VISION OF HEALTH SERVICE REGINATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL011377		B. WING		R-0 07/12	, 2/2024
AME OF PROVIDER OR SUPPLIER	30 DALE	DDRESS, CITY, STAT A DRIVE LLE, NC 28805	re, zip code		
(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 000 Initial Comments		D 000			
	nsure Section conducted a decomplaint investigation from 7/12/24.				
 (a) Each staff perso (7) have a criminal in accordance with available in the stat This Rule is not m Based on record re facility failed to ens F) had a criminal b upon hire. The findings are: Review of Staff F's file revealed: There was no door -She was hired as facility. There was no door background check Interview with Staff revealed: She started worki or October of 2022 -She was hired as needed at night. She signed a cor 	07 Other Staff Qualifications on at an adult care home shall: background check completed G.S. 131D-40 and results if person's personnel file; et as evidenced by: eviews and interviews, the surve 1 of 4 sampled staff (Staff ackground check completed a, on-call supervisor, personnel sumentation of a hire date. the on-call supervisor for the sumentation a criminal was completed upon hire. if F on 07/12/24 at 10:16am ing at the facility in September	D 139	All Staff, curre and future, wh undergo comprete audit to ensure compliance. Pres staff will be regardless of contrat take of ensure compra To be performed facility Managemen facility Managemen prior to new he date and then checics performed ongoing basis.	nousive nous screen der to nee. by nt kau re Storr	

Reviewed + acknowledged and 08/29/24

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		SURVEY	
NU PLAN O	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		HAL011377	B. WING			R-C 07/12/2024	
AME OF PF	NOVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE			
		30 DALI	EA DRIVE				
VILHAM P	RIDGE	ASHEVI	LLE, NC 28805				
(X4) ID		TATEMENT OF DEFICIENCIES	ai	PROVIDER'S PLAN O		(X5) COMPLET	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE	
			0.400				
D 139	Continued From page	je 1	D 139				
		the former ED completed a					
(criminal background	check for her.					
	Interview with the Re	esident Care Coordinator					
	(RCC) on 07/12/24 a						
		hy there was not a criminal					
	background check o	working when the RCC					
	came to the facility.	working when the rece					
		about checking to see if Staff					
		kground check on file.					
		ning and would not have					
		for with Staff F because she					
	was a registered nu	• •					
		Staff F was hired would have r making sure paperwork was					
	completed.	плакия эле рарстион was					
		dministrator on 07/12/24 at					
	10:54am and 3:34p						
		e to complete the criminal for new employees upon hire.					
		ny Staff F did not have a					
	criminal background						
	-	was hired before he came to					
	the facility.						
		four owner's of the facility in					
	was signed by Staff	ontract for on-call Supervisor				1	
		a personnel file because she					
		d not work on a shift.					
	-At the time Staff F	was hired, it was the					
	· · ·	former Administrator to				Ì	
	completed upon hir	kground checks were e.					
U 140	10A NCAC 13F .04 Qualifications	ur(a)(8) Other Staff	D 140				
	Quanneations						

BK2H11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
	001112011017		A. BUILDING:			-
		HAL011377	B. WING		R-0 07/12	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		30 DALE	A DRIVE			
VILHAM I	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLE DATE
D 140	Continued From pag	je 2	D 140			
	 (a) Each staff person (8) have an examination presence of controller accordance with G.S. 	7 Other Staff Qualifications n at an adult care home shall: ation and screening for the ed substances completed in 5, 131D-45 and results person's personnel file;		HII staff, rurre and fasture, u undergo completen and to ensure compliance for c	sine	8/2
	facility failed to ensu examination and scr	and record reviews, the ire documentation of an reening for the presence of es was completed for 1 of 4		Staff will be s Braff will be s Regardless of re Control take or	scaldes cult recto	1
	file revealed: -There was no docu -She was hired as th facility.	on-call supervisor, personnel mentation of a hire date, ne On-Call Supervisor for the mentation a drug screening n hire.		To be performed factily managem team pror to here stort date then monthly c performed on an	1 by new and tecks	
	revealed: -She started workin 2023 or October of -She was hired to a when needed at nig -She remembered h	s the On-Call Supervisor		performed on au basis.	1 Ongain	7
	(RCC) on 07/12/24 -She did not know v screening on file for	esident Care Coordinator at 9:25am revealed: why there was not a drug r Staff F. y working when the RCC				

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If continuation sheet -3 of 68

 Division of Health	Service	Regulation	
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	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	
					R	к-С
		HAL011377	B. WING		07/	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	E, ZIP CODE		
	RIDGE		A DRIVE			
			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULO BE	(X5) COMPLET DATE
D 140	Continued From page	ə 3	D 140			
	came to the facility.					
		bout checking to see if Staff				
	F had a drug screeni	na on file.				
		ng and would not have				
	known what to look for	or with Staff F because she				
	was a registered nurs	se (RN).				
		Staff F was hired would have				
	been responsible for	making sure paperwork was				
	completed.					
	Interview with Admini	strator on 07/12/24 at				
	10:54am and 3:34pm					
	-He was responsible					
-	screenings for new er	nployees upon hire.				
		Staff F did not have a drug				
Í	screen completed.					
		as hired before he came to				
ŀ	the facility.	our owners of the facility in				
	July 2023 and the cor	ntract was signed by Staff F				
ļ	on 09/15/23.	and the signed by other r	i i			
	-Staff F did not have a	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				
	responsibility of the for	rmer Administrator to				
1	hire.	gs were completed upon				
D 218	10A NCAC 13E.0605	(g) Staffing Of Personal	D 218			
	Care Aide Supervisors		5210			
		Staffing Of Personal Care				
	Aide Supervisors					
	(n) A superview chall	most the following				
	(g) A supervisor shall qualifications:	meet the following				
	(1) be 21 years or old	der:				
	(2) be a high school	graduate or certified under				
l	the G.E.D. program, o					
·····	th Service Regulation	•				

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
NAME OF P			DDRESS, CITY, ST	ATE, ZIP CODE		12/2024
WILHAM I	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI- (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	DBE	(X5) COMPL DATI
	Department; (3) meet the general according to Rule .04 (4) have at least six performing or supervise years prior to the efferd date of hire, whicheve health professional of administrator; (5) meet the same of competency requirem supervised; and (6) earn at least 12 education credits related disabled persons in a established by the Definition Human Services. This Rule is not met Based on interviews a facility failed to ensure the qualifications of a The findings are: Review of the facility revealed there were a facility. Review of Staff F's, of file revealed: -There was no docum years or older. -There was no docum	ion established by the al health requirements 406 of this Section; a months of experience in vising the performance of sed during a period of three ective date of this Rule or the ver is later, or be a licensed or a licensed nursing home minimum training and nents of the aides being hours a year of continuing ated to the care of aged and accordance with procedures epartment of Health and as evidenced by: and record reviews, the re 1 of 3 sampled staff met a supervisor (Staff F.). census dated 07/09/24 32 residents residing in the m-call supervisor, personnel nentation Staff F was 21 mentation Staff F was a high ertified under the G.E.D.	D 218	All shaft superior will be hered, on trained to mee the qualification supervisors. In the event a supervisors is not presence ensore presence Compliance Will reviewed monthly the administration an ongoing basis.	t of e of the the the by on	Yka

STATE FORM

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If continuation sheet 5 of 68

Division of Health Service Regulation	
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	AND PLAN (OFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e survey IPleted
Since			HAL011377	8. WING	B. WING		
MULHAM RIDGE 30 DALEA DRIVE ASHEVILLE, NC 28005 (M) D PTEN 150 BUMARY STATEMENT OF GERIERCIES (CONTINGT NOT STATEMENT OF GERIERCIES (CONTINUED TO BERIERCIES) (CONTINUED REPORTING INCOMMINION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EXCH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APROPRIATE DEFICIENCY) Continued From page 5 D PLAN D 218 Continued From page 5 D 218 D PREFIX	NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ASHEVILLE, NC 28805 PMD D PREXE IAG SUMMARY STATEMENT OF DECIDENCIES (EACH DEFICIENCY MUST BE PRECEDENCIES) (EACH DEFICIENCY MUST BE PRECEDENCIES) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFIRENCED TO THE APPROPRIATE CONTINUED FOR USC DEMINIPHING INFORMATION) PEOVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFIRENCED TO THE APPROPRIATE CROSS-REFIRENCED TO THE APPROPRIATE OPE CROSS-REFIRENCED TO THE APPROPRIATE CROSS-REFIRENCED TO THE APPROPRIATE OPE CROSS-REFIRENCED TO THE APPROPRIATE CROSS-REFIRENCED TO THE APPROPRIATE OPE CROSS-REFIRENCED TO THE APPROPRIATE OPE		RIDGE					
PHEERX (EACH DEFICIENCY MUSI BE PRECEDED BY FULL TAG PRECEDED BY FULL TAG PRECEDED BY FULL TAG PRECEDED BY FULL COOSE-FEFERENCED TO THE APROPRIATE DEFICIENCY Continues and the second DEFICIENCY Continues and the second DEFICIENCY <thcontis and="" second<br="" the="">DEFICIENCY</thcontis>			ASHEVI	LLE, NC 28805			
examination established by the Department. -There was no documentation Staff F met the general health requirements according to Rule .4406 of this Section. -There was no documentation Staff F had at least six months of experience in performing or supervising the performance of duties to be supervised during a period of three years prior to the effective date of this rule or the date of hire, whichever was later, or be a licensed health professional or a licensed nursing home administrator. -Thore was no documentation Staff F met the same minimum training and competency requirements of the aides being supervised. -There was no documentation Staff F met the same minimum training education credits related to the care of aged and disabled persons in accordance with procedures established by the Department of Health and Human Services. Interview with Staff F on 07/12/24 at 10:16am revealed: -She was a registered nurse (RN). -She was a negletered nurse (RN). -She was needed. -She did not complete infection control training within 30 days of hire. -She bigned a consent with the former Executive Director (ED) to have a criminal background check but she was not sure it was completed.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE	(X5) COMPLET DATE
Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed: -She did not know why Staff F did not have a		examination establish -There was no docum general health require .0406 of this Section. -There was no docum six months of experie supervising the perfor supervised during a p the effective date of th whichever was later, of professional or a licer administrator. -There was no docum same minimum training requirements of the ai -There was no docum least 12 hours year of credits related to the persons in accordance established by the De Human Services, Interview with Staff F revealed: -She was hired Septer 2023. -She was a registered -She was hired as an shifts when needed. -She signed a consent Director (ED) to have a check but she was not -She completed a drug previous Executive Dir Interview with the Res (RCC) on 07/12/24 at	hed by the Department. hentation Staff F met the aments according to Rule hentation Staff F had at least nce in performing or trance of duties to be heriod of three years prior to his rule or the date of hire, for be a licensed health head nursing home hentation Staff F met the hig and competency ides being supervised. hentation Staff F earned at i continuing education care of aged and disabled e with procedures partment of Health and fon 07/12/24 at 10:16am mber 2023 or October of nurse (RN). on-call supervisor on night infection control training t with the former Executive a criminal background t sure it was completed. g screening with the rector (ED) at the facility. ident Care Coordinator 9:25am revealed:	D 218			

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If continuation sheet 6 of 68

Division	<u>of Health</u>	Service	Regulation	
				_

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011377	B. WING			R-C 712/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			
			A DRIVE			
WILHAM	RIDGE					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	LLE, NC 28805			
PREFIX TAG	(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	n Should be Eappropriate	(X5) COMPLEI DATE
D 218	Continued From pag	e 6	D 218			
	personnel file.					
		ampleurad at the feature				1
	she (RCC) was hired	employed at the facility when				
		i. hat qualifications Staff F				
:	Would have been rec	uired to qualified as a				
	supervisor because					
	(RN).	she was a registered nurse				
[ired, the Executive Director				
	at that time would be	ve been responsible for				
	making sure paperwo	ork was completed				
ļ	manig sho paparite	ant was completed.				
	Interview with the fac	ility's registered nurse (RN)		-		
	on 07/11/24 at 3:34pt	m révealed:				l
	-She was one of the	facility's four owners.				ĺ
	-Staff F did not have	a personnel file.				
	-The facility did not ke	eep personnel files for staff				
	who fulfilled an "on-ca	all" position.				
	Interview with the Adi 10:23am revealed:	ministrator on 07/11/24 at				
		a personnel file because she				
	did not work "shifts" a	it the facility.				
		as hired for her position				
	before he became Co	Owner of the facility in July				
	2023.	• • · · · · · · · · ·				
1	and Staff E sizes d = -	vner of facility in July 2023 contract for the on-call				
	supervisor's position	on D9/15/92				
	-When he was not pro	esent in the facility at night,				
	Staff F the on-call su	pervisor, was available for				
l	staff assistance.					
		aff F was current with all				1
	qualifications required	to fulfill the on-call				i
	supervisor's position of	other than her professional				
	status as a registered	nurse (RN).				
	-He did not know if St	aff F had a criminal				
	background check, dr	ug screening, infection				-
	control training, or 12	hours of continuing				
	education.	-				
	-He thought she had a	all of the staffing				

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If continuation sheet 7 of 68

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		(X3) DATE SURVE COMPLETED	
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF F	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	TATE, ZIP CODE		
	RIDGE		EA DRIVE			
· · · · · · · · · · · · · · · · · · ·		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CON	
D 218	Continued From pag	ie 7	D 218			
		se she was licensed as a RN.				
D 269	10A NCAC 13F .090 Supervision	1(a) Personal Care and	D 269	Resource care p	lans	
	Supervision (a) Adult care home care to residents acc plans and attend to a	1 Personal Care and staff shall provide personal cording to the residents' care any other personal care be unable to attend to for		Resource care p will be and the weekly to ensur- items have be implemented app	ocen spicky	
	interviews, the facility care and supervision resident's care plan f	as evidenced by: ns, record review, and / failed to provide personal in accordance with the or 1 of 5 sampled residents ing assistance for dressing		by the facility administrator. An audit of one pi to occur and the maintained weeks	immediate. lans in be	
	The findings are:				·	
		f2's current FL2 dated agnoses included diabetes, and obesity.				
	Review of Resident # revealed:	2's care plan dated 07/21/23				
	dressing and bathing					
-	-There was no docun Resident #2's left gre	nentation related to care of at toe.				
	facility tour at 9:02am -She had diabetes.	nt #2 on 07/09/24 during the revealed: medical complications due				

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Division of Health Service Regulation

AND PLAN	DFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
<u> </u>		HAL011377	B. WING	B. WING		R-C 7/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
			ADRIVE			
	(ID/SE		LE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 269	Continued From pag	е 8	D 269			
	to her diabetes, inclu great toe.	ding amputation of her right				
	Observation of Resid at 9:02am revealed:	ent #2's left foot on 07/09/24				
	left great toe.	andage wrapped around her				
	-when Resident #2 re had a calloused area great toe.	emoved the bandage, she on the bottom of her left				
	-There was an openir calloused area appro	ng in the center of the ximately 0.5 centimeters by				
	0.5 centimeters in siz -There was no draina opening.	e. ge or bleeding from the				
	Interview with Reside 11:50am revealed:	nt #2 on 07/10/24 at				
	-She took a shower a more.	t least twice a week or				
	-She did not need as:	sistance and was				
	independent with her -Staff would assist he them to.	showers. r with a shower if she asked				
1	-She was independer	t with dressing.				
	07/11/24 at 10:11am i					
	-There was a shower but Resident #2 did n dressing or bathing.	schedule for all residents, ot need assistance with				
i	-Resident #2 was ass	isted in and out of the				
	-Resident #2 was not feet or putting on sock					
	-There was no docum observations during s					
	of. -She was not aware F area on the boltom of	Resident #2 had an open				

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If continuation sheet 9 of 68

ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VILHAM E	RIDGE	30 DALE	A DRIVE LE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	4 SHOULD BE	(X5) COMPLET DATE
D 269	Continued From page	9 9	D 269			
	(RCC) on 07/10/24 at -Resident #2 was ind bathing. -If Resident #2 neede	sident Care Coordinator : 9:29am revealed: ependent with dressing and id assistance with dressing ask staff to assist her.				
	on 07/10/24 at 1:07pr -Resident #2 was see wound on her left grea April of 2024. -The wound had heald Resident #2 was disc April 2024. -If the personal care a assistance for Reside dressing according to her left great toe woul	n by home health for a at toe in March 2024 and ed to a "tiny scab" and harged from home health in lides (PCAs) provided nt #2 with bathing and her care plan, the area on d have been discovered.				
	on 07/11/24 at 10:53a -Resident #2 had diab -She had not been ma left great toe wound u	etes. ade aware of Resident #2's				
	07/12/24 at 3:23pm re -Resident #2 self-show -If she needed person	vealed: vered daily.				
	10A NCAC 13F .0902i 10A NCAC 13F .0902 (b) The facility shall a	Health Care ssure referral and follow-up	D 273			
	to meet the routine and of residents.	d acute health care needs				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	<u> </u>	HAL011377	B. WING	R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STA	TE, ZIP CODE	
WILHAM	RIDGE		A DRIVE LLE, NC 28805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL
D 273	Continued From pag	je 10	D 273		
	This Rule is not me FOLLOW-UP TO TY	as evidenced by: PE A2 VIOLATION		Factily doss,	C.15.
	Based on these findings, the previous Type A2 Violation was not abated.			beheve these ,	tems
	reviews, the facility for referral and follow-up sampled resident (#4 the Primary Care Pro- values greater than 4	ns, interviews, and record ailed to ensure health care b was completed for 1 of 5 b) related to failure to notify bvider (PCP) of blood sugar 450, insulin refusals, and errors involving two blood s.		the with these facility will C to monitor the	findings;
	The findings are:			necds of resin ans uce sui	Elly
	06/06/24 revealed di	#4's current FL2 dated agnoses included essential insion, and type II diabetes		to ensure the met. Comprehensive	y are noice
	06/06/24 revealed:	nt #4's current FL2 dated		Will occur weeking all usidents and following any subst	Interestedy
	lower blood sugar) 10 subcutaneously per s blood sugar (FSBS) of	00 unit/ml pen inject sliding scale: fingerstick checks less than 150=0 unit, 300=2 units, 301-350=3	2	to ilowing any noss Changes to the r Park plan. Facility a to oversee this p	2 Sider 69 Umin Strater
	units, 351-400=5 unit scheduled daily at 8: 5:45pm.	is, 450 or more call PCP 15am, 12:45pm, and		to oversee this ,	process.
	pen inject subcutane bedtime: FSBS less l unit, 251-300=2 units	for insulin aspart 100 unit/ml ously per sliding scale at han 200=0 unit, 201-250=1 , 301-350=3 units, or more call PCP scheduled			

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Division of Health Service Regulation

	FOF DEFICIENCIES DFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
WILHAM I	NAC					
	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETI DATE
D 273	Continued From page	: 11	D 273			
	Review of Posident #	4's June 2024 electronic				
	medication administra	tion record (eMAR)				
	-There was an entry for insulin aspart (used to lower blood sugar) 100 unit/ml pen inject					
	subcutaneously per sliding scale: FSBS checks					
	less than 150=0 unit, 151-200=1 unit, 201-300=2					
	units 301-350=3 units	3, 351-400=5 units, 450 or				
	more call PCP schedu	lled daily at 8:15am				
	12:45pm, and 5:45pm	ieu dany at o. roam,				
	-There was an entry for	or insulin aspart 100 unit/ml				
	pen inject subcutaneo	usly per sliding scale at				
	bedtime: FSBS less th	an 200=0 unit, 201-250=1				
	unit, 251-300=2 units,	301-350=3 units.				
	351-400=5 units, 450 at 8:00pm,	or more call PCP scheduled				
	-On 06/09/24 at 8:15a	m, the documented FSBS				;
	was 460, there was no notified.	documentation PCP was				
	-On 06/14/24 at 5:45p	m, the documented FSBS				
	notified.	o documentation PCP was				
	-On 06/15/24 at 8:15a	m, the documented FSBS				
	was 476, there was no notified.	o documentation PCP was				
	Review of Resident #4	's July 2024 eMAR				
	revealed:					
	 mere was an entry for lower blood amount 100 	r insulin aspart (used to				
	lower blood sugar) 10(subcutaneously por cli	ding apple: EEDC study				
	less than 150-0 cmile 4	ding scale: FSBS checks 51-200=1 unit, 201-300=2				
	units, 301-350=3 unite	, 351-400=5 units, 450 or				
	more call PCP schedu	led daily at 8:15am				
	12:45pm, and 5:45pm.	ion abiy at 0. roalli,				:
		r insulin aspart 100 unit/ml				í.
	pen inject subcutaneoi	usly per sliding scale at				
	bedtime: FSBS checks	less than 200=0 unit.				}
	201-250=1 unit, 251-3	00=2 units, 301-350=3				1
	units, 351-400=5 units					;

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If continuation sheet 12 of 68

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
·		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	LLE, NC 28805			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING (NFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY	N SHOULD BE E APPROPRIATE	(XS) COMPLI DATE
D 273	Continued From pag	e 12	D 273			
	scheduled at 8:00pm -On 07/02/24 at 12:4 was 566, there was in notified.	n. 5pm, the documented FSBS no documentation PCP was				
	06/06/24-07/10/24 re documentation the P	#4's chart note entries dated evealed there was no CP was notified for the r than 450 on 06/09/24, and 07/02/24.				
	at 10:04am revealed -There was an order Resident #4's FSBS -If she took Resident	to notify the PCP when was greater than 450. #4's FSBS and the result), she would notify the PCP		·		
	(RCC) on 07/11/24 a -The MAs were respo of Resident #4's elev the parameters in the -The MAs were to us to report the elevated	onsible for notifying the PCP ated FSBS's according to order. e the telehealth application I FSBS results. hrough the telehealth				
	11:10am revealed: -She was not notified greater than 450 on 0 and 07/02/24. -If she had known ab	ont #4's PCP on 07/11/24 at of Resident #4's FSBS 06/09/24, 06/14/24, 06/15/24, out the elevated FSBS, it ther to consider revising his age.				
	International data and	ministrator on 07/12/24 at				

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if continuation sheet 13 of 68

Division of Health Service Regulation

AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETEO
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	, ZIP CODE		
WILHAM I	RINGE	30 DALE	A DRIVE			
		ASHEVI	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
D 273	Continued From page	e 13	D 273			
	3:24pm revealed:					
		sident #4's telehealth				1
	communications for 0	6/09/24-07/10/24 and could				
	find no staff communi	ications reporting high FSBS				
	values to the PCP.	issuerie reporting night 666				
	-The medication aide	(MA) staff received training				
	on notifying the PCP	when parameters were				
	ordered.					
	 The MAs all acknowl 	ledged on 06/02/24 they				
	understood they need	led to report ordered				
	parameter values and					
	information to the PC	• •				
	-He and his staff met discuss resident conc	weekly with the PCP to				
	discuss resident conc	ems.				
-	b. Review of Residen	t #4's current FL2 dated				
	06/06/24 revealed:					
	-There was an order f	for insulin aspart 100 unit/ml				
İ	pen inject 4 units sub-	cutaneously with meals				
	scheduled at 8:15am,	12:45pm, and 5:45pm.				
	-There was an order f	or insulin aspart 100 unit/ml				
	pen inject subcutanec	ously per sliding scale (SSI):				
-	tingerstick blood suga	r (FSBS) checks less than				
:	301_350=2 unit, 151-200=	1 unit, 201-300=2 units,				
	call PCP scheduled d	-400=5 units, 450 or more aily at 8:15am, 12:45pm,				
	and 5:45pm.	any acto. (38/11, 12:45pm,				
	•	or insulin aspart 100 unit/ml				
	pen inject subcutaneo	usly per sliding scale at				
	bedtime: FSBS check	s less than 200=0 unit,				
	201-250=1 unit, 251-3	300=2 units, 301-350=3				
		s, 450 or more call PCP				
	scheduled at 8:00pm.			•		
	Review of Resident #	4's June 2024 electronic				1
	medication administra	ition record (eMAR) from				
	06/08/24-06/30/24 rev	ealed:				
		or insulin aspart 100 unit/ml				
	pen inject 4 units subc	utaneously with meals				
	scheduled at 8:15am,	12:45om and 5:45pm				1

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If continuation sheet 14 of 68

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	HAL011377 B. WING			R-C 7/12/2024
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
NILHAM I			A DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	0000000000	
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLI DATE
D 273	Continued From pag	ge 14	D 273			
	There was an onter					
	-mole was an entry	for insulin aspart 100 unit/ml				
	checke loss than 15	eously per sliding scale: FSBS 0=0 unit, 151-200=1 unit,				
	201-300-2 unite 20	1-350=3 units, 351-400=5				
	unite 450 or more o	all PCP scheduled daily at				ĺ
	8:15am, 12:45pm, a	all FOF scheduled daily at				İ
	-There was an ontro	for insulin aspart 100 unit/ml				
	pen inlect subcutane	eously per sliding scale at				
	bedtime: FSBS chec	ks less than 200=0 unit,				
	201-250=1 unit. 251	-300=2 units, 301-350=3				
	units, 351-400=5 un	its, 450 or more call PCP				
	scheduled at 8:00pm	1.				
		pm, FSBS 102, premeal				
	insulin aspart 4 units	was documented as not				
	administered due to	resident refusal.	1			
	-On 06/11/24 at 7:49	pm, no documented FSBS,				
	premeal insulin aspa	irt per SSI was documented				
		due to resident refusal.				
	-On 06/13/24 at 1:19	pm, FSBS 194, premeal				
	insulin aspart 4 units	and per SSI was				
1	refusal.	administered due to resident				
		pm, FSBS 179, premeal				
	insulin aspart 4 units	and ner SSI was				
	documented as not a	administered due to resident				
	refusal.					
	-On 06/20/24 at 1:55	pm, FSBS 288, premeal				
	insulin aspart 4 units	was documented as not				
	administered due to	resident refusal.				1
		pm, FSBS 128, premeal				
		was documented as not				
	administered due to					
	-On 06/26/24 at 9:18	pm, no documented FSBS,				
ļ	administered due to	I was documented as not				
	aurinistered due IO	resident (elusal.				
	Interview with the Re	sident Care Coordinator				
		t 10:16am revealed Resident				
	#4 refused to take his	s scheduled and SSI insulin				-
1	on occasion.		1			1

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If continuation sheet 15 of 68

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		E \$URVEY IPLETED		
		HAL011377	B. WING			R-C 07/12/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE			
VILHAM F	RIDGE		A DRIVE LLE, NC 28805				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF	CORRECTION		
PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE	
D 273	Continued From pag	je 15	D 273		·········		
	Provider (PCP) on 0 -She was not notified insulin doses in June -There was nothing a #4 refused doses of -She may need to re doses if he frequent	anyone could do if Resident insulin. vise Resident #4's premeal					
	3:24pm revealed: -He could find no tele PCP about Resident 2024, -The State regulation facility was responsit refusals to the PCP, -The facility policy wa	ehealth documentation to the #4's insulin refusals in June as did not specifically say the ole to report all insulin as for staff to report three of the same medication to					
A 1000 1000 1000 1000 1000 1000 1000 10	06/06/24 revealed th midodrine (used to tr take one tablet twice Review of Resident #	eat low blood pressure) 5mg daily. #I's Primary Care Provider's					
	(PCP) order dated 06 5mg one tablet three	5/27/24 revealed midodrine times daily.					
	06/28/24 revealed: -Discontinue midodri: -Start midodrine 10m -Start midodrine 5mg -Check blood pressu						
	Review of Resident #						

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If continuation sheet 16 of 68

Division of Health	Service	Regulation	

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIEI&CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
		HAL011377	B. WING			R-C 12/2024
VAME OF P	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE	, ZIP CODE		
			ADRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From page	e 16	D 273		***************************************	
	medication administr	ation report (aMAD) from				
	medication administration record (eMAR) from 06/09/24-06/28/24 revealed: -There was an entry for midodrine 5mg one tablet					
						ĺ
	twice daily; hold dose	e if systolic blood pressure				
	was greater than 140	, scheduled at 8:00am and				
-	6:00pm (with a start of	date of 05/17/24).				
	-There was an entry f	for midodrine 5mg one tablet				
	twice daily; hold for s	ystolic blood pressure				
	greater than 120; not	ify PCP if systolic blood				
	pressure was less that	an 90 or greater than 140,				
		and 8:00pm (with a start				
	date of 06/28/24).	for midodrine 10mg one	-			
	tablet once daily: hot	d for systolic blood pressure				
	greater than 120; not	ify PCP if systolic blood				
	pressure was less that	an 90 or greater than 140				
	(with a start date of 0	6/28/24)				
	-On 06/27/24 at 8:00a	am, the documented blood				
	pressure was 89/42, i	midodrine 5mg was				
ł		dministered due to withheld				
	per order.					
	Review of Resident #	4's record revealed there				
	was no documentatio	n the PCP was notified the				
	midodrine was not ad	dministered as ordered on				
-	06/12/24 at 8:00am, 0)6/17/24 at 8:00am,				
	06/18/24 at 8:00am, 0)6/26/24 at 8:00am, and				
	06/27/24 at 8:00am.					
ļ	Interview with Resider	nt #4 on 07/09/24 at 9:07am				
	revealed:	nt a + OF VITUBIZ4 AL S.UTAIN				
	-His blood pressure w	as constantly low.				
	-His low blood pressu	re made him feel weak, light				1
	headed, and dizzy.					
	-These symptoms ma	de it very difficult for him to				l
	walk down to the dinir	ng room for meals.				
	Interview with Resider	nt #4's PCP on 07/11/24 at				
	11:10am revealed:					
	-Resident #4 was pres	manife and second at the second				

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If continuation sheet 17 of 68

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	8. WING		R-C 07/12/20	
iame of Pi	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	RIDGE	30 DALE	A DRIVE			
		ASHEVI	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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	n Should Be E Appropriate	(X5) COMPLET DATE
D 273	Continued From page	e 17	D 273			
	increase his blood pr	9990170				
	-If the midodrine was	not administered as ordered				
	Resident #4 could ex	perience more hypotension.				
	-The risk associated	with hypotension were poor				
	perfusion (the passag	e of blood through the blood				
	vessels or other nature	ral channels in an organ or				
	tissue) and decrease	d level of consciousness.				
	-She was not notified	of the occurrences when				
	the facility MAs had n midodrine as ordered	lot administered the				
	-There were no triane	telehealth notes related to				
	issues with Resident	#4's midodrine in June				•
l	2024.					
	-She had received mu	ultiple telehealth				
	communications "last	week" (06/30/24-07/07/24)				
	about Resident #4's b	lood pressures being low.				
	06/28/24 revealed:	4's Nurses Note dated				
	-On 06/20/24, there w	as an order to alert the PCP				
	if systolic blood press	ure was less than 90.				
1	-The PCP was made	aware today (06/28/24) of				
	blood pressure results pressures less than 9					
	,	o. od pressure was 76/38.				
	-On 06/22/24, the bloc	od pressure was 84/68.				
	-On 06/23/24, the bloc	od pressure was 88/45.				
	-On 06/24/24, the bloc 55/30.	od pressure was 72/41 and				
	88/48.	od pressure was 61/27 and				
	82/65.	od pressure was 89/42 and				
i	-On 06/28/24, the bloc	od pressure was 84/50.				
		ninistrator on 07/12/24 at				
	3:24pm revealed Resi					
F	pressures were discus	ssed with the PCP on				
	06/20/24, 06/27/24, a	10 00/28/24.				

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If continuation sheet 18 of 68

Division	of Health	Service	Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	700.0005		/12/2024
				, ZIP CODE		
MLHAM F	RIDGE					
2840.10	PLIM IA DV OT		LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From page	9 18	D 273			
	06/06/24 revealed the (used to treat high blo	t #4's current FL2 dated are was an order for losartan bod pressure) 25mg one /stolic blood pressure less		н - Солона - Солона		
(PC los: Rev 06/ -Th	Review of Resident # (PCP) order dated 06 losartan.	4's Primary Care Provider /20/24 revealed discontinue				
	medication administra 06/09/24-06/20/24 rev -There was an entry for	4's June 2024 electronic ation record (eMAR) from /ealed: or losartan 25mg one tablet or systolic blood pressure				
	less than 120. -The losartan was doo 11 occurrences out of 06/09/24-06/20/24,	cumented as administered 12 opportunities from				
i	was 78/41; losartan w administered.	umented blood pressure as documented as as no documented blood				
	pressure; losartan wa charted on MAR." -On 06/11/24, the doc	s documented as "done not umented blood pressure				
	was 80/45; losartan w administered. -On 06/13/24, the doc	as documented as umented blood pressure				
	was 107/85; losartan y administered. -On 06/14/24, the doc	umented blood pressure				
	was 98/71; losartan w administered.	as documented as umented blood pressure				
	was 85/54; losartan w administered.	as documented as				
i i	-On 06/16/24, the doc was 71/57; losartan wa administered.	umented blood pressure as documented as				

Division of Health Service Regulation

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If continuation sheet 19 of 68

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:			E SURVEY
	HAL011377		B. WING			R-C 7/12/2024
NAME OF #	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			11212024
WILHAM	RIDCE		EA DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ion should be The appropriate	(X5) COMPLE DATE
D 273	Continued From pag	je 19	D 273			
	was 95/58; losartan administered.	ocumented blood pressure was documented as ocumented blood pressure				
	was 61/28; losartan v administered.	was documented as				
	was 89/88; losartan v administered.	was documented as				
	-On 06/20/24, the do was 92/87; losartan v administered.	cumented blood pressure was documented as				
	Observation of Resid hand on 07/10/24 at 1 no losartan.	lent #4's medications on 3:44pm revealed there was				
	revealed:	ent #4 on 07/09/24 at 9:07am				
	headed, and dizzy.	ire made him feel weak, light				
	-These symptoms ma walk down to the dini	ade it very difficult for him to ng room for meals.				
	at 10:26am revealed:					
	2024. -She documented adr	a MA in the facility since May ministration of Resident #4's				
	 She did not realize sl 	06/18/24, and 06/20/24, he was supposed to hold the				
	than 120,	blood pressure was less				
	11:10am revealed:	nt #4's PCP on 07/11/24 at				:
Í.	-Resident #4's blood p hypotensive (low bloo -Resident #4 was at ri	pressure was "typically" d pressure)				

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If continuation sheet 20 of 68

	Division	of Health	Service	Regulation
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER. HAL011377		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		8. WING		R-C 7/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE		<u> </u>	
WILHAM						
******	KIDOE		LLE, NC 28805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
D 273	Continued From pa	ge 20	D 273	······		
	when the losartan w ordered parameter. -She was not notifie incidents from 06/09 losartan was admin should have been h blood pressure. -The risks of low blo included decreased that keeps blood flo body) and a decreased -Resident #4 could d dizziness, lighthead increased risk for fa was low. -She discontinued F 06/20/24 after she w	vas administered outside the				
	3:24pm revealed: -Resident #4's continued discussed with the F	dministrator on 07/12/24 at at nued hypotension was PCP on 06/20/24. discontinued the losartan on				
	multiple medication pressure medication 2024 which put the r blood flow and decre This failure resulted	notify Resident #4's PCP of errors involving two blood is during the month of June resident at risk for decreased eased level of consciousness. in substantial risk for serious resident and constitutes a				
	The facility provided accordance with G.S this violation.	a plan of protection in 5. 131D-34 on 07/12/24 for				

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Division of Health	Service	Regul	ation	
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DPLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	8. WING		R-C 07/12/2024
ME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODF	
ILHAM RIDGE		EA DRIVE		
	ASHEVI	LLE, NC 28805		
PREFIX CEACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLE
D 344 Continued From pag	je 21	D 344		
 D 344 10A NCAC 13F .100 10A NCAC 13F .100 (a) An adult care how the resident's physic for verification or clas medications and treat (1) if orders for admission or readmines and the resident are not date of admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readmines admission or readm	2(a) Medication Orders 2 Medication Orders me shall ensure contact with ian or prescribing practitioner rification of orders for atments: ssion or readmission of the ed and signed within 24 hours mission to the facility; clear or complete; or ion forms are received upon ssion and orders on the me. ure that this verification or tented in the resident's as evidenced by: and record reviews, the re clarification of medication pled residents (#2) related to r fluid retention and monthly 42's current FL-2 dated agnoses included diabetes, c obstructive pulmonary a orders dated 05/30/24	□ 344	Medications w. to be Series administrator (p to discover and that may be as indicated torings presen Administrator b weekly, at minis	therm D) y issues present, S/Re in the ted.

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e survey Pleted
HAL011377		HAL011377	B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			12/2024
			EA DRIVE	, ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF C		
PREFIX TAG	(EACH DEFICIENT REGULATORY OR	CY MUST RE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)n should be Ie appropriate	(X5) COMPLE DATE
D 344	Continued From pag	e 22	D 344		· · · · · · · · · · · · · · · · · · ·	
	medication administr revealed: -There was an entry once a month. -Staff documented a 06/08/24 at 8:00am. -There was an entry one-half tablet daily (weight gain of two lb:	to check and record weight weight of 231.4 lbs. on for furosemide 40mg take (20mg) as needed for a s. in 24 hours. nentation weights were				
	once a month. -Staff documented a 07/08/24 at 8:00am.	to check and record weight weight of 219.8 lbs. on				
	one-half tablet daily (weight gain of two lbs -There was one entry Resident #2 did not n furosemide due to be	on 07/05/24 that indicated eceive as needed ing out of the facility. nentation weights were				
	scheduled to be obtai	cation aide (MA) on evealed when weights were ined for a resident, the often the weight was due.				
	(RCC) on 07/10/24 at -She noticed the disc	sident Care Coordinator t 9:11am revealed: repancy in the order for the order for as needed				

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	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
HAL011377		B. WING			R-C 7/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS. CITY, STATE	. ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NÇ 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
D 344	Continued From pag	je 23	D 344			
	more than two lbs. ir -She did not know he noticed the discrepa primary care provide orders, -She never received about the two orders Interview with Reside 11:50am revealed: -Staff at the facility w once a month.	ow long it had been since she ncy, but she asked the r (PCP) to clarify the two a response from the PCP ent #2 on 07/10/24 at ere checking her weight d "last week" for difficulty				
	-She was feeling bett facility, but was still w -She was receiving a medication that was l	er since returning to the				
	07/05/24 revealed Re discharged with diage failure, lung disease,	esident #2 had been noses that included heart and acute kidney injury.				
	revealed: -Resident #2 had a d failure. -She needed to have monitoring to determi -No one had tried to d	P on 07/11/24 at 10:53am iagnosis of congestive heart 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. -She would have exp herself to catch the di orders.	ected the facility staff or screpancies in the two ninistrator on 07/12/24 at				

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE S COMPL	
	·····	HAL011377	B, WING	····	R-	C 2/2024
NAME OF P	ROVIDER OR SUPPLIER	SIREET	ADDRESS, CITY, STA			2/2024
				(IE, ZIP CODE		
WILHAM	RIDGE		EA DRIVE ILLE, NC 28805			
(X4) (D	SUMMARY ST		LLE, NL 28805			
PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETI DATE
D 344	Continued From page	9 24	D 344			
	-The eMAR was revie	weu dally by staff.				
	-rie expected the RC	C to review orders and				
	address any discrepa	ncies with the PCP.				
D 358	10A NCAC 13F .1004	(a) Madinati				
2 000	Administration	(a) medication	D 358			
				Medications la	il contra	with the second
	10A NCAC 13F .1004	Medication Administration		to be seen	J h	
	(a) An adult care hon	ne shall assure that the			24	
	preparation and admi	nistration of medications,		administration (" to discover a	the second	
	prescription and non-	prescription, and treatments		()	narm())	s. t.
	by staff are in accorda	and with		to descourse a		820
	(1) orders by a linena	ed prescribing practitioner			y issure	\$
	which are maintained	in the residue the way		that mary be as indicated in	0	
	(0) miles in this Could	in the resident's record; and	l l	, , , , , , , , , , , , , , , , , , , ,	pro sent	
	(2) rules in this Section	on and the facility's policies		ag Indicated in	× 11	
	and procedures.			P	. Contaco	
	This Duty is not much			findings pasen	Net.	
i	This Rule is not met a			A		
1	FOLLOW-UP TO TYP	'E A2 VIOLATION		Administrator 4	1.1	
-	Based on these findin	gs, the previous Type A2		Pacform week	_	
	Violation was not abai	ad		pactorn week	by, all	
	nordion nacinot apa			m, n'miser,	· ·	
	Based on observation	e intonvious and record		in the case	i i	
	reviews the facility for	s, interviews, and record led to ensure medications				
	wero administered as	ordered for 3 of 5 sampled				
	residents (#1 #2 and	#4) related to medications				
		low blood pressure and				
	neuropathy (#4), medi					
	infection and pain (#1)), and a medication for high				
	blood pressure that wa	and a medication (or high			and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se	
	provouro undi Wi	20 0100011111000 (# 2).				
	The findings are:					
	Review of the facility's	Medication Administration		·		
	policy and procedures	dated 06/21/23 revealed:				
	-Medications procedures	tions and non-prescription,				
	and treatments will be	administerod in				
	accordance with the p					
1						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN INFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;			E SURVEY PLETED
HAL011377		B. WING			R-C //12/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
VILHAM I			EA DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (FACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Complet Date
D 358	Continued From page	e 25	D 358			
	orders.					
	-me inedication adm	inistration record will be				
	tootmost and change	d when medication or				
		n the prescribing practitioner				
	changes.					ļ
	1 Review of Residen	it #4's current FL2 dated				ļ
	06/06/24 revealed dis	agnoses included essential				
	tivnertension hypote	nsion, and type II diabetes				
	with neuropathy.	nsion, and type it diabetes				
	and notropatily.					
	a. Review of Residen	it #4's current FL2 dated				
	06/06/24 revealed the	ere was an order for losartan				
	(used to treat high hid	pod pressure) 25mg one				
	tablet daily: hold for s	systolic blood pressure less				
l	than 120.	yerene blood probbile 1688				
	Basian at Duble 14					
	(DCD) order detail (DCD)	4's Primary Care Provider				
1		6/20/24 revealed discontinue				
	losartan.					
	Review of Resident #	4's June 2024 electronic				
	medication administra	ation record (eMAR) from				
	06/09/24-06/20/24 rev	vealed:				
		or losartan 25mg one tablet				
	daily at 8:00am; hold	for systolic blood pressure				
	less than 120.	process				
	-The losartan was doo	cumented as administered				1
1	11 occurrences out of	12 opportunities from				
	06/09/24-06/20/24.					
	-On 06/09/24, the doc	sumented blood pressure				
	was 78/41, and losart	an was documented as				i
	administered.					
	-On 06/10/24, there w	as no documented blood				
	pressure, and losarta	n was documented as "done				
	not charted on MAR."					
	-Un 06/11/24, the doc	umented blood pressure				
		an was documented as				
	administered.					
	-On 06/13/24, the doc	umented blood pressure				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING;			e survey Pleteo
HAL011377		6. WING			R-C 7/12/2024	
VAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			
NILHAM	RIDGE		EA DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	al	PROVIDER'S PLAN OF CO	RRECTION	(X5
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
D 358	Continued From pag	e 26	D 358			
	was 107/85, and los:	artan was documented as				
	administered,					
	-On 06/14/24, the do	cumented blood pressure				
	was 98/71, and losar	tan was documented as				
	administered.					1
	-On 06/15/24, the do	cumented blood pressure				
	was 85/54, and losar	tan was documented as				
	administered.	·····				
	-00 00/10/24, the do	cumented blood pressure tan was documented as				
	administered.	tan was uocumented as				
		cumented blood pressure				
	was 95/58, and losar	tan was documented as				
	administered.					
	-On 06/18/24, the do	cumented blood pressure				
	was 61/28, and losar	tan was documented as				
ļ	administered.					
	-Un Ub/19/24, the doi	cumented blood pressure				
ľ	administered.	tan was documented as				
ŀ		cumented blood pressure				
ļ	was 92/87, and losar	tan was documented as				
1	administered.					
ļ	Observation of Resid	ent #4's medications on				
		3:44pm revealed there was				
	no losartan.					
	Interview with Reside	nt #4 on 07/09/24 at 9:07am				
	revealed:					
	-His blood pressure w	as constantly low.				
	headed, and dizzy.	re made him feel weak, light				
		de it very difficult for him to				
	walk down to the dinir	ng room for meals.				
	Interview with a media	cation aide (MA) on 07/11/24				
	at 10:26am revealed:					
	-She had worked as a	MA in the facility since May				
	2024.		1	•		1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	700000		11212024
				E, ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X6) COMPLET DATE
D 358	Continued From pag	je 27	D 358		· · · · · · · · · · · · · · · · · · ·	-
	losartan on 06/11/24 -She did not realize	dministration of Resident #4's , 06/18/24, and 06/20/24. she was supposed to hold the c blood pressure was less				
	11:10am revealed: -She did not know w Resident #4. -Resident #4's blood hypotensive (low blo -Resident #4 was at when the losartan wa ordered parameter. -The risks of low bloc included decreased p blood through the blo channels in an organ level of consciousnes -Resident #4 could e dizziness, lightheade increased risk for fall: was low. -She discontinued Re	risk for more hypotension as administered outside the od pressures to Resident #4 perfusion (the passage of bod vessels or other natural or tissue) and a decreased as. xperience weakness, dness, and could be at an s when his blood pressure esident #4's losartan on as notified by the facility				
	3:24pm revealed: -Resident #4's contin discussed with the P0	ministrator on 07/12/24 at at ued hypotension was CP on 06/20/24. liscontinued the losartan on				
	06/06/24 revealed the	eat low blood pressure) 5mg				

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ivision of Health Service Regu	lation
	(X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING;		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		R-C 07/12/202	
ламе ог р	Rovider or supplier	STREET	ADDRESS, CITY, STATE	ZIP CODE		
MILHAM I						
			LLE, NC 28805			
(X4) ID	SUMMARY S	NECTION				
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)				SHOULD BE	(X5) COMPLE DATE
D 358	Continued From pag	e 28	D 358		<u> </u>	
	Review of Resident : (PCP) order dated 0 5mg one tablet three	#4's Primary Care Provider's 6/27/24 revealed midodrine times daily.				
06, -Di -St -Oi ber -Ci hol	06/28/24 revealed: -Discontinue midodri	#4's PCP order dated				
	bedtime.	ng every morning. The 5mg midday and at re prior to administration and				
		d pressure greater than 120. #4's June 2024 electronic				
	medication administr 06/09/24-06/30/24 re	ation record (eMAR) from vealed:				
	twice daily; hold dose	for midodrine 5mg one tablet e if systolic blood pressure eduled at 8:00am and				
	6:00pm (with a start of	date of 05/17/24).				
	twice daily; hold for s	for midodrine 5mg one tablet ystolic blood pressure fy PCP if systolic blood				
	pressure less than 90) or greater than 140 and 8:00pm (with a start				
	date of 06/28/24).	for midodrine 10mg one				
	tablet once daily; hold	d for systolic blood pressure fy PCP if systolic blood				
	pressure is less than a start date of 06/28/2	90 or greater than 140 (with 24).				
4	pressure was 100/53	am, the documented blood ; midodrine 5mg was				
	per order.	dministered due to withheld	-			
	pressure was 96/62; i	om, the documented blood midodrine 5mg was				
	documented as not a medication on order f	dministered due to				

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Division of Health Service Regulation

AND PLAN	OFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADORESS, CITY, STATE,	ZIP CODE		
WILHAM	RIDGE		EADRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 358	Continued From page	e 29	D 358			
	-On 06/17/24 at 8:00	am the decomposited block				
	-On 06/17/24 at 8:00am, the documented blood pressure was 95/58; midodrine 5mg was documented as not administered due to withheld					
						Ì
	per order.	diministered due to withheid				
	•	am, the documented blood				
	pressure was 61/28,	Midodrine 5mg was				
	documented as not a	dministered due to withheld				
	per order.					
	-On 06/26/24 at 8:00a	am, the documented blood				
	pressure was 61/27, i	midodrine 5mg was				
		dmlnistered due to withheld				
	per order.					
	-On 06/27/24 at 8:00a	am, the documented blood				
	pressure was 89/42, i	midodrine 5mg was				
ĺ	per order.	dministered due to withheld				
	Review of Resident #	4's July 2024 eMAR from				
Í	07/01/24-07/10/24 rev	/ealed:				
	-There was an entry f	or midodrine 10mg one				
Ì	tablet daily scheduled	at 8:00am; hold for systolic				
	blood pressure greate	r than 120 and notify PCP				
	than 140.	sure less than 90 or greater				
1		or midodrine 5mg one tablet				
	twice daily scheduled	at 2:00pm and 8:00pm;				
	hold for systolic blood	pressure greater than 120				
	and notify the PCP if a	systolic blood pressure less				
1	than 90 or greater tha	n 140.				
	-On 07/05/24 at 8:00a	m, the documented blood				
	pressure was 81/56; t	he midodrine 10mg was				
		iministered due to withheld				
1	per order.					í
	Observation of manit					
	band on 07/40/04 -+ 0	ent #4's medications on				
	hand on 07/10/24 at 3 -There was one bubbl	:44pm revealed: e pack of midodrine 10mg				•
1	tablets with 31 tablets	remaining with a dispense				
ĺ	date of 06/28/24.	remaining with a dispense				
		e pack of midodrine 5mg				

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	8. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		A DRIVE			
			LLE, NC 28805			
(X4) ID PREFíX	SUMMARY STATEMENT OF DEFICIENCIES		iD	PROVIDER'S PLAN OF COL	RECTION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AFPRI DEFICIENCY)				SHOULD BE	COMPLET DATE
D 358	Continued From pag	ie 30	D 358			
	tablets with 59 tablet date of 07/12/24.	s remaining with a delivery				
	Telephone interview facility's contracted p 4:39pm revealed:	with a pharmacist at the harmacy on 07/10/24 at				
		ensed mldod <i>r</i> ine 5mg 60 and 06/12/24				ILD BE COMPLET
	-The pharmacy did n	ot dispense additional				
	midodrine 5mg tablet	ts on 06/28/24 when the				
	order changed because the facility should use up the previous supply until cycle fill delivery around					
	the 10th day of the m	INUI CYCle IIII delivery around				
	-The pharmacy dispe	nsed midodrine 10mg 60				
	tablets on 06/28/24.					1
	Interview with Reside revealed:	ent #4 on 07/09/24 at 9:07am				
	-His blood pressure w	vas constantly low.				
1	-His low blood pressu	ire made him feel weak, light				
	headed, and dizzy.	ade it very difficult for him to				
	walk down to the dini	nd room for meals				
	-He was taking a med	dication to help to raise his				
	blood pressure, but th working.	ne medication was not				
	5:51pm revealed:	ninistrator on 07/10/24 at				
l	-He and the Resident	Care Coordinator (RCC)				
	had recognized Resid	lent #4's blood pressure				
	fluctuations during a c	care audit.				
- R	-Most of the MAs had Resident #4's blood p	received training on ressure parameters and				
	midodrine administrat	ion on 07/01/24				
	-He spoke with the las	st MA who had not received				
	the training on 07/01/2	24 by phone on 07/06/24				
	and provided the train	ing to him.				
	Interview with Resider					

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TATEMENT OF DEFICIENCIES (X1) PROV ND PLAN OF CORRECTION RDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION			
			A. BUILDING:		COM	PLETED	
··		HAL011377	B. WING	······		R-C 07/12/2024	
ME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			112/2024	
ILHAM	RIDGE		ADRIVE				
			LLE, NC 28805				
(X4) 1D	SUMMARY ST	TATEMENT OF DEFICIENCIES	ai	PROVIDER'S PLAN OF CO			
PREFIX TAG	REGULATORY OR	2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	n Should Be Appropriate	(XS) Comple Date	
D 358	Continued From page	e 31	D 358				
	11:10am revealed:					ł	
	-Resident #4 was pre	Scribed midodrine to					
	increase his blood pr	essure.					
l	-If the midodrine was	not administered as ordered					
	Resident #4's could a	experience more hypotension				4	
	(abnormally low blood	d pressure)					
	-She received multipl	e telehealth messages					
	concerning low blood	pressures from the facility					
	staff "last week" (06/3	80/24-07/07/24)					
ĺ	-The risks associated	with hypotension was					
	decreased blood flow	through the blood vessels					
	and decreased level of	f changing the blood vessels				ĺ	
	-She was not potified	of the occurrences when					
	the facility MAs had n	of the occurrences when					
	midodrine as ordered	in lune 2024					
		e telehealth notes related to	•				
	issues with Resident 2024.	#4's midodrine in June					
	Review of Resident # 06/28/24 revealed:	4's Nurses Note dated					
	-On 06/20/24, there w	as an order to alert the PCP					
	if systolic blood press	ure was less than 90.					
;	-The PCP was made	aware today (06/28/24) of					
	blood pressure results	s for systolic blood					
	pressures less than 9	0.					
	-On 06/21/24, the bloc	od pressure was 76/38.					
	-On 06/22/24, the bloc	od pressure was 84/68.					
	-On 06/23/24, the bloc	od pressure was 88/45,					
	-On 06/24/24, the bloc 55/30.	od pressure was 72/41 and					
	88/48.	od pressure was 61/27 and					
	-On 06/27/24, the bloc 82/65,	od pressure was 89/42 and					
	-On 06/28/24, the bloc	od pressure was 84/50.					
	Interview with the Adm	ninistrator on 07/12/24 at					
	3:24pm revealed:						
	-Resident #4's low blo	od pressuros were	1 1			1	

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If continuation sheet 32 of 68

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS. CITY, STATE	, ZIP CODE		
VILHAM I	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			CTION	
PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED DEFICI DEFICIENCY DEFICIENCY			IOULD BE	(XS) Comple Date
D 358	Continued From page	e 32	D 358			
	discussed with the Pi	CP on 06/20/24.				
	-He implemented trai	ining with staff on 07/01/24				
	concerning administr	ation of Resident #4's				
	medications.					ĺ
	c. Review of Residen	it #4's current FL2 dated				
	06/06/24 revealed the	ere was an order for				
	gabapentin (used to t	treat nerve pain) 600mg four				
	times daily.					
	Review of Resident #	4's PCP order dated				
	05/06/24 revealed ga daily.	bapentin 600mg four times				
80.4 L L	Review of Resident # medication administra revealed:	4's May 2024 electronic ation record (eMAR)				
	tablet four times a day 12:00pm, 4:00pm, an	for gabapentin 600mg one y scheduled at 8:00am, d 8:00pm from 05/06/24 at				
	12:00pm to 05/31/24	at 8:00pm.				
	-The gabapentin was					
	administered 100 occ opportunities.	surrences out of 103				
		om, the gabapentin was				
-	documented as not as notes."	dministered "see chart				
		om, the gabapentin was				ŀ
	documented as not as	dministered due to the				
	resident being out of t	the facility.				
	-On 05/08/24 at 8:00p	om, the gabapentin was				
	documented as not ad notes."	dministered "see chart				
	Paviou of Desident	4's luns 0004 stress				
	Review of Resident # revealed:	e's June 2024 eMAR				1
		or gabapentin 600mg one				
	tablet four times a day	/ scheduled at 8:00am,				
Í	12:00pm, 4:00pm, and	d 8:00pm.				
	-The gabapentin was	documented as				

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If continuation sheet 33 of 68

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E ŞURVEY PLETED
		HAL011377	B. WING		R-C 7/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
A/14 LEA 88 1	DIDOR		EADRIVE			
	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 10	PROVIDER'S PLAN OF		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
D 358	Continued From pag	e 33	D 358			1
	the gabapentin was a administered due to a -On 06/19/24 at 8:00 documented as not a blood pressure 87/70 -On 06/26/24 at 9:18 documented as not a refusal. Review of Resident # 07/01/24-07/10/24 at -There was an entry of tablet four times a da 12:00pm, 4:00pm, an -The gabapentin was administered 36 occu opportunities.	5/01/24-06/30/24, pm and 06/14/24 at 7:03pm, documented not resident being out of facility, pm, the gabapentin was idministered due to resident b, pm, the gabapentin was idministered due to resident 4's July 2024 eMAR from 12:00pm revealed: for gabapentin 600mg 1 y scheduled at 8:00am, id 8:00pm.				
	documented as not a refusal. -On 07/05/24 at 9:31a	dministered due to resident am, the gabapentin was dministered due to being				
	hand 07/10/24 at 3:44 -There was one bubb 600mg tablets with 2 dispensed 06/15/24 la to take one tablet four -There was one bubb 600mg tablets with 30	le pack of gabapentin out of 30 tablets remaining abeled "AM" with instructions - times a day.				
	instructions to take on -There was one bubbl 600mg tablets with 24	e tablet four times a day.				

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If continuation sheet 34 of 68

Division of	Health	Service	Regulation	

AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. 8UILDING:			E SURVEY PLETED
		HAL011377	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
NILHAM I			EA DRIVE			
	NUGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			0000000000	
PREFIX TAG	(EACH DEFICIENC	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	(XS) COMPLE DATE
D 358	Continued From page	e 34	D 358			
	instructions to take or	ne tablet four times a day.				
	-There was one hubb	le pack of gabapentin				}
	600mg tablets with 9	tablets out of 63 tablets				
	remaining dispensed	on 05/06/24 with a				1
	handwritten label "12	N" with instructions to take				
	four times a day.					LD BE COMPLETE
ļ						
ſ	Telephone interview v	vith a pharmacist at the				
	facility's contracted pl	narmacy on 07/10/24 at				
	4:11pm revealed:					
	-The pharmacy receiv	ed a prescription on				
		#4 for gabapentin 600mg				
	one tablet three times					
	-On 02/16/24, the pha					
-	gabapentin 600mg tai					
	-On 03/13/24, the pha					
	gabapentin 600mg tal					
	-On 04/12/24, the pha gabapentin 600mg tal	armacy dispensed 90				
	-The pharmacy receiv					
ł	05/06/24 for Resident	#4 for gabapentin 600mg				
	one tablet four times a	a dav.				
	-On 05/06/24, the pha					
·	gabapentin 600mg tal					
ĺ	-On 05/14/24, the pha	rmacy dispensed 120				
	gabapentin 600mg tal	plets.				
		rmacy dispensed 120				
	gabapentin 600mg tal	plets.				
	Interview with Resider	nt #4 on 07/10/24 at 5:15pm				
	revealed:	in a on on torze at p. topin	1			1
		pentin to numb or eliminate				1
	neuropathy pain in his	feet.				
	-The neuropathy was	caused by poor control of				
1	his diabetes early in h	is life.				
	-Neuropathic pain in h	is feet made it difficult for				
	him to walk.					
		gabapentin three times a				
	day.					
1	 The gabapentin table 	t was a large white tablet.	I			1

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If continuation sheet 35 of 68

Division of Health Service Regulation

AND PLAN	OFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011377	B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS. CITY, STATE	ZIP CODE		
	RIDGE		ADRIVE			
			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 CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	n Should Be E Appropriate	(X5) Complet Date
D 358	Continued From page	e 35	D 358	, <u>2000</u> 40.0	······································	1
	-The gabapentin table he had taken for the I	et was the same white tablet				
	 -Resident #4 was ord neuropathy pain. -If gabapentin was no 	/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 department (ED) discl 06/28/24 revealed:	t #1's emergency harge summary dated				
	pain. -There was an order f	en for the complaint of ear or Augmentin (used to treat ng one tablet every 12 to treat left sided ear				
	Review of Resident #' medication administra revealed: -There was an entry for					
	875mg-125mg one tai days scheduled at 8:0 -The Augmentin was c	plet every 12 hours for 7 0am and 8:00pm.				
	Review of Resident #1 revealed: -There was an entry fo					

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If continuation sheet 36 of 68
Division -	of <u>Health</u>	Service	Regulation	

AND PLAN	OFCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
<u>. </u>		HAL011377	B. WING		R-C 07/12/202	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
WILHAM	RIDGE		EADRIVE			
		ASHEV	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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) Comple Date
D 358	Continued From page	36	D 358			
	875mg-125mg one ta days scheduled at 8:0 07/01/24-07/05/24 at -The Augmentin was	blet every 12 hours for 7 00am and 8:00pm from 8:00am.				
	hand on 07/09/24 at 2 -There was one bubbl 875mg-125mg tablets	e pack of 14 Augmentin dispensed on 06/28/24, gmentin 875mg-125mg				
	dated 07/07/24 reveal -The resident was see pain.	n for the complaint of ear was prescribed twice daily				
	provider was recomme	ended.				
	facility's contracted ph 4:18pm revealed: -They received an ord Augmentin 875mg-126 hours for 7 days in the	5mg one tablet every 12				
	delivered to the facility -The Augmentin should	nun was dispensed and on 06/28/24. d have been started at nd ended on 07/05/24 in				
	(RCC) on 07/10/24 at a -She did not know why Augmentin left over for	r there were three doses of Resident #1.				
;	The facility policy was	to create a control sheet				ł

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if continuation sheet 37 of 68

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e survey Pleted
		HAL011377	8. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES					
PREFIX TAG	EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLE DATE
D 358	Continued From pag	ge 37	D 358			
	for antibiotics to held	her to keep track of who did				
	not correctly adminis	ster an antibiotic				
	-The antibiotics were	e stored with the controlled				
	substances in the m	edication cart				
	-She was on leave for					
	06/21/24-07/08/24 a	nd a control sheet was not				
	created for Resident	#1's Augmentin.				
	-If she had worked, s	she would have checked for				
	administration of the	Augmentin daily.				
	Interview with the Ad	lministrator on 07/10/24 at				
	10:52am revealed:					
-	-The RCC duties we	re his responsibility while the				
-	RCC was on leave fr	om 06/21/24-07/08/24				
	-He did not know wh	y Resident #1's Augmentin				
F	was documented as	administered and completed				
	on the eMAR on 07/(05/24, but three doses				
	remained.	· · · ·				
	-Ine MAs were not d	louble checking all the				
i	neocations they che	ecked on the eMAR were				İ
	administration to the	he medication cup prior to resident.				
	Interview with Reside 10:45am revealed:					
	her ears hurting.	on 06/28/24 due to both of				
	06/28/24 for an ear in	per an oral antibiotic on ifection.				
	-She did not know if s	she received all of the				:
	antibiotic ordered on	06/28/24.				
	-On 07/07/24, she ret	turned to the hospital				
	because both of her e	ears still "really hurt,"				
	-Her left ear was still	infected behind her				
	eardrum.					
	-The ear infection cau "off" when she walked	used her equilibrium to be d.				}
	Interview with Reside	nt #1's Primary Care				
	Provider (PCP) on 07	/11/24 at 11:10am revealed:				1

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If continuation sheet 38 of 68

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			
					R-C	
	·····	HAL011377	B. WING		0	7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE		
MILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
D 358	Continued From page	je 38	D 358			
	-She was not aware	Resident #1 did not complete				
	the Augmentin order	red on 06/28/24 at the local				
	ED for an ear Infecti	on.				
		doses of an antibiotic				
	administered so the	infection being treated can				
	be "completely clear	ed,*				
	-She did not think th	ree missed doses of the				
	Augmentin would ha	ive caused Resident #1 to				
r il	need another round	of antibiotics to clear the ear				
	infection.					
	b. Review of Reside	nt #1's current FL2 dated				
	05/30/24 revealed th	ere was an order for				
	oxycodone 10mg on	e tablet every six hours as				
	needed for pain.					
	Review of Resident a revealed an admission	#1's Resident Register on date of 04/15/24.				
	Interview with Reside revealed:	ent #1 on 07/12/24 at 2:05pm				
	-The facility did not a	idminister her oxycodone for				
-	one week after being	admitted on 04/15/24.				
	The facility staff told	her they were waiting on the				
	facility's contracted p	harmacy to deliver the				
	oxycodone to the fac	-				
	-one prought all of he	er medications with her from				
ŀ	The staff told ber the	ng facility where she lived. By could not give her any of				
	those medications fro	om the prior facility, but had				
	to get with a physicia	in to get new prescriptions.				
	-The staff told her the	ey could not administer any				
	medications which di	d not come from their				1
ŀ	contracted pharmacy	и <u>.</u>				•
	-She was prescribed	oxycodone for pain in her				
	back and legs.					
	-Her pain was very "t	pad" during the week without				
1	her medication.					
	-She was unable to s	leep or eat due to pain.				
	-one did not want to	be with anybody because of	1			1

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If continuation sheet 39 of 68

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
			EA DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	up I	PROVIDER'S PLAN OF (140
PREFIX TAG	(EACH DEFICIEN REGULATORY ON	CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTA CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
D 358	Continued From page	je 39	D 358		·····	
	the pain.					
	Review of Resident	#1's April 2024 electronic				
	medication administ	ration record (eMAR)	•			
	revealed:	adon record (eMAR)				
		for axycodone 10mg one				
	tablet every six hour	s as needed for pain.				
	-There were 12 occu	irrences of documented				
	administrations of ox	ycodone 10mg from				
	04/24/24-04/30/24.					
	Review of Resident :	#1's Controlled Substance				
	Count Sheet (CSCS) for oxycodone 10mg tablets					
	dispensed on 03/28/	24 quantity of 30 revealed:				
:	-Administration dates	s on the CSCS included				
	04/02/24 to 04/17/24	(prior facility documented				
	administrations were	04/02/24 to 04/15/24).				
	There was a balanc	e of three oxycodone 10mg				
	tablets upon admissi	on to the facility.				
	-01 04/16/24 at 6:00	pm, a dose was signed out				
	on the CSCS but not administered on the					
		Oam, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the					
	-On 04/17/24 at 6:00	am, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the	əMAR.				
	Interview with the Re	sident Care Coordinator				
	(RCC) on 07/12/24 a	t 2:24pm revealed:				1
ļ	-On Resident #1's CS	SCS sheet, there were three				
İ	oxycodone 10mg tab	lets which were available				
	from a prior supply up	pon admission.				
	-She signed out three	e doses of oxycodone 10mg	i			
	for Resident #1 on 04	1/16/24 at 6:00pm, on				
	04/17/24 at 12:00am.	, and on 04/17/24 at 6:00am.				
	-Resident #1 "probab	ly" came with "pills from the				
	other facility" was wh	y she signed the oxycodone				1
	out on the prior facilit	VS USCS sheet	1			1

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If continuation sheet 40 of 68

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI.TIPLE C A. BUILDING:			e survey Ipleted
	HAL011377		B. WING		1	R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	E, ZIP CODE		
VILHAM I	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1			
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(XS) COMPLE DATE
D 358	Continued From pag	e 40	D 358			
	administrations on the -At the time, she did Resident #1's Primar through use of the te -She put Resident #7 by the PCP on the P the facility which was Telephone interview 07/15/24 at 2:31pm r -She was not Reside resident was admitte -Resident #1 was cur lower back pain. -The first time she was needed a prescription 04/23/24. -Resident #1 could e effects, and possibly symptoms with an ab	not know how to contact y Care Provider (PCP) lehealth application. I's name on a list to be seen CP's next scheduled visit to a 04/23/24. with Resident #1's PCP on evealed: nt #1's PCP when the				
	pain clinic. Interview with the Ad 3:24pm revealed: -Oxycodone was a so -Resident #1 had to t new prescription for t 3. Review of Resided	be seen by her PCP to get a he medication. ht #2's FL-2 dated 05/30/24				
	disease and obesity. Interview with Reside revealed:	ncluded diabetes, obstructive pulmonary ant #2 on 07/09/24 at 9:02am the hospital "last week."				
	-She was admitted to -She was admitted be	ecause she had cramping in				

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Division of Health Service Regulation	Division	of Health	Service	Regulation
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS CITY, STATE			
WILHAM	RIDGE					
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
D 358	Continued From page	e 41	D 358			
	her right hand.	I land the tree and				
	-She was "weak" and	nad a "bad heart."				
	-one did not know all	the medications she took.				
	Review of Resident # orders dated 07/05/2-	2's hospital discharge				
	-She was admitted to	the hospital on 07/03/24 for				1
	heart and respiratory injury.	failure and acute kidney				
		irge orders dated 07/05/24				
	included discontinuine	g lisinopril (used to treat high				
	blood pressure) 20mg	g tablet daily.				
	Review of Resident # revealed:	2's July 2024 eMAR				
		or lisinopril 20mg tablet daily				
	-There was document	tation lisinopril was				
	administered daily fro 07/09/24 at 8:00am,	m 07/06/24 through				
	-The order was still ac 07/09/24.	ctive on the eMAR on				
	Interview with the Res (RCC) on 07/10/24 at	sident Care Coordinator 9:29am revealed:				
	-The medication aide Resident #2 returned	(MA) on shift when				
	responsible for letting	all administrative staff know				
	about the discharge o	rders and sending the				1
	orders to the pharmac	су.				
İ	-She was not the shift	supervisor when Resident				
	#2 returned from the h	ospital on 07/05/24.				
	-Sile Was not aware o	f the discontinuation of				
	resident #2's lisinopri	I since she was not here				
	hospitalization.	urned to the facility after her				
	Intonious with Deal-					-
	Interview with Resider 11:50am revealed:	n #∠ on 07/10/24 at				•
		wook ologo har anterna ta st				
	-She was suil teeling v	veak since her return to the				

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Division	of Health	Service	Regulation
	or round		NGUUMMUM

	r of Deficiencies DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. 8UILDING:			E SURVEY IPLETED
<u> </u>		HAL011377	B. WING		R-C 07/12/20	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE		
NILHAM E	RIDGE		A DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PRÉFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE	(X5) COMPLE DATE
	-When her blood pres fatigued and had a ba -She felt bad on 07/08 better. Review of Resident # revealed her blood pre 07/08/24. Interview with the prin 07/11/24 at 10:53am r -She had not been no order for Resident #2' -She was not notified pressure of 98/57 on 0 -The blood pressure of for Resident #2. -She wrote an order of the lisinopril. Telephone interview w 07/11/24 at 11:16am r -He was working wher the hospital on 07/05/2 -There was a MA who that was responsible for when she returned fro -He placed the hospita Resident #2 on the RO -He assumed the hospita for Resident #2 on the RO	tal last week. d pressure had been e returned to the facility. isure was low, she felt very id headache. 8/24 but was feeling some 2's July 2024 eMAR essure was 98/57 on hary care provider (PCP) on revealed: tified about the discharge s lisinopril. of Resident #2's blood 07/08/24, if 98/57 was a low reading in 07/11/24 to discontinue	D 358	DEFICIENC	27)	
	10:51am and 07/12/24 -The MA who was resp	at 3:23pm revealed: ponsible for Resident #2 m the hospital on 07/05/24				

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If continuation sheet 43 of 68

Division of Health Service Regulation

AND PLAN	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			e survey Pleteo	
		HAL011377	B. WING			R-C 07/12/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	F. ZIP CODE			
VILHAM	BIDCE		EA DRIVE				
	KIDGE		LLE, NC 28805				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	iD			· <u> </u>	
PREFIX TAG	EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE	(X5) COMPLE DATE	
D 358	Continued From pag	e 43	D 358				
	should have faxed th	e hospital discharge orders					
	directly to the oharm	acy or gave the hospital					
	discharge orders to t	he RCC to scan them to the					
	pharmacy.						
	-He was responsible	to complete the RCC duties					
	when she was abser	t from the facility.					
	-The hospital dischar	ge orders dated 07/05/24 for		,			
	Resident #2 were no	t scanned to the pharmacy.					
	-The MA on duty whe	en Resident #2 returned to					
	the facility should ha	ve faxed the hospital					
	diventinge orders dire	ectly to the pharmacy or					
	pharmacy.	supervisor to send to the					
	The facility failed to e	insure medications were					
1	administered as orde	red for three sampled					
	residents including a	resident who was					
	administered a medic	ation to lower his blood					
	pressure when his bl	ood pressure was below the					
	parameter establishe	d by the PCP (#4) and failed					
-	to administer a medic	ation to raise the resident's					
	blood pressure when	the blood pressure was low					
	(#4). The facility faile	d to administer pain					
	to obtain a preserintic	ent for 7 days due to failure on from the PCP putting the					
	resident at risk for na	in and rebound effects (#1).					
	The facility failed to d	iscontinue a blood pressure					
!	medication resulting i	n a resident feeling weak					
:	and having a headac	he due to low blood pressure					
	(#2). These failures i	resulted in substantial risk					
	for serious physical h	arm to the residents and					
	constitutes a Type A2	Violation.					
	The facility provided a	nion of protection in					
	accordance with G.S.	131D-34 on 07/12/24 for					
	this violation,						
D 367	10A NCAC 13F .1004	(i) Modication	0.007				
- 557	Administration	(I) medication	D 367			j	
	- when a stration		1			ì	

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If continuation sheet 44 of 68

Division	of Health	Service	Regulation	

		IDENT/FICATION NUMBER:	A. BUILDING:			SURVEY LETED
		HAL011377	B. WING		R-C 07/12/2024	
VAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
WILHAM R	IDGE	30 DALE	EA 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLET DATE
D 367	Continued From page	: 44	D 367			
F F C a	 (j) The resident's median record (MAR) shall be following: (1) resident's name; (2) name of the medicies (3) strength and dosage administered; (4) instructions for administered; (4) instructions for administered; (5) reason or justification medications or treatment; (5) reason or justification of a medications or treatment (6) date and time of a documenting the result (6) date and time of a medications or treatment omission, including reference (8) name or initials of the medication or treatment (8) name or initials of the medication or treatment (1) documented and main administration record (1) This Rule is not met a Based on observations reviews, the facility fail of the electronic medic (eMAR) for 1 of 6 sample documentation of actingectable medication usugar levels). The findings are: Review of Resident #2 05/30/24 revealed diagent (2) and obesity. 	any omission of ents and the reason for the fusals; and, the person administering tment. If initials are used, a b those initials is to be tained with the medication (MAR). Is evidenced by: is, interviews, and record red to ensure the accuracy eation administration record pled residents (#2) related dministration of insulin (an used to help control blood		Resident MARS be reviewed dat ensure accuracy, with be complet Medication admi orders, and the to better entre Compliance. Daily to be overseen Administrator,	ly 1.8 frainined on nistratives - Mether nce 1 neview	5 • ,

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If continuation sheet 45 of 68

Division of Health Service Regulation

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e survey Pleted
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			
WILHAM	Piboe		EA DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	n Should be E appropriate	(X5) COMPLE DATE
D 367	Continued From page	9 45	D 367			
	An order for lienze (e					
	units subcutaneous (s	short acting insulin) inject 8				
	-An order for lispro ini	ect 12 units sub-q at lunch				
	and dinner.	ect 12 units sub-q at lunch				
		ect sub-q as directed per				
	sliding scale insulin (9	SSI) before meals and at				
	bedtime for fingerstick	blood sugars (FSBS): less				
	than 100 hold insulin a	and initiate hypoglycemia				
	protocol, less than 25	0 administer 0 units, 250 to				
1	299 administer 4 units	, 300-350 administer 6				
	units, greater than 350	D administer 8 units, and				
	greater than 500 notify	y physician.				
	Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed;					
ŀ	-There was an entry fo	or lispro (a short acting				
	insulin) inject 8 units s	ubcutaneous (sub-q) at				
	breakfast					Í
	-There was an entry fo	or lispro inject sub-q as				
	directed per SSI befor	e meals and at bedtime for				
	fingerstick blood sugar	rs (FSBS): less than 100				
	hold insulin and initiate	e hypoglycemia protocol,				
	less than 250 administ	ter 0 units, 250 to 299				
i	aurninister 4 units, 30()-350 administer 6 units,				
	than 500 notify physici	nister 8 units, and greater				
	-There was an entry for					
	sub-q at lunch and din					
		ation staff administered SSI				
	lispro 8 units on 06/10/	/24 at 8:00am for blood				
	glucose level of 129.					
	-There was documenta	ation staff administered SSI				
		0/24 at 5:00pm for blood				
	glucose level of 326.					
	-There was documenta	ation staff administered SSI				
		1/24 at 12:00pm for blood				
	glucose level of 208.					
	- Inere was documenta	ation staff administered SSI				
	IISPRO 12 Units on 06/17 th Service Regulation	1/24 at 5:00pm for blood				

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If continuation sheet 46 of 68

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY
		HAL011377	B. WING			R-C 7/12/2024
NAME OF P	RÖVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		
VILHAM	RIDGE		EA DRIVE			
	·····	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLI DATE
D 367	Continued From pag	je 46	D 367			
	glucose level of 240					
		#2's July 2024 eMAR				
	revealed: -There was an entry	for lispro inject 12 units				
	sub-q at lunch and d	linner,				
	-There was an entry	for lispro inject sub-q as				
	finderstick blood suc	ore meals and at bedtime for ars (FSBS): less than 100				
	hold insulin and initia	ate hypoglycemia protocol,				
	less than 250 admin	ister 0 units, 250 to 299				
ĺ	administer 4 units, 3	00-350 administer 6 units, ninister 8 units, and greater				
	than 500 notify physi	ician.				
	-There was an entry	for lispro inject 8 units sub-q				
	at breakfast.	ntation staff administered SSI				
	lispro 8 units on 07/0	18/24 at 8:00am for blood				
	glucose level of 182.					
	Interview with a med 07/09/24 at 3:45pm r	ication aide (MA) on				
1		evealed. e SSI and the scheduled				
	insulin together.					
İ	-She did not have tra	ining until sometime in June lize this was an incorrect way				
	to document,	lize this was an incorrect way				
	-The SSI and schedu	iled insulin had been given				
	correctly but docume	nted incorrectly on two				
	06/11/24.	A and two occasions on				
	Telephone interview	with a second MA on				
	07/10/24 at 10:13am					
	-He dld receive training documenting the SSI	and scheduled insulin				
	logether.					
1	-He documented 8 ur	hits of SSI lispro was				
	incorrect.	8/24 at 8:00am but that was	1 İ			i.

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If continuation sheet 47 of 68

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011377	8. WING		R-C 07/12/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENT REGULATORY OR	DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROS DEFICIENCY	D BE COMPLE
D 367	Continued From pag	e 47	D 367		
	-The 8 units of Ilspro scheduled morning c	documented was for the lose of lispro.			
	10:51am and 07/12/2 -All MAs received dia -The training include documentation of ins -There was a new M his training documen incorrectly. -The MAs should hav the correct doses giv	ulin on the eMAR. A who had not yet received ted administering SSI lispro re accurately documented en for SSI lispro on the ve not documented the			
	10A NCAC 13F .1008 (a) An adult care hor controlled substances receipt, administration controlled substances maintained with the m and in such an order reconciliation of contron This Rule is not met TYPE B VIOLATION Based on observation reviews, the facility far retrievable record that receipt and administrat substances for 2 of 3 (Resident #1 and #6) substances for pain a	n, and disposition of a. These records shall be asident's record in the facility that there can be accurate olled substances. as evidenced by: as, interviews, and record iled to ensure a readily t accurately reconciled the ation of controlled	ć	Controlled Substance anders, MAR. cod. Shiets, etc. Will Screende more to to ensure compt- by administrator Ensuring all iter accurately reflece the all enci-use Controlled Substance be audited weeks by the administrato	ted bed sauces

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If continuation sheet 48 of 68

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. 8UILDING;			E SURVEY PLETED
		HAL011377	8. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE.			
VILHAM	Dinor		EA DRIVE	211 GODE		
	RIDGE		LLE, NC 28805			
(X4) ID PREFIX TAG) (EACH DEFICIENC)	NTEMENT 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 OEFICIENCY	on Should Be He appropriate	(X6) COMPLET DATE
D 392	Continued From page	48	D 392			
	The findings are:					
	-The record of docum- resident's record (exa drug sign-out record). -Documentation of rec substance by the phar	dated 06/21/23 revealed: entation will be kept in the mple eMAR or controlled ceipt of the controlled macy will be maintained.				
 Review of Resident #1's current FL2 dated 05/30/24 revealed diagnoses included dementia, congestive heart failure, polyneuropathy, and dysphagia. 						
	Review of Resident #1 revealed an admission	l's Resident Register a date of 04/15/24.				
	a. Review of Resident 05/30/24 revealed oxy every six hours as nee	#1's current FL2 dated codone 10mg one tablet ided for pain.				
	(RCC) on 07/12/24 at : -Resident #1 was adm	ident Care Coordinator 2:24pm revealed: itted from another facility. h oxycodone from another				
	11:58am regarding Re 10mg one tablet every revealed:	armacy on 07/09/24 at sident #1's oxycodone síx hours as needed				
	Count Sheet (CSCS) for to be used to document inventory control. -On 04/23/24, oxycodo	ed a Controlled Substance or each quantity dispensed it the administration for ne 10mg was dispensed				
	for a quantity of 56 tab -On 05/20/24, oxycodo th Service Regulation	ets. ne 10mg was dispensed				

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Division of Health Service Regulation

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	E. ZIP CODE		
WILHAM	RIDGE		A DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES				1
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE	(X5) COMPLR: DATE
D 392	Continued From page	9 49	D 392			
	for a quantity of 28 tal	blote				
	-On 06/03/24 oxycod	one 10mg was dispensed				
	for a quantity of 12 tal	blete				
	-On 06/10/24, oxycod	one 10mg was dispensed				
	for a quantity of 40 tai	oleta				
	-On 06/27/24, oxycodone 10mg was dispensed					ļ
	for a quantity of 40 tak	plets,				
	Review of Resident #	1's Controlled Substance				
	Count Sheet (CSCS)	for oxycodone 10mg tablets				
	dispensed on 03/28/24	4 quantity of 30 revealed:				
	-Administration dates	on the CSCS included				-
1	04/02/24 to 04/17/24 (prior facility documented				
	administrations were (04/02/24 to 04/15/24).				
	 There was a balance 	of three oxycodone 10mg				
	tablets upon admission	n to the facility on 04/15/24.				
	-On 04/16/24 at 6:00p	m, a dose was signed out				
	on the CSCS but not c	locumented as				
1	administered on the el					
	on the CSCS but not c	am, a dose was signed out				-
	administered on the et	locumented as				
		m, a dose was signed out				
	on the CSCS but not d	ocumented as				
	administered on the el	MAR.				
	Review of Resident #1	's CSCS for oxycodone				
	10mg tablets dispense	d on 04/23/24 quantity of				
	30 revealed:					
	-Administration dates of	on the CSCS included				
ļ	04/23/24-05/06/24.					
	-On 04/23/24 at 6:00pr	n, a dose was signed out				
	on the CSCS but not d					
	administered on the eN					
ĺ	on the CSCS had not a	n, a dose was signed out				
	on the CSCS but not de administered on the eA					
		n, a dose was signed out				
	on the CSCS but not d	n, a uose was signed out				
	administered on the eN	AR				
	h Service Regulation					

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Division of	Health	Service	Regulation
	1100	0014108	1 CQUIATION

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING;			E SURVEY PLETED
	······	HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, STATE,			
WILHAM	BIOCE		EADRIVE			
	RIUGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
D 392	Continued From page	ə 50	D 392			
	-On 04/25/24 at 12:00	Opm, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the e	MAD				
Ì		am, a dose was signed out				
	on the CSCS but not	ann, a uuse was signed out				
	administered on the e					ĺ
	-On 04/27/24 at 7:00am, a dose was signed out					
	on the CSCS but not documented as					
	administered on the e	MAR				
)pm, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the e	MAR				
	-On 04/28/24 at 2:00am, a dose was signed out					
	on the CSCS but not	documented as				
ļ	administered on the e					
		om, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the e					
	-On 04/30/24 at 6:31p	m, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the e					
	-On 04/31/24 at 12:00	pm, a dose was signed out				
	on the CSCS but not o	documented as				
	administered on the e	MAR.				
ļ	-On 05/02/24 at 3:31a	m, a dose was signed out				
	on the CSCS but not o	focumented as				
	administered on the e					
	-On 05/04/24 at 9:00a	m, a dose was signed out				
	on the CSCS but not o					1
	administered on the el					
	-Un U5/U5/24 at 6:00a	m, a dose was signed out				
	on the CSCS but not c	locumented as				•
	administered on the el	MAR.				
	Review of the pharma	cy delivery sheet for				
	Resident #1's oxycode	one 10mg tablets quantity				
	56 dated 04/23/24 rev	ealed there was no				
1	documented signature	onice mere was no				
	received the medication	in from the pharmany				
		n non me phannacy,	4			1

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Division	of Health	Service	Regulation	
		_	The spended of 1	

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. 8UILDING:			E SURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE			•
	RIDGE					
		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X6) COMPLE DATE
D 392	Continued From page	9 51	D 392			
	Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every six hours as needed for pain. -There were 12 occurrences of documented					
-There w administr 04/24/24 Review c 10mg tab 26 revea -Adminis	-There were 12 occur administrations of oxy 04/24/24-04/30/24.	rences of documented codone 10mg from				
	10mg tablets dispense 26 revealed:	1's CSCS for oxycodone ed on 04/23/24 quantity of on the CSCS included				
	on the CSCS but not administered on the e -On 05/07/24 at 8:00a	MAR. m, a dose was signed out				
	on the CSCS but not a administered on the e -On 05/07/24 at 4:21 (dose was signed out o documented as admir	MAR. (no specific time of day), a on the CSCS but not				
	-On 05/07/24 (no spec was signed out on the as administered on the	cific time of day), a dose CSCS but not documented				
	dose was signed out o documented as admin	on the CSCS but not Istered on the eMAR. (no specific time of day), a				
	documented as admin -On 05/16/24 at 10:45 on the CSCS but not c	istered on the eMAR. pm, a dose was signed out locumented as				
	administered on the el	MAK.				
	Review of the pharma Resident #1's oxycodo 28 dated 05/20/24 revo received by facility stat	ne 10mg tablets quantity ealed the medication was				

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If continuation sheet 52 of 68

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e Survey IPleted
	·····	HAL011377	B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
WILHAM	RIDGE		EA DRIVE	,		
			LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				<u> </u>
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	on should be Ie appropriate	(X5) Comple Date
D 392	Continued From page	e 52	D 392		·	
1						
	Review of Resident #	1's CSCS for oxycodone				
	10mg tablets dispens 28 revealed:	ed on 05/20/24 quantity of				
	-There were two CSC	S for the 28 oxycodone.				
	 One CSCS had a ph 	armacy label and there was				
	one administration da	ite of 05/21/24 at 2:47am				
	leaving a count of 27	tablets.				
	-All of the information	provided on the second				
	CSCS label was hand	written and the starting				
ŀ	count was 18 tablets.					
	included 05/22/24-05/	on the second CSCS				
		was signed out on the				
	CSCS (no documente	ed time), documented on the				
	eMAR as 4:35pm.	a anoy accumented on the				
	Review of Resident # revealed:	1's May 2024 eMAR				
		or oxycodone 10mg one				
	tablet every six hours	as needed for pain.				
	-There were 50 occur	rences of documented				
	administrations of oxy 05/01/24-05/31/24,	codone 10mg from				
	Review of Resident #	I's CSCS for oxycodone				
	10mg tablets dispense 12 revealed:	ed on 06/03/24 quantity of				
l	-Administration dates 06/03/24-06/09/24.	on the CSCS included				
1	-On 06/03/24 at 8:30p	m, a dose was signed out				
	on the CSCS but not o	locumented as				
	administered on the el					1
	-On 06/04/24 at 3:36 (no specific time) a dose				
	was signed out on the as administered on the	CSCS but not documented				
		emark. m, a dose was signed out				4
	on the CSCS but not c	In, a uose was signed out				
	administered on the ef	MAR				
	-On 06/04/24 at 1:00a					1

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Division	of Health	Service	Regulation	
DIVIDIO	OFFECTION		Recusion	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
· · · · · ·		HAL011377	B. WING			R-C 7/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE			
WILHAM I	RIDGE	30 DALE	A DRIVE				
		ASHEVI	LLE, NC 28805				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLET DATE	
D 392	Continued From page	ge 53	D 392				
	on the CSCS but no	ot documented as					
	administered on the						
	-On 06/07/24 at 7:3	0pm, a dose was signed out					
	on the CSCS but no						
	administered on the						
	-On 06/09/24 at 2:00am, a dose was signed out						
	on the CSCS but not documented as administered on the eMAR.						
]	
		#1's CSCS for oxycodone					
	10mg tablets dispen	sed on 06/10/24 quantity of					
	40 revealed:						
	-Administration date 06/10/24-06/29/24.	s on the CSCS included					
)am, a dose was signed out					
	on the CSCS but no	t documented as					
	administered on the						
	Review of the pharm	nacy delivery sheet for					
	Resident #1's oxyco	done 10mg tablets quantity					
		evealed there was no					
	documented signatu	re of the facility staff who					
	received the medica	tion from the pharmacy.					
	Review of Resident ; revealed:	#1's June 2024 eMAR					
		for oxycodone 10mg one					
	tablet every six hour	s as needed for pain.					
	-There were 50 occu	irrences of documented					
	administrations of ox	vycodone 10mg from					
	06/04/24-06/30/24.						
	Review of the pharm	acy delivery sheet for					
	Resident #1's oxycol	done 10mg tablets dispensed					
	on 06/27/24 quantity	of 40 revealed there was not					
ł	documented signatu	re of the facility staff who				÷	
	received the medical	tion from the pharmacy.					
	Review of Resident /	#1's CSCS for oxycodone					
	10mg tablets dispension	sed 06/27/24 quantity of 20					

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If continuation sheet 54 of 68

Division of Health Service Regulation

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			e Survey Pleted
		HAL011377	B. WING			R-C //12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	ZIP CODE		
WILHAM I	RINGE		EA DRIVE			
-	NIDOL.		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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLET DATE
D 392	Continued From page	54	D 392		······	-
	revealed administration dates on the CSCS included 06/29/24-07/07/24. 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 pain. -There were 18 occurrences of documented administrations of oxycodone 10mg. -There was no documented administration of		0.392			
	oxycodone on 07/09/2 Observation of Reside	4 at 12:03am. Int #1's oxycodone 10mg 2:45pm revealed there		,		
	Interview with Resider revealed she received 10mg around midnight	at #1 on 07/09/24 at 3:28pm one tablet of oxycodone t on 07/08/24.				
	3:45pm revealed: -There were nine oxyc went missing from Res delivery of 28 tablets.					
	-A MA reported the mist the RCC and the Admi -He notified the pharm					
	oxycodone. -On 06/12/24, the phar of all the residents con not find any discrepand	macy performed an audit trolled substances and did cies.				
	Refer to the interview v on 07/09/24 at 3:05pm	with a medication aide (MA)				

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If continuation sheet 55 of 68

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
••••••••	HAL011377		B. WING			R-C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		**************************************
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR		<u> </u>
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
D 392	Continued From page	e 55	D 392			
	Refer to the interview at 8:34am.	with the RCC on 07/10/24				
	Refer to the interview with the Administrator on 07/10/24 at 10:52am.					
	Refer to the interview 07/12/24 at 3:24pm.	with the Administrator on				
	05/30/24 revealed Fio headaches) 50-325-4	10mg one capsule every				
	eight hours as needed	d for headaches/migraine.				
	Telephone interview w	vith the facility's contracted				
	pharmacy on 07/09/24 Resident #1's Fiorinal	50-325-40mg one capsule				
[every eight hours as r	needed revealed:				
	- The pharmacy provid	ed Controlled Substance				
	to be used to docume	for each quantity dispensed nt the administration for				
	inventory control.	nt the administration for				
	-On 04/16/24, Fiorinal	was dispensed for a				
	quantity of 12 capsule	s.				
	-On 04/30/24, Fiorinal	was dispensed for a				
	quantity of 30 capsule	S.				
	-On 05/14/24, Fiorinal	was dispensed for a				
İ	quantity of 30 capsule	s.				
	-On 05/30/24, Fiorinal quantity of 20 capsule	was dispensed for a				
	-On 05/31/24, Fiorinal	s, was disponsed for a				
i	quantity of 10 capsules	was dispensed for a				
	-On 06/17/24, Fiorinal	was dispensed for a				
	quantity of 15 capsules	s.				
	-On 06/25/24, Fiorinal	Was dispensed for a				
	quantity of 15 capsule:	S.				
	-On 07/02/24, Fiorinal	was dispensed for a				
	quantity of 15 capsules	s.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			e survey IPleted
	<u> </u>	HAL011377	B. WING		R-C 7/12/2024	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
	NINGE		ADRIVE			
			LE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page	e 56	D 392			
	Resident #1's Fiorina 04/16/24 quantity of 1	acy delivery sheet for Il capsules dispensed on 12 revealed:				
	facility staff who rece pharmacy.	nented signature of the ived the medication from the				
	The quantity of 12 was marked through in and "on order" was handwritten beside capsules.					
	Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 04/16/24 quantity of 12 revealed:					
	04/22/24-04/30/24.	on the CSCS included				
	on the CSCS but not administered on the e	documented as MAR.				
	on the CSCS but not administered on the e	MAR,				
	-On 04/23/24 at 2:00p on the CSCS but not administered on the e					
		om, a dose was signed out documented as				2
		am, a dose was signed out documented as				
	medication administra revealed:					
İ	-There was an entry fo every eight hours as r not take within an hou	or Fiorinal take 1 capsule needed for headaches do ir of oxycodone.				
	-There were 8 occurre administrations of Fior 04/23/24-04/27/24.	ences of documented				

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If continuation sheet 57 of 68

(X3) DATE SURVEY COMPLETED R-C

Division	of Health Service Regi	ulation		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	
		HAL011377	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE
WILHAM	RIDGE		EA DRIVE /ILLE, 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 (EACH CORREC CROSS-REFEREN
D 392	Continued From page	e 57	D 392	
	50-325-40mg capsule	1's CSCS for Fiorinal es revealed there was no dispensed on 04/30/24		

07/12/2024 S PLAN OF CORRECTION (X5) COMPLETE CTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DATE DEFICIENCY) SUS for quantity 30 dispensed on 04/30/24. Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 05/14/24 quantity of 30 revealed there was no documented signature of the facility staff who received the medication from the pharmacy. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 05/14/24 quantity of 30 revealed: -Administration dates on the CSCS included 05/15/24-05/29/24. -On 05/19/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/20/24 at 1:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for FiorInal one capsule every eight hours as needed for headaches. -There were 56 occurrences of documented administrations of Fiorinal from 05/01/24-05/31/24. Review of the pharmacy delivery sheet for Resident #1's FiorInal capsules dispensed on 05/30/24 quantity of 20 revealed there was no documented signature of the facility staff who received the medication from the pharmacy. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 05/30/24 quantity of 20 revealed: -Administration dates on the CSCS included Division of Health Service Regulation

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(X3) DATE SURVEY COMPLETED

R-C

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:
	HAL011377	B. WING

				07/12/2024
OF P	ROVIDER OR SUPPLIER STREET A	DDRESS, CITY, STATE	, ZIP CODE	
ILHAM F		A DRIVE		
		LE, NC 28805		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLE
	STATE OF LOO DELTIN AND IN ORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATI	E OATE
			DEFICIENCY)	
D 392	Continued From page 58	D 392		
i	05/30/24-06/19/24.			
ĺ	-On 06/01/24 at 6:30 (no specific time), a dose			
	was signed out on the CSCS but not documented			
	as administered on the eMAR.			
	-On 06/01/24 at 1:20pm, a dose was signed out			
	on the CSCS but not documented as			
	administered on the eMAR.			i.
	-On 06/02/24 at 2:00 (no specific time) and no			
	name of staff, a dose was signed out on the			
	CSCS but not documented as administered on			
	the eMAR.			
	-On 06/03/24 at 2:30am, a dose was signed out			
	on the CSCS but not documented as			
	administered on the eMAR.			
	-On 06/03/24 at 3:36 (no specific time), a dose			
	was signed out on the CSCS but not documented			
1	as administered on the eMAR.			
	-On 06/04/24 at 6:30am, a dose was signed out			
ł	on the CSCS but not documented as			
	administered on the eMAR.			
i	-On 06/19/24 at 3:00pm, a dose was signed out			
	on the CSCS but not documented as			
	administered on the eMAR.			
	Review of Resident #1's CSCS for Fiorinal			
	50-325-40mg capsules dispensed on 05/31/24			
	quantity of 10 revealed:			
	-Administration dates on the CSCS included			
	06/12/24-06/19/24.			:
	-On 06/12/24 at 6:00 (no specific time), a dose			ĺ
	was signed out on the CSCS but not documented			
	as administered on the eMAR.			
	Review of Resident #1's CSCS for Fiorinal			
l	50-325-40mg capsules dispensed on 06/17/24			1
	quantity of 15 revealed;			I
	-Administration dates on the CSCS included			
	06/18/24-06/24/24.			
	-On 06/24/24 at 12:30am, a dose was signed out			
[.	on the CSCS but not documented as			
	on the CSCS but not documented as			

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Division of Health Service Regulation

and plan	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E ŠURVEY PLETED
		HAL011377	B. WING		R-C 07/12/2024	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	RIDGE	30 DALI	EA DRIVE			
			LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFIGIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 59		D 392			-
	administered on the eMAR.					
	Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 06/25/24 quantity of 15 revealed there was no documented signature of the facility staff who received the medication from the pharmacy.					
	revealed: -There was an entry every eight hours as	1's June 2024 eMAR for Fiorinal one capsule needed for headaches, rrences of documented prinal from				
	50-325-40mg capsule	1's CSCS for Fiorinal es dispensed on 06/25/24 ed administration dates on 6/25/24-07/02/24.				
	50-325-40mg capsule quantity of 15 reveale -Administration dates 07/03/24-07/08/24.	1's CSCS for Fiorinal es dispensed on 07/02/24 ed: on the CSCS included d administration date was				
	07/08/24 at 12:43pm remaining.	with a count of two				
	every eight hours as a	or Fiorinal one capsule needed for headaches, rences of documented				
	Observation of Reside	ent #1's Fiorinal s on 07/09/24 at 2:45pm				

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Division of Health Service Regulation

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					ĺ,	2.0	
		HAL011377	B. WING			२-С / 12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	, ZIP CODE			
WILHAM I	RIDGE	30 DALE	EA DRIVE				
	·····		LLE, NC 28805				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		IĎ PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5)	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
D 392	Continued From page 60		D 392				
	revealed there was one capsule available.						
	Interview with Resider	nt #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 Coordinator (RCC) on	with the Resident Care 07/10/24 at 8:34am.					
	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					
	04/24/24 revealed diag Alzheimer's disease, c	#6's current FL2 dated gnoses included dementia with mood rostatic hyperplasia, and					
	a. Review of Resident	#6's current FL2 revealed eat anxiety) 1mg one tablet reded for agitation.					
	Review of Resident #6 1mg tablets dispensed revealed:	's CSCS for lorazepam on 03/25/24 quantity of 20					
	-Administration dates of 04/07/24-07/02/24.						
	-On 04/07/24 at 6:00pi on the CSCS but not d administered on the eN						
	-On 05/03/24 at 8:00ar	m, a dose was signed out					
	on the CSCS but not d administered on the effection	locumented as					
		nt on the CSCS was 16.					

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Division of Health Service Regu	
 Division of nealth Service Renn 	lation
	Tation 1

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			e survey Pleted
		HAL011377	B. WING			R-C 7/12/2024
IAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	ZIP CODE		
	RIDGE		ADRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 392	Continued From pag	e 61	D 392	n annan ann an Annan an Annan Annan Annan Annan Annan Annan Annan Annan Annan Annan Annan Annan Annan Annan Ann		
	medication administr revealed:	for lorazepam 1mg take one				
	agitation/anxiety. -Lorazepam 1mg was					
	tablet every four hour agitation/anxiety. -Lorazepam 1mg was	or lorazepam 1mg take one s as needed for				
	tablet every four hour agitation/anxiety. -Lorazepam 1mg was	or lorazepam 1mg take one s as needed for				
	tablet every four hour agitation/anxiety. -Lorazepam 1mg was	or lorazepam 1mg take one s as needed for				
	Observation of Reside tablets on 07/11/24 at	ent #6's lorazepam 1mg 3:09pm revealed there				

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	TOP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED R-C 07/12/2024	
·		HAL011377	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DORESS, CITY, STATE	. ZIP CODE		
NILHAM	RIDGE		A DRIVE			
			LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	GL	PROVIDER'S PLAN OF COR	RECTION	
PREFIX TAG	RÉGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLE DATE
D 392	Continued From pag	je 62	D 392			
·	were 16 tablets.					
				i		
-	Interview with a med	lication aide (MA) on 07/11/24				
	at 10:04am revealed	: a controlled substance, she				
	would reference the	eMAR to prepare the				
	medication.					
	-She would then doo	ument the CSCS with her				
	name, the date and t	time she was signing the				
	medication out, the r documented the curr	rent count.				
	Interview with the Pe	sident Care Coordinator				
	(RCC) on 07/12/24 a	t 2:24pm revealed:				
	-The MA who signed	out the lorazepam dose on				
	the CSCS on 05/03/2	24 no longer worked at the				
	facility,					
	pharmacy cart audits	pharmacy reviews and two				
	-These issues had no	ot been brought to their				
	altention.	girle and girle and a				
	Refer to the interview 07/12/24 at 3:24pm.	v with the Administrator on				
	b. Review of Resider	nt #6's current FL2 revealed				l
	morphine 100mg/5m. hours as needed (use	0.25ml (5mg) every four				
	Review of Resident #	6's CSCS for morphine				
	100mg/5ml 20mg/ml	dispensed 03/25/24 quantity				
	of 30ml revealed:	· · ·				
		on the CSCS included				
	04/04/24-07/08/24.					
	on the CSCS but not	pm, a dose was signed out				
	administered on the					
	-On 07/08/24 at 1:15a	am, a dose was signed out				
	on the CSCS but not	documented as				
	administered on the e	MAR.				i

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Division of Health Service Regulation

AND PLAN (ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		1	-C 12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DORESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE		A DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(XS) COMPLET DATE
D 392	Continued From page 63		D 392			
	medication administra revealed:					
	0.25ml (5mg) every fo	ocumented as administered				
	Review of Resident # revealed:	6's May 2024 eMAR				
	0.25ml (5mg) every for	ocumented as administered				
	0.25ml (5mg) every fo	or morphine 100mg/5ml ur hours as needed. ocumented as administered				
	0.25ml (5mg) every fo	or morphine 100mg/5ml ur hours as needed. ocumented as administered				
	Interview with Resider revealed the resident of that time.	nt #6 on 07/11/24 at 2:55pm denled having any pain at				
	Interview with a medic at 10:04am revealed:	ation aide (MA) on 07/11/24				

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Division of Health Service Regulation

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R-C 07/12/2024	
		HAL011377				
IAME OF P	ROVIDER OR SUPPLIER	STREET	DRESS, CITY, STATE,	ZIP CODE		
VILHAM I	PIDOE		ADRIVE			
		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(XS) COMPLET DATE
D 392	Continued From page	9 64	D 392	·····		
	-When administering a controlled substance, she would reference the eMAR to prepare the medication. -She would then document the CSCS with her name, the date and time she was signing the medication out, the number given, and documented the current count.					
	Refer to the interview 07/12/24 at 3:24pm.	with the Administrator on				
	and responsibility of the Resident #1's medical -She and the night shi did not count the contrant and confirm matching before she took possed keys that morning. -The night shift MA re her because the night signed off yet as a MA -She did not know wh keys to the medication -The night shift MA too medications on night shift MA too	avealed: am, she accepted the keys the medication cart where tions were stored. ift (8:00pm to 8:00am) MA rolled substances together counts on the CSCS's ession of the medication cart fused to count the cart with shift MA said she was not A; y the night shift MA had the n cart in her possession. Id her she did not pass any shift.				
	revealed: -The night shift MA or 8:00pm-8:00am. -The night shift MA ca 07/08/24 and explained to the eMAR were not -The night shift MA did credentials were not v	lled her during the night on od that her login credentials working. d not figure out her eMAR vorking until she had ident #1's as needed pain				

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AND PLAN (MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	1 ' '	(X3) DATE SURVEY COMPLETED		
		HAL011377	B. WING	VING		R-C 07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	RINGE		ADRIVE				
		ASHEVI	LE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) Comple Date	
D 392	Continued From page 65		D 392				
	-She told the MA to have Resident #1 confirm the						
	administration of the	e dose of pain medications.					
	as needed medicativ	t to administer any additional					
	as needed medications and she would figure it out the following morning (07/09/24) when she arrived to work.						
	-She had written up both the night shift MA and						
	the day shift MA up for not counting the controlled						
	substances prior to t	transfer of keys.					
	medications ended	60 days to be able to pass					
		JI 01/10/24.					
-	Interview with the Administration on 07/10/24 at						
1	10:52am revealed th	e MAs had all received					
	training to count the	controlled substances and					
	verify the controlled	substance counts at shift					
	change with the onc	oming staff.					
	Interview with the Ac 3:24pm revealed:	ministrator on 07/12/24 at					
	-The MAs document	ation on the CSCS sheets					
	did not violate facility	/ policy.					
	-The facility policy st	ated controlled substances d on the CSCS sheet or the					
	eMAR.	d on the USUS sheet of the					
	The facility failed to a	accurately document and					
	reconcile controlled s	substances resulting in a total					
	of 12 missing oxycod	done tablets (Resident #1).					
	This failure was detri	imental to the health, safety					
	Type B Violation.	sidents and constitutes a					
	. Jeo D Violation.						
	The facility provided	a plan of protection in					
	accordance with G.S	. 131D-34 on 07/12/24 for					
	this violation.						
	CORRECTION DATI						
	VIOLATION SHALL	NOT EXCEED AUGUST 26,					
	2024.					1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL011377	B. WING	· · · · · · · · · · · · · · · · · · ·	R-C 07/12/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE		
VILHAM	RIDGE		A DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		id Prefix Tag	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	
D 613	Control Policies & Pr 10A NCAC 13F .180 PREVENTION AND PROCEDURES (d) In accordance wi Subchapter and G.S. shall ensure all staff i hire and annually on listed in Subparagraphic this Rule is not met Based on interviews facility failed to ensure state approved infect completed for 1 of 4 30 days of hire. The findings are: Review of Staff F's file -There was no docur -She was hired as the facility. -There was no docur annual state approved was completed within Interview with Staff F revealed:	1 INFECTION CONTROL POLICIES AND ith Rule .1211 of this .131D-4.4A(b)(4), the facility are trained within 30 days of the policies and procedures obs (b)(1) through (b)(2) of and record reviews, the re the mandatory annual tion control training was sampled staff (Staff F) within le revealed: mentation of a hire date. e On-Call Supervisor for the mentation a mandatory ed infection control training	D 613	Facility Will case training of all ancollary, induced Such as the Supervisor. Compte aucht of reco. Lill be perform identify any dis and Fac. 1. by the address. Training annually thereafter, by the administrat	ete es esto screparties	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL011377		IX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER: A. BUILDING:				(X3) DATE SURVEY COMPLETED	
		8. WING			R-C		
			DDRESS, CITY, STATE		[07	/12/2024	
14/11 LI & L4			A DRIVE	. ZIP CODE			
WILHAM			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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
D 613	 Continued From page 67 She was hired to fill in as the On-Call Supervisor when needed at night. She did not remember completing infection control training within 30 days of hire with the previous Executive Director (ED). Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed: She was unsure why they did not have infection control training on file for the Staff F. Staff F was already working when the RCC came to the facility. She never thought about checking to see if Staff F had infection control training and would not have known what to look for with Staff F because she was a registered nurse (RN). The ED at the time Staff F was hired would have been responsible for making sure paperwork was completed. 		D 613				
				D 613			
	should be completed a -He was not sure why infection control trainin -He thought Staff F was the facility. -He came to the facilit contract was signed by -They did not keep a p because she was "on shift. -It would have been th	revealed: he infection control training within 30 days of hire. Staff F did not have ng on file. Is hired before he came to y in July 2023 and the y Staff F on 09/15/23. Personnel file on Staff F call" and did not work on a e responsibility of the e infection control trainings					

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