	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMIT EL TEB	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF D					07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	30 DALEA	DRESS, CITY, STA	I E, ZIP CODE		
WILHAM I	RIDGE		E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 000	Initial Comments		D 000			
	The Adult Care Licensure Section conducted a follow up survey and complaint investigation from 07/09/24 through 07/12/24.					
D 139	10A NCAC 13F .0407 Qualifications	7(a)(7) Other Staff	D 139			
	(a) Each staff person (7) have a criminal ba in accordance with G	7 Other Staff Qualifications at an adult care home shall: ackground check completed .S. 131D-40 and results person's personnel file;				
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff F) had a criminal background check completed upon hire.					
	The findings are:					
	file revealed: -There was no docum	n-call supervisor, personnel nentation of a hire date. e on-call supervisor for the				
	-There was no docum background check wa	nentation a criminal as completed upon hire.				
	revealed: -She started working or October of 2023She was hired as the needed at night.					

Division of Health Service Regulation

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

TITLE (X6) DATE

STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL011377	B. WING		R-C 07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
WILHAM F	DIDGE	30 DALE	A DRIVE		
WILHAW	NIDGE	ASHEVIL	LE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 139	Continued From page	e 1	D 139		
	-She did not know if the criminal background of	he former ED completed a check for her.			
	(RCC) on 07/12/24 at -She did not know wh background check on -Staff F was already was a reverthought at F had a criminal back -She was still in traini known what to look for was a registered nurse -The ED at the time S been responsible for completed.	by there was not a criminal file for Staff F. working when the RCC bout checking to see if Staff ground check on file. In and would not have or with Staff F because she is (RN). Staff F was hired would have making sure paperwork was ministrator on 07/12/24 at			
	10:54am and 3:34pm revealed: -He was responsible to complete the criminal background checks for new employees upon hire. -He did not know why Staff F did not have a criminal background check completed. -He thought Staff F was hired before he came to				
	July 2023 and the cor was signed by Staff F	a personnel file because she not work on a shift. as hired, it was the rmer Administrator to			
D 140	10A NCAC 13F .0407 Qualifications	(a)(8) Other Staff	D 140		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING		R-C
		HAL011377	B. WING		07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILHAM F	RIDGE	30 DALEA			
			LE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 140	Continued From page	2	D 140		
	(a) Each staff person (8) have an examinat presence of controller accordance with G.S.	Other Staff Qualifications at an adult care home shall: ion and screening for the d substances completed in 131D-45 and results person's personnel file;			
	facility failed to ensure examination and screen	and record reviews, the e documentation of an ening for the presence of s was completed for 1 of 4			
	Review of Staff F's, on-call supervisor, personnel file revealed: -There was no documentation of a hire dateShe was hired as the On-Call Supervisor for the facilityThere was no documentation a drug screening was completed upon hire.				
	revealed: -She started working 2023 or October of 20 -She was hired to as when needed at night -She remembered ha	the On-Call Supervisor			
	(RCC) on 07/12/24 at -She did not know wh screening on file for S	y there was not a drug			

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 3 of 68

	or riealth Service Regu		1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
					R-0	^
		UAL 044277	B. WING	B WING		
		HAL011377	5: :::::0		07/12	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		30 DALE				
WILHAM I	RIDGE		LE, NC 28805			
		ASHEVIL	LE, NC 20005			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR I	ESCIDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	MAIL	5,2
				,		
D 140	Continued From page	e 3	D 140			
	came to the facility.					
	_	bout checking to see if Staff				
	F had a drug screenir					
		ng and would not have				
	known what to look for	or with Staff F because she				
	was a registered nurs	se (RN).				
	-The ED at the time S	Staff F was hired would have				
	been responsible for	making sure paperwork was				
	completed.					
	Interview with Adminis	strator on 07/12/24 at				
	10:54am and 3:34pm	revealed:				
	-He was responsible					
	screenings for new er					
		Staff F did not have a drug				
	•	Stall 1 did flot flave a didg				
	screen completed.	as hired before he came to				
		as hired before he came to				
	the facility.					
		our owners of the facility in				
	_	ntract was signed by Staff F				
	on 09/15/23.					
		a personnel file because she				
	was "on call" and did	not work on a shift.				
	-At the time Staff F wa	as hired, it was the				
	responsiblity of the fo	rmer Administrator to				
	ensure drug screenin	gs were completed upon				
	hire.					
ח 218	10.4 NCAC 13E 0606	5 (g) Staffing Of Personal	D 218			
D 210	Care Aide Supervisor		5210			
	Care Alue Supervisor	3				
	10 A NO A O 40 E 000 F	Stoffing Of Darcasal Casa				
		Staffing Of Personal Care				
	Aide Supervisors					
	(g) A supervisor shal	I meet the following				
	qualifications:					
	(1) be 21 years or ol					
		graduate or certified under				
	the G.E.D. program, of	or have passed an				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 4 of 68

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(712)021 22		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		7 20.22	7.1. 50.125.11tg.		
	HAL011377	B. WING		R-C	
	HALUTI377			07/12/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM RIDGE	30 DALEA	DRIVE			
WEITAM RIBGE	ASHEVIL	LE, NC 28805			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 218 Continued From page 4		D 218			
alternative examination es Department; (3) meet the general hea according to Rule .0406 o (4) have at least six mon performing or supervising duties to be supervised du years prior to the effective date of hire, whichever is health professional or a lic administrator; (5) meet the same minim competency requirements supervised; and (6) earn at least 12 hours education credits related to disabled persons in accor- established by the Depart Human Services.	alth requirements of this Section; of this Section; of the performance of ouring a period of three of date of this Rule or the later, or be a licensed ocensed nursing home of the aides being of the aides being of the care of aged and ordance with procedures				
This Rule is not met as end assed on interviews and refacility failed to ensure 1 of the qualifications of a super The findings are: Review of the facility censure as a revealed there were 32 refacility. Review of Staff F's, on-ca	record reviews, the of 3 sampled staff met ervisor (Staff F.). sus dated 07/09/24 esidents residing in the				
file revealed: -There was no documenta years or olderThere was no documenta school graduate or certifie program or had passed a	ation Staff F was 21 ation Staff F was a high ed under the G.E.D.				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 5 of 68

	r of Deficiencies		(VO) MULTIPLE	CONCEDUCTION	(X3) DATE SURVEY	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	CONSTRUCTION	COMPLETED	
,	5. 55. u. 25. u. 5. u. 5		A. BUILDING: _		00 22.25	
					R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE ZIP CODE		
TW WILL OF T	NOVIBER OR GOLF EIER	30 DALE	, ,			
WILHAM I	RIDGE		LE, NC 28805			
	I		LE, NC 20005	I		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 218	Continued From page	, E	D 218			
D 210	Continued From page	÷ 0	D 2 10			
		ned by the Department.				
		nentation Staff F met the				
		ements according to Rule				
	.0406 of this Section.	0				
		nentation Staff F had at least				
	six months of experie	. •				
		rmance of duties to be				
		period of three years prior to his rule or the date of hire,				
		or be a licensed health				
	professional or a licer					
	adminstrator.	iscu nursing nome				
		nentation Staff F met the				
	same minimum trainii					
		ides being supervised.				
	-	nentation Staff F earned at				
		f continuing education				
	_	care of aged and disabled				
	persons in accordance	e with procedures				
	established by the De	epartment of Health and				
	Human Services.					
		on 07/12/24 at 10:16am				
	revealed:					
	· ·	ember 2023 or October of				
	2023.	d accorded (DNI)				
	-She was a registered	` ,				
	shifts when needed.	on-call supervisor on night				
		e infection control training				
	within 30 days of hire					
		nt with the former Executive				
		a criminal background				
		ot sure it was completed.				
	-She completed a dru					
		irector (ED) at the facility.				
		· · · · · ·				
		sident Care Coordinator				
	(RCC) on 07/12/24 at					
	-She did not know wh	y Staff F did not have a				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 6 of 68

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X			
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		PLETED
		HAL011377	B. WING		I	R-C 7/ 12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE	•	
		30 DALE		,		
WILHAM	RIDGE		LE, NC 28805			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRI	=CTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 218	Continued From page	e 6	D 218			
	personnel file.					
	-	employed at the facility when				
	she (RCC) was hired	· · ·				
		nat qualifications Staff F				
	would have been requ					
	supervisor because s (RN).	he was a registered nurse				
		red, the Executive Director				
		ve been responsible for				
	making sure paperwo	ork was completed.				
		ility's registered nurse (RN)				
	on 07/11/24 at 3:34pr					
	-She was one of the f					
	-Staff F did not have	eep personnel files for staff				
	who fulfilled an "on-ca					
	Interview with the Adr 10:23am revealed:	ministrator on 07/11/24 at				
	-Staff F did not have a did not work "shifts" a	a personnel file because she at the facility.				
	-He thought Staff F w	as hired for her position				
	before he became Co 2023.	o-Owner of the facility in July				
	-He became a Co-Ov	vner of facility in July 2023				
	_	contract for the on-call				
	supervisor's position					
		esent in the facility at night,				
		pervisor, was available for				
	staff assistance.					
		taff F was current with all				
	qualifications required	other than her professional				
	status as a registered	•				
	-He did not know if St					
		rug screening, infection				
	control training, or 12	-				
	education.					
	-He thought she had	all of the staffing				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 7 of 68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		I DDRESS, CITY, STA	TE ZIP CODE	1 07/12/2024	
		30 DALE		11, 211 CODE		
WILHAM F	RIDGE		LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 218	Continued From page	e 7	D 218			
	requirements becaus	e she was licensed as a RN.				
D 269	10A NCAC 13F .0901 Supervision	(a) Personal Care and	D 269			
	10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.					
	care and supervision resident's care plan for					
	The findings are:					
	Review of Resident # 05/30/24 revealed dia high blood pressure a	agnoses included diabetes,				
	revealed: -Resident #2 required dressing and bathing.	nentation related to care of				
	facility tour at 9:02am -She had diabetes.	nt #2 on 07/09/24 during the revealed:				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 8 of 68

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
HAL011377		B. WING		R-C		
		HALUTI377			07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
			LE, NC 28805			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 269	Continued From page	e 8	D 269			
	to her diabetes, include great toe.	ding amputation of her right				
	Observation of Residat 9:02am revealed:	ent #2's left foot on 07/09/24				
	-There was a small be left great toe.	andage wrapped around her				
	had a calloused area	emoved the bandage, she on the bottom of her left				
	great toe.	ag in the center of the				
		ng in the center of the ximately 0.5 centimeters by				
	0.5 centimeters in siz	-				
	-There was no draina opening.	ge or bleeding from the				
	Interview with Reside	ent #2 on 07/10/24 at				
		t least twice a week or				
	-She did not need ass independent with her					
	-Staff would assist he them to.	er with a shower if she asked				
	-She was independer	nt with dressing.				
	Interview with a person 07/11/24 at 10:11am	onal care aide (PCA) on revealed:				
		schedule for all residents, ot need assistance with				
	dressing or bathing.					
	-Resident #2 was ass	sisted in and out of the				
		assistance was provided.				
		assisted with washing her				
	feet or putting on soc -There was no docum					
		showers that she was aware				
	of.	mas and and				
	-She was not aware F area on the bottom of	Resident #2 had an open f her left great toe.				

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		.52	A. BUILDING: _			
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
		ASHEVILL	.E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 269	Continued From page	9	D 269			
	(RCC) on 07/10/24 at -Resident #2 was indebathingIf Resident #2 neede or bathing she would Interview with a Regis on 07/10/24 at 1:07pm	d assistance with dressing and assistance with dressing ask staff to assist her. Stered Nurse (RN)/Owner #2 in revealed:				
	wound on her left great April of 2024. -The wound had healed Resident #2 was discondant #2 was discon	en by home health for a lat toe in March 2024 and led to a "tiny scab" and harged from home health in laides (PCAs) provided nt #2 with bathing and her care plan, the area on lid have been discovered.				
	on 07/11/24 at 10:53a -Resident #2 had diab	petes. ade aware of Resident #2's				
	07/12/24 at 3:23pm re- Resident #2 self-shor- If she needed person	wered daily.				
D 273	10A NCAC 13F .0902	(b) Health Care	D 273			
		Health Care assure referral and follow-up ad acute health care needs				

Division of Health Service Regulation

STATE FORM BK2H11 If continuation sheet 10 of 68

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILHAM I	RIDGE	30 DALEA			
		ASHEVILI	LE, NC 28805		
(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 APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 10	D 273		
	This Rule is not met FOLLOW-UP TO TYPE				
	Violation was not aba				
	Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up was completed for 1 of 5 sampled resident (#4) related to failure to notify the Primary Care Provider (PCP) of blood sugar values greater than 450, insulin refusals, and reporting medication errors involving two blood pressure medications.				
	The findings are:				
	Review of Resident #4's current FL2 dated 06/06/24 revealed diagnoses included essential hypertension, hypotension, and type II diabetes with neuropathy.				
	hypertension, hypotension, and type II diabetes				

Division of Health Service Regulation

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		5.0
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WILHAM I	DIDGE	30 DALEA	DRIVE		
WILITAWI	NDGE	ASHEVILL	E, NC 28805		
(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 COMPLETE
D 273	Continued From page	e 11	D 273		
	Review of Resident # medication administrate revealed: -There was an entry flower blood sugar) 10 subcutaneously per sless than 150=0 unit, units, 301-350=3 unit more call PCP schedu 12:45pm, and 5:45pm -There was an entry find pen inject subcutaneously bedtime: FSBS less than the subcutaneously t	4's June 2024 electronic ation record (eMAR) for insulin aspart (used to 00 unit/ml pen inject liding scale: FSBS checks 151-200=1 unit, 201-300=2 s, 351-400=5 units, 450 or uled daily at 8:15am, n. for insulin aspart 100 unit/ml busly per sliding scale at than 200=0 unit, 201-250=1			
	Review of Resident # revealed:	•			
	lower blood sugar) 10	or insulin aspart (used to 00 unit/ml pen inject			
	subcutaneously per s	liding scale: FSBS checks			
		151-200=1 unit, 201-300=2 s, 351-400=5 units, 450 or			
	more call PCP sched				
	12:45pm, and 5:45pm	1.			
		or insulin aspart 100 unit/ml ously per sliding scale at			
	-	s less than 200=0 unit,			
	201-250=1 unit, 251-3	300=2 units, 301-350=3 s, 450 or more call PCP			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		ED
	HAL011377 B. WING			R-C 07/12		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM I	RIDGE	30 DALEA				
			_E, NC 28805			
(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 APPROFILIENCY)	D BE	(X5) COMPLETE DATE
	was 566, there was notified. Review of Resident # 06/06/24-07/10/24 redocumentation the PC FSBS results greater 06/14/24, 06/15/24, a Interview with a mediat 10:04am revealed: -There was an order to Resident #4's FSBS verif she took Resident was greater than 450 through the telehealth Interview with the Resident #4's elevate parameters in the	5pm, the documented FSBS or documentation PCP was desired there was no CP was notified for the than 450 on 06/09/24, and 07/02/24. Cation aide (MA) on 07/11/24 to notify the PCP when was greater than 450. #4's FSBS and the result provided the second of the policy of the pcp in application. Sident Care Coordinator 10:16am revealed: Insible for notifying the PCP ated FSBS's according to order.				
	to report the elevated -Any issue reported the application would pro resident's record.	nrough the telehealth				
	11:10am revealed: -She was not notified greater than 450 on 0 and 07/02/24If she had known about would have prompted meal time insulin dose	of Resident #4's FSBS 16/09/24, 06/14/24, 06/15/24, but the elevated FSBS, it I her to consider revising his age.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
			A. BOILDING.			D 0
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	A DRIVE			
WILLIAM	NIDOL	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	find no staff communi		D 273			
	on notifying the PCP orderedThe MAs all acknowl understood they need parameter values and information to the PC	I how to report the P. weekly with the PCP to				
	06/06/24 revealed: -There was an order in pen inject 4 units subscheduled at 8:15amThere was an order in pen inject subcutaned fingerstick blood sugato-150=0 unit, 151-200=301-350=3 units, 351 call PCP scheduled dand 5:45pmThere was an order in pen inject subcutaned bedtime: FSBS check 201-250=1 unit, 251-3	for insulin aspart 100 unit/ml cutaneously with meals 12:45pm, and 5:45pm. for insulin aspart 100 unit/ml cusly per sliding scale (SSI): ar (FSBS) checks less than 1 unit, 201-300=2 units, -400=5 units, 450 or more laily at 8:15am, 12:45pm, for insulin aspart 100 unit/ml cusly per sliding scale at 100 unit, 300=2 units, 301-350=3 s, 450 or more call PCP				
	medication administra 06/08/24-06/30/24 re -There was an entry f pen inject 4 units sub	4's June 2024 electronic ation record (eMAR) from vealed: for insulin aspart 100 unit/ml cutaneously with meals 12:45pm, and 5:45pm.				

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STATE FORM BK2H11 If continuation sheet 14 of 68

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
		30 DALEA	DRIVE			
WILHAM I	RIDGE		E, NC 28805			
0.40.15	CUMMADV CT		1	DROVIDERIS DI ANI OF CORRECTIO	N OFF	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 14	D 273			
	-There was an entry f	for insulin aspart 100 unit/ml				
		ously per sliding scale: FSBS				
		=0 unit, 151-200=1 unit,				
		-350=3 units, 351-400=5				
		III PCP scheduled daily at				
	8:15am, 12:45pm, an					
		for insulin aspart 100 unit/ml				
	•	ously per sliding scale at				
	·	s less than 200=0 unit,				
		300=2 units, 301-350=3				
		s, 450 or more call PCP				
	scheduled at 8:00pm.	•				
		om, FSBS 102, premeal				
		was documented as not				
	administered due to r					
	-On 06/11/24 at 7:49p	om, no documented FSBS,				
		rt per SSI was documented				
	as not administered of	due to resident refusal.				
	-On 06/13/24 at 1:19p	om, FSBS 194, premeal				
	insulin aspart 4 units	and per SSI was				
	documented as not a	dministered due to resident				
	refusal.					
	-On 06/19/24 at 6:41	om, FSBS 179, premeal				
	insulin aspart 4 units	and per SSI was				
	documented as not a	dministered due to resident				
	refusal.					
	-On 06/20/24 at 1:55p	pm, FSBS 288, premeal				
	insulin aspart 4 units	was documented as not				
	administered due to r					
		om, FSBS 128, premeal				
	T =	was documented as not				
	administered due to r					
		om, no documented FSBS,				
		I was documented as not				
	administered due to r	esident refusal.				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 07/11/24 at	t 10:16am revealed Resident				
	, ,	s scheduled and SSI insulin				

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on occasion.

STATE FORM BK2H11 If continuation sheet 15 of 68

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			E SURVEY PLETED
			A. BOILDING.			R-C
		HAL011377	B. WING		I	7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MAIL LLAM	BIDGE	30 DALE	A DRIVE			
WILHAM	RIDGE	ASHEVII	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 15	D 273			
	-She was not notified insulin doses in June -There was nothing a #4 refused doses of i -She may need to revidoses if he frequently Interview with the Add 3:24pm revealed: -He could find no teles PCP about Resident 2024The State regulation facility was responsible refusals to the PCPThe facility policy was	7/11/24 at 11:10am revealed: of Resident #4's refused 2024. inyone could do if Resident nsulin. vise Resident #4's premeal				
	06/06/24 revealed the	eat low blood pressure) 5mg				
		44's Primary Care Provider's 6/27/24 revealed midodrine times daily.				
	-Check blood pressul hold for systolic blood	ne 5mg twice daily.				

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A. BUILDING: R-C HAL011377 B. WING 07/12/2	
D 14910	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
WILHAM RIDGE 30 DALEA DRIVE	
ASHEVILLE, NC 28805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273 Continued From page 16 D 273	
medication administration record (eMAR) from 06/09/24-06/28/24 revealed: -There was an entry for midodrine 5mg one tablet twice daily; hold dose if systolic blood pressure was greater than 140, scheduled at 8:00am and 6:00pm (with a start date of 05/17/24). -There was an entry for midodrine 5mg one tablet twice daily; hold for systolic blood pressure greater than 120; notify PCP if systolic blood pressure greater than 120; notify PCP if systolic blood pressure was less than 90 or greater than 140, scheduled at 2:00pm and 8:00pm (with a start date of 06/28/24). -There was an entry for midodrine 10mg one tablet once daily; hold for systolic blood pressure greater than 120; notify PCP if systolic blood pressure greater than 120; notify PCP if systolic blood pressure was less than 90 or greater than 140 (with a start date of 06/28/24). -On 06/27/24 at 8:00am, the documented blood pressure was 89/42, midodrine 5mg was documented as not administered due to withheld per order. Review of Resident #4's record revealed there was no documentation the PCP was notified the midodrine was not administered as ordered on 06/12/24 at 8:00am, 06/17/24 at 8:00am, 06/18/24 at 8:00am, 06/27/24 at 8:00am,	

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-Resident #4 was prescribed midodrine to

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DIVISION	i Health Service Negu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
						_
			B. WING		R-	
		HAL011377	B. WING		07/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
	10115211 011 001 1 21211		, ,	, 2 0032		
WILHAM F	RIDGE	30 DALEA				
		ASHEVILLI	E, NC 28805			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DATE
				DEI IOIEITOT)		
D 273	Continued From page	e 17	D 273			
	increase his blood pre					
	-If the midodrine was	not administered as ordered				
	Resident #4 could exp	perience more hypotension.				
	-The risk associated v	with hypotension were poor				
	perfusion (the passag	e of blood through the blood				
		ral channels in an organ or				
		d level of consciousness.				
	,	of the occurrences when				
	the facility MAs had n					
	midodrine as ordered					
		telehealth notes related to				
	_	#4's midodrine in June				
	2024.	#4 3 IIIIdodiiile iii Julie				
		مالا مرام المنظر				
	-She had received mu					
		week" (06/30/24-07/07/24)				
	about Resident #4's b	lood pressures being low.				
	Review of Resident #	4's Nurses Note dated				
	06/28/24 revealed:					
	-On 06/20/24, there w	as an order to alert the PCP				
	if systolic blood press	ure was less than 90.				
		aware today (06/28/24) of				
	blood pressure results	- , ,				
	pressures less than 9					
	•	od pressure was 76/38.				
	·	od pressure was 84/68.				
		od pressure was 88/45.				
		od pressure was 72/41 and				
	55/30.	ou pressure was 12141 allu				
		ad proceure was 61/27 and				
		od pressure was 61/27 and				
	88/48.	ad procesure was 00/40 ===d				
	•	od pressure was 89/42 and				
	82/65.	- 1 0.1/50				
	-On 06/28/24, the blo	od pressure was 84/50.				
	Interview with the Adr	ninistrator on 07/12/24 at				
	3:24pm revealed Res					
		ssed with the PCP on				
	06/20/24, 06/27/24, a					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
	HAL011377 B. WIN		B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		30 DALEA	A DRIVE		
WILHAM I	RIDGE	ASHEVIL	LE, NC 28805		
(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 COMPLETE
D 273	Continued From page	÷ 18	D 273		
	06/06/24 revealed the (used to treat high blo tablet daily hold for sy than 120.	t #4's current FL2 dated ere was an order for losartan ood pressure) 25mg one vstolic blood pressure less			
		4's Primary Care Provider /20/24 revealed discontinue			
	medication administra 06/09/24-06/20/24 rev	4's June 2024 electronic ation record (eMAR) from vealed: or losartan 25mg one tablet			
	daily at 8:00am hold f	or systolic blood pressure			
		cumented as administered			
	11 occurrences out of 06/09/24-06/20/24.	12 opportunities from			
	-On 06/09/24, the doc was 78/41; losartan w	cumented blood pressure vas documented as			
	administered.				
	pressure; losartan wa charted on MAR."	as no documented blood s documented as "done not			
	was 80/45; losartan w	cumented blood pressure vas documented as			
	was 107/85; losartan	cumented blood pressure was documented as			
		cumented blood pressure			
	was 98/71; losartan was 98	vas documented as			
	was 85/54; losartan was administered.	•			
	-On 06/16/24, the doc was 71/57; losartan w administered.	cumented blood pressure vas documented as			

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Division c	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
						^
		1141 044277	B. WING		R-	
		HAL011377			U //1	2/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
		30 DALE	A DRIVE			
WILHAM F	RIDGE		LE, NC 28805			
2(1) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	d .	0/5)
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 273	Continued From page	2 10	D 273			
22.0						
		cumented blood pressure				
	was 95/58; losartan w	vas documented as				
	administered.					
		cumented blood pressure				
	was 61/28; losartan w	vas documented as				
	administered.					
		cumented blood pressure				
	was 89/88; losartan w	vas documented as				
	administered.					
		cumented blood pressure				
	was 92/87; losartan w	vas documented as				
	administered.					
	Observation of Resid	lent #4's medications on				
	-	3:44pm revealed there was				
	no losartan.	5.1 p 5.5555				
	Interview with Reside	ent #4 on 07/09/24 at 9:07am				
	revealed:					
	-His blood pressure w					
	· ·	ure made him feel weak, light				
	headed, and dizzy.					
		ade it very difficult for him to				
	walk down to the dini	ng room for meals.				
	Intoniow with a modi	ication aids (MA) on 07/11/24				
	at 10:26am revealed:	ication aide (MA) on 07/11/24				
		a MA in the facility since May				
	2024.	a WA III the facility shilled way				
		ministration of Resident #4's				
		, 06/18/24, and 06/20/24.				
	· ·	she was supposed to hold the				
		c blood pressure was less				
	than 120.	•				
	Interview with Reside	ent #4's PCP on 07/11/24 at				
	11:10am revealed:					
		pressure was "typically"				
	hypotensive (low bloc					
	-Resident #4 was at r	risk for more hypotension				

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_
	HAL011377		B. WING		07/12	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
WILHAM I	DINGE	30 DALE	A DRIVE			
WILLIAM	NIDGE	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 20	D 273			
D 213	when the losartan was ordered parameterShe was not notified incidents from 06/09/2 losartan was adminis should have been helphood pressureThe risks of low blood included decreased pthat keeps blood flow body) and a decreased resident #4 could explicate the dizziness, lightheader increased risk for falls was lowShe discontinued Resident #4 was experiences. Interview with the Adma 3:24pm revealed: -Resident #4's continued discussed with the PC-Resident #4's PCP of 06/20/24. The facility failed to no multiple medication expressure medications 2024 which put the resident	there were multiple 24-06/20/24 when the tered to Resident #4 when it id based on the resident's id pressures to Resident #4 perfusion (the mechanism ing to every part of the ed level of consciousness, when his blood pressure esident #4's losartan on as notified by the facility periencing low blood in inistrator on 07/12/24 at at used hypotension was CP on 06/20/24. Its continued the losartan on office in the losartan office in the				
	2024 which put the resident at risk for decreased blood flow and decreased level of consciousness. This failure resulted in substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/24 for this violation.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R-C	,
		HAL011377	B. WING		1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
	OLUMBA DV OT		E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	21	D 344			
D 344	10A NCAC 13F .1002	2(a) Medication Orders	D 344			
	D 344 10A NCAC 13F .1002(a) Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clarification of medication orders for 1 of 6 sampled residents (#2) related to					
	weights. The findings are:					
	Review of Resident #2's current FL-2 dated 05/30/24 revealed diagnoses included diabetes, hypertension, chronic obstructive pulmonary disease and obesity.					
	hypertension, chronic obstructive pulmonary					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL011377	B. WING		07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
WILHAM	RIDGE		A DRIVE		
	T		LLE, NC 28805		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 22	D 344		
	medication administrative revealed: -There was an entry to once a month. -Staff documented a wook/08/24 at 8:00am. -There was an entry fone-half tablet daily (weight gain of two lbstained daily or that administered. Review of Resident # revealed: -There was an entry to once a month. -Staff documented a wook/08/24 at 8:00am. -There was an entry fone-half tablet daily (weight gain of two lbstained daily of two lbstained daily or that administered. Interview with a medicum obtained daily or that administered. Interview with a medicum of two lostained daily or that administered. Interview with a medicum of two lostained daily or that administered. Interview with a medicum of two lostained daily or that administered. Interview with a medicum of two lostained daily or that administered. Interview with a medicum of two lostained daily or that administered.	o check and record weight weight of 231.4 lbs. on for furosemide 40mg take 20mg) as needed for a i. in 24 hours. hentation weights were furosemide was 2's July 2024 eMAR o check and record weight weight of 219.8 lbs. on for furosemide 40mg take 20mg) as needed for a i. in 24 hours. on 07/05/24 that indicated eceive as needed ing out of the facility. hentation weights were furosemide was cation aide (MA) on evealed when weights were ned for a resident, the often the weight was due.			

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	r of Deficiencies		(VO) MULTIPLE	CONCEDUCTION	(X3) DATE SURVEY	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	5. 55. u. 25. u. 5. u. 5		A. BUILDING: _		33 22.23	
					R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIR CODE		
INAME OF T	NOVIDEN ON 301 1 EIEN		, ,	II., ZII CODE		
WILHAM I	RIDGE	30 DALE	LE, NC 28805			
			LE, NC 20005			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
				DEFICIENCY)		
D 344	Continued From page	e 23	D 344			
	furosemide if Resider	nt #2 had a weight gain of				
	more than two lbs. in	24 hours.				
	-She did not know ho	w long it had been since she				
	noticed the discrepan	icy, but she asked the				
	primary care provider	(PCP) to clarify the two				
	orders.					
	-She never received a	a response from the PCP				
	about the two orders.					
	Interview with Reside	nt #2 on 07/10/24 at				
	11:50am revealed:	110 1/2 011 017 10/2 1 dt				
		ere checking her weight				
	once a month.	3 3				
	-She was hospitalized	d "last week" for difficulty				
	breathing and hand c					
	-She was feeling bett	er since returning to the				
	facility, but was still w	eak.				
	-She was receiving a	weekly injectable diabetic				
	medication that was h	nelping her lose weight.				
	· ·	al discharge record dated				
	07/05/24 revealed Re					
		noses that included heart				
	failure, lung disease,	and acute kidney injury.				
		P on 07/11/24 at 10:53am				
		iagnosis of congestive heart				
	failure.					
		daily weights taken for				
		ne if she was retaining fluid.				
		clarify the order for the				
		d when the resident gained				
	two lbs. in 24 hours.	acted the facility stoff or				
	-	ected the facility staff or				
	orders.	iscrepancies in the two				
	olucis.					
	Interview with the Adr	ministrator on 07/12/24 at				
	3:23pm revealed:					

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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	
			71. 201221110.		R-C
		HAL011377	B. WING		07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WILHAM F	RIDGE	30 DALEA			
	OLUMBA DV OT		E, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	24	D 344		
	-The eMAR was revie -He expected the RCo address any discrepa	C to review orders and			
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358		
	10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.				
	This Rule is not met a FOLLOW-UP TO TYPE	<u> </u>			
	Based on these findin Violation was not aba	ngs, the previous Type A2 ted.			
	reviews, the facility fa were administered as residents (#1, #2 and used to treat high and neuropathy (#4), med), and a medication for high			
	The findings are:				
	policy and procedures -Medications, prescrip and treatments will be	s Medication Administration s dated 06/21/23 revealed: otions and non-prescription, e administered in prescribing practitioner's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILHAM I	RIDGE	30 DALEA	DRIVE		
WILLIAM	(IDOL	ASHEVILI	E, NC 28805		
(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 SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
D 358	updated and changed treatment orders from changes. 1. Review of Residen 06/06/24 revealed dia hypertension, hypote with neuropathy. a. Review of Residen 06/06/24 revealed the (used to treat high blot tablet daily; hold for sthan 120. Review of Resident # (PCP) order dated 06 losartan. Review of Resident # medication administra 06/09/24-06/20/24 revenue of Resident # medication administra 06/09/24 revenue of Resident # medication administra 06/09/24 revenue of Resident # medication admini	inistration record will be d when medication or in the prescribing practitioner at #4's current FL2 dated agnoses included essential insion, and type II diabetes at #4's current FL2 dated ere was an order for losartan good pressure) 25mg one systolic blood pressure less at 4's Primary Care Provider 6/20/24 revealed discontinue	D 358		
	less than 120. -The losartan was do	for systolic blood pressure cumented as administered f 12 opportunities from			
	-On 06/09/24, the doc was 78/41, and losard administered. -On 06/10/24, there w	cumented blood pressure tan was documented as vas no documented blood			
	not charted on MAR.' -On 06/11/24, the doc was 80/45, and losard administered.	n was documented as "done cumented blood pressure tan was documented as			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
				_	_	
		1101 044077	B. WING		R-	
		HAL011377	D. WING		07/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		30 DALE				
WILHAM F	RIDGE		LE, NC 28805			
			LL, NC 20003			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
	0 " 1-	00	D 050			
D 358	Continued From page	e 26	D 358			
	was 107/85. and losa	rtan was documented as				
	administered.					
		cumented blood pressure				
		tan was documented as				
	administered.					
		cumented blood pressure				
		tan was documented as				
	administered.	an was documented as				
		cumented blood pressure				
		tan was documented as				
		an was uocumenteu as				
	administered.	numented bleed pressure				
		cumented blood pressure				
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	administered.					
		cumented blood pressure				
		tan was documented as				
	administered.					
		cumented blood pressure				
		tan was documented as				
	administered.					
		cumented blood pressure				
		tan was documented as				
	administered.					
	_	ent #4's medications on				
	hand on 07/10/24 at 3	3:44pm revealed there was				
	no losartan.					
	Interview with Reside	nt #4 on 07/09/24 at 9:07am				
	revealed:					
	-His blood pressure w					
	-His low blood pressu	ıre made him feel weak, light				
	headed, and dizzy.					
		ade it very difficult for him to				
	walk down to the dini					
		cation aide (MA) on 07/11/24				
	at 10:26am revealed:					
	-She had worked as a	a MA in the facility since May				

2024.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		R-C	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIR CODE	07/12/2024	
		30 DALEA		ie, zir Gobe		
WILHAM I	RIDGE		.E, NC 28805			
(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 358	Continued From page	2 7	D 358			
	losartan on 06/11/24, -She did not realize s losartan if the systolic than 120.	ministration of Resident #4's 06/18/24, and 06/20/24. he was supposed to hold the blood pressure was less				
	11:10am revealed:					
	-She did not know why losartan was ordered for Resident #4. -Resident #4's blood pressure was "typically" hypotensive (low blood pressure). -Resident #4 was at risk for more hypotension when the losartan was administered outside the ordered parameter. -The risks of low blood pressures to Resident #4 included decreased perfusion (the passage of blood through the blood vessels or other natural channels in an organ or tissue) and a decreased level of consciousness. -Resident #4 could experience weakness, dizziness, lightheadedness, and could be at an increased risk for falls when his blood pressure was low. -She discontinued Resident #4's losartan on 06/20/24 after she was notified by the facility					
	3:24pm revealed: -Resident #4's continudiscussed with the PC-Resident #4's PCP d06/20/24. b. Review of Residen	CP on 06/20/24. iscontinued the losartan on t #4's current FL2 dated				
	06/06/24 revealed the midodrine (used to tre	ere was an order for eat low blood pressure) 5mg				

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take one tablet twice daily.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
744012744	or correction.	ISENTI IONIONI NOINISEN.	A. BUILDING: _		OOM EETED	
					R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		30 DALEA	DRIVE			
WILHAM F	RIDGE	ASHEVILL	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	2 8	D 358			
		4's Primary Care Provider's //27/24 revealed midodrine times daily.				
	bedtimeCheck blood pressur hold for systolic blood Review of Resident # medication administra 06/09/24-06/30/24 red-There was an entry for the systom of the system of	ne 5mg twice daily. g every morning. ne 5mg midday and at re prior to administration and d pressure greater than 120. 4's June 2024 electronic ation record (eMAR) from wealed: for midodrine 5mg one tablet				
	twice daily; hold dose if systolic blood pressure greater than 140 scheduled at 8:00am and 6:00pm (with a start date of 05/17/24). -There was an entry for midodrine 5mg one tablet twice daily; hold for systolic blood pressure greater than 120 notify PCP if systolic blood pressure less than 90 or greater than 140 scheduled at 2:00pm and 8:00pm (with a start					
	tablet once daily; hold greater than 120 notifing pressure is less than a start date of 06/28/2 -On 06/12/24 at 8:00a pressure was 100/53 documented as not a	am, the documented blood				
	per orderOn 06/16/24 at 6:00p pressure was 96/62; documented as not a medication on order f	dministered due to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		D 0	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM I	PINGE	30 DALEA	DRIVE			
WILHAM	RIDGE	ASHEVILL	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	29	D 358			
	pressure was 95/58; r documented as not ac per order. -On 06/18/24 at 8:00a pressure was 61/28, r documented as not ac per order. -On 06/26/24 at 8:00a pressure was 61/27, r documented as not ac per order. -On 06/27/24 at 8:00a pressure was 89/42, r	dministered due to withheld am, the documented blood midodrine 5mg was dministered due to withheld am, the documented blood midodrine 5mg was dministered due to withheld am, the documented blood				
	07/01/24-07/10/24 rev-There was an entry frablet daily scheduled blood pressure greate for systolic blood pressurant 140. -There was an entry fraction of twice daily scheduled hold for systolic blood and notify the PCP if than 90 or greater than -On 07/05/24 at 8:00a pressure was 81/56; the standard pressure was 81/56; the standard pressure was an entry fraction of the pressure was 81/56; the standard pressure was 81/56; the	or midodrine 10mg one at 8:00am; hold for systolic er than 120 and notify PCP esure less than 90 or greater or midodrine 5mg one tablet at 2:00pm and 8:00pm; I pressure greater than 120 esystolic blood pressure less				
	hand on 07/10/24 at 3 -There was one bubb tablets with 31 tablets date of 06/28/24.	ent #4's medications on 3:44pm revealed: le pack of midodrine 10mg remaining with a dispense				

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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	
			D WING		R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF FI	NOVIDER OR SUFFLIER			ie, zir code		
WILHAM F	RIDGE	30 DALE	A DRIVE			
VVIETIZANI	(IDOL	ASHEVIL	LE, NC 28805			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(710)	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
			1	DEFICIENCY)		
D 350	0	- 00	D 358			
D 358	Continued From page	9 30	D 356			
	tablets with 59 tablets	remaining with a delivery				
	date of 07/12/24.	Tomaning war a delivery				
	date of 07/12/24.					
	Talanhana intansiaw w	with a pharmagist at the				
	-	vith a pharmacist at the				
	-	harmacy on 07/10/24 at				
	4:39pm revealed:					
		nsed midodrine 5mg 60				
	tablets on 05/09/24 ar					
	-The pharmacy did no					
		s on 06/28/24 when the				
	order changed becau	se the facility should use up				
	the previous supply u	ntil cycle fill delivery around				
	the 10th day of the m	onth.				
	•	nsed midodrine 10mg 60				
	tablets on 06/28/24.	3 3				
	1451010 011 00/20/2 11					
	Interview with Reside	nt #4 on 07/09/24 at 9:07am				
	revealed:	111 #4 011 01/09/24 at 9.07 att				
		vaa aanatantky lavy				
	-His blood pressure w					
		ıre made him feel weak, light				
	headed, and dizzy.	1.50				
		ade it very difficult for him to				
	walk down to the dinir					
	_	dication to help to raise his				
	blood pressure, but th	ne medication was not				
	working.					
	Interview with the Adr	ministrator on 07/10/24 at				
	5:51pm revealed:					
	-He and the Resident	Care Coordinator (RCC)				
		dent #4's blood pressure				
	fluctuations during a					
	-Most of the MAs had					
		pressure parameters and				
	midodrine administrat					
		st MA who had not received				
	•					
	_	24 by phone on 07/06/24				
	and provided the train	iing to nim.				

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Interview with Resident #4's PCP on 07/11/24 at

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	or riealth Service Regu		1			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		JOINI LETED	
					R-C	
		HAI 044277	B. WING			
		HAL011377			07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		30 DALEA	DRIVE			
WILHAM F	RIDGE		.E, NC 28805			
	OLIMANA DV. OT.		1	DDO//IDEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(*)	TF
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 050	0 11 1-		D 050			
D 358	Continued From page	31	D 358			
	11:10am revealed:					
	-Resident #4 was pre	scribed midodrine to				
	increase his blood pre					
	•	not administered as ordered				
		xperience more hypotension				
	(abnormally low blood					
		e telehealth messages				
	T	pressures from the facility				
	staff "last week" (06/3	•				
		with hypotension was				
		through the blood vessels				
	and decreased level of	•				
		of the occurrences when				
	the facility MAs had n					
	midodrine as ordered					
	_	telehealth notes related to				
		#4's midodrine in June				
	2024.					
	Davious of Davidant #	4's Nurses Note dated				
		4 s Nurses Note dated				
	06/28/24 revealed:					
	· ·	as an order to alert the PCP				
	if systolic blood press					
		aware today (06/28/24) of				
	blood pressure results	-				
	pressures less than 9					
		od pressure was 76/38.				
		od pressure was 84/68.				
		od pressure was 88/45.				
		od pressure was 72/41 and				
	55/30.					
		od pressure was 61/27 and				
	88/48.					
	-On 06/27/24, the block	od pressure was 89/42 and				
	82/65.					
	-On 06/28/24, the block	od pressure was 84/50.				
	Interview with the Adr	ninistrator on 07/12/24 at				
	3.34nm revealed:		1			

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-Resident #4's low blood pressures were

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C
HAL011377		B. WING		07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
WILHAM I	RIDGE	30 DALE	A DRIVE		
WILLIAM		ASHEVIL	LE, NC 28805		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 358	Continued From page	e 32	D 358		
	concerning administrations. c. Review of Residen 06/06/24 revealed the	ning with staff on 07/01/24 ation of Resident #4's t #4's current FL2 dated			
	Review of Resident #4's PCP order dated 05/06/24 revealed gabapentin 600mg four times daily.				
	medication administrative revealed: -There was an entry fitablet four times a da 12:00pm, 4:00pm, an 12:00pm to 05/31/24 -The gabapentin was administered 100 occopportunities. -On 05/05/24 at 1:00pd documented as not a notes." -On 05/06/24 at 4:00pd documented as not a resident being out of -On 05/08/24 at 8:00p	for gabapentin 600mg one y scheduled at 8:00am, ad 8:00pm from 05/06/24 at at 8:00pm. documented as currences out of 103 pm, the gabapentin was dministered "see chart pm, the gabapentin was dministered due to the			
	_	for gabapentin 600mg one y scheduled at 8:00am, id 8:00pm.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING			R-C //12/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		30 DALE	A DRIVE			
WILHAM	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	administered 116 or opportunities from 0 -On 06/01/24 at 7:13 the gabapentin was administered due to -On 06/19/24 at 8:00 documented as not blood pressure 87/7 -On 06/26/24 at 9:18 documented as not refusal. Review of Resident 07/01/24-07/10/24 at -There was an entry tablet four times a d 12:00pm, 4:00pm, a -The gabapentin was administered 36 occopportunitiesOn 07/04/24 at 8:00 documented as not refusalOn 07/05/24 at 9:33 documented as not withheld per physici Observation of Resihand 07/10/24 at 3:4-There was one bub 600mg tablets with 3 dispensed 06/15/24 to take one tablet fo -There was one bub 600mg tablets with 3 dispensed on 06/15 instructions to take 0-There was one bub 10-10 table 10-10 tab	courrences out of 120 6/01/24-06/30/24. 3pm and 06/14/24 at 7:03pm, documented not resident being out of facility. Dpm, the gabapentin was administered due to resident 0. 3pm, the gabapentin was administered due to resident 4/4's July 2024 eMAR from at 12:00pm revealed: for gabapentin 600mg 1 ay scheduled at 8:00am, and 8:00pm. s documented as currences out of 38 Dpm, the gabapentin was administered due to resident 1am, the gabapentin was administered due to being an order. dent #4's medications on 44pm revealed: ble pack of gabapentin 2 out of 30 tablets remaining labeled "AM" with instructions	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. Boilbino.		
		HAL011377	B. WING			R-C / 12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
		ASHEVILI	_E, NC 28805			
(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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 34	D 358			
	instructions to take or -There was one bubb 600mg tablets with 9 remaining dispensed	ne tablet four times a day. le pack of gabapentin tablets out of 63 tablets				
	facility's contracted pl 4:11pm revealed: -The pharmacy receiv 02/16/24 for Resident one tablet three times -On 02/16/24, the pha gabapentin 600mg ta -On 03/13/24, the pha gabapentin 600mg ta -On 04/12/24, the pha gabapentin 600mg ta -The pharmacy receiv 05/06/24 for Resident one tablet four times a -On 05/06/24, the pha gabapentin 600mg ta -On 05/14/24, the pha gabapentin 600mg ta	a #4 for gabapentin 600mg a a day. armacy dispensed 83 blets. armacy dispensed 90 blets. armacy dispensed 90 blets. armacy dispensed 90 blets. ared a prescription on a #4 for gabapentin 600mg a day. armacy dispensed 35 blets. armacy dispensed 120				
	gabapentin 600mg tabletsOn 06/12/24, the pharmacy dispensed 120 gabapentin 600mg tablets.					
	revealed: -He was ordered gab: neuropathy pain in his -The neuropathy was his diabetes early in h -Neuropathic pain in h him to walkHe currently received day.	caused by poor control of				

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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		
			A. DUILDING: _		R-	
		HAL011377	B. WING		1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
			E, NC 28805		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 35	D 358			
	he had taken for the later He did not receive gas Interview with Reside Provider (PCP) on 07-Resident #4 was ord neuropathy painIf gabapentin was no	abapentin four times a day. nt #4's Primary Care /11/24 at 11:10am revealed:				
	05/30/24 revealed dia	t #1's current FL2 dated ignoses included dementia, re, polyneuropathy, and				
	a. Review of Resident #1's emergency department (ED) discharge summary dated 06/28/24 revealed: -The resident was seen for the complaint of ear pain. -There was an order for Augmentin (used to treat infection) 875mg-125mg one tablet every 12 hours for seven days to treat left sided ear infection.					
	hours for seven days to treat left sided ear infection. Review of Resident #1's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Augmentin 875mg-125mg one tablet every 12 hours for 7 days scheduled at 8:00am and 8:00pm. -The Augmentin was documented as administered as ordered from 06/28/24 8:00pm to 06/30/24 8:00pm. Review of Resident #1's July 2024 eMAR					

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-There was an entry for Augmentin

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			R-C	
		HAL011377	D: VIIIVO		07	7/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
WILHAM	RIDGE		EA DRIVE LLE, NC 28805				
040.15	QUIMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 36	D 358				
	days scheduled at 8:0 07/01/24-07/05/24 at -The Augmentin was						
	Observation of Resident #1's medications on hand on 07/09/24 at 2:45pm revealed: -There was one bubble pack of 14 Augmentin 875mg-125mg tablets dispensed on 06/28/24. -There were three Augmentin 875mg-125mg tablets in the bubble pack. Review of Resident #1's ED discharge summary dated 07/07/24 revealed: -The resident was seen for the complaint of ear pain. -A differnent antibiotic was prescribed twice daily for 10 days. -A consult with a local ear, nose, and throat provider was recommended.						
	facility's contracted pl 4:18pm revealed: -They received an ord Augmentin 875mg-12 hours for 7 days in th -Resident #1's Augmedelivered to the facilit -The Augmentin shou	25mg one tablet every 12 e evening on 06/28/24. entin was dispensed and					
	(RCC) on 07/10/24 at -She did not know wh Augmentin left over fo	y there were three doses of					

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STATE FORM BK2H11 If continuation sheet 37 of 68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
\A/II A B A F	NDOE	30 DALEA	A DRIVE			
WILHAM F	RIDGE	ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
D 358	Continued From page	e 37	D 358			
D 358	for antibiotics to help not correctly administ -The antibiotics were substances in the me -She was on leave fo 06/21/24-07/08/24 and created for Resident and created for RCC duties were RCC was on leave from the did not know why was documented as a continuous on the eMAR on 07/0 and created and cr	her to keep track of who did er an antibiotic. stored with the controlled dication cart. In two weeks from an account of the would have checked for Augmentin daily. In the would have checked for Augmentin daily. In the initiation of 10/10/24 at the series of the work	D 358			
	"off" when she walked					
	Interview with Reside	nt #1's Primary Care				

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Provider (PCP) on 07/11/24 at 11:10am revealed:

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
,	5. GGT120.TGT.	.52.11.116.11.16.11.16.11.15.11.1	A. BUILDING: _			
		UAL 044277	B. WING			R-C
		HAL011377			077	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓE, ZIP CODE		
WILHAM I	RIDGE	30 DALE				
		ASHEVIL	LE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 38	D 358			
	-She was not aware if the Augmentin ordered ED for an ear infection. She liked to see all conditions administered so the intermediate to the completely cleared. She did not think through the condition would have need another round confection. b. Review of Resident 05/30/24 revealed the	Resident #1 did not complete ed on 06/28/24 at the local n. doses of an antibiotic effection being treated can ed." ee missed doses of the re caused Resident #1 to of antibiotics to clear the ear				
	Review of Resident # revealed an admission	1's Resident Register in date of 04/15/24.				
	revealed: -The facility did not at one week after being -The facility staff told facility's contracted ploxycodone to the facility's contracted ploxycodone to the facility's contracted ploxycodone to the facility staff told her the prior skilled nursingThe staff told her the those medications from the staff told her the medications which did contracted pharmacyShe was prescribed back and legsHer pain was very "the medicationShe was unable to see the staff told not be seen to the staff told ner the medication.	er medications with her from ing facility where she lived. by could not give her any of in the prior facility, but had in to get new prescriptions. by could not administer any id not come from their				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:			SURVEY PLETED	
						₹-C
		HAL011377	B. WING		07	/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATI	E, ZIP CODE		
WILHAM I	RIDGE		A DRIVE			
		ASHEVI	LLE, NC 28805			
(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 HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	2 39	D 358			
	the pain.					
	medication administrative revealed: -There was an entry to tablet every six hours	or oxycodone 10mg one as needed for pain. rences of documented				
	Count Sheet (CSCS) dispensed on 03/28/2 -Administration dates 04/02/24 to 04/17/24 administrations were -There was a balance tablets upon admissic -On 04/16/24 at 6:00 on the CSCS but not administered on the e-On 04/17/24 at 12:00 on the CSCS but not administered on the e-On 04/17/	om, a dose was signed out documented as eMAR. Dam, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR.				
	(RCC) on 07/12/24 at -On Resident #1's CS oxycodone 10mg tab from a prior supply up -She signed out three for Resident #1 on 04/04/17/24 at 12:00am, -Resident #1 "probab	SCS sheet, there were three lets which were available on admission. de doses of oxycodone 10mg le/16/24 at 6:00pm, on and on 04/17/24 at 6:00am. Iy" came with "pills from the y she signed the oxycodone				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM I	RIDGE	30 DALEA	DRIVE E, NC 28805			
	OLIMANA DV. OT		1	DDOUIDEDIO DI AN OF CODDECTIO	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 40	D 358			
	administrations on the -At the time, she did r Resident #1's Primary through use of the tel -She put Resident #1 by the PCP on the PC the facility which was	not know how to contact y Care Provider (PCP) ehealth application. 's name on a list to be seen CP's next scheduled visit to 04/23/24.				
	Telephone interview with Resident #1's PCP on 07/15/24 at 2:31pm revealed: -She was not Resident #1's PCP when the resident was admitted to the facilityResident #1 was currently ordered oxycodone for lower back painThe first time she was made aware Resident #1 needed a prescription for oxycodone was on 04/23/24Resident #1 could experience pain, rebound effects, and possibly go through withdrawal symptoms with an abrupt stop of oxycodone.					
	•	escription for oxycodone for 1/24 and referred her out to a				
	3:24pm revealed: -Oxycodone was a so	e seen by her PCP to get a				
	revealed diagnoses ir	nt #2's FL-2 dated 05/30/24 ncluded diabetes, obstructive pulmonary				
	revealed: -She was admitted to	nt #2 on 07/09/24 at 9:02am the hospital "last week." ecause she had cramping in				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	LETED	
					F	R-C	
		HAL011377	B. WING		07/	12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
14/11 114 84 1	ND OF	30 DALE	A DRIVE				
WILHAM I	RIDGE	ASHEVIL	LE, NC 28805				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE	
D 358	Continued From page	e 41	D 358				
	her right hand.						
	-She was "weak" and	had a "bad heart "					
		the medications she took.					
	Review of Resident #	2's hospital discharge					
	orders dated 07/05/24	4 revealed:					
		the hospital on 07/03/24 for					
		failure and acute kidney					
	injury.	1 1 1 07/05/04					
	-Resident #2's discharge orders dated 07/05/24 included discontinuing lisinopril (used to treat high						
	blood pressure) 20mg						
	biood pressure) zomi	g tablet dally.					
	Review of Resident #	2's July 2024 eMAR					
	revealed:						
	_	or lisinopril 20mg tablet daily					
	at 8:00am.						
	 There was documen administered daily fro 						
	07/09/24 at 8:00am.	iii 07/00/24 tillough					
	-The order was still a	ctive on the eMAR on					
	07/09/24.						
		sident Care Coordinator					
	(RCC) on 07/10/24 at						
	-The medication aide	` ,					
		from the hospital was all administrative staff know					
		orders and sending the					
	orders to the pharma	_					
		t supervisor when Resident					
	#2 returned from the						
		of the discontinuation of					
	-	il since she was not here					
		urned to the facility after her					
	hospitalization.						
	Interview with Reside	nt #2 on 07/10/24 at					
	11:50am revealed:	111 π2 011 01/10/24 at					
		weak since her return to the					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			. .
		HAL011377	B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
	212.05	30 DALE	A DRIVE			
WILHAM	RIDGE	ASHEVII	LLE, NC 28805			
(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 ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	-When her blood pres fatigued and had a ba -She felt bad on 07/0 better. Review of Resident # revealed her blood pr 07/08/24.	d pressure had been e returned to the facility. ssure was low, she felt very ad headache. 8/24 but was feeling some				
	07/11/24 at 10:53am -She had not been not order for Resident #2 -She was not notified pressure of 98/57 on -The blood pressure of r Resident #2.	revealed: otified about the discharge 's lisinopril. of Resident #2's blood				
	07/11/24 at 11:16am -He was working whe the hospital on 07/05 -There was a MA who that was responsible when she returned fre -He placed the hospit Resident #2 on the R -He assumed the hos discharge orders for contracted pharmacy Interviews with the Ad 10:51am and 07/12/2 -The MA who was res	en Resident #2 returned from /24. by was from a staffing agency for Resident #2's orders from the hospital on 07/05/24. cal discharge orders for CC's desk on 07/05/24. spital faxed the hospital Resident #2 to the facility's				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL011377	B. WING		07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE	
WILHAM I	RINGE	30 DALEA	DRIVE		
VVIETI/AIII I		ASHEVILL	E, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	directly to the pharmadischarge orders to the pharmacy. -He was responsible when she was absentable absentable. The hospital discharge resident #2 were noted. The MA on duty where the facility should have discharge orders directly given the orders to a pharmacy. The facility failed to enadministered as orderesidents including a administered a medic pressure when his blood pressure when his blood pressure when (#4). The facility failed medication to a reside to obtain a prescription resident at risk for path The facility failed to define the medication resulting in and having a headaction.	the hospital discharge orders acy or gave the hospital the RCC to scan them to the sto complete the RCC duties at from the facility. The ge orders dated 07/05/24 for a scanned to the pharmacy. The facility are faxed the hospital country to the pharmacy or supervisor to send to the supervisor to send to the scanned to the supervisor to send to the supervisor to send to the supervisor to send to the scanned to lower his blood pressure was below the dop the PCP (#4) and failed cation to raise the resident's the blood pressure was low	D 358		
	for serious physical h constitutes a Type A2 The facility provided a	arm to the residents and			
D 367	10A NCAC 13F .1004 Administration	4(j) Medication	D 367		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING		R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA	DRIVE			
***************************************		ASHEVILL	E, NC 28805			
(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 APPROPF DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 44	D 367			
	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justifical medications or treatmedocumenting the result (6) date and time of a (7) documentation of medications or treatmomission, including reason (8) name or initials of the medication or treasignature equivalent the documented and main administration record. This Rule is not met Based on observation reviews, the facility face	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 nationed with the medication (MAR). as evidenced by: as, interviews, and record illed to ensure the accuracy				
	of the electronic medication administration record (eMAR) for 1 of 6 sampled residents (#2) related to documentation of administration of insulin (an injectable medication used to help control blood sugar levels).					
	The findings are: Review of Resident #2's current FL-2 dated 05/30/24 revealed diagnoses included diabetes and obesity.					
	Review of Resident # 05/30/24 revealed:	2's physician's orders dated				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SU COMPLE		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLE	ILED	
						R-C	
		HAL011377	B. WING		07/12	2/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
14/11 114 84 1	ND OF	30 DALEA	A DRIVE				
WILHAM I	RIDGE	ASHEVIL	LE, NC 28805				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLETE DATE	
D 367	Continued From page	e 45	D 367				
	-An order for lispro (a	short acting insulin) inject 8					
	units subcutaneous (s						
	,	ject 12 units sub-q at lunch					
	and dinner.	· ·					
	-An order for lispro inj	ect sub-q as directed per					
		SSI) before meals and at					
		k blood sugars (FSBS): less					
		and initiate hypoglycemia					
		0 administer 0 units, 250 to					
		s, 300-350 administer 6 0 administer 8 units, and					
	greater than 500 notif	•					
	greater than 500 noth	y priysician.					
	Review of Resident #	2's June 2024 electronic					
	medication administra	ation record (eMAR)					
	revealed:						
	_	or lispro (a short acting					
	, .	subcutaneous (sub-q) at					
	breakfast	ar lianza inicat aub a ca					
		or lispro inject sub-q as re meals and at bedtime for					
	•	ars (FSBS): less than 100					
		te hypoglycemia protocol,					
		ster 0 units, 250 to 299					
		0-350 administer 6 units,					
		inister 8 units, and greater					
	than 500 notify physic						
		or lispro inject 12 units					
	sub-q at lunch and dir						
		tation staff administered SSI					
	•	0/24 at 8:00am for blood					
	glucose level of 129.	totion staff administrated CCI					
		tation staff administered SSI					
	glucose level of 326.	10/24 at 5:00pm for blood					
		tation staff administered SSI					
		11/24 at 12:00pm for blood					
	glucose level of 208.						
		tation staff administered SSI					
		11/24 at 5:00pm for blood					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL011377	B. WING		1	/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALE				
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	LE, NC 28805	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 46	D 367			
	glucose level of 240.					
	sub-q at lunch and dir -There was an entry f directed per SSI befo fingerstick blood suga hold insulin and initial less than 250 adminis administer 4 units, 30 greater than 350 adm than 500 notify physic -There was an entry f at breakfast. -There was document	for lispro inject 12 units nner. for lispro inject sub-q as re meals and at bedtime for ars (FSBS): less than 100 te hypoglycemia protocol, ster 0 units, 250 to 299 to 350 administer 6 units, and greater				
	insulin togetherShe did not have trai 2024 and did not real to documentThe SSI and schedu correctly but documel occasions on 06/10/2 06/11/24. Telephone interview v 07/10/24 at 10:13am -He did receive trainir documenting the SSI togetherHe documented 8 ur	evealed: e SSI and the scheduled ining until sometime in June ize this was an incorrect way led insulin had been given inted incorrectly on two 4 and two occasions on with a second MA on revealed: ing related to not and scheduled insulin				

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incorrect.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-	C
		HAL011377	B. WING		1	2/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA				
	OUNTARY OF		E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	÷ 47	D 367			
	-The 8 units of lispro of scheduled morning do	documented was for the ose of lispro.				
	10:51am and 07/12/2 -All MAs received dial -The training included documentation of insuThere was a new MA his training document incorrectlyThe MAs should have the correct doses give	ulin on the eMAR. A who had not yet received ed administering SSI lispro e accurately documented en for SSI lispro on the we not documented the				
D 392	10A NCAC 13F .1008	(a) Controlled Substances	D 392			
	10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.					
	This Rule is not met a TYPE B VIOLATION	as evidenced by:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		D.O.
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILHAM I	RIDGE	30 DALEA			
	_	ASHEVILL	E, NC 28805		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 392	Continued From page	e 48	D 392		
	The findings are:				
	controlled substances -The record of docum resident's record (exa drug sign-out record)Documentation of re substance by the pha 1. Review of Residen 05/30/24 revealed dia congestive heart failu dysphagia.				
	revealed an admissio	<u> </u>			
		ycodone 10mg one tablet			
	Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 2:24pm revealed: -Resident #1 was admitted from another facilityResident #1 came with oxycodone from another facility.				
	facility's contracted pl 11:58am regarding R 10mg one tablet ever revealed: -The pharmacy provid Count Sheet (CSCS) to be used to docume inventory control. -On 04/23/24, oxycoo for a quantity of 56 ta	with a pharmacist at the harmacy on 07/09/24 at esident #1's oxycodone y six hours as needed ded a Controlled Substance for each quantity dispensed ent the administration for lone 10mg was dispensed blets.			

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STATE FORM BK2H11 If continuation sheet 49 of 68

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		
		HAL011377	B. WING		l l	R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
10/// 11 0 0//	DIDOE	30 DALE	A DRIVE			
WILHAM	RIDGE	ASHEVII	LLE, NC 28805			
(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 392	Continued From page	e 49	D 392			
	for a quantity of 28 ta -On 06/03/24, oxycood for a quantity of 12 ta -On 06/10/24, oxycood for a quantity of 40 ta -On 06/27/24, oxycood for a quantity of 40 ta -On 06/27/24, oxycood for a quantity of 40 ta Review of Resident # Count Sheet (CSCS) dispensed on 03/28/2 -Administration dates 04/02/24 to 04/17/24 administrations were -There was a balance	blets. done 10mg was dispensed blets. done 10mg was dispensed blets. done 10mg was dispensed				
	-On 04/16/24 at 6:00p on the CSCS but not administered on the 6 -On 04/17/24 at 12:00 on the CSCS but not administered on the 6	om, a dose was signed out documented as eMAR. Dam, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR.				
	10mg tablets dispens 30 revealed: -Administration dates 04/23/24-05/06/24On 04/23/24 at 6:00g on the CSCS but not administered on the 6-On 04/24/24 at 8:00g on the CSCS but not administered on the 6-dadministered on the 6-dadm	eMAR. am, a dose was signed out documented as eMAR. om, a dose was signed out documented as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE ZIR CODE	
		30 DALEA	, ,	, 2 3332	
WILHAM I	RIDGE		LE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 392	2 Continued From page 50		D 392		
	-On 04/25/24 at 12:00 on the CSCS but not administered on the e-On 04/25/24 at 7:00 on the CSCS but not administered on the e-On 04/27/24 at 7:00 on the CSCS but not administered on the e-On 04/28/24 at 12:00 on the CSCS but not administered on the e-On 04/28/24 at 2:00 on the CSCS but not administered on the e-On 04/29/24 at 8:00 on the CSCS but not administered on the e-On 04/30/24 at 6:31 on the CSCS but not administered on the e-On 04/31/24 at 12:00 on the CSCS but not administered on the e-On 05/02/24 at 3:31 on the CSCS but not administered on the e-On 05/04/24 at 9:00 on the CSCS but not administered on the e-On 05/05/24 at 6:00 on the CSCS but not administered on th	Opm, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. Opm, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. om, a dose was signed out documented as eMAR. om, a dose was signed out documented as eMAR. Opm, a dose was signed out documented as eMAR. Opm, a dose was signed out documented as eMAR. Opm, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR.			
	Review of the pharma Resident #1's oxycod 56 dated 04/23/24 rev documented signatur	one 10mg tablets quantity vealed there was no			

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received the medication from the pharmacy.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _	A. BUILDING:	
		HAL011377	B. WING		R-C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
WILHAM	RINGE	30 DALEA	DRIVE		
WILLIAM	(IDOL	ASHEVIL	LE, NC 28805		
(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
D 392	Continued From page	÷ 51	D 392		
D 392	Review of Resident # medication administration revealed: -There was an entry fit tablet every six hours -There were 12 occur administrations of oxy 04/24/24-04/30/24. Review of Resident # 10mg tablets dispense 26 revealed: -Administration dates 05/06/24-05/17/24On 05/06/24 at 6:00a on the CSCS but not administered on the e-On 05/07/24 at 8:00a on the CSCS but not administered on the e-On 05/07/24 at 4:21 dose was signed out of documented as administered on the as administered on the as administered on the on 05/07/24 (no spewas signed out on the as administered on the on 05/08/24 at 9:23 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the on 05/14/24 at 12:05 dose was signed out of documented as administered on the of the other of the	ation record (eMAR) or oxycodone 10mg one as needed for pain. rences of documented redone 10mg from 1's CSCS for oxycodone ed on 04/23/24 quantity of on the CSCS included am, a dose was signed out documented as and a dose was signed out documented on the eMAR. (no specific time of day), a dose a CSCS but not documented as e eMAR. (no specific time of day), a on the CSCS but not nistered on the eMAR. (no specific time of day), a on the CSCS but not nistered on the eMAR. (no specific time of day), a on the CSCS but not nistered on the eMAR. (on the CSCS but not nistered on the eMAR. (on the CSCS but not nistered on the eMAR. (on the CSCS but not nistered on the eMAR. (on the CSCS but not nistered on the eMAR. (on the CSCS but not nistered on the eMAR. (on the cSCS but not nistered on the eMAR. (on the cSCS but not nistered on the eMAR.	D 392		
		one 10mg tablets quantity vealed the medication was			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	ובט
					R-0	С
		HAL011377	B. WING		07/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM I	DIDCE	30 DALEA	DRIVE			
VVILHAIVII	RIDGE	ASHEVIL	LE, NC 28805			
(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	(X5) COMPLETE DATE
D 392	92 Continued From page 52		D 392			
	10mg tablets dispens 28 revealed: -There were two CSC -One CSCS had a ph one administration da leaving a count of 27 -All of the information CSCS label was hand count was 18 tablets -Administration dates included 05/22/24-05 -On 05/29/24, a dose	provided on the second dwritten and the starting on the second CSCS				
	Review of Resident #1's May 2024 eMAR revealed: -There was an entry for oxycodone 10mg one tablet every six hours as needed for pain. -There were 50 occurrences of documented administrations of oxycodone 10mg from 05/01/24-05/31/24. Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 06/03/24 quantity of 12 revealed: -Administration dates on the CSCS included 06/03/24-06/09/24. -On 06/03/24 at 8:30pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 06/04/24 at 3:36 (no specific time) a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 06/04/24 at 4:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	• • • • • • • • • • • • • • • • • • • •	EA DRIVE			
	I		LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	on the CSCS but not administered on the CSCS but not administered on the CON 06/07/24 at 7:30 on the CSCS but not administered on the CSCS but not administeration dates 06/10/24-06/29/24. On 06/12/24 at 1:30 on the CSCS but not administered in the CSCS but not administered on the CSCS but not administered on the CSCS but not administered in the CSCS but not ad	documented as eMAR. pm, a dose was signed out documented as eMAR. am, a dose was signed out documented as eMAR. #1's CSCS for oxycodone sed on 06/10/24 quantity of son the CSCS included am, a dose was signed out documented as eMAR. acy delivery sheet for done 10mg tablets quantity evaled there was no re of the facility staff who ion from the pharmacy. #1's June 2024 eMAR for oxycodone 10mg one is as needed for pain. rrences of documented ycodone 10mg from acy delivery sheet for done 10mg from acy delivery sheet for done 10mg from acy delivery sheet for done 10mg tablets dispensed of 40 revealed there was not re of the facility staff who ion from the pharmacy.	D 392			
		#1's CSCS for oxycodone sed 06/27/24 quantity of 20				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D.C.	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM I	RIDGE	30 DALEA				
			E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	e 54	D 392			
	revealed administration	on dates on the CSCS /07/24.				
	Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed 06/27/24 quantity of 20 revealed one administration date of 07/08/24 at 3:05pm with a count of 19 remaining. Review of Resident #1's July 2024 eMAR from 07/01/24 to 07/10/24 revealed: -There was an entry for oxycodone 10mg one tablet every six hours as needed for painThere were 18 occurrences of documented administrations of oxycodone 10mg.					
		nented administration of				
		ent #1's oxycodone 10mg t 2:45pm revealed there able.				
		nt #1 on 07/09/24 at 3:28pm d one tablet of oxycodone nt on 07/08/24.				
	3:45pm revealed:	ministrator on 07/12/24 at				
	went missing from Redelivery of 28 tablets.					
	the RCC and the Adm					
	oxycodone.	nacy about the missing				
	•	ntrolled substances and did				
	Refer to the interview on 07/09/24 at 3:05pr	with a medication aide (MA) m.				

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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		
			7. BOILBING.			
		HAL011377	B. WING	B. WING		2/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA	DRIVE			
WILLIAM		ASHEVILL	E, NC 28805			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	÷ 55	D 392			
	Refer to the interview at 8:34am.	with the RCC on 07/10/24				
	Refer to the interview 07/10/24 at 10:52am.	with the Administrator on				
	Refer to the interview 07/12/24 at 3:24pm.	with the Administrator on				
	b. Review of Resident #1's current FL2 dated 05/30/24 revealed Fiorinal (used to treat					
		40mg one capsule every d for headaches/migraine.				
	pharmacy on 07/09/2 Resident #1's Fiorinal every eight hours as I -The pharmacy provide	led Controlled Substance				
	,	for each quantity dispensed ent the administration for I was dispensed for a				
	quantity of 12 capsule -On 04/30/24, Fiorina quantity of 30 capsule	l was dispensed for a es.				
	-On 05/14/24, Fiorina quantity of 30 capsule -On 05/30/24, Fiorina	es.				
	quantity of 20 capsule -On 05/31/24, Fiorina quantity of 10 capsule	l was dispensed for a				
	-On 06/17/24, Fiorina quantity of 15 capsule	l was dispensed for a es.				
	-On 06/25/24, Fiorina quantity of 15 capsule -On 07/02/24, Fiorina quantity of 15 capsule	es. I was dispensed for a				

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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	
	HAL011377 B. WING		R-C 07/12/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WILHAM F	RIDGE	30 DALEA			
		ASHEVILL	E, NC 28805		
(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 COMPLETE
D 392	Continued From page	÷ 56	D 392		
D 392	Review of the pharma Resident #1's Fiorinal 04/16/24 quantity of 1-There was no docum facility staff who receipharmacy. -The quantity of 12 was "on order" was handw Review of Resident #50-325-40mg capsule quantity of 12 reveale -Administration dates 04/22/24-04/30/24. -On 04/22/24 at 8:00p on the CSCS but not administered on the electron -On 04/22/24 at 7:00p on the CSCS but not administered on the electron 04/23/24 at 2:00p on the CSCS but not administered on the electron 04/24/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/30/24 at 6:00p on the CSCS but not administered on the electron 04/24/24 at 6:00p on the CSCS but not administered on the electron 04/24/24 at 6:00p on the CSCS but not administered on the electron 04/24/24 at 6:00p on the CSCS but not administered on the electron 04/24/24 at 6:00p on the	acy delivery sheet for a capsules dispensed on 2 revealed: nented signature of the ved the medication from the ved through in and vritten beside capsules. 1's CSCS for Fiorinal as dispensed on 04/16/24 and: on the CSCS included on, a dose was signed out documented as and a documented as and a dose was signed out documented as and a dose was signed out documented as and a dose was signed out documented as and a dose was a documented as a documented a	D 392		
	administrations of Fio 04/23/24-04/27/24.				

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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	
			A. BUILDING	A. Boilding.		_
		HAL011377	B. WING		l l	-C 12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
WILHAM	RIDGE	30 DALE	A DRIVE			
WILLIAM	(IDOL	ASHEVII	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 57	D 392			
	Review of Resident#	1's CSCS for Fiorinal				
		es revealed there was no				
	CSCS for quantity 30	dispensed on 04/30/24.				
	D i £ 44 b					
	Review of the pharma	cy delivery sneet for I capsules dispensed on				
		80 revealed there was no				
		e of the facility staff who				
	received the medicati	on from the pharmacy.				
	Review of Resident #	1's CSCS for Fiorinal				
		es dispensed on 05/14/24				
	quantity of 30 reveale	•				
	-Administration dates 05/15/24-05/29/24.	on the CSCS included				
	-On 05/19/24 at 6:00p on the CSCS but not	om, a dose was signed out documented as				
	administered on the e	eMAR.				
		am, a dose was signed out				
	on the CSCS but not administered on the e					
	administered on the e	EWAK.				
	Review of Resident # revealed:	1's May 2024 eMAR				
	-There was an entry f	or Fiorinal one capsule				
		needed for headaches.				
		rences of documented				
	administrations of Fio 05/01/24-05/31/24.	rinai from				
	00/01/24-00/01/24.					
	Review of the pharma	-				
		capsules dispensed on				
		20 revealed there was no				
		e of the facility staff who on from the pharmacy.				
		•				
	Review of Resident #					
		es dispensed on 05/30/24				
	quantity of 20 reveale -Administration dates	on the CSCS included				

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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
			P MINC		R-C
		HAL011377	B. WING		07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	NOVIDEN ON OUT LIEN			12, 211 0002	
WILHAM I	RIDGE	30 DALE			
		ASHEVIL	LE, NC 28805		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 392	Continued From page	. E0	D 392		
D 392	Continued From page	30	D 392		
	05/30/24-06/19/24.				
		(no specific time), a dose			
		e CSCS but not documented			
	as administered on th				
		om, a dose was signed out			
	on the CSCS but not				
	administered on the				
		(no specific time) and no			
		was signed out on the			
	CSCS but not docum	ented as administered on			
	the eMAR.				
	-On 06/03/24 at 2:30a	am, a dose was signed out			
	on the CSCS but not	documented as			
	administered on the e	MAR.			
	-On 06/03/24 at 3:36	(no specific time), a dose			
		e CSCS but not documented			
	as administered on th				
		am, a dose was signed out			
	on the CSCS but not				
	administered on the				
		om, a dose was signed out			
	on the CSCS but not				
	administered on the e	eMAR.			
	Review of Resident #	1's CSCS for Fiorinal			
	50-325-40mg capsule	es dispensed on 05/31/24			
	quantity of 10 reveale	ed:			
	-Administration dates	on the CSCS included			
	06/12/24-06/19/24.				
		(no specific time), a dose			
		e CSCS but not documented			
	as administered on th				
	ao administra di ti	io own u.			
	Povious of Posidors #	the CSCS for Eigring!			
	Review of Resident #				
		es dispensed on 06/17/24			
	quantity of 15 reveale				
		on the CSCS included			
	06/18/24-06/24/24.				
	-On 06/24/24 at 12:30	Dam, a dose was signed out			

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on the CSCS but not documented as

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING:	A. BUILDING:		LETED
		HAL011377	B. WING		l l	R-C / 12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
WILHAM I	RIDGE		EA DRIVE LLE, NC 28805			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 59	D 392			
	administered on the	eMAR.				
	06/25/24 quantity of documented signatur	acy delivery sheet for I capsules dispensed on I5 revealed there was no e of the facility staff who ion from the pharmacy.				
	every eight hours as	for Fiorinal one capsule needed for headaches. rrences of documented				
		es dispensed on 06/25/24 ed administration dates on				
	50-325-40mg capsule quantity of 15 reveale -Administration dates 07/03/24-07/08/24.	on the CSCS included d administration date was				
	every eight hours as -There were 18 occur administrations of Fio 07/01/24-07/07/24.	for Fiorinal one capsule needed for headaches. rrences of documented orinal from				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		5.0	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILHAM I	RIDGE	30 DALEA ASHEVILL	DRIVE E, NC 28805			
(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 COMPLETE	
D 392	Continued From page	e 60	D 392			
	revealed there was or	ne capsule available.				
	Interview with Resident #1 on 07/09/24 at 3:28pm revealed she received one tablet of Fiorinal around midnight on 07/08/24. Refer to the interview with a MA on 07/09/24 at 3:05pm. Refer to the interview with the Resident Care Coordinator (RCC) on 07/10/24 at 8:34am. Refer to the interview with the Administrator on 07/10/24 at 10:52am. Refer to the interview with the Administrator on 07/12/24 at 3:24pm. 2. Review of Resident #6's current FL2 dated 04/24/24 revealed diagnoses included Alzheimer's disease, dementia with mood disturbance, benign prostatic hyperplasia, and chronic conjunctivitis. a. Review of Resident #6's current FL2 revealed lorazepam (used to treat anxiety) 1mg one tablet every four hours as needed for agitation.					
	1mg tablets dispense revealed: -Administration dates 04/07/24-07/02/24. -On 04/07/24 at 6:00p	6's CSCS for lorazepam d on 03/25/24 quantity of 20 on the CSCS included om, a dose was signed out				
	on the CSCS but not documented as administered on the eMAR. -On 05/03/24 at 8:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -The documented count on the CSCS was 16.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		R-C	
		HAL011377	B. WING		07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALEA	DRIVE			
WILLIAM	NDGL	ASHEVILL	E, NC 28805			
(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 COMPLETE	
D 392	Continued From page	e 61	D 392			
	medication administratevealed: -There was an entry fitablet every four hour agitation/anxietyLorazepam 1mg was administered 0 occur 04/01/24-04/30/24. Review of Resident # revealed: -There was an entry fitablet every four hour agitation/anxietyLorazepam 1mg was administered 1 occur 05/01/24-05/31/24. Review of Resident # revealed: -There was an entry fitablet every four hour	for lorazepam 1mg take one is as needed for a documented as rences on the eMAR from 6's May 2024 eMAR for lorazepam 1mg take one is as needed for a documented as rence on the eMAR from 6's June 2024 eMAR for lorazepam 1mg take one				
	agitation/anxietyLorazepam 1mg was documented as administered 0 occurrences on the eMAR from 06/01/24-06/30/24.					
	tablet every four hour agitation/anxietyLorazepam 1mg was administered 1 occurs 07/01/24-07/11/24.	for lorazepam 1mg take one is as needed for is documented as rence on the eMAR from				
Observation of Resident #6's lorazepam 1mg tablets on 07/11/24 at 3:09pm revealed there						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		00 22.120	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WILHAM I	RIDGE	30 DALEA				
	T		LE, NC 28805			
(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 APPROVIDENCE)	D BE COMPLETE	
D 392	Continued From page	e 62	D 392			
	were 16 tablets.					
	at 10:04am revealed: -When administering would reference the emedicationShe would then documented the curred medication out, the number of the following medication out, the number of the curred linterview with the Result (RCC) on 07/12/24 at 1-The MA who signed the CSCS on 05/03/2 facilityThe facility had two pharmacy cart audits	a controlled substance, she eMAR to prepare the ument the CSCS with her me she was signing the umber given, and ent count. sident Care Coordinator t 2:24pm revealed: out the lorazepam dose on 4 no longer worked at the				
	Refer to the interview with the Administrator on 07/12/24 at 3:24pm. b. Review of Resident #6's current FL2 revealed morphine 100mg/5ml 0.25ml (5mg) every four hours as needed (used to treat pain).					
	100mg/5ml 20mg/ml of 30ml revealed: -Administration dates 04/04/24-07/08/24On 04/07/24 at 6:00p on the CSCS but not administered on the 6	eMAR. am, a dose was signed out documented as				

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		0.20.000		Tares = =		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING:	A. BUILDING:		COMPLETED	
					R-C	
	HAL011377		B. WING		1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
WILHAM F	RIDGE	30 DALE				
		ASHEVIL	LE, NC 28805			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL	5/112
D 392	Continued From page	e 63	D 392			
	Review of Resident #	6's April 2024 electronic				
	medication administra	-				
	revealed:	, ,				
	-There was an entry f	for morphine 100mg/5ml				
	0.25ml (5mg) every for	our hours as needed.				
	-Morphine 5mg was o	documented as administered				
	1 occurrence on the	eMAR from				
	04/01/24-04/30/24.					
	Review of Resident #	6's May 2024 eMAR				
	revealed:					
		for morphine 100mg/5ml				
	0.25ml (5mg) every for	documented as administered				
	3 occurrences on the					
	05/01/24-05/31/24.	EWAR HOIT				
	03/01/24-03/31/24.					
	Review of Resident #	6's June 2024 eMAR				
	revealed:					
	-There was an entry f	or morphine 100mg/5ml				
	0.25ml (5mg) every for					
	-Morphine 5mg was o	documented as administered				
	0 occurrences on the	eMAR from				
	06/01/24-06/30/24.					
	Review of Resident #	்s July 2024 eMAR				
	revealed:	ion manufacture 400				
		for morphine 100mg/5ml				
	0.25ml (5mg) every for	our nours as needed. locumented as administered				
	3 occurrences on the					
	07/01/24-07/11/24.	CIVICITY IIOITI				
	01/01/2 1 -01/11/2 1 .					
	Interview with Reside	nt #6 on 07/11/24 at 2:55pm				
		denied having any pain at				
	that time.	J , 1,				
	Interview with a medi	cation aide (MA) on 07/11/24				
	at 10:04am revealed:	, ,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN (OF CORRECTION	RECTION IDENTIFICATION NUMBER: A. BUILDING:		COMPLETED				
		HAL011377	B. WING		R-C 07/12/2024			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE				
VAZIL LLA BALI	WILHAM RIDGE 30 DALEA DRIVE							
WILHAM	RIDGE	ASHEVILL	.E, NC 28805					
(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 392	Continued From page	e 64	D 392					
	-When administering would reference the emedicationShe would then docuname, the date and timedication out, the nedocumented the current	a controlled substance, she MAR to prepare the ument the CSCS with her me she was signing the umber given, and ent count.						
	Refer to the interview with the Administrator on 07/12/24 at 3:24pm.							
	and responsibility of the Resident #1's medical responsibility of the Resident #1's medical responsibility and the night shift of the control and confirm matching before she took possible keys that morning. The night shift MA responsible of the responsibility of the night signed off yet as a Markeys to the medication. The night shift MA to medications on night	evealed: am, she accepted the keys he medication cart where tions were stored. ift (8:00pm to 8:00am) MA trolled substances together counts on the CSCS's ession of the medication cart of used to count the cart with t shift MA said she was not A. by the night shift MA had the n cart in her possession. Id her she did not pass any						
	revealed: -The night shift MA or 8:00pm-8:00amThe night shift MA ca 07/08/24 and explaine to the eMAR were no -The night shift MA di credentials were not were not to the shift was the company of the night shift MA di credentials were not were not to the shift MA di credentials were not the shift MA di credent	n 07/09/24 worked alled her during the night on ed that her login credentials t working. d not figure out her eMAR working until she had sident #1's as needed pain						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL011377		B. WING		R-C 07/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE	30 DALE ASHEVIL	A DRIVE .LE, NC 28805			
(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 392	Continued From page		D 392			
	administration of the cashe told the MA not as needed medication out the following more arrived to work. She had written up be the day shift MA up for substances prior to training the substances ended or linear with the Adra 10:52am revealed the training to count the cashe with the onco linear with the Adra 3:24pm revealed: The MAs documented did not violate facility The facility policy state could be documented eMAR.	60 days to be able to pass in 07/10/24. ministration on 07/10/24 at a MAs had all received controlled substances and substance counts at shift ming staff. ministrator on 07/12/24 at at tion on the CSCS sheets policy. ted controlled substances on the CSCS sheet or the				
	reconcile controlled s of 12 missing oxycod This failure was detrir	ccurately document and ubstances resulting in a total one tablets (Resident #1). mental to the health, safety, sidents and constitutes a				
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/24 for this violation.					
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 26.					

2024.
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANC	A. BUILDING:					
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01/12/202	
		30 DALEA		,		
WILHAM F	RIDGE	ASHEVILLE	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	X5) MPLETE MATE
D 613	Control Policies & Production 10A NCAC 13F .1801 PREVENTION AND OPROCEDURES (d) In accordance with Subchapter and G.S. shall ensure all staff a hire and annually on a listed in Subparagraphis Rule. This Rule is not met Based on interviews a facility failed to ensure state approved infection completed for 1 of 4 state approved infection 20 days of hire. The findings are: Review of Staff F's filling the review of Staff F's filling the review as no document of the review of Staff F's filling the review of	INFECTION CONTROL POLICIES AND th Rule .1211 of this 131D-4.4A(b)(4), the facility are trained within 30 days of the policies and procedures ths (b)(1) through (b)(2) of as evidenced by: and record reviews, the te the mandatory annual tion control training was to sampled staff (Staff F) within the revealed: the revealed: the revealed: the con-Call Supervisor for the the mentation a mandatory definition in the date of the mentation a mandatory definition in the control training	D 613			
	Interview with Staff F revealed:	on 07/12/24 at 10:16am at the facility in September				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					R-C	;
HAL011377		B. WING		07/12	/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ILE, ZIP CODE		
\A/II LI A B/I F	DIDCE	30 DALEA	DRIVE			
WILHAM F	RIDGE	ASHEVILL	E, NC 28805			
0/10/15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S BLAN OF CORRECTION		0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,		DEFICIENCY)		
D 613	Continued From page	e 67	D 613			
	Cha waa birad ta fill i	in an the On Call Commission				
		n as the On-Call Supervisor				
	when needed at night					
		er completing infection				
	control training within	30 days of hire with the				
	previous Executive D	irector (ED).				
		•				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 07/12/24 at	9:25am revealed				
		they did not have infection				
	control training on file					
	•					
	· · · · · · · · · · · · · · · · · · ·	vorking when the RCC				
	came to the facility.					
	-She never thought about checking to see if Staff					
	F had infection control training on file.					
	-She was still in training and would not have					
	known what to look for	or with Staff F because she				
	was a registered nurs	e (RN).				
	_	Staff F was hired would have				
	been responsible for making sure paperwork was					
	completed.					
		07/40/04				
	Interview with Adminis					
	10:54am and 3:34pm					
	-His expectation was	the infection control training				
	should be completed	within 30 days of hire.				
	-He was not sure why	Staff F did not have				
	infection control traini					
		as hired before he came to				
	the facility.	as imparations no dame to				
		ty in July 2022 and the				
		ty in July 2023 and the				
	contract was signed by Staff F on 09/15/23. -They did not keep a personnel file on Staff F					
	because she was "on	call" and did not work on a				
	shift.					
	-It would have been th	ne responsibility of the				
		re infection control trainings				
	were completed within					
	word dompleted within	11 00 days of fillo.				
			1			

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