Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT ELTED
		HAL011374	B. WING		06/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
RICHMON	ID HILL REST HOME # 3	95 RICHN	IOND HILL ROA	D	
		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 CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 000	Initial Comments		D 000		
	annual survey with ar 05/27/21 and a desk	sure Section conducted an nonsite visit on 05/26/21 and review on 05/28/21 and conference via telephone on			
D 131	10A NCAC 13F .0406	6(a) Test For Tuberculosis	D 131		
	(a) Upon employment home, the administration any live-in non-reside tuberculosis disease measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, I				
	facility failed to ensur	and record reviews, the e 2 of 3 sampled staff (Staff for Tuberculosis (TB)			
	The findings are:				
	personnel record reve -There was no docum				
		on 05/27/21 at 2:41pm ponsible for administering sidents, cooking, and			

Division of Health Service Regulation

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

TITLE (X6) DATE

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL011374	B. WING		001	14/2024
		HALUTI374			1 06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
		95 RICHI	MOND HILL ROA	AD		
RICHMON	D HILL REST HOME # 3	ASHEVIL	LE, NC 28806			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	·N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 131	Continued From page	<u>.</u> 1	D 131			
5 101	Continued From page	, I	2 .0.			
	providing assistance	with activities of daily living				
	(ADLs).					
	Interview with Staff A	on 06/01/21 at 12:29pm				
	revealed:					
	-She was hired in late	e February 2021 or early				
	March 2021.					
	-She completed a TB	skin test at a local urgent				
	care on the same day	she had completed				
	pre-employment drug	testing.				
	-She did not have do	cumentation of the TB skin				
	test.					
	-She was not sure if t	he local urgent care kept				
	records of TB skin tes	sting.				
	Refer to the telephone	e interview with the Nurse				
	Consultant (RN) from	the facility's contracted				
	pharmacy on 05/28/2	1 at 8:20am.				
	Refer to the interview	with the Business Office				
		ervisor-in-Charge (SIC) on				
	05/27/21 at 4:44pm.					
	Refer to the telephon					
	Administrator on 05/2	7/21 at 11:45am.				
		Housekeeper, personnel				
	record on 05/27/21 re					
	-There was a hire dat					
		nentation of a TB skin test				
	completed upon hire.					
	Intomious with Otaff O	on 05/27/24 of 2:45				
		on 05/27/21 at 2:45pm				
	revealed:	2 months ago as -				
	-He was hired about 3	•				
	medication aide (MA)	•				
	(PCA)/cook and trans					
	-	vere to assist residents with				
		g (ADLs), cook meals and				
	transport the resident	s to and from appointments.	1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011374	B. WING		06/01/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,	
RICHMON	D HILL REST HOME # 3		MOND HILL ROA LLE, NC 28806	AD.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 131	Continued From page	2	D 131		
	Consultant (RN) from pharmacy on 05/28/2	e interview with the Nurse the facility's contracted 1 at 8:20am. with the Business Office			
		ervisor-in-Charge (SIC) on			
	Refer to the telephone Administrator on 05/2				
	-	the facility's contracted pharmacy on			
	and resident's TB skir -The Administrator wa	or administering the staff n test for the facility. ns responsible for notifying or resident needed a TB			
	and had administered	in the past 2 to 3 weeks a TB skin test but did not esident or staff member.			
	Interview with the Bus (BOM)/Supervisor on revealed:	siness Office Manager 05/27/21 at 4:44pm			
	-The Administrator wa the Nurse Consultator TB skin test.	arted working in April 2021. as responsible for notifying for the MAs who required a			
	all required training a	is responsible for ensuring nd requirements were acility hired a new staff			
	11:45am revealed:	ninistrator on 05/27/21 at for making sure all staff st upon hire.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL011374	B. WING		06/01	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 3		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 131	test upon hire but she documentationShe remembered a rompleting TB skin te pandemic but did not recommendation had -She had not resumenewly hired staff.	ceived the first step TB skin could not find the recommendation to stop est during the coronavirus know if the changed. d obtaining a TB skin test for	D 131			
D 161	For LHPS Tasks  10A NCAC 13F .0504 Licensed Health Profe (a) An adult care hornon-licensed personnot practicing in their governed by their pralicensing laws are cordemonstration for any specified in Subparage Rule .0903 of this Sulperforming the task a	tel and licensed personnel licensed capacity as ctice act and occupational mpetency validated by return personal care task graph (a)(1) through (28) of bechapter prior to staff and that their ongoing at through facility staff	D 161			
	facility failed to ensure A) were competency Health Professional S	as evidenced by: and record reviews, the e 1 of 3 sampled staff (Staff validated for Licensed Support (LHPS) tasks who resident who had an order				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		HAL011374	B. WING		06	s/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
DIG: 11401		95 RICHN	OND HILL ROAD			
RICHMON	ID HILL REST HOME # 3	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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 161	Continued From page	<del>2</del> 4	D 161			
	for compression hose checks (FSBS).	and fingerstick blood sugar				
	The findings are:					
	the state approved mon 10/31/17.  -There was no docume completed the compectinical skills checklist.  -There was no docume competency validated hose or collect FSBS.	25/27/21 revealed: Dented date of hire. Dented date				
	Review of a resident's	s May 2021 eMAR revealed ompression hose for a				
	revealed: -She started working February 2021 or earl -She administered me and assisted with othe (ADLs) as neededShe remembered the completing the compe checklist soon after st facility.	-				

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STATE FORM 8NRJ11 If continuation sheet 5 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		R WING		
	HAL011374	D. WING		06/01/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
RICHMOND HILL REST HOME # 3		OND HILL ROA	.D	
CUMMADVCT		_E, NC 28806	DROWDEDIC DI AN OF CORDECTIO	N
PREFIX (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 COMPLETE
D 161 Continued From page	Continued From page 5			
-The Administrator sh documentation.	-The Administrator should have the documentation.			
(RN) from the facility 05/28/21 at 8:20am re-He was responsible competency checklist -The Administrator was him if the facility had to complete the checkled to complete the checkled that he had competer LHPS tasks.  -He did not remembe completed a LHPS coat the facility.  Interview with the Bust (BOM)/Supervisor on revealed:  -The Administrator state -The LHPS training a competency in the LHP-The Administrator was the Nurse Consultant the LHPS training and -The Administrator was the staff had all of the check off completed patasks.  Telephone interview woos/06/01/21 at 2:41pm results -Staff A was hired as -She was "sure" Staff competency validatio -She could not find the	for completing the LHPS at for new staff at the facility. as responsible for notifying a staff member that needed klist. ords of the staff at the facility acy validated to perform  In the last time he had competency checklist for staff  siness Office Manager 05/27/21 at 4:44pm  arted working in April 2021. and check off was to ensure HPS tasks. as responsible for notifying afor the staff who required d competency check off. as responsible for ensuring a required LHPS training and porior to performing the LHPS  with the Administrator on evealed: a MA on 02/19/21. A had completed the LHPS			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		HAL011374	B. WING		06	6/01/2021
	ROVIDER OR SUPPLIER	95 RICH	ADDRESS, CITY, STATE MOND HILL ROAD LLE, NC 28806	ZIP CODE		
(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 161	Continued From page -She was trying to ge documents organized LHPS competency va	et the staff training d so she could find Staff A's	D 161			
D 176	With a Capacity or Corresponsible for the tohome and shall also Division of Health Secounty department of and maintaining the rather co-administrator, share equal responsifor the operation of the	1 Management of Facilities ensus of Seven to Thirty  me administrator shall be stal operation of an adult care be responsible to the rvice Regulation and the f social services for meeting rules of this Subchapter.  when there is one, shall bility with the administrator ne home and for meeting rules of this Subchapter.  or also refers to	D 176			
	reviews, the Administ management and tota were maintained to a compliance with the r	ns, interviews, and record trator failed to ensure the al operations of the facility				

Division of Health Service Regulation

STATE FORM 8NRJ11 If continuation sheet 7 of 42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011374	B. WING		06	6/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
RICHMON	ID HILL REST HOME # 3		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 176	Continued From page	e 7	D 176			
	services and to be free the management of fa	and appropriate care and see of neglect as related to acilities, infection prevention and staff qualifications.				
	The findings are:					
	revealed: -There was no staff m -The MA had been or minutesHe thought the MA h to help give medicationHe was administered MA had left the builditure.	d his medications before the ng. v to find where the MA was. e MA to return to the building				
	9:30 am revealed: -The MA was not in the know where she was -She complained of ppain scale and wante medication but had to in the building in order-She "just knew" she to another building if in an emergency ther call 911There were issues womonth, but more so in staff to give medication-She had to wait sever for her medication or	pain, an 8 out of 10 on the d her prescribed pain of wait until the MA got back for to get it.  Would have to wait or walk she needed anything except in send someone for help or with staffing over the past in the last week with getting ons.  Earl times over the past week received them late.				
	Interview with the MA revealed:	on 05/26/21 at 10:00am				

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STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_	<del></del>	
		HAL011374	B. WING		06/01/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		95 RICHMO	OND HILL ROA	VD	
RICHMON	D HILL REST HOME # 3	ASHEVILL	E, NC 28806		
240.15	CLIMMADV CT		1	DDOVIDED'S DI AN OF CORRECTIO	M orro
(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 APPROPRIATE OF THE APPR	BE COMPLETE
				DEFICIENCY)	
D 176	Continued From page	<b>8</b>	D 176		
	-She was the MA assigned to this facility.				
		er morning medications to			
		icility and then went to			
		ster morning medications.			
	•	t approximately 8:30am.			
		ximately an hour to give			
	medications in sister				
		-			
	-There were many times over the past month, but more so over the past week she had to administer medications in more than one facility				
	during her 7:00am - 7	•			
	-The Administrator wa				
	residents while she w	<u> </u>			
		nistrator and was instructed			
		medications to a sister			
	watch the residents.	istrator would come up and			
		as not in the facility when			
		as not in the facility when			
	she left.	staff in the facility while abo			
	was gone.	staff in the facility while she			
		ed something while she was			
		<del>-</del>			
	and get her.	t the Administrator or come			
		e for a 1 hr. to 1-1/2 hr.			
	using the facility phon	call 911 in an emergency by			
	• .				
	-She was not provide				
		evice by the Administrator.			
	-She did have her per				
		t have her personal cell			
	•	as not written down for easy			
	access for them to us				
	_	nt pain medication after she			
	returned to the facility				
	-The residents would				
		ny medication because the			
	Administrator could no	ot administer medications.			

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A second interview with the second resident on

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL011374	B. WING		06/01/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DICHMON	DIUII DECTUOME#A	95 RICHM	OND HILL ROA	ND.		
RICHIVION	D HILL REST HOME # 3	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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	Ξ
D 176	Continued From page	9	D 176			
	05/26/21 at 10:15am pain medication about pain was still 8 out of Interview with a third 3:00pm revealed: -There have been a for 2021 when staff were timesOn 05/24/21 there w	revealed she received her t 20 minutes ago and her 10 on the pain scale.  resident on 05/27/21 at ew occasions during May not in the building at all as no staff for his building to				
	-On 05/24/21 there was no staff for his building to administer medications so he had to wait for medications while the staff member gave medications in the other buildings first.  -He did not get his medications on time that dayHe was instructed to call for help if he needed it, but the phone in the facility was "spotty at best" and did not work every timeThe only number he had to call was 911He could not call the staff if he needed them because he did not know their numbers so he would have to go find them.					
	3:20pm revealed: -There had been 2 or not in the building and staff wasThere were 2 occasion by the staff what building and staff what building the needed staff he or walk down to the or yards away) where the -There were two other where he did not received or eat on time and he found them in anothed -He was told by the A was an emergency like hurt or needed help.	would have to go find them ffice (approximately 50 e Administrator was. r occasions in the past week eive his medications on time had to go look for staff and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
,		152.111110711101111011152111	A. BUILDING: _			
		HAL011374	B. WING	<del></del>	06/	01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 3	95 RICHN	IOND HILL ROA	ND.		
		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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 176	Continued From page	e 10	D 176			
D 176	and if you went out you unless you rang the do you back in.  -He was concerned if middle of the night to back in  Interview with a MA or revealed:  -The doors to the facility every night and the alling of the alling went out the dowere locked and the alling would sound.  -If you were out after were locked, in order would have to be rung.  -The residents were that after 10:00pm the resident or stay with family and the facility before 10:00pm the residents all known that facility before 10:00pm the residents required in the facility, then they were member got back in the sun of the resident could contain the resident contain the resident contains the resident contain	bu could not get back in loor bell and someone let  The left the building in the get help, he could not get  In 05/27/21 at 3:30pm  It were locked at 10:00pm larm was set.  Oors at night after the doors alarm was set then alarm  10:00pm and the doors to get back in the doorbell ge.  Old by the Administrator that aidents would have to go to a ily or friends.  We they need to be back in coppm.  The dassistance, or staff member was not in the get to wait until the staff the facility or come and get  all 911 if needed but they le to find staff because we	D 176			
		e other buildings. nattended because she ility giving medications.				
	-She would be out of medications in sister in -She has been one of several times this past facility unattended to sister facility.	the facility administering facility 1-2 hours tops. If two MAs in the facility set 2 weeks and had to leave administer medications to a				
	Interview with a fifth r	esident on 05/27/21 at	1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
7.1.15 . 27.11 .		152.1111.107.1101.152.11	A. BUILDING: _			
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 3		OND HILL ROA	AD.		
			.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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 176	Continued From page	e 11	D 176			
١/٥	4:00pm revealed: -There has been time buildingThe last time was on because the MA went medicationsBecause there were she needed to talk or would go find the MA facilitiesShe could not call the no number to call the linterview with a sixth 4:15pm revealed: -The facility only had -Over the past week the buildings to give med -Over the past week the medications late either mornings depended con 05/23/21, after the 10:00pm, he woke up and there was no stated -He could not go find would automatically led -He did not need anytoconcern him if someth he would have to call -On 05/24/21 there we until after 8:00am who Manager (BOM) came medication late.  Interview with the Bus (BOM)/Supervisor on revealed:	as there were no staff in the 105/26/21 in the morning to another building to give no staff in the facility and if needed something she in one of the other sister e staff because there was m.  resident on 05/27/21 at a MA and no PCA. The MA had to go to other ications. The had received his er in the evenings or in the on where the MA went first. The doors were locked at to in the middle of the night fir in the building. Them because the door tock behind him. Thing at that time but it did ning would have happened 911.  as no staff in the building en the Business Office e in to give the morning				
		as responsible for notifying for the MAs who required				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  95 RICHMOND HILL ROAD  ASHEVILLE, NC 28806   (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D 176 Continued From page 12    B. WING	STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		
RICHMOND HILL REST HOME # 3  ASHEVILLE, NC 28806   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  95 RICHMOND HILL ROAD ASHEVILLE, NC 28806  ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DEFICIENCY)			
ASHEVILLE, NC 28806  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ASHEVILLE, NC 28806  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)	NAME OF PROVIDER OR SU		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  PREFIX TAG  PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RICHMOND HILL REST HOME # 3		
D 176 Continued From page 12	PREFIX (EACH		
the training.  The Administrator was responsible for ensuring the medication aides (MAs) had all of the required qualifications prior to administering medications.  Interview with the Administrator on 05/26/21 at 9:15am revealed:  -She was responsible for being in the facility while the medication aide (MA) went to building #2 to administer medications.  -She was working on other duties in the officeThere was upposed to be someone in the facility while the MA was goneThere was upposed to be someone in the facility atll timesIf the residents needed anything, they could come and get her.  Interview with the Administrator on 05/26/21 at 4:00pm revealed: -She had issues with staffing of the past month more so the past 2 weeksShe had -2-3 MAs giving medications in all 5 buildings dailyShe was supposed to have a MA in each of the 5 buildings at all timesOn Sunday, 05/23/21 at 8:00pm a staff member called in for the 8:00am shift on 05/24/21Between 05/23/21 at 8:00pm as taff member called in for the 8:00am shift on 05/24/21Between 05/23/21 at 8:00pm and 8:00am there were several staff that called out for their shifts on 05/24/21There was a staff member that did not call or show up for her shift on 05/24/21, 8:00am to 8:00pmShe was responsible for staffing 5 buildings with at least a MA in each buildingOn 05/24/21, be staffed the 5 buildings with the	the trainingThe Admin the medicat qualification. Interview wi 9:15am revision. She was returned the medicat administer respectively. She was well-there was facility whileThere was facility at allIf the reside come and good interview with 4:00pm revisionShe had 2-buildings das she was stouldings are share, that we building at a show up for 8:00pmShe was real least a Minimum and the share real teast a Minimum and the share real teas		

Division of Health Service Regulation

Business Office Manager (BOM) and the Activity

STATE FORM 8NRJ11 If continuation sheet 13 of 42

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06/0	1/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
RICHMON	D HILL REST HOME # 3		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 176	herselfOn 05/24/21, all the of the front porches of two Because there were approximately 50 resifacilities, the 4 staff con the grills, and ever dayIt was "not the best to but under the circums approximately 50 residid.  Non-compliance was areas:  1. Based on interview facility failed to ensure A and C) were tested disease upon hire [Ref 13F .0406(a) Test for Deficiency)].  2. Based on interview facility failed to ensure A) were competency Health Professional Sprovided care for one for compression hose checks (FSBS) [Refer 13F .0504(a) Compet	re MAs and could as to the residents, a CA) for assistance and residents were brought up to the volume of the volu	D 176	BEHOLINGT)		
	facility failed to ensure	ions and interviews, the e that at no time residents home without a qualified				

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STATE FORM 8NRJ11 If continuation sheet 14 of 42

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/0	7172021
RICHMON	ID HILL REST HOME #3		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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 176	staff and the Administ Administrator-in-Char of the home with mea communication [Refe 13F .0601(b)3 Manage Capacity or Census of (Type A1 Violation)].  4. Based on observative reviews the facility fair recommendations and for Disease Control (Opepartment of Health (NCDHHS) were implied to the common of staff and visitors [Final transport of the common of the commo	ge (AIC) was within 500 feet ans of two-way or to Tag D0177 10 NCAC gement of Facilities with a service of Seven to Thirty Residents and Human Services gemented when caring for 10 global Coronavirus or as related to the screening Refer to Tag 0612 10 NCAC revention and Control geficiency)].	D 176			

Division of Health Service Regulation

STATE FORM 8NRJ11 If continuation sheet 15 of 42

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DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		UAL 044274	B. WING		00/0	4/0004
		HAL011374			1 06/0	1/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
		95 RICH	MOND HILL ROA	VD		
RICHMON	D HILL REST HOME # 3	ASHEVI	LLE, NC 28806			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID 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 176	Continued From page	e 15	D 176			
	sampled staff (Staff A	and C) were tested for				
		ease upon hire, failed to				
	ensure 1 of 3 sample	•				
	competency validated	` ,				
		(LHPS) tasks who provided				
	care for one resident	•				
		d fingerstick blood sugar				
	· · · · · · · · · · · · · · · · · · ·	I to ensure there was no				
	, , ,					
	time the residents were left alone in the home without a qualified staff, failed to ensure					
		d guidance by the Centers				
		CDC) and the North Carolina				
	,	and Human Services				
	•	lemented when caring for 10				
	residents during the g					
		c as related to the screening				
	` , .	nd failed to ensure 2 of 3				
		and B) had completed the				
		d medication clinical skills,				
		state approved medication				
	administration training	• •				
		glect and constitutes a Type				
	A1 Violation.	gicot and constitutes a Type				
	, i. violation.					
	The facility failed to p	rovide a Plan of Protection				
	in accordance with G					
	CORRECTION DATE	FOR THIS TYPE A1				
		IOT EXCEED JULY 1, 2021.				
		- ,				
D 177	10A NCAC 13F .0601	(h) Management Of	D 177			
וווט	Facilities With A Capa					
	i aciiilies vvilii A Capa	only Oi				
	104 NCAC 13E 0601	Management Of Facilities				
		ensus Of Seven To Thirty				
	Residents	ensus Or Seven 10 Itility				
	Residents					
	(b) At all times the	shall be one administrator				
	• •	shall be one administrator				
	or administrator-in-ch	arge who is directly				

Division of Health Service Regulation

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 3		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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 177	are carried out in the at no time is a resider without a staff member in Paragraph (c) of the arrangements shall be with a capacity or cere (1). The administrator 500 feet of the home telecommunication within 500 feet of the two-way telecommunitimes; or (3). When there is a ceach with a capacity of adjacently on the same least one staff members hall be at least one administrator-in-charge each home with a metelecommunication with and directly responsible.	ing 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 issus of 7 to 30 residents: r is in the home or within with a means of two-way with the home at all times; in-charge is in the home or home with a means of ication with the home at all cluster of licensed homes, of 7 to 12 residents, located he site, there shall be at er, either live-in or on a shift e homes. In addition, there administrator or ge who is within 500 feet of	D 177			
	This Rule is not met TYPE A1 VIOLATION	-				
	failed to ensure that a alone in the home wit Administrator or Admi	ns and interviews, the facility at no time residents were left hout a qualified staff and the inistrator-in-Charge (AIC) f the home with means of ion.				

Division of Health Service Regulation

STATE FORM 8NRJ11 If continuation sheet 17 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) D  C			
		HAL011374	B. WING		06	6/01/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 00	70172021
TVAINE OF T	NOVIDEN ON GOLF EIEN		MOND HILL ROAD	, 211 0002		
RICHMON	ID HILL REST HOME # 3		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 177	Continued From page	e 17	D 177			
	The findings are:					
	9:15am revealed the the office approximate parking area of building	of the facility on 05/26/21 at Administrator walked out of ely 50 yards up to the front ng #2 which was located #3.				
	Interview with the Administrator on 05/26/21 at 9:15am revealed: -She was responsible for being in the facility while the medication aide (MA) went to building #2 to administer medicationsShe was working on other duties in the officeThere was no personal care aide (PCA) in the facility while the MA was goneThere was supposed to be someone in the facility at all timesIf the residents needed anything, they could come and get her.  Observation inside of the facility on 05/26/21 from 9:20am to 9:36am revealed: -There were 6 residents inside the buildingThere were 3 of the 6 residents in the building asleep in their roomsThere were 3 resident outside the building smoking in the smoking areaThere were no staff located in the building.					
	revealed: -There was no staff m -The MA had been ou minutesHe thought the MA h to help give medication	his medications before the				

Division of Health Service Regulation

STATE FORM 8NRJ11 If continuation sheet 18 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 ti BoileBiitoi _			
		HAL011374	B. WING		06/01/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DICUMON	DUIL DEST HOME # 2	95 RICHM	OND HILL ROA	ND.		
KICHWON	D HILL REST HOME # 3	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 APPROPE DEFICIENCY)	BE COMPLETE	
D 177	Continued From page	<del>:</del> 18	D 177			
	-He was not sure how	to find where the MA was.  MA to return to the building				
	9:30 am revealed: -The MA was not in the know where she wasShe complained of ppain scale and wanter medication but had to in the building in ordeto another building if sin an emergency them call 911There were issues we month, but more so in staff to give medication.	ain, an 8 out of 10 on the d her prescribed pain wait until the MA got back r to get it.  would have to wait or walk she needed anything except a send someone for help or ith staffing over the past a the last week with getting ons.				
	staff to give medications.  -She had to wait several times over the past week for her medication or received them late.  Interview with the MA on 05/26/21 at 10:00am revealed:  -She was the MA assigned to this facility.  -She administered her morning medications to the residents in the facility and then went to building #2 to administer morning medications.  -She left the facility at approximately 8:30am.  -She was gone approximately an hour to give medications in sister facility.  -There were many times over the past month, but more so over the past week she had to administer medications in more than one facility during her 7:00am - 7:00pm shift.  -The Administrator was responsible for the residents while she was out of the facility.  -She called the Administrator and was instructed					

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facility and the Administrator would come up and

STATE FORM 8NRJ11 If continuation sheet 19 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			B WING			
		HAL011374	B. WING		06	6/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE		
БІСНМОК	ID HILL REST HOME # 3	95 RICHI	MOND HILL ROAD			
KICHWION	ID HILL REST HOME # 3	ASHEVII	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 177	Continued From page	e 19	D 177			
	she leftThere was no other swas goneIf the residents need gone they were to ge and get herShe was usually goneThe residents could using the facility phoreshe was not provide telecommunication decenses and have her peromain the residents did not phone number or it was access for them to use. She gave the residents would returned to receive an	d a two-way evice by the Administrator. rsonal cell phone. t have her personal cell as not written down for easy se. nt pain medication after she				
	05/26/21 at 10:15am pain medication about pain was still 8 out of Interview with a third 3:00pm revealed: -There have been a frequency when staff were timesOn 05/24/21 there wadminister medication medications while the medications in the other than the did not get his medicated to the medica	<b>O</b>				

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STATE FORM 8NRJ11 If continuation sheet 20 of 42

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL011374	B. WING		06	5/01/2021
	ROVIDER OR SUPPLIER	95 RICHM	DDRESS, CITY, STATE	, ZIP CODE		
		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 1 DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 177	Continued From page	<del>2</del> 20	D 177			
		had to call was 911. staff if he needed them now their numbers so he				
	3:20pm revealed: -There had been 2 or not in the building and staff wasThere were 2 occasion by the staff what builded if he needed staff he or walk down to the owards away) where the the or walk down to the owards away) where the or eat on time and he found them in anothed in the was told by the A	would have to go find them ffice (approximately 50 e Administrator was. r occasions in the past week vive his medications on time had to go look for staff and r building.				
	hurt or needed helpThe building was loc and if you went out yo unless you rang the d you back inHe was concerned if middle of the night to back in  Interview with a MA o revealed: -The doors to the faci every night and the al -If you went out the do were locked and the al would sound.	ked every night at 8:00pm bu could not get back in loor bell and someone let  the left the building in the get help, he could not get  n 05/27/21 at 3:30pm  lity were locked at 10:00pm larm was set.  oors at night after the doors alarm was set then alarm				
		to get back in the doorbell				

Division of Health Service Regulation

STATE FORM 8NRJ11 If continuation sheet 21 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		- CONCINCOTION	COMPL	
			A. BOILDING.			
		1101.044274	B. WING		00%	4/0004
		HAL011374			06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 3		IOND HILL ROA	AD		
		ASHEVIL	LE, NC 28806			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
D 177	Continued From page	21	D 177			
וווט	Continued From page	; 21				
	would have to be run					
		old by the Administrator that				
		idents would have to go to a				
	hotel or stay with fam					
		w they need to be back in				
	the facility before 10:0 -If the residents requi					
		staff member was not in the				
		e to wait until the staff				
		he facility or come and get				
	us.	, 3				
	-The resident could ca	all 911 if needed but they				
	have always been ab	le to find staff because we				
	would be in one of the	e other buildings.				
	_	nattended because she				
		ility giving medications.				
		the facility administering				
	medications in sister t					
		f two MAs in the facility				
		et 2 weeks and had to leave				
	sister facility.	administer medications to a				
	Sister racility.					
	Interview with a fifth r	esident on 05/27/21 at				
	4:00pm revealed:					
	-There has been time	s there were no staff in the				
	building.					
	-The last time was on	05/26/21 in the morning				
		to another building to give				
	medications.					
		no staff in the facility and if				
		needed something she				
		in one of the other sister				
	facilities.	e staff because there was				
	no number to call the					
	no number to can the					
	Interview with a sixth	resident on 05/27/21 at				
	4:15pm revealed:					
	-The facility only had	a MA and no PCA.				

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STATE FORM 8NRJ11 If continuation sheet 22 of 42

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
			-			
			B. WING			
		HAL011374	B. WING		06	5/01/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			OND HILL ROA			
RICHMON	D HILL REST HOME # 3		LE, NC 28806			
		ASHEVIL	LE, NC 20006			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		COMPLETE DATE
TAG	REGOLATORI ORT	EGO IDENTI TING INI GRAMATIGN)	TAG	DEFICIENCY)		
			+			
D 177	Continued From page	e 22	D 177			
	Over the mast week t	alba NAA baad ta ara ta atbarr				
		the MA had to go to other				
	buildings to give med					
	-Over the past week h					
	medications late either	er in the evenings or in the				
	mornings depended of	on where the MA went first.				
	-On 05/23/21, after th	e doors were locked at				
	10:00pm, he woke up	in the middle of the night				
	and there was no stat	ff in the building.				
		them because the door				
	would automatically lo					
		thing at that time but it did				
	-	hing would have happened				
	he would have to call					
		as no staff in the building				
		en the Business Office				
	- , ,	e in to give the morning				
	medication late.					
		ministrator on 05/26/21 at				
	4:00pm revealed:					
	-She had issues with	staffing of the past month				
	more so the past 2 we	eeks.				
	-She had 2-3 MAs giv	ring medications in all 5				
	buildings daily.					
	-She was supposed to	o have a MA in each of the 5				
	buildings and 3-5 per	sonal care aides (PCA) to				
	•	would be a MA in each				
	building at all times.					
		1 at 8:00pm a staff member				
	called in for the 8:00a					
		t 8:00pm and 8:00am there				
		at called out for their shifts on				
	05/24/21.	it danca dut foi tricii stilits dil				
		ember that did not call or				
		on 05/24/21, 8:00am to				
	8:00pm.					
		e for staffing 5 buildings with				
	at least a MA in each					
	-On 05/24/21, she sta	-On 05/24/21, she staffed the 5 buildings with the				

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Business Office Manager (BOM) and the Activity

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  95 RICHMOND HILL ROAD ASHEVILLE, NC 28805  RICHMOND HILL REST HOME #3  SUMMARY STATEMENT OF DEPCINCIPS PROFIX FIGAL SUMMARY STATEMENT OF DEPCINCIPS PROFIX FIGAL SUMMARY STATEMENT OF DEPCINCIPS PROFIX FIGAL DEPCINCIPS WISH THE PROFICE OF PUBLIC PROFIX TAG  PROVIDER'S RLAN OF CORRECTION SEACH DOSINGTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APROPRIATE DATE  DIrector (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself On 05/24/21, all the residents were brought up to the front porches of two sister facilitiesBecause there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked funch and supper out on the grills, and everyone enjoyed a cookout day It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents with in all 5 sister facilities, the A staff cooked funch and supper out on the grills, and everyone enjoyed a cookout day It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did The MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each other The residents did not have access to the staff's personal cell phone numbers Any resident who required assistance could come to the office or to one of the other buildings In the event of an emergency the residents could come to the office or to one of the other buildings The Business Office Manager (BOM)/Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  95 RICHMOND HILL RADA ASHEVILLE, NC 28806    Maj 10   PREPRIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION (CRAFT COMPACTIVE ACTION SHOULD BE NOT TAG.)    D 177   Continued From page 23   D 177	AND PLAN C	)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  95 RICHMOND HILL RADA ASHEVILLE, NC 28806    Maj 10   PREPRIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION (CRAFT COMPACTIVE ACTION SHOULD BE NOT TAG.)    D 177   Continued From page 23   D 177							
RICHMOND HILL REST HOME # 3    SUMMARY STATEMENT OF DEFICIENCIES   PREPRICE   NO 28896     PREPRIX TAG			HAL011374	B. WING		06/0	1/2021
RICHMOND HILL REST HOME # 3  SUMMARY STAIRMENT OF DEFICIENCIES  PREFIX TAG  SUMMARY STAIRMENT OF DEFICIENCIES  PREFIX TAG  CONTINUED FOR LSC IDENTIFYING INFORMATION)  D177  Continued From page 23  Director (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself.  -On 05/24/21, all the residents were brought up to the front porches of two sister facilitiesBecause there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked lunch and supper out on the grills, and everyone enjoyed a cookout day.  -It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did.  -The MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each other.  -The residents did not have access to the staff's personal cell phone numbers.  -Any resident who required assistance could call or text each other.  -The residents did not have access to the staff's personal cell phone numbers.  -Any resident who required assistance could call or the event of an emergency the residents could call path of the properties of the staff's personal cell phone on the content of the properties of the facility to help care for the residents at all times.  -The Business Office Manager (BOM)/Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY MUST STATEMENT OF DEFICIENCES   TAG	DICUMON	DUIL DESTUDME#2	95 RICHMC	OND HILL ROA	.D		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 177  Continued From page 23  Director (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself.  -On 05/24/21, all the residents were brought up to the front porches of two sister facilitiesBecause there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked funch and supper out on the grills, and everyone enjoyed a cookout day.  -It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did.  -The MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each other.  -The residents did not have access to the staff's personal cell phone numbers.  -Any resident who required assistance could come to the office or to one of the other buildings.  -In the event of an emergency the residents could call 911, if staff could not be located.  Interview with the Owner on 05/27/21 at 4:00pm revealed:  -There should always be a staff member inside the facility to help care for the residents at all times.  -The Business Office Manager (BOM)Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.	RICHWON	D HILL REST HOME # 3	ASHEVILLE	E, NC 28806			
Director (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself.  -On 05/24/21, all the residents were brought up to the front porches of two sister facilitiesBecause there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked lunch and supper out on the grills, and everyone enjoyed a cookout dayIt was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they didThe MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each otherThe residents did not have access to the staff's personal cell phone numbersAny resident who required assistance could come to the office or to one of the other buildingsIn the event of an emergency the residents could call 911, if staff could not be located.  Interview with the Owner on 05/27/21 at 4:00pm revealed: -There should always be a staff member inside the facility to help care for the residents at all timesThe Business Office Manager (BOM)/Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
administer medications to the residents, a personal care aide (PCA) for assistance and herself.  -On 05/24/21, all the residents were brought up to the front porches of two sister facilities. Because there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked funch and supper out on the grills, and everyone enjoyed a cookout day.  -It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did.  -The MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each other.  -The residents did not have access to the staff's personal cell phone numbers.  -Any resident who required assistance could come to the office or to one of the other buildings.  -In the event of an emergency the residents could call orly its fatff could not be located.  Interview with the Owner on 05/27/21 at 4:00pm revealed:  -There should always be a staff member inside the facility to help care for the residents at all times.  -The Business Office Manager ((BOM)/Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.	D 177	Continued From page	23	D 177			
-He did not know the residents in the facility were left alone for a period of time during the morning		Director (AD) who we administer medication personal care aide (PherselfOn 05/24/21, all the rathe front porches of two Because there were approximately 50 resifacilities, the 4 staff con the grills, and ever dayIt was "not the best the but under the circums approximately 50 resididThe MAs or PCAs did two-way telecommunicate their personal cell call or text each other. The residents did not personal cell phone in -Any resident who recome to the office or the come to the office or the come to the office or the call 911, if staff could revealed: -There should always the facility to help care timesThe Business Office (BOM)/Supervisor, the Resident Care Coordinesponsible for makin member in each build. He did not know the	ere MAs and could his to the residents, a PCA) for assistance and residents were brought up to wo sister facilities.  only 4 staff for a total of idents with in all 5 sister cooked lunch and supper out ryone enjoyed a cookout hey could do at the time", stances of only 4 staff for idents, that was what they d not have means of ication with the home, they ill phone which they could for the access to the staff's numbers.  quired assistance could to one of the other buildings. hergency the residents could not be located.  After on 05/27/21 at 4:00pm  as be a staff member inside the for the residents at all  Manager the e Administrator, and the inator (RCC) was and sure there was a staff thing at all times. residents in the facility were				

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-If a resident left the building during the night after

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011374	B. WING		06	6/01/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	,		
RICHMON	ID HILL REST HOME #3		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 177	-The alarm would ale had went out of the farwhen the alarm was unlockHe thought the resid facility if needed if a stacility.  The Administrator failt time the residents we without a qualified standinistrator-in-Charof the home with mean communication which being left alone in the atime with no means which resulted in one pain medication when and late medications; calling 911 themselve emergency; and one for staff when in need of a facility and havin hotel if after 10:00pm serious neglect to the Type A1 Violation.  The facility provided a accordance with G.S.	en the alarm would go off. In the staff that a resident acility. It triggered then the doors It triggered then the doors It triggered the doo	D 177			
D 367	10A NCAC 13F .1004 Administration		D 367			
		Medication Administration dication administration				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 3		OND HILL ROA E, NC 28806	ND.		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
D 367	Continued From page	e 25	D 367			
	following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justificat medications or treatm documenting the resu (6) date and time of a (7) documentation of medications or treatm omission, including re (8) name or initials of the medication or treas signature equivalent to	any omission of nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication				
	facility failed to ensure Administration Record documenting the adm for 1 out of 3 sampled. The findings are:  Review of Resident # revealed diagnoses of bipolar type, suicidal hallucinations, major intellectual disability of	and record reviews the e a Medication d (MAR) w available for ninistration of medications d residents.  3's current FL2 dated of schizoaffective disorder ideations, auditory depressive disorder, mild disorder and prediabetes.				
		3's Resident Register was admitted to the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DICUMON	ID UILL DEST HOME # 2	95 RICHM	OND HILL ROA	.D		
KICHWION	ID HILL REST HOME # 3	ASHEVILI	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 COMPLETE	
D 367	Continued From page	e 26	D 367			
	dated 05/10/21 revea -There was a physicia two times a day (a me anxiety)There was a physicia extended release 500 medication used to tre disorder)There was a physicia 500mg three times a treat seizures and net -There was a physicia injected every 3 week treat schizoaffective of -There was a physicia every day (a medicati pressure)There was a physicia 10mg every day (a medicati pressure)There was a physicia 15mg every day (a medicati pressure)There was a physicia 15mg every day (a medicati pressure)There was a physicia 15mg every day (a medicati pressure)There was a physicia 2 capsules at physicia 2 capsules at bedtime high blood pressure)There was a physicia 100mg at bedtime (a bipolar disorder)There was a physicia	an's order for buspirone 5mg edication used to treat  an's order for divalproex order for divalproex order for gabapentin day (a medication used to rve pain).  an's order for Invega 234mg as (a medication used to disorder).  an's order for lisinopril 10mg an's order for lisinopril 10mg an's order for loratadine edication used to treat high blood an's order for meloxicam edication used to treat  an's order for meloxicam edication used to help stop  an's order for Paliperidone grat bedtime (a medication fective disorder).  an's order for prazosin 5mg, er (a medication used to treat				

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reaction.

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  RICHMOND HILL REST HOME # 3  SIMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipation.  -There was a physician's order for imodium 2mg PRN with each loose stool.  -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  95 RICHMOND HILL ROAD ASHEVILLE, NC 28806   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipationThere was a physician's order for imodium 2mg PRN with each loose stoolThere was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  95 RICHMOND HILL ROAD ASHEVILLE, NC 28806   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipationThere was a physician's order for imodium 2mg PRN with each loose stoolThere was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.					
RICHMOND HILL REST HOME # 3  95 RICHMOND HILL ROAD ASHEVILLE, NC 28806  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipationThere was a physician's order for imodium 2mg PRN with each loose stoolThere was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.		HAL011374	B. WING		06/01/2021
ASHEVILLE, NC 28806  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367 Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipation.  -There was a physician's order for imodium 2mg PRN with each loose stool.  -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	NAME OF PROVIDER OR SUPPL	LIER STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ASHEVILLE, NC 28806  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipation.  -There was a physician's order for imodium 2mg PRN with each loose stool.  -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	DICHMOND HILL DECT HO	95 RICHMO	OND HILL ROA	ND.	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 27  -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipation.  -There was a physician's order for imodium 2mg PRN with each loose stool.  -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	RICHMOND HILL REST HO	ASHEVILL	E, NC 28806		
-There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipationThere was a physician's order for imodium 2mg PRN with each loose stoolThere was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	PREFIX (EACH DE	EFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
powder 17gm in 8oz of water every day PRN for constipation.  -There was a physician's order for imodium 2mg PRN with each loose stool.  -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn.	D 367 Continued Fro	m page 27	D 367		
-There was a physician's order for melatonin 5mg at bedtime PRN for sleep.  -There was a physician's order for milk of magnesia 400mg/5ml 2 times a day PRN for constipation.  -There was a physician's order for quetiapine 50mg PRN for anxiety every 4 hours, not to exceed 4 doses.  -There was a physician's order for Robitussin DM 100mg/10ml, 10ml every 6 hours PRN cough.  -There was a physician's order for trazodone 50mg at bedtime PRN for sleep.  -There was a physician's order for Tylenol ES 500mg every 6 hours PRN for minor discomfort/headache.  Review of Resident #3's May 2021 Medication Administration Record (MAR) revealed there was no MAR available for review.  Review of the facility's Electronic Medical Record policy revealed:  -The orders were inputted to the electronic MAR by the contracted pharmacy and received in the facility daily.  -The medication aide (MA) would compare the eMAR to the current doctor's orders and immediately correct any errors.  -If for some reason a hand written MAR must be completed, there must be written orders from the	-There was a powder 17gm constipationThere was a pRN with each and pRN pRN for exceed 4 dose and part and pRN for exceed 4 dose and provided and	physician's order for clearlax in 8oz of water every day PRN for physician's order for imodium 2mg in loose stool. physician's order for maalox g/ml, 30ml up to 4 times a day PRN artburn. physician's order for melatonin 5mg th for sleep. physician's order for milk of img/5ml 2 times a day PRN for physician's order for quetiapine anxiety every 4 hours, not to es. physician's order for Robitussin DM 10ml every 6 hours PRN cough. physician's order for trazodone me PRN for sleep. physician's order for Tylenol ES 5 hours PRN for minor adache.  Sident #3's May 2021 Medication a Record (MAR) revealed there was able for review.  facility's Electronic Medical Record do: ere inputted to the electronic MAR ted pharmacy and received in the current doctor's orders and correct any errors. ason a hand written MAR must be	D 367		

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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
		HAL011374	B. WING		06/01/2021
		IIAE011074	1		1 00/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
RICHMON	ID HILL REST HOME # 3	95 RICHM	OND HILL ROA	AD .	
111011111011		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 APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	÷ 28	D 367		
D 367	Interview with a MA or revealed: -Resident #3 came to -Resident #3 had men physician orders with facilityShe was not the MA arrived at the facility or -The MA on duty at the faxing the orders to the inthe eMAR systemThe MA was responsed MAR with Resident #1 neededOn 05/21/21 was the medications to Reside -There were no medications to Reside -There were no medications were system so she could as administeredThere were no paper document she adminimedicationsThe facility did not had -On 05/21/21 she rep MARs and no eMAR who was also the Sup-The BOM/Supervisor it"On 05/21/21 later the Administrator about in	the facility on 05/11/21. dications, an FL2 and her when she arrived to the on duty when Resident #3 on 05/11/21. nat time was responsible for ne pharmacy to be entered sible for completing a paper 3's medications on them if e first time she administered ent #3. cations listed in the eMAR is administered. responsible for making sure approved in the eMAR document the medications or MARs or an eMAR to istered Resident #3's eave paper MARs to use. orted the lack of paper for Resident #3 to the BOM	D 367		
	medications she adm	inistered to Resident #3.			

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-There should have been something to document

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011374	B. WING		06/01/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
ысниси	D HILL REST HOME # 3	95 RICHM	OND HILL ROA	D	
KICHWION	D HILL REST HOME # 3	ASHEVIL	LE, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPR DEFICIENCY)	BE COMPLETE
D 367	Continued From page	29	D 367		
	notebook paperShe administered the as the other MA by re medication bubble pa on paper.	e medications the same way ading the instructions on the ck without documenting it			
	Interview with a second MA on 05/27/21 at 9:47am revealed: -She faxed Resident #3's orders to the pharmacy on 05/11/21She did not fill out a paper MAR for Resident #3's medications because the facility did not have paper MARs to useShe reported the issue to the BOM on 05/11/21 after Resident #3 arrived to the facilityShe was instructed by the Administrator and the BOM/Supervisor to administer the medications to Resident #3 according to the instructions on the medication bubble pack.				
	at 11:55am revealed: -The medications for linto the eMAR system-It was the responsibi approve the orders in to document administ administered.	representitive on 05/26/21  Resident #3 were entered on 05/11/21. lity of the facility staff to the eMAR system in order ration of the medications			
	the medications were and a new eMAR was -The records indicated	tions administered to e month of May 2021 until approved by the facility staff s generated. d there were multiple phone ity on 05/13/21, 05/21/21 to Resident #3's			

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	n riealth Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			OND HILL ROA			
RICHMON	D HILL REST HOME # 3		LE, NC 28806			
			LE, NC 20006	T		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
170		,	IAG	DEFICIENCY)		
D 367	Continued From page	> 20	D 367			
D 307			5 307			
		ocumented Resident #3's				
		nt #3's pharmacy profile.				
	_	e responsible for approving				
		acy profile in order to allow				
		cument the administration of				
		ions in the eMAR system.				
		dent #3's medications were				
		mented as administered in				
	the eMAR system.					
	Interview with the BOM on 05/26/21 at 12:44pm					
	revealed:	W 011 05/20/21 at 12.44β111				
		ed Resident #3's orders in				
		stration because she thought				
	she had already com	•				
	_	sible for faxing all orders to				
	the pharmacy.	sizio for faxing all ordero to				
	-The pharmacy was r	esponsible for entering the				
	orders into the eMAR	system.				
		ere responsible for approving				
	all of the orders in the					
		e they could approve the				
	orders in the eMAR for					
	• •	as completed then the MAs				
		medications and document				
	them in the eMAR.					
		rder faxed after the eMAR				
		e MAs were responsible for				
		orders on a paper MAR.				
		inistered to a resident must				
		paper MAR or in the eMAR.				
	-There should never b					
	administered without	documentation.				
	Interview with the Adr	ministrator on 05/26/21 at				
	3:48pm revealed:					
	•	onsible for faxing the orders				
	to the pharmacy.	-				
		entered the orders into the				
	eMAR system the MA					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVE COMPLETED		
		HAL011374	B. WING		06/01/20	)21
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
RICHMON	D HILL REST HOME # 3	95 RICHMO	ND HILL ROA	.D		
- INIGINION	D THEE REOT FIGHE # 0	ASHEVILLE	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 CO	(X5) OMPLETE DATE
D 367	Continued From page	: 31	D 367			
	hand written MAR for orders showed up in the The MAs were responsed in the MAR or in the eMAR administration of the result. The policy was to do paper MARs or in the end of the were administered with eMAR and that they wadministered.	nsible for completing a all of the orders until the he eMAR. nsible for administering the g to the orders on the paper				
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 directive communicable disease 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 es, and sued by the CDC; however, es specific to the le infectious disease threat vriting by the NCDHHS or  fic guidance or directives by the facility.	D 612			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011374	B. WING		06	6/01/2021
	ROVIDER OR SUPPLIER  ID HILL REST HOME # 3	95 RICHI	DDRESS, CITY, STATE  MOND HILL ROAD  LE, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 612	Based on observation reviews the facility far recommendations an for Disease Control (Department of Health (NCDHHS) were impresidents during the QCOVID-19) pandemi of staff and visitors.  The findings are:  Review of the current prevention and spread Disease in long term 03/29/21 revealed: -All essential visitors presence of fever and when entering the burner of the NCDH program is critical to the althcare personnel.  Review of the NCDH prevention and spread Disease in LTC facilities. Prevention and spread Disease in LTC facilities are included so the althcare facility for COVID-19Establishing a procest the facility are assess COVID-19.  Review of the facility' dated 03/29/21 reveations must cooper screening process at	ins, interviews, and record illed to ensure diguidance by the Centers CDC) and the North Carolina and Human Services demented when caring for 10 global Coronavirus crass related to the screening crass related to the screening crass (LTC) facilities dated should be screened for the disymptoms of the virus illding. Evention and control protect both residents and cross dated 05/05/21 revealed: the infection prevention in the covidence of the coronavirus in the covidence of the covidence of the coronavirus in the covidence of the coronavirus in the covidence of the	D 612			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06/01/2021	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 06/01/2021	
			OND HILL ROA	,		
RICHMON	D HILL REST HOME # 3	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 SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE	
D 612	Continued From page	33	D 612			
	must provide docume meet CDC criteria for precautions.  -Any individuals with a infection will not be president.  -The visitor should caentry for the staff to make facility for screening.  -The screening proce questionnaire, temperas may be recommer NCDHHS.	symptoms of COVID-19 ermitted to visit with a  Il the facility staff prior to neet the visitor outside the ss includes the visitor rature, and other screenings ided by the CDC or the				
	surveyors entered the screening or tempera no screening question located near the entra Observations of the e 9:40am revealed:  -A medication aide (Marched and Screen et al.)  -She did not screen et have any supplies use Observation of the Nufacility on 05/26/21 at not screened upon er Interview with the Marched are usually visitors stop screened prior to visit	ntry hall on 05/26/21 at  1A) entered the building and hall towards the surveyors. ither surveyor and did not ed for screening with her.  urse Consultant entering the 11:00am revealed he was ntering the facility.  on 05/26/21 at 11:10am  at the office and get				
	from the facilityIf a provider comes to screened when they expressed the screened when the	o the facility, they were				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 3		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 612	the facility to begin he -The surveyors should they entered the facili Interview with the Bus (BOM)/Supervisor on revealed: -All visitors should be screened and not in th -The office was locate facilityAll visitors to the faci way to the facility.  Telephone interview w the local health depar 10:22am revealed: -All facilities should so their temperatures an questionnaire upon er -The facility should be from the CDC and the Interview with the Adr 1:07pm revealed: -She did not know vis screened before they -She was told by som they did not have to fo one had tested positiv -She could not remen -She assumed the faci visitorsThe facility had scree March 2021.	er shift. d have been screened when ty. siness Office Manager 05/26/21 at 12:35pm  directed to the office to be ne facility. ed down the road from the lity passed the office on the with a Registered Nurse from tment on 05/27/21 at  creen visitors by checking d completing a ntry into the facility. e following the guidelines e NCDHHS.  ministrator on 05/26/21 at itors still needed to be entered the facility. eone from the county that ollow guidelines because no	D 612			
		screened prior to entering				

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the facility.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL011374	B. WING		06/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
RICHMON	D HILL REST HOME # 3		OND HILL ROA E, NC 28806	D		
	CLIMMA DV CT		,	DDOWNERIC PLAN OF CORRECTION		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
D 612	Continued From page	e 35	D 612			
	were screenedEach building should questionnaires availa visitorsHe did not know the available in the building	" go by the office first and I have a visitor log and ble to properly screen all facility did not have supplies ng to screen the visitors, eter and the questionnaire.				
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914			
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.					
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect related to the management of facilities with a capacity or census of seven to thirty residents.					
	The findings are:					
	facility failed to ensur- were left alone in the staff and the Administ Administrator-in-Char of the home with mea communication. [Refe	ge (AIC) was within 500 feet ans of two-way or to Tag D0177, 10A NCAC ement Of Facilities With A Of Seven To Thirty				
		ions, interviews, and record rator failed to ensure the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED
		HAL011374	B. WING		06/01/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
RICHMON	ID HILL REST HOME # 3		OND HILL ROA E, NC 28806	D	
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D914	Continued From page	36	D914		
	management and total were maintained to electromorphisms with the readult care homes to perform to receive adequate a services and to be free the management of fall and control program, [Refer to Tag D0176, Management Of Facility	al operations of the facility			
D935	Training and Compete G.S. § 131D-4.5B (b)	Adult Care Home ining and Competency	D935		
	home is prohibited from any unsupervised methat individual has presented in an adult care home or of the following:  (1) A five-hour training Department that incluin 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.	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 on infection control and, if			

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DIVISION	n Health Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
				<u>—</u>		
			P WING			
		HAL011374	B. WING		06/0	1/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			OND HILL ROA			
RICHMON	D HILL REST HOME # 3		_E, NC 28806			
		ASHEVIL	_E, NC 20006			
(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 SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	REGOLATORT OR E	100 IDENTIFY THE INTO ON MATION,	TAG	DEFICIENCY)	MAIL	
			+			
D935	Continued From page	e 37	D935			
	NCAC 12E 0E02 and	I 10A NCAC 13G .0503.				
		om the date of hire, the				
		completed the following:				
	a. An additional 10-ho	0. 0				
	· · · · · · · · · · · · · · · · · · ·	partment that includes				
		n in all of the following:				
	1. The key principles	of medication				
	administration.					
	2. The federal Center	s of Disease Control and				
	Prevention guidelines	on infection control and, if				
	applicable, safe inject	tion practices and				
		oring or testing in which				
		e potential for bleeding				
	exists.					
	b. An examination de	veloped and administered				
		alth Service Regulation in				
	-	section (c) of this section.				
	This Rule is not met	as evidenced by:				
		and record reviews, the				
		e 2 of 3 sampled staff (Staff				
	A and B) who adminis	• ` ` `				
	•					
	residents had comple	•				
		clinical skills, the 5, 10, or				
	• •	ed medication administration				
		successfully passed the state				
	medication aide exam	nination as required.				
	The findings are:					
	The findings are:					
	1 Review of Staff A's	, Medication Aide (MA),				
	personnel record on (					
	-There was no docum					
		tation Staff A had passed				
		edication aide written exam				
	on 10/31/17.					
	-There was no docum					
		tency validated medication				
	clinical skills checklist	t.				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06	6/01/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
RICHMON	D HILL REST HOME # 3		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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
D935	Medication Administrator revealed Staff A had of were administered to Interview with Staff A revealed:  -She started working February or March of -She completed the March Skills Validation Check Consultant (RN) from pharmacy after she had facility.  -The Administrator she the office.  -She was usually the facility while she was -She administered medically while she was -She was responsible completed the require facility.  -Staff A was hired as a -She was "sure" Staff Medication Administration Checklist with the RN medications in the facility while she was "sure" Staff Medication Administration Checklist with the RN medications in the facility with the RN medications in the facility was "trying" to fishe had not organized documentation.  Refer to the telephone	s May 2021 electronic ation Record (eMAR) documented medications the resident.  on 05/27/21 at 2:57pm  at the facility in late 2021.  Medication Administration elistist with the Nurse the facility's contracted ad started working in the ould have the paper work in only staff member in the working.  edications to the residents.  with the Administrator on evealed:  for making sure all MAs ed training upon hire to the ation Skills Validation prior to administering sility.  e documentation showing the competency validation and the documentation but do the staff training.	D935				
	Consultant (RN) from pharmacy on 05/28/2	the facility's contracted 1 at 8:20am.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			3) DATE SURVEY COMPLETED	
		HAL011374	B. WING		06	5/01/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
RICHMON	ID HILL REST HOME # 3	95 RICH	MOND HILL ROAD				
		ASHEVI	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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D935	Continued From page	e 39	D935				
		with the Business Office ervisor on 05/27/21 at					
	personnel record reversely personnel record						
	Medication Administra	documented medications					
	revealed: -She worked as a MA -She did not rememb 15-hour medication a the current facilityShe worked as a MA in 2018 and thought s training at the previou -She told the Adminis	er completing the 5, 10, or ide training while working at at another facility beginning she had completed the is facility. Itrator she had worked at a was told she did not have to					
	06/01/21 at 2:41pm re- She was responsible completed the require facility. -She had completed to	with the Administrator on evealed: for making sure all MAs ed training upon hire to the the Employment Verification use she had previously					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

D935  Continued From page 40  worked as a MA at another facility in 2018 and 2019She did not know if Staff B had worked as a MA prior to 2013She did not know the employment verification process should only be completed for staff that had worked as a MA prior to October 2013.  Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
RICHMOND HILL REST HOME # 3  95 RICHMOND HILL ROAD ASHEVILLE, NC 28806  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D935  Continued From page 40  worked as a MA at another facility in 2018 and 2019She did not know if Staff B had worked as a MA prior to 2013She did not know the employment verification process should only be completed for staff that had worked as a MA prior to October 2013.  Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted			HAL011374	B. WING		06/0	1/2021
ASHEVILLE, NC 28806    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   D935	NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D935  Continued From page 40  worked as a MA at another facility in 2018 and 2019She did not know if Staff B had worked as a MA prior to 2013She did not know the employment verification process should only be completed for staff that had worked as a MA prior to October 2013.  Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted	RICHMOI	ND HILL REST HOME # 3			D		
worked as a MA at another facility in 2018 and 2019.  -She did not know if Staff B had worked as a MA prior to 2013.  -She did not know the employment verification process should only be completed for staff that had worked as a MA prior to October 2013.  Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETE
pharmacy on 05/28/21 at 8:20am.  Refer to the interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm.  Telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am revealed: -He provided the 5, 10, and 15-hour medication training and was responsible for completing the competency validated medication clinical skills checklist for the MAsThe Administrator was responsible for notifying him if the facility had a MA that needed to complete the trainingHe had completed some training for the facility in the past 2 to 3 months but he did not keep records of which MAs had completed the training.  Interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm revealed: -The Administrator started working in April 2021The Administrator was responsible for notifying the Consultant Nurse for the MAs who required the trainingThe Administrator was responsible for ensuring the medication aides (MAs) had all of the required	D935	worked as a MA at ar 2019She did not know if Sprior to 2013She did not know the process should only that worked as a MA  Refer to the telephone Consultant (RN) from pharmacy on 05/28/2  Refer to the interview Manager (BOM)/Super 4:44pm.  Telephone interview words (RN) from the facility of 05/28/21 at 8:20am related the 5, 1 training and was respected to the complete of the MASThe Administrator was the past 2 to 3 month records of which MAS.  Interview with the Bus (BOM)/Supervisor on revealed: -The Administrator was the Consultant Nurse the trainingThe Administrator was the Administrator was the Consultant Nurse the training.	Staff B had worked as a MA e employment verification be completed for staff that prior to October 2013. e interview with the Nurse of the facility's contracted of at 8:20am.  with the Business Office pervisor on 05/27/21 at  with the Nurse Consultant s contracted pharmacy on evealed: of and 15-hour medication consible for completing the of medication clinical skills of as responsible for notifying a MA that needed to of the facility in s but he did not keep of had completed the training.  Siness Office Manager of 05/27/21 at 4:44pm  arted working in April 2021. as responsible for notifying for the MAs who required as responsible for ensuring	D935			

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06/01/2021

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_

B. WING \_\_ HAL011374

DICHMOND HILL DEST HOME # 3

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 95 RICHMOND HILL ROAD

RICHMOND HILL REST HOME # 3  ASHEVILLE, NC 28806						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		

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