806	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 273	insulin was administe 04/14/21 at 8:00am; at Review of Resident # 05/12/21 -05/26/21 re-There was an entry funits twice a day at 8 -There was no docum FlexTouch insulin was at 4:30pm; 05/13/21 at 4:30pm. Interview with Reside revealed: -He was diabetic and blood sugarsHe was supposed to checked with each morning of 05/26/21He generally receive with his FSBS and on He received his schemorning of 05/26/21There were times in needed the insulin be were below 150He never felt like his high-"I never felt bad sugars"He missed his FSBS not give specific times. Interview with a medio 05/26/21 at 1:50pm re-She was the MA for the sugars was the MA for the sugar was the MA for the sugar was	entation Levemir FlexTouch red on 04/13/21 at 8:00am; and 04/24/21 at 8:00am. 4's May 2021 eMAR for vealed: or Levemir FlexTouch 25:00am and 4:30pm. rentation the Levemir s administered on 05/12/21 at 4:30pm; and 05/17/21 at at 4:30pm; and 05/17/21 at at 4:30pm; and object on the discount of the blood sugar real and at bedtime. Polood sugar checked on the discount of the discount of the past that he had not cause his blood sugars were too because of my blood at times before, but could section aide (MA) on revealed: two buildings today.	D 273			
		rk more than one building miss giving medications.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL011375	B. WING		06/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DICHMON	DINI DECT LONE # 0	95 RICHM	OND HILL ROA	AD .		
RICHMON	D HILL REST HOME # 2	ASHEVILL	.E, NC 28806			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	(- /	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE DATE	
D 273	Continued From page	e 29	D 273			
	-The reason she miss	sed Resident #4's FSBS and				
		Oam was because when				
	_	nister his Levemir, it was				
	still going to be an ho					
		Novolog insulin had to be				
	given close to when h	_				
		vemir insulin when she gave				
	him his morning medi	•				
		medications in multiple				
	houses".	•				
	Telephone interview v	vith Resident #4's primary				
	care provider (PCP) or revealed:	on 06/01/21 at 3:39pm				
	-She was not notified	by the facility of Resident				
	#4's missed dose of in	nsulin on 05/26/21.				
	-She was not notified	by the facility of any missed				
	doses of insulin for R	esident #4.				
	-She expected the fac	cility to call for any missed				
	doses of medications					
		emoglobin A1c (a blood test				
		etes over a period of about				
	120 days to ensure the and maintained) was	ne glycemic goals are met 5.6 on 03/15/21.				
		stick blood sugars (FSBS)				
	=	olled" but his current range of				
	readings (113 through	n 348) for May 2021 was not				
		olood sugar levels due to				
	missed doses of insul	•				
	complications of the	eyes, heart, kidneys, and				
	nerves.	<u>-</u>				
	-If the MA had admini	stered Resident #4's				
	scheduled am dose o	f insulin right before his				J
	scheduled lunch mea	l dose it would have been				
	"harmful" to Resident	#4.				
	-Resident #4 could ha	ave experienced severe				
	hypoglycemia (low blo	ood sugar) or a diabetic				
		too much insulin too close				
	together.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		SURVEY PLETED		
		HAL011375	B. WING		06	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	-	
DICUMON	ID HILL REST HOME # 2	95 RICHN	OND HILL ROAL	D		
RICHIVION	ID HILL REST HOME # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 30	D 273			
	at 10:40am revealed: -There were times whadminister medication-She had to administed did not have enough the e	nen one MA had to ns in multiple buildings. er medications because they MAs to cover each building. " times when medications MAs due to the workload. ministrator on 05/27/21 at uled for multiple buildings ed to give the medications ies-accurate and on time. so she was not sure why I insulins that had not been				
	at 10:30am revealed: -There was a small, wof the dresser in Resi -The medication cup and half of another ta -One tablet was white cut in halfOne tablet was a me colorOne tablet was an obcolorOne tablet was round an imprint of CL 75 or one tablet was round an imprint of CL 75 o	white medication cup on top dent #4's room. contained 9 whole tablets blet. e and round and had been edium round and yellowish in blong and dark burgundy in d and light pink colored with				

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BLIII DING:		COMPLET	ED
			/ DOILDING			
		HAL011375	B. WING		06/02/	/2021
			1			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		95 RICHM	OND HILL ROA	AD.		
RICHMON	ID HILL REST HOME # 2	ASHEVII I	E, NC 28806			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORY	100 IDEIVIII TIIVO IIVI ONWATION)	TAG	DEFICIENCY)	NATE	
				,		
D 273	Continued From page	e 31	D 273			
	Interview with Resident #4 on 05/26/21 at					
	10:30am revealed:					
	-He did not know how	long the medication cup				
		een setting on the dresser.				
	.	had put the medication cup				
	with pills on the dress					
		e medications in the cup				
	,	he thought they were his				
	because they were le					
	-He did not know wha	at his medications looked like				
	except he recognized	the long, burgundy colored				
		nultivitamin by comparing a				
		nedication cup containing				
	pills and the multivitar					
		min bubble pack for				
	Resident #4).					
	-He could not rememl					
	administered his sche	eduled medications by staff				
	earlier that morning b	ecause the medications				
	"come at different time	es".				
	Observation of Reside	ent #4 on 05/26/21 at				
	10:37am revealed he	picked up the medication				
		and poured the pills into his				
	mouth and swallowed					
	mouth and swallowed	i mem.				
		on 05/26/21 at 11:30am				
	revealed:					
	-She was the MA for a	a sister facility but was also				
	administering medica	tions to residents on				
	05/26/21 for this facili	ty because there was not a				
	MA assigned to work.					
		ı "short staffed" so she had				
	•	tions at this facility and a				
		ions at this facility affu a				
	sister facility.	tored Decident #41- 0:00-				
		tered Resident #4's 8:00am				
	scheduled medication	ns yet but was preparing to				
	dose.					
	-She did not leave me	edications in a medicine cup				
	in Resident #4's room					

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-She did not know when or who had left a cup of

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
				_		
			B. WING			
		HAL011375	B. WING		06/02	2/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
		95 RICHMO	OND HILL ROA	.D		
RICHMON	D HILL REST HOME # 2		E, NC 28806			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGOLATORT OR E	100 IDENTIFY TING INFORMATION	TAG	DEFICIENCY)	WALL	
D 273	Continued From page	e 32	D 273			
	nille in Decident #4'e	room actting on the drooper				
		room setting on the dresser.				
	• • •	or medication administration				
		medications to the resident,				
		swallow the pills, and sign				
	the eMAR before pas	sing medication to another				
	resident.					
	-	sident #4's primary care				
	provider (PCP) that he	e had taken a medicine cup				
	full of pills that had be	een left in his room and get				
	clarification on whether	er or not to give his				
	scheduled 8:00am do	ses of medications.				
	Interview with the MA	on 05/27/21 at 9:30am				
	revealed:					
	-She did not administ	er the scheduled morning				
		ent #4 on 05/26/21 because				
	Resident #4 had take	n "some pills" left in his				
	room.	•				
	-She documented she	e had administered Resident				
		ations on 05/26/21 because				
	_	ave a "blank space" on the				
	eMAR.	ave a blank space on the				
		otify the PCP Resident #4				
		d medication on 05/26/21				
	because she thought					
	•	was "busy" and the facility				
	was "short staffed".	was busy and the facility				
	was short stalled.					
	Intorvious with the De	raistored Nurse (PN) from				
		egistered Nurse (RN) from				
		d pharmacy on 05/27/21 at				
	12:45pm revealed:	age the regidents take				
		ness the residents take				
	medications administ					
		notified of any missed doses				
	of medication.					
		notified Resident #4 took 10				
	•	edications left in his room.				
		t self-medicate without a				
	physician's order.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DICUMON	ID HILL REST HOME # 2	95 RICHM	OND HILL ROA	D		
RICHIVION	D HILL REST HOWE # 2	ASHEVILL	.E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	33	D 273			
	Interview with the Adr 4:43pm revealed: -The MA should never residents unsuperviseShe was unaware a Resident #4's room of answer for that"She did not know whith in Resident #4's room belonged toThe MA on duty was #4's scheduled 8:00ath because she was resided and procedures for madministering the medications to reside the PCP of missed down and the resident take the the PCP of missed down and the resident take the the PCP of missed down and the resident take the the PCP of missed down and sign the eMAR that administered to the resident #4 swallowed a medicine cup in Resident #4 swallowed a medicine cup in Resident #4 swallowed a medications and for Ference and resident #4's medications and for	r leave medications with ed. MA had left medications in in the dresser, "I have no in the medications were left in or who the medications at late administering Resident in medications on 05/26/21 ponsible for administering int's at multiple facilities. Thad "problems" because ugh staff. In follow the facility's policies edication administration by dications on time, observing interesting interestin				
	Interview with Reside	nt #/I's PCP on 06/01/21 at				

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3:39pm revealed:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		IOND HILL ROA	D		
	OLUMBA DV OT		LE, NC 28806	DD0 //DD0 D1 A 4 05 00DD5 07/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 34	D 273			
	-She was not notified Resident #4 had inge in a medicine cup in F 05/26/21She expected the fact missed doses of med when Resident #4 took impincluding high blood predications, an anticomedicationsIf the medications Rebelonged to him and second dose, it could complications with Recomplications Residexperienced from recomedication included to or heart rate, blood viblood sugar which wo monitoring or hospital the symptomsAdditional complications medications would incomplicate in pressure, too high bloon-therapeutic levels medications being us non-therapeutic levels could cause increase antidepressant. Attempted telephone legal guardian on 05/3 unsuccessful.	by staff from the facility sted 10 unidentified pills left Resident #4's room on cility to notify her of any ications for residents and ok 10 unidentified pills on cortant medications or essure, psychiatric convulsant, and anti-diabetic esident #4 had swallowed the MA had administered a have caused serious esident #4. eent #4 could have eiving two doses of each cool ow of a blood pressure scosity too thin, too low of a could have required additional dization for treatment of all cons from missed doses of colude too high of a blood sod sugar levels, and so of his blood thinner ed to prevent strokes, so of his anticonvulsant which diseizures, and interview with Resident #4's				
	unsuccessful.	t #2's current, outdated FL2 led:				

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schizoaffective disorder, bipolar disorder,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
	HAL011375	B. WING		06	6/02/2021
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RICHMOND HILL REST HOME	# 2 95 RICH	MOND HILL ROAD			
	ASHEVI	LLE, NC 28806			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
disease, hypo-osn levels of electrolyte lower than normal hypertension. -There was an ord time of the day and provider (PCP) of a in a day. Review of Resider Medication Admini revealed: -Weight was docur 05/07/21. -Weight was docur 05/08/21. -Weight was docur 05/09/21. -Weight was docur 05/10/21. -There was no docur 05/10/21.	ual functioning, chronic kidney notality (a condition where the es, proteins, and nutrients are in the blood), and er for daily weights at the same d to notify the primary care a 3 pound or more weight gain at #2's May 2021 electronic stration Record (eMAR) mented as 317 pounds on mented as 320.2 pounds on mented as 322.4 pounds on mented as 326.0 pounds on mented as 326.0 pounds on eumentation the PCP was aund weight gain on 05/08/21. Eumentation the PCP was aund weight gain on 05/10/21. medication aide (MA) on the merevealed: ght "constantly" fluctuated. Sible for notifying the PCP on 0/21 for Resident #2's weight or more. the PCP of Resident #2's	D 273			

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25 10.			
		HAL011375	B. WING		06/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		OND HILL ROA E, NC 28806	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPO DEFICIENCY)	BE COMPLETE	
D 273	PCP to notify them of or 3 pounds or more of a pounds or more of a pounds or more of a pounds and notifying the same procedures for place of 3 pounds or more of 4 pou	y the MA did not call the Resident #2's weight gain on 05/08/21 and 05/10/21. sible for following physician's he PCP when indicated. of follow the facility's policies hysician orders. of or the total operations of with Resident #2's PCP on evealed: of Resident #2's weight gain on 05/08/21 or 05/10/21. Resident #2's weight ag diuretics (a medication ess fluid from the body) for dema (swelling caused by on the body's tissues). cility staff to call if Resident gain of 3 pounds or more. hey and heart disease and d overload" so it was very ty to notify her of the weight on much excess fluid in the hortness of breath, increase rate, harm the heart muscle of the heart, and cause an essure because of too much m. huge staffing issue" with not at the facility when she	D 273			
	provider (PCP) for the sampled residents rel insulin and taking 10	ontact the primary care health care needs of 2 of 3 ated to missed doses of unidentified medications left putting the resident at risk				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06	/02/2021
	ROVIDER OR SUPPLIER	95 RICH	DDRESS, CITY, STAT MOND HILL ROAD LLE, NC 28806	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 273	with increased monitor hospitalization, and Research related to excess fluid cause increased come kidney disease, and sexcess fluid in the lundetrimental to the heat the residents and come The facility provided a accordance with G.S. this violation.	e levels and unknown king unidentified medication oring and possible resident #2's weight gain I in the body that could plications with his heart and shortness of breath from gs. This failure was alth, safety, and welfare of stitutes a Type B Violation.	D 273			
D 338	all residents guaranted Declaration of Resider and may be exercised. This Rule is not met TYPE A1 VIOLATION. Based on observation review, the facility fail free from neglect relation the facility and wounder of days while	Resident Rights hall assure that the rights of hed under G.S. 131D-21, hots' Rights, are maintained d without hindrance. as evidenced by: his, interviews, and record ed to ensure residents were ted to a resident who eloped was gone for an unknown not knowing the residents int #5), and staff leaving	D 338			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		HAL011375	B. WING	B. WING		/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DIO!!!!		95 RICH	MOND HILL ROAD			
RICHMON	ID HILL REST HOME # 2	ASHEVII	LLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	38	D 338			
	06/29/20 revealed: -Diagnoses included intellectual disability, disorder, depressionHe was ambulatory vassistive deviceOrientation and beharmark and b	without the use of an aviors were left unmarked. ves, a legal guardian, or a sted. 5's record on 06/02/21 was 10 individual papers nt register with guardian				
	The policy for missing on 05/28/21 at 1:55pr	g resident's was requested m but not provided.				
	out on 05/09/21 at 6:5 pm and resident/resp destination were left the resident #5's name out on 05/11/21 at 11 documentation of the destination. -On 05/21/21 at 8:54 produmented as signed signature documenting property manager, and Resident #5 leave and	was documented as signed 53 and did not indicate am or onsible person and blank. was documented as signed 50 am with no responsible person or om Resident #5 was dout with a note under staff				

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Division of	of Health Service Regu	lation					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING	B. WING		06/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
DICHMON	ID HILL REST HOME # 2	95 RICHI	MOND HILL ROA	۷D			
RICHIVION	D HILL REST HOWE # 2	ASHEVIL	LE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 338	Continued From page	2 39	D 338				
	departure from the building on 05/10/21 or 05/13/21.						
	care aide (PCA) and a dated 05/15/21 at 11: -On 05/13/21, the MA medications to him be 2-3 days but had not facility for a "few hour Resident #5 his medications to the MA texted it was Resident #5 out where the PCA responded talked to the Administ Manager and they tole person's report, but si "he's a legit missing particular terrible"The PCA responded was "terrible"The PCA asked the concept Resident #5 was whee "they had no idea whealth and the manager and communications that didn't hap Review of the record revealed: -There were no Care of Resident #5 leaving out on the sign out should be a signed to the record revealed: -There was no missing completed for Reside to There was no Incider completed for Reside to the manager and they are the manager and they are the signed when the sign out should be a signed to the sign out should be signed to the s	A gave Resident #5's ecause he was leaving for planned on leaving the rs" after she had given cations. Is staff's responsibility to sign in he left. It to the MA that she had trator and the Property in he was "confused" because berson from our facility". The staffing for the facility in the staff working where in she reported to work but ere he was". With the day shift staff should it #5 out on the sign out eated he had left but "of open". In requested for Resident #5 Notes with documentation in gothe facility without signing eneet. In giperson's checklist in the sign of the facility without signing eneet. In giperson's checklist in the signing of the facility without report.					

Division of Health Service Regulation

05/28/21 at 10:47am revealed:

STATE FORM 6899 4W5411 If continuation sheet 40 of 80

Division	of Health Service Regu	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL011375	B. WING		06/0	2/2021
NAME OF D	DOVIDED OD CUDDUED	OTDEET AS	DRESS, CITY, STA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER			,		
RICHMON	ID HILL REST HOME # 2		IOND HILL ROA	AD .		
	.5	ASHEVIL	LE, NC 28806			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 338	Continued From page	<u>.</u> 40	D 338			
В 000	Continued From page	- 1 0	5 000			
	-Resident #5 left the f	facility about 2 weeks ago				
	without signing out ar	nd was gone for about 4				
	days.	C				
		5/13/21 and she returned to				
		d Resident #5 was "missing"				
		working that day knew the				
	whereabouts of Resid					
		text to staff that worked at				
		nyone knew where Resident				
	#5 was when she had					
		ained on elopement or what				
	to do for missing resid					
	-She called the Admir	•				
		sing from the facility and was				
		on a missing person's				
	report.					
	-The Administrator ins	structed her to not call the				
	police and fill out the	missing person's report				
	since Resident #5 left	t the facility weekly.				
	-She was "scared" sh	e would "get into trouble" if				
	she called the police	to report Resident #5				
		s told not to call by the				
	Administrator.	•				
	Interview with the Adr	ministrator on 05/28/21 at				
	1:45pm revealed:					
		nt/Accident report filled out				
	for Resident #5.					
		ecialist (AHS) or local County				
		was not notified Resident #5				
		facility because "he was not				
	_	t did not sign Resident #5				
		_				
	out on the sign out sh					
		eave the facility for 2 or 3				
	days per week becau	se ne nad a job				
	"somewhere".	"				
		nere Resident #5 had a job.				
		nere Resident #5 went or				
		ne facility, but he walked to				
	the bus stop to ride th	ne city bus.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	· , ,	(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/0	02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
RICHMON	ID HILL REST HOME # 2		OND HILL ROA E, NC 28806	.D			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 338	-She thought Resider but could not find a R he had a guardian or -The policy for resider for the staff working a resident out on a sign notebook in the living -The facility had been days the staff were sh facilities. Interview with Reside revealed: -He left for a few days at a laundromat and hele stayed with a frier. The maintenance wo medications to take whe facility on 05/10/21He did not sign out on staff working in the sheed walked to a smaintenance worker the medications off the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the fact the sheetIt was the responsibility working in the sheetIt was the respons	record for Resident #5. Int #5 was his own guardian resident Register to check if family listed. Ints leaving the facility was It the facility to sign the rout sheet located in a room of the facility. In short on staff and some reared between the sister Int #5 on 05/28/21 at 3:49pm Is on 05/10/21 to go to work Intell. Ind when he left the facility. In when he left the In the sign out sheet If find a pen and there was It find a pen and there was It find a pen and there was It find a pen and get his It find a guardian, but he It had a guardian, but he It had a guardian, but he It had a guardian. It had a given Resident It take with him when It had given Resident It take with him when It had given Resident It take with him when It had given Resident It take with him when It had given Resident It take with him when It without signing out on	D 338				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			R WING			
		HAL011375	B. WING		06/02/2021	<u> </u>
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2	95 RICHN	OND HILL ROA	.D		
		ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP	PLETE
D 338	Continued From page 42		D 338			
	were leaving the facility.					
	Interview with the Adr 1:50pm revealed: -Resident #5 told her and he was responsit -There was no docum or emergency contact -If there was an emer what she would do or Resident #5 as she had information. 2. Interview with the Adrien expension of the 9:15am revealed: -She was responsible (approximately 150 fer medication aide (MA) administer medication	he did not have a guardian ble for himself. hentation of a legal guardian at for Resident #5. gency, she did not know who she would contact for ad no documented Administrator on 05/26/21 at for being in a sister facility et away) while the went to this facility to its.				
	in the buildingThe facility had a per assigned to work in the housekeeper".	rsonal care aide (PCA) ne building, "actually she's				
	facility at all times.	ed anything, the residents				
	revealed: -There were 11 reside -A night shift PCA had facility before she arri "few minutes" late and until she arrivedShe reported the nig	A on 05/26/21 at 9:53am ents who lived in the facility. If recently been leaving the ved if she was running a dieft the residents alone that shift PCA "last week" to eaving the residents alone				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			
		HAL011375	B. WING		06	6/02/2021
	ROVIDER OR SUPPLIER	95 RICHN	ODRESS, CITY, STATI			
		ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	÷ 43	D 338			
	revealed: -She left the facility to -The residents were lest aff in the building with dining room. Observation of the Positive She and the second sec	CA on 05/26/21 at 12:42pm If find the Property Manager. Left unattended with no other hile eating lunch in the CA on 05/27/21 at 3:21pm Lacility with no other staff				
	working in the building to find the Administrator and left the residents alone for 5 minutes.					
	Interview with the PCA on 05/27/21 at 3:25pm revealed: -She was the only staff member working at the facility on 05/26/21 and 05/27/21 from 8:00am through 8:00pm. -She never left residents alone in the facilityShe would go to a sister facility to "cover" when the MA came to administer medications to the residentsThe facility did not have a MA and a MA would come from a sister facility (up to approximately 200 feet away) on the property to administer medicationsShe left the residents unattended on 05/26/21 and 05/27/21 because she was locating other staff on the property.					
	3:26pm revealed: -She had been "short per each facilityShe did not have a Nand the staff would have for the MA to administ residentsStaff were allowed to	" on staff and had one staff "A assigned to the facility ave to "switch out" in order ter medications to the sit outside on the porch or om their vehicles parked				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL011375	B. WING		06	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		MOND HILL ROAD .LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 338	residents and not lear-She did not know whalone on 05/26/21 and the property instead or-She was ultimately residents alone until the facility. She did not know the leaving the facility at residents alone until the shift. The facility failed to ear from neglect related the from the facility for an while not knowing the the resident had a leg person to notify (Resident had a leg	o stay in the buildings with we them unattended. by the PCA left the residents of 05/27/21 to find staff on of calling staff on the phone. The staffing of the enight shift PCA had been shown and left the she PCA had arrived for day to a resident who eloped to unknown number of days the residents whereabouts or if the gal guardian or responsible dent #5), and ensuring that the was left alone without a staff when a day shift personal that residents alone on the she looked for other and when a night shift PCA several occasions leaving the day shift PCA arrived lect and constitutes a Type	D 338			
D 358	10A NCAC 13F .1004 Administration		D 358			
	10A NCAC 13F .1004	Medication Administration	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL011375	HAL011375 B. WING		06	6/02/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		<i></i>
DIGUMON	ID DEST LIGHE # 0	95 RICHI	MOND HILL ROAD			
RICHMON	ID HILL REST HOME # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	preparation and admi prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met TYPE B VIOLATION Based on observation reviews, the facility fawere administered as residents related to a scheduled a slow action. The findings are: Review of Resident # 06/29/20 revealed: -Diagnosis included T-The medications inclinsulin sliding scale for and at bedtime (a fast blood glucose levels) -The medications inclinits twice a day at 8 acting insulin used to Observation of the no 05/26/21 at 11:55am -The medication aide and said she was the morning blood sugar	ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: as, interviews and record iled to ensure medications ordered for 1 of 3 sampled fast acting insulin and a ng insulin. 4's current FL2 dated Type 2 diabetes. uded Novolog Flexpen our times per day with meals tacting insulin used to lower the second insulin used to lower acting insulin used to lower blood glucose levels). The second in the building reto do Resident #4's and insulin because she had	D 358	DEFICIENC		
	morning blood sugar forgotten to do it that -The Pharmacy Nurse	and insulin because she had morning.				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL011375	B. WING		06/0	2/2024
			1		1 06/0	02/2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
RICHMON	D HILL REST HOME # 2		OND HILL ROA LE, NC 28806	NO.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 46	D 358			
	now".	g to do the morning insulin t #4's April 2021 electronic				
	Medication Administrative revealed:	, ,				
	-There was an entry for Novolog Flexpen per sliding scale, 0-150= 0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-500=10 units. -There was no documentation of fingerstick blood sugars (FSBS) was obtained on 04/02/21 at 5:00pm; 04/13/21 at 8:00am; 04/14/21 at 8:00am; 04/24/21 at 8:00am and 12:00pm.					
	Review of Resident # 05/12/21 - 05/26/21 re	4's May 2021(eMAR) for evealed:				
	sliding scale, 0-150= 201-250=4 units, 251 units, 351-500=10 un					
		nentation of (FSBS) results 2/21 at 5:00pm and 8:00pm; 05/14/21 at 12:00pm;				
	Medication Administrative revealed:	,				
	units twice a day at 8 -There was no docum FlexTouch insulin for	nentation the Levemir				
		3/21 at 8:00am; 04/14/21 at				
	-05/26/21 revealed:	4's (eMAR) for 05/12/21 for Levemir FlexTouch 25				

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units twice a day at 8:00am and 4:30pm.

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DIVISION	n nealth Service Negu	iation	_				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	COMPLETED	
			_				
		HAL011375	B. WING		06/0	2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE			
DICHMON	ID HILL REST HOME # 2	95 RICHM	OND HILL ROA	AD			
KICHWICK	ID HILL REST HOWE # 2	ASHEVILL	.E, NC 28806				
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
D 358	Continued From page	e 47	D 358				
	-There was no docum	nentation Levemir FlexTouch					
		inistered on 05/12/21 at					
	I	1:30pm; and 05/17/21 at					
	4:30pm.						
	Interview with Reside	nt #4 on 05/26/21 at 1:50pm					
	revealed:						
	-He was diabetic and	received insulin for his					
	blood sugars.						
	-He was supposed to	have his blood sugar					
	checked with each me	-					
		blood sugar checked on the					
	morning of 05/26/21.						
		d two types of insulin, one					
		e that was scheduled.					
	-He received his sche	eduled insulin on the					
	morning of 05/26/21.						
	-There were times in	the past that he had not					
		cause his blood sugars					
	were low.	3					
		blood sugars were too					
	high-"I never felt bad						
		because of fifty blood					
	sugars".	attions before but sould					
		at times before, but could					
	not give specific times	5.					
	Interview with a medic	` ,					
	05/26/21 at 1:50pm re						
	-She was the (MA) for	r two buildings today.					
	-When she had to wo	rk more than one building					
		s miss giving medications.					
		sed Resident #4's FSBS and					
		Oam was because when					
	_						
		nister his Levemir, it was still					
	going to be an hour b						
	_	olog insulin had to be given					
	close to when he was						
	-She gave him his Le	vemir insulin when she gave					
	him his morning medi						

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-"It is stressful to give medications in multiple

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		HAL011375	D. WING		06/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		95 RICHM	OND HILL ROA	AD.		
RICHMON	D HILL REST HOME # 2		E, NC 28806	-		
	OLIMANA DV OT		Ť	DDO//IDEDIO DI ANI OE CODDECTION		—
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		TE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 358	Continued From page	. 40	D 358			
D 330	Continued From page	: 40	D 336			
	houses".					
	Telephone interview v	vith Resident #4's primary				
	care provider (PCP) of	on 06/01/21 at 3:39pm				
	revealed:					
	-She was not notified	by the facility of Resident				
	#4's missed dose of in	nsulin on 05/26/21.				
	-She was not notified	by the facility of any missed				
	doses of insulin for Ro	esident #4.				
	-She expected the fac	cility to call for any missed				
	doses of medications					
	-Resident #4's last he	emoglobin A1c (a blood test				
		etes over a period of about				
		ne glycemic goals are met				
		5.6 (an A1C of less than 5.7				
	means that an individ	•				
	controlled).					
	,	stick blood sugars (FSBS)				
		olled" but his current range of				
		n 348) for May 2021 was not				
	- ,	ave missed more than one				
	•	A1C of 5.6 equates to an				
	average blood sugar					
	-If the MA had admini	,				
		f insulin right before his				
		I dose (the MA was stopped				
		e am dose of insulin with the				
		d dose of insulin by the				
	nurse consultant (RN	•				
		on 05/26/21 at 11:45am) it				
	would have been "har	•				
		ave experienced severe				
		ood sugar) or a diabetic				
		too much insulin too close				
	together.	mach maaiin too dose				
		a blood sugar lovels due to				
	_	n blood sugar levels due to lin which could lead to				
		g Resident #4's eyes, heart,				
	kidneys, and/or nerve	S.				

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		SURVEY PLETED				
		HAL011375	B. WING		0.6	6/02/2021
		TIALUTI373			1 00	0/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
RICHMON	ID HILL REST HOME # 2	95 RICH	MOND HILL ROAD			
KIOIIIIOI	ID THEE REOT HOME # 2	ASHEVII	LLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 49	D 358			
	at 10:40am revealed: -There were times whadminister medication -She had to administed don't have enough MThere were "possibly were missed by the M. Interview with the Admandary and the series of	nen one MA had to ns in multiple buildings. er medications because they As. y" times when medications MAs due to the workload. ministrator on 05/27/21 at th MAs to staff each house uled for multiple facilities ed to give the medications sies. so she was not sure why d insulins that had not been nistered. nich MA had the diabetic sidents who are diabetic to that she knows of in place to				
	The facility failed to e administered as orde a medication orders f	nsure medications were red to one resident that had for FSBS / sliding scale				
	Levemir insulin for Remissed doses of Nov April 2021 and May 2 Provider stated that the could lead to complice eyes, heart, kidneys a	and a scheduled dose of esident #4 with a total of 16 olog and Levemir insulin in 2021. The Primary Care he missed doses of insulin ations affecting the residents and nerves. This failure was alth, safety, and welfare of				
		nstitutes a Type B Violation a plan of protection in				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL011375	B. WING		06	6/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		IMOND HILL ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	this violation. THE CORRECTION	e 50 . 131D-34 on 05/28/21 for DATE FOR THIS TYPE B NOT EXCEED JULY 17,	D 358			
D 366	10A NCAC 13F .100 Administration	4 (i) Medication	D 366			
	(i) The recording of the medication administrate staff person who adminimmediately following medication to the res					
	reviews, the facility facility facility facility facility facility for 10 tablets of ordered. The findings are: Review of Resident # 06/29/20 revealed dishypertension, convul ischemic attack, depression.	ns, interviews, and record ailed to complete 1 sampled residents taking medications (Resident #4). #4's current FL-2 dated agnoses included sions, history of transient ression, and type 2 diabetes.				
	hypertension, convul ischemic attack, dep	ression, and type 2 diabetes. #4's May 2021 electronic				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7410 1 2741	or contraction	IDEITH IO/HIOH HOMBER.	A. BUILDING: _		00.000	
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA	AD.		
		ASHEVILL	E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 300	revealed: -The diagnoses included history of transient ischemic attack, occlusion and stenosis of the carotid artery, weak gait, intracranial injury with loss of consciousness, convulsions, hypertension, hyperlipidemia, major depressive disorder, chronic back pain, chronic kidney disease, chronic obstructive pulmonary disease, and history of mental and behavioral disorderThere were 9 tablets and a half of a tablet (10 tablets total) ordered for the 8:00am scheduled medications.		D 366			
	Observation in Reside 10:30am revealed:	ent #4's room on 05/26/21 at				
	on top of the dresser	vhite medication cup setting in Resident #4's room. contained 9 whole tablets				
	and half of another ta -One tablet was white cut in half.	blet. e and round and had been				
	colored.	dium round and yellowish				
	colored.	olong and dark burgundy d and light pink colored with				
	an imprint of CL 75 or	• .				
	-There were 5 more r sizes.	ound white tablets in varying				
	Interview with Reside 10:30am revealed:					
	 -He did not know how long the medication cup containing pills had been setting on the dresser. -He did not know who had put the medication cup 					
	with pills on the dress					
		he thought they were his				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRICHMOND HILL REST HOME # 2 STREET ADDRESS, CITY, STATE, ZIP CODE 95 RICHMOND HILL ROAD ASHEVILLE, NC 28806 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG B. WING PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE 95 RICHMOND HILL ROAD ASHEVILLE, NC 28806 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE DATE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
RICHMOND HILL REST HOME # 2 95 RICHMOND HILL ROAD ASHEVILLE, NC 28806 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			HAL011375	B. WING		06/0	2/2021
ASHEVILLE, NC 28806 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) ASHEVILLE, NC 28806 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE COMPLETE DATE	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	RICHMOND	HILL REST HOME # 2			D		
	PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
D 366 Continued From page 52 He did not know what his medications looked like except he recognized the long, burgundy colored one (identified as a multivitamin by comparing a picture taken of the medication cup containing pills and the multivitamin bubble pack for Resident #4). He could not remember if he had been administered his scheduled medications by staff earlier that morning because the medications "come at different times". Observation of Resident #4 on 05/26/21 at 10:37am revealed he picked up the medication cup from the dresser and poured the pills into his mouth and swallowed them. a. Review of a physician order for Resident #4 dated 04/17/20 revealed metoprolol (used to treat high blood pressure and control the hearts rhythm) 25 mg take haif a tablet twice daily. Review of Resident #4's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg take one half tablet (12.5mg) twice daily. -There was documentation Resident #4 was administered metoprolol 25mg one half tablet (12.5mg) daily at 8:00am from 05/01/21 through 05/27/21 except on 05/03/21 where it was documented he was out of the facility. Refer to the interview with the medication aide (MA) on 05/26/21 at 11:30am. Refer to the interview with the nurse consultant (RN) from the facility's contracted pharmacy on 05/26/21 at 14.45mm.	-HeoppR-Hae" C1cm adhrt Rmr - o'-a('0d R(I	He did not know what except he recognized one (identified as a mpicture taken of the mpills and the multivitar Resident #4). He could not remember administered his scheer at different time. Observation of Reside 10:37am revealed he cup from the dresser mouth and swallowed as. Review of a physic dated 04/17/20 reveating blood pressure at the properties of the properties. Review of Resident # medication administrate revealed: There was an entry from half tablet (12.5mg) daily at 8:00 05/27/21 except on 05 documented he was concepted the interview (MA) on 05/26/21 at 1 Refer to the interview (RN) from the facility's recognitions.	at his medications looked like the long, burgundy colored autitivitamin by comparing a nedication cup containing min bubble pack for the had been eduled medications by staff ecause the medications es". The state of the had been enduled medications by staff ecause the medication and poured the pills into his at them. The state of the hearts are tablet twice daily. The state of the hearts are tablet twice daily. The state of the state of the pills into his at them. The state of the hearts are tablet twice daily. The state of the state of the pills into his at them. The state of the hearts are tablet twice daily. The state of the hearts are tablet of the state of the state of the facility. The state of the state of the state of the facility. The state of the state of the state of the facility. The state of the state of the state of the facility. The state of the state of the state of the facility. The state of the state of the state of the facility. The state of the s	D 366			

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Refer to the interview with the Administrator on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL011375	B. WING		06	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		IOND HILL ROA LE, NC 28806	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page 05/26/21 at 4:43pm.	e 53	D 366			
		with Resident #4's primary on 06/01/21 at 3:39pm.				
	dated 04/17/20 revea	ian order for Resident #4 led clopidogrel (used to '5mg take 1 tablet daily.				
	medication administrative revealed:	,				
	tablet daily at 8:00am -There was documen administered clopidoo from 05/01/21 through	tation Resident #4 was grel 75mg daily at 8:00am				
	Refer to the interview (MA) on 05/26/21 at	with the medication aide 11:30am.				
		with the nurse consultant s contracted pharmacy on				
	Refer to the interview 05/26/21 at 4:43pm.	with the Administrator on				
		with Resident #4's primary on 06/01/21 at 3:39pm.				
		ian order for Resident #4 led aspirin (used to prevent ew 1 tablet daily.				
	Review of Resident #	4's May 2021 electronic				

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
			D WING			
		HAL011375	B. WING		06/02	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA	,D		
		ASHEVILL	.E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 366	Continued From page	e 54	D 366			
D 300	-There was an entry fidaily at 8:00amThere was document administered aspirin 8:05/01/21 through 05/2 where it was document facility. Refer to the interview (MA) on 05/26/21 at 12:45pm. Refer to the interview (RN) from the facility's 05/26/21 at 12:45pm. Refer to the interview 05/26/21 at 4:43pm. Refer to the interview care provider (PCP) of d. Review of a physic dated 04/17/20 revea seizures with convuls twice daily. Review of Resident # medication administrative was an entry fitablets twice dailyThere was document administered topiraminat 8:00am from 05/01	for aspirin 81mg take 1 tablet tation Resident #4 was 81mg daily at 8:00am from 27/21 except on 05/03/21 Inted he was out of the with the medication aide 11:30am. with the nurse consultant is contracted pharmacy on with the Administrator on with Resident #4's primary on 06/01/21 at 3:39pm. ian order for Resident #4 led topiramate (used to treat ions) 25mg take 3 tablets 4's May 2021 electronic	D 366			
	of the facility.	with the medication aide				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		HAL011375	B. WING		06	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		IOND HILL ROA LE, NC 28806	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 366	(RN) from the facility's 05/26/21 at 12:45pm. Refer to the interview 05/26/21 at 4:43pm. Refer to the interview care provider (PCP) of the expension of the e	with the nurse consultant is contracted pharmacy on with the Administrator on with Resident #4's primary on 06/01/21 at 3:39pm. Join order for Resident #4 led escitalopram (used to not take 1 tablet daily. 4's May 2021 electronic ation record (eMAR) or escitalopram 10mg take m. tation Resident #4 was pram 10mg daily at 8:00am in 05/27/21 except on is documented he was out of with the medication aide lat:30am. with the nurse consultant is contracted pharmacy on	D 366	DEFICIENC	1)	
	dated 04/17/20 revea	an order for Resident #4 led Januvia (used to treat l0mg take 1 tablet daily.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		95 RICHM	OND HILL ROA	.D	
RICHMON	D HILL REST HOME # 2		E, NC 28806		
240.15	CLIMMADV CT		<u>, </u>	DROVIDEDIS DI ANI OF CORRECTIO	NN OUT
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 366	Continued From page	e 56	D 366		
	medication administratevealed: -There was an entry fitablet daily at 8:00am -There was document administered Januvia from 05/01/21 through 05/03/21 where it was the facility. Refer to the interview (MA) on 05/26/21 at 1	for Januvia 100mg take 1 tation Resident #4 was 100mg daily at 8:00am n 05/27/21 except on s documented he was out of with the medication aide 11:30am. with the nurse consultant s contracted pharmacy on			
	Refer to the interview 05/26/21 at 4:43pm.	with the Administrator on			
		with Resident #4's primary on 06/01/21 at 3:39pm.			
	dated 04/17/20 revea	ian order for Resident #4 led pioglitazone (used to rs) 45mg take 1 tablet daily.			
	medication administrative revealed: -There was an entry for tablet daily at 8:00am -There was document administered pioglitate 05/01/21 through 05/2	or pioglitazone 45mg take 1			

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL011375	B. WING		06	5/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		IMOND HILL ROAD			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ILLE, NC 28806	PROVIDER'S PLAN OF (CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page	e 57	D 366			
	Refer to the interview (MA) on 05/26/21 at	with the medication aide 11:30am.				
		with the nurse consultant s contracted pharmacy on				
	Refer to the interview 05/26/21 at 4:43pm.	with the Administrator on				
		with Resident #4's primary on 06/01/21 at 3:39pm.				
	dated 04/17/20 revea	cian order for Resident #4 lled therems-M (a reat vitamin deficiency) take				
	medication administrative revealed: -There was an entry to daily at 8:00amThere was document administered therems from 05/01/21 throug	t4's May 2021 electronic ation record (eMAR) for therems-M take 1 tablet tation Resident #4 was s-M 1 tablet daily at 8:00am h 05/27/21 except on s documented he was out of				
	Refer to the interview (MA) on 05/26/21 at	with the medication aide 11:30am.				
		with the nurse consultant s contracted pharmacy on				
	Refer to the interview 05/26/21 at 4:43pm.	with the Administrator on				
	Refer to the interview	with Resident #4's primary				

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Division of	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		0	6/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE, ZIP CODE			
DICUMON	D IIII I BEST HOME # 2	95 RICHI	OND HILL ROA	ND			
RICHIVION	D HILL REST HOME # 2	ASHEVIL	LE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 366	Continued From page	÷ 58	D 366				
	care provider (PCP) on 06/01/21 at 3:39pm.						
	05/26/21 at 11:30am -She was the MA for a administering medica 05/26/21 for this facili MA assigned to workShe had not adminis scheduled medication doseShe did not know wh pills in Resident #4's -The MA was stopped administering Reside medications at 11:30a primary care provider instructionsThe facility's policy for was to administer the observe the resident.	a sister facility but was also itions to residents on ity because there was not a					
	the facility's contracted 12:45pm revealed: -He did not have a row MA administering med Clinical Skills or MA to the gave the docume provided to the staff at The MA should witned medications administration.	entation of all training at the facility to the facility. ess the residents take ered to them.					
	4:43pm revealed:	ministrator on 05/26/21 at releave medications with ed.					

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-She was unaware a MA had left medications in

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STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		95 RICHMO	OND HILL ROA	D		
RICHMON	ID HILL REST HOME # 2	ASHEVILL	E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	Continued From page	59	D 366			
	Resident #4's room of answer for that". -She did not know whith in Resident #4's room belonged to. -The MA on duty was #4's scheduled 8:00a because she was resided. The policy and procest administration included bubble packs, pop the medicine cup, administration included bubble packs, pop the medicine cup, administered to the resident was responsively with a resident mission and for the incident the swallowed a cup or pills that had been leful -She did not know who with Resident #4's PCP or doses and taking 10 to medicine cup left in Resident #4 had inge in a medicine cup in Fob/26/21. -She was not notified Resident #4 had inge in a medicine cup in Fob/26/21. -She expected the fact missed doses of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of med when Resident #4 took impincluding high blood process and the process of the process o	en the medications were left or who the medications late administering Resident m medications on 05/26/21 ponsible for administering nt's at multiple facilities. Educe for medication and the MA would scan the emedications out into a ster them to the resident, we medication had been esident. Sible for notifying the PCP and doses of medications is morning when Resident ontaining 10 unidentified to in his room. The MA did not notify the MA did not notify the MA did not notify the medication are sident #4's room. The MA the MA did not notify the sident #4's room. The MA did not notify the sident #4's room on the sident #4'				

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-If the medications Resident #4 had swallowed

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011375	B. WING		06	/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2	95 RICHI	MOND HILL ROAD			
	THE REST TIOME # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 366	belonged to him and to second dose, it could complications with Re-Complications Residexperienced from recomedication included to or heart rate, blood viblood sugar which wo monitoring or hospital the symptoms. -Additional complication medications would incompressure, too high bloom non-therapeutic levels medications being usenon-therapeutic levels could cause increased antidepressant. Attempted telephone legal guardian on 05/3 unsuccessful. The facility failed to an according to their police leaving a medication wursure if the medication took the pills while state care provider (PCP) of was detrimental to the of the residents and of Violation.	the MA had administered a have caused serious esident #4. ent #4 could have every five doses of each too low of a blood pressure scosity too thin, too low of a build have required additional ization for treatment of all toons from missed doses of clude too high of a blood tood sugar levels, and so of his blood thinner end to prevent strokes, and interview with Resident #4's 27/21 at 8:50am was dminister medications cies and procedures by a p containing 10 pills in there Resident #4 was ons belonged to him and the fidid not notify the primary of the incident. This failure is health, safety and welfare	D 366			
	CORRECTION DATE	FOR THE TYPE B				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011375	B. WING		06/02/2024
NAME OF D				TE ZID OODE	06/02/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA OND HILL ROA		
RICHMON	ID HILL REST HOME # 2		.E, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETI
D 366	Continued From page	e 61	D 366		
	2021.				
D 378	10a NCAC 13F .1006	(b) Medication Storage	D 378		
	10A NCAC 13F .1006	Medication Storage			
	requiring refrigeration	y the facility, including those , shall be maintained in a cked security except when or direct physical			
	failed to ensure medic	ns and interviews, the facility cations were maintained in a cked security or under direct			
	The findings are:				
	containing insulin pen				
	revealed: -The insulin pens for to locked in the medication -She did not know whe medication refrigerate.	ere the lock was for the			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		, ,	E SURVEY PLETED
		HAL011375	B. WING		06	5/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
RICHMON	ID HILL REST HOME # 2	95 RICH	MOND HILL ROAD			
KICHWION	ID HILL REST HOME # 2	ASHEVII	LLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 378	Continued From page	e 62	D 378			
		gerator in the main living to be locked at all times.				
	Refer to the interview 05/26/21 at 4:43pm.	with the Administrator on				
	hallway outside reside 05/28/21 at 10:38am	was left unattended and				
	outside room #1 and revealed: -The medication cart	al care aide (PCA) but no				
	revealed: -She was the MA ass was also administerin in this facilityShe did not know the left unlockedIf the medication car certain way it would " have been what happ	igned to a sister facility but any medications to residents a medication cart had been to lock was not pushed in a pop back out" and that must bened to the cart.				
	4:43pm revealed: -She previously had r the facility beforeThe medication refrig was supposed to be I	ministrator on 05/26/21 at medications missing from gerator in the living room ocked at all times. was supposed to be locked				

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
ысниси	ID HILL REST HOME # 2	95 RICHM	OND HILL ROA	D	
KICHWICK	ID HILL REST HOME # 2	ASHEVILL	.E, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 378	Continued From page	e 63	D 378		
	administering medica -She did not know wh the medication refrige -She expected staff to procedures of the fac	y the lock was missing from			
D 433	10A NCAC 13F .1201	(a) Resident Records	D 433		
	resident in an orderly record in the adult car for review by represent Health Service Regul departments of social (1) FL-2 or MR-2 form form or hospital dischapplicable; (2) Resident Register (3) receipt for the follour of this Subchapplicable; (A) contract for service rates; (B) house rules as spof this Subchapter; (C) Declaration of Re 131D-21); (D) the home's grieval (E) civil rights statemed (4) resident assessmed (5) contacts with the rephysician service or coprofessional as required Subchapter;	all be maintained on each manner in the resident's re home and made available intatives of the Division of ation and county a services: ins and the patient transfer targe summary, when arge summary, when better: each accommodations and ecified in Rule .0704(a)(2) sidents' Rights (G.S. ance procedures; and ent; eent and care plan; resident's physician, other licensed health red in Rule .0902 of this reatments or procedures			

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` '	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
	HAL011375	B. WING		06/02	/2021
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/02	
RICHMOND HILL REST HOME # 2		OND HILL ROA E, NC 28806	D		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 433 Continued From page 64 professional and their imple (7) documentation of immul influenza virus and pneumo according to G.S. 131D-9 oresident did not receive the on this law; and (8) the Adult Care Home Not Adult Care Home Hearing Fresident is being or has bee When a resident leaves the evaluation, records necesse evaluation such as Subpara (6) and (7) above may be s This Rule is not met as evi Based on observations, rec interviews, the facility failed records were maintained in 4 of 5 sampled residents (Fand #5). The findings are: 1. Observation of Resident 05/26/21 at 10:20am reveal -There was no FL2 in the re -There was no quarterly me residents recordThere was no quarterly me residents recordThere was no Licensed He Support assessment in the Review of Resident #1's Re revealed an admission date Interview with the Property at 10:40pm revealed she di documents were for Reside	nizations against occoccal disease or the reason the immunizations based office of Discharge and Request Form if the en discharged. If a facility for a medical ary for that medical agraphs (1), (4), (5), when the with the resident. Idenced by: Ford reviews and an orderly manner for Residents #1, #2, #3 #1's record on led: Fesidents record. Fesidents	D 433			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	- CONCINCOTION	COMPL	
			A. BOILDING.			
			5 4444			
		HAL011375	B. WING		06/0	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		95 RICHI	MOND HILL ROA	AD.		
RICHMON	D HILL REST HOME # 2		LE, NC 28806	-		
0/10/15	STIMMADA ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	NI	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D 433	Continued From page	e 65	D 433			
	Refer to the telephon	e interview with the				
	Administrator on 05/2					
		-1				
	2. Review of Residen	t #2's record on 05/26/21				
	revealed:					
	-The current FL2 was	dated 01/13/20.				
	-There was no care p					
	·	sment of the LHPS tasks				
	were not current with					
		nt quarterly medication				
		's contracted pharmacy.				
		nt physician's orders in the				
	record.					
	Paviou of the Posido	nt Register revealed an				
	admission date of 03/	-				
	aumission date of 05/	30/10.				
	Refer to the interview	with the Property Manager				
	on 05/26/21 at 10:40a					
	Refer to the telephon	e interview with the				
	Administrator on 05/2	6/21 at 4:43pm.				
	Review of Residen	t #3's record on 05/26/21				
	revealed:					
	-There was no FL2 in					
	-There was no care p					
		nt quarterly medication				
		's contracted pharmacy.				
		nt physician's orders in the				
	record.					
	Review of Resident #	3's Resident Register				
	revealed an admissio					
	10704104 411 4411113310	44.5 51 5 1/5 1/20.				
	Refer to the interview	with the Property Manager				
	on 05/26/21 at 10:40a					
	Refer to the telephon	e interview with the				

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Administrator on 05/26/21 at 4:43pm.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 2	95 RICHMO	OND HILL ROA	D		
		ASHEVILL	E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
D 433	Continued From page	÷ 66	D 433			
	o6/29/20 revealed: -Diagnoses included intellectual disability, disorder, depressionHe was ambulatory vassistive deviceOrientation and behate-There were no relative. Interview with the me 05/28/21 at 11:53am Resident #5's resident he used to reside in the resided. Review of Resident # revealed: -The resident record vinside a folderThere was no reside status or admission destatus or a	without the use of an aviors were left unmarked. Wes or legal guardians listed. dication aide (MA) on revealed she could not find at record in the sister facility or the current facility of which 5's record on 06/01/21 was 10 individual documents at register with a guardian atte available for review. It quarterly medication are available for review. It quarterly medication are contracted pharmacy. In the physician's orders in the physician's orders undated nost current orders as of a the top of the page. Tots or documentation of a accommodations, and eclaration of Resident devance procedures, or a superty Manager on 05/28/21				

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-She did not know Resident #5's record was not

STATE FORM 6899 4W5411 If continuation sheet 67 of 80

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		OND HILL ROA	ND.		
			E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 433	Continued From page	e 67	D 433			
	in the facility he reside -She did not know wh was located.	ed. nere Resident #5's record				
	Telephone interview v 06/01/21 at 3:26pm re -She had worked for t Administrator for about	the facility as the				
	-She only found a "fevrecord.	w papers" for Resident #5's				
	Resident #5's record -Resident #5 lived in a	were. a sister facility until he was				
	admitted to the facility -Staff looked in the sis find Resident #5's rec	ster facility and could not				
		ny Resident #5's resident				
	-It was the responsibi physician orders and	lity of the MA to place new				
	resident's recordsShe was responsible had a record.	e for ensuring each resident				
		e for the overall operations of				
	at 10:40pm revealed:	operty Manager on 05/26/21				
	for the residents had					
	the buildings.	all did not get returned to				
		pt locked in the storage and not everyone had a				
		nere to key for teh storage				

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Telephone interview with the Administrator on

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00/0/	2,2021
DICHMON	ID LIII L BEST HOME # 2		OND HILL ROA			
RICHMON	ID HILL REST HOME # 2	ASHEVILL	E, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 433	Continued From page	e 68	D 433			
	closet in each facility. -The medication aide a key for the storage records. -She did not know wh key for the storage clorecords. -She kept copies of pidocuments for the results -She did not know who physician orders or of resident's records. -She was responsible had a record. -She had not had time.	(MA) was supposed to have closet with the resident y the MA did not have the coset with the resident hysician orders and sident's in her office. y the MAs had not filed new ther documents in the for ensuring each resident e since working for the each resident record to				
D 612	Control Program (tem 10A NCAC 13F .1801 PREVENTION AND C (c) When a communic been identified at the emerging infectious disease threat, the fac implementation of the policies and procedur published guidance is if guidance or directiv communicable diseas outbreak or emerging have been issued in v local health	INFECTION CONTROL PROGRAM cable disease outbreak has facility or there is an cility shall ensure facility 's IPCP, related tes, and sued by the CDC; however, tes specific to the te infectious disease threat viriting by the NCDHHS or	D 612			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011375	B. WING		06	5/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
RICHMON	ID HILL REST HOME # 2	95 RICHI	MOND HILL ROAD			
KICIIWICI	ID THEE REST HOWE # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 612	Continued From page	e 69	D 612			
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews the facility fair recommendations and for Disease Control (Control (NCDHHS)) were implied to the facility of residents during the Control (COVID-19) pandeming of residents, staff, and	d guidance by the Centers CDC) and the North Carolina and Human Services emented when caring for 11				
	The findings are:					
	and spread of the Coterm care (LTC) facilities. -All essential visitors apresence of fever and when entering the builties. -A strong infection presence.	should be screened for the I symptoms of the virus ilding. evention and control protect both residents and				
	Long Term Care Staff	/ebinar Series for n Message for Frontline " revealed "Screening for uding temperature should be				
	control (IPC) practice pandemic include scr	d of the Coronavirus				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011375	B. WING		06	6/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		MOND HILL ROAD .LE, NC 28806)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 612	COVID-19 by tempera questions, and observed symptomsEstablish a process of the facility are assessed COVID-19 and temperature checksEstablish a process of the facility are assessed COVID-19 and temperature checksShe was not wearing facility.	ature checks, screening vations of signs and so ensure visitors entering sed for symptoms of trature was checked. Sion on COVID-19 signs and control precautions, and use mask. Is infection control policy ate with the facility's each visit and attest to not toms or current diagnosis of the had a COVID-19, they entation that they no longer transmission-based symptoms of COVID-19 ermitted to visit with a all the facility staff prior to neet the visitor outside the ses includes the visitor rature, and other screenings added by the CDC or the sonal care aide (PCA) on	D 612			
	revealed:	5111 OH UO/20/2 FAL 9.003III				

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	SUPPLIER/CLIA FION NUMBER:			(X3) DATE SURVEY COMPLETED
HAL011	375	B. WING		06/02/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
RICHMOND HILL REST HOME # 2		OND HILL ROA	D	
	ASHEVILI	E, NC 28806		
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
-She had not received a COVID-19 -She did not wear a face mask in the The facility staff or other residents face mask inside the facility. Observation of the Administrator in room on 05/26/21 at 10:50am reveal not wearing a face mask. Interview with the Administrator on the facility vaccinated for COVID-19Some resident residing at the facility vaccinated for COVID-19Some staff had not received the CovaccinationShe screened all staff and resident 6 weeks with a COVID-19 testVisitors were required to sign into a located at the main office building by asked screening questions or temporate taken anymoreShe received her guidance to no lovisitors from either the NC DHHS or health department (LHD)She did not have documentation of she had received for no longer screen. The facility had not checked temperasked screening questions for COV last couple of weeks. Telephone interview with a infectiou Registered Nurse from the local head department on 05/27/21 at 10:22am -All facilities should screen visitors their temperatures and completing a questionnaire upon entry into the faresidents and staff should be weathere are any unvaccinated resident the facilityThe facility should be following the	e facility. did not wear a the dining aled she was 05/26/21 at had not been 0VID-19 s about every a notebook at were not eratures were enger screen the local the guidance ening visitors. ratures or ID-19 in the s disease alth a revealed: by checking a cility. ring a mask if ts or staff in	D 612		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D. MANAGO	5 111116			
		HAL011375	B. WING		06	/02/2021	
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA MOND HILL ROA				
RICHMON	ID HILL REST HOME # 2		LE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 612	Continued From page	e 72	D 612				
	from the CDC and the	e NCDHHS.					
	facility and went to the main living room while Interview with the MA revealed: -She was the MA for the facility located on the -She was mainly work had come to administ residentsThe facility did not remask anymore since been vaccinated for Conterview with the Regithe facility's contracted	revealed she entered the e medication cart in the e not wearing a mask. I on 05/26/21 at 11:30am This facility and a sister same property. King in the other facility but the medications to the equire her to wear a face most of the residents had COVID-19. Igistered Nurse (RN) from and pharmacy on 05/26/21 at					
	11:45am revealed he was not screened by staff with COVID-19 screening questions or temperature checked upon entrance to the facility. Interview with a residents home health nurse contracted by the facility on 05/26/21 at 1:20pm revealed she was not screened by the facility staff with COVID-19 screening questions or temperature was not checked.						
		wner on 05/27/21 at 9:00am the DHHS survey team into OVID-19 screening or					
	11:45am revealed the	cility hallway on 05/28/21 at ere were three men working he building alarm system not					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011375	B. WING		06	6/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		MOND HILL ROAD LLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 612	Continued From page	e 73	D 612			
	11:45am revealed: -They were contracte the facility's alarm system of the property of the prop	OVID-19 screening questions on arrival but their of checked. Coted by facility staff to wear orking inside the facility. Inaintain the guidelines and tablished by the Centers for C), the North Carolina and Human Services ocal health department evention and transmission pandemic related to staff sks with an unvaccinated are facility, staff not screening emperatures or asking questions, and not wear face masks inside the lain an increased risk for the facility. This failure was alth, safety and welfare of a plan of protection in a 131D-34 on 05/27/21 for				
D912		laration of Residents' Rights	D912			
	G.S. 131D-21 Declar	ration of Residents' Rights				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			74. BOILBING.			
		HAL011375	B. WING		06/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 2		IOND HILL ROA LE, NC 28806	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D912	Continued From page	e 74	D912			
	2. To receive care an adequate, appropriate	nave the following rights: nd services which are e, and in compliance with state laws and rules and				
	reviews, the facility fareceived care and se appropriate, and in confederal and state laws related to Infection Program, Medication Competency, Health Follow-up, Training of	ns, interviews, and record alled to ensure residents rvices which were adequate, ompliance with relevant and rules and regulations revention and Control Aide Training and Care Referral and				
	The findings are:					
	reviews the facility fair recommendations an for Disease Control (Coppartment of Health (NCDHHS) were impresidents during the CovID-19) pandemi of residents, staff, an required personal pro [Refer to Tag 0612, 1]	d guidance by the Centers CDC) and the North Carolina n and Human Services lemented when caring for 11				
	reviews, the facility facare provider (PCP) f related to one resider sliding scale (a fast a	tions, interviews and record hiled to notify the primary for 2 of 3 sampled residents, int who missed doses of cting insulin), scheduled (a and swallowed 10 unidentified				

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		HAL011375	B. WING 06/02		6/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 2		MOND HILL ROAD			
	T		LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D912	Continued From page	e 75	D912			
	(Resident #4), and a notify the primary can weight gain of 3 or me	o left in the residents room resident who had an order to e provider (PCP) for a daily ore pounds (Resident #2). 0A NCAC 13F .0902(b) Violation)].				
	reviews, the facility fa staff was on the prem completed a course in resuscitation (CPR) a within the last 24 mor (Staff B and C) who, a residents residing in t considered full resusce	nd choking management on this for 2 of 3 sampled staff alone, cared for the 11 he building who were citate code status. [Refer to				
	reviews, the facility fa were administered as residents related to a	, ,				
	reviews, the facility fa observations for 1 of 10 tablets of ordered [Refer to Tag 366, 10	1 sampled residents taking medications (Resident #4).				
	facility failed to ensur Administrator or Adm the home and ensurir	ions and interviews, the e there was always one inistrator-In-Charge (AIC) in ng that at no time a resident t a staff member in the				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED		
		HAL011375	B. WING		00	6/02/2021	
	ROVIDER OR SUPPLIER	95 RICH	NDDRESS, CITY, STATE MOND HILL ROAD LLE, NC 28806	, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D912	home. [Refer to Tag (.0601(b)(3) Managen		D912				
D914	G.S. 131D-21 Declar Every resident shall h	laration of Residents' Rights ration of Residents' Rights nave the following rights: al and physical abuse, iion.	D914				
	reviews, the facility fa	ns, interviews, and record hilled to ensure all residents of related to a resident who					
	The findings are:						
	review, the facility fail free from neglect relations the facility and v number of days while whereabouts (Reside residents alone in the	cions, interviews, and record led to ensure residents were sted to a resident who eloped was gone for an unknown enot knowing the residents ent #5), and staff leaving a facility. [Refer to Tag D0338 of Resident Rights (Type A1					
	reviews, the Administ management and total were carried out relat care, ensuring reside unsupervised, medical infection prevention a						

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL011375	B. WING	B. WING		2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
DICUMON	ID UILL DEST HOME # 2	95 RICHN	OND HILL ROA	ND.		
RICHIVION	ID HILL REST HOME # 2	ASHEVIL	LE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	Continued From page	e 77	D914			
	13F .0601(a) Manage Violation)].	ement of Facilities (Type A1				
D935	G.S.§ 131D-4.5B(b) A	ACH Medication Aides; ency	D935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirement	aining and Competency				
	home is prohibited from any unsupervised methat individual has promedication aide during an adult care home of the following: (1) A five-hour training Department that incluing all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days from individual must have as An additional 10-hode developed by the Department and the same and th	g the previous 24 months in r successfully completed all g program developed by the des training and instruction of medication s for Disease Control and s on infection control and, if tion practices and oring or testing in which e potential for bleeding aluation consistent with 10A 10A NCAC 13G .0503. In the date of hire, the completed the following: our training program partment that includes in in all of the following:				
		s of Disease Control and on infection control and, if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		GOIVII LETED
		HAL011375	B. WING		06/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
RICHMON	ID HILL REST HOME # 2		MOND HILL ROA	D	
	OUR MARK OF		LE, NC 28806	DD0/4DED10 DLAM OF GODDE0	TION .
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D935	Continued From page	e 78	D935		
	bleeding occurs or the exists. b. An examination de by the Division of Heat accordance with substitution. This Rule is not met Based on interviews a facility failed to ensur A and B) who administresidents had complete.	veloped and administered alth Service Regulation in section (c) of this section. as evidenced by: and record reviews, the e 1 of 2 sampled staff (Staff			
	The findings are:				
	state approved medic 02/06/16There was documen Medication Administration Checklist dated 03/02-There was no documenthe 5, 10 or 15 hour residue.	ealed: 01/19/21. tation she had passed the cation aide written exam on tation of completion of the ation Clinical Skills Validation 2/21. nentation of completion of medication aide training.			
	electronic Medication (eMAR) revealed Sta medications were add	Administration Record ff B documented ministered to the residents. interview with Staff B, MA,			
	on 05/28/21 at 1:15pi	m was unsuccessful.			
	Interview with the Pro at 3:00pm revealed s	pperty Manager on 05/27/21 he stopped being			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011375	B. WING		06	02/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
RICHMON	ID HILL REST HOME # 2		OND HILL ROA .E, NC 28806	VD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	responsible for the methe new Administrator Interview with the Adr 3:30pm revealed: -She was responsible had their required quadministering medica -She had been unable of the 5, 10, 15-hour unstaff BStaff B had been hire previous administrator-She thought Staff B complete the 5, 10, or	edication qualifications when was hired in April 2021. ministrator on 05/27/21 at for making sure all the MAs alifications prior to tions to the residents. The eto find the documentation medication aide training for ed in January 2021 by the	D935			

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