	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			TE SURVEY MPLETED
		HAL011377	B. WING		1	R 2/10/2024
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
		30 DALE	EA DRIVE			
WILHAM R		ASHEV	ILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
D 000	Initial Comments	Initial Comments				
		ensure Section conducted a 12/04/24-12/06/24 and				
D 087	10A NCAC 13F .030 Furnishings	06(b)(1) Housekeeping And	D 087			
	 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed 					
	shall have the follow (A) at least one pillo (B) clean top and bo bed changed as ofte once a week; and					
	as needed;	ly to new and existing				
	This Rule is not met TYPE B VIOLATION					
	failed to provide a cle	ions and interviews, the facility clean top and bottom sheet on s and at least one pillow with a r four resident beds.				
	The findings are:					
vision of Her	alth Service Regulation			A.I.	n.n.staber	
		R/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE MUT	in ytor	(X6) DATE 01

Reviewed and acknowledged 02/05/25 JG

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		COM	(X3) DATE SURVEY COMPLETED R 12/10/2024	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE				
				, ZIP CODE			
WILHAM	RIDGE		A DRIVE LLE, NC 28805				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
D 087	Continued From pag	le 1	D 087				
	initial tour on 12/04/2 -There was not a top -The resident was us and a folded up fleed -The bottom sheet w light brown colored s the bed. Interview with the firs 9:30am and 12/06/24 -She needed to use a because she did not pillow for her bed. -The light brown smee wiping her fingers on -The facility staff did bed. -The bottom sheet ha washed for "months". -She had a hard time apply the bottom shee	sing a decorative couch pillow ce throw blanket as a pillow. as dingy, stained and had mear marks near the head of st resident on 12/04/24 at 4 at 3:10pm revealed: a decorative couch pillow currently have a regular ear marks were from her the bed. not change the linens on her ad not been changed or					
	the initial tour on 12/C -The resident was lyir blanket pulled up ove -There was no bottom bed. -There was no top shi Interview with the sec 9:30am revealed: -He had a fitted sheet would not stay on the -He threw the fitted sh	n sheet on the resident's eet on the resident's bed. ond resident on 12/05/24 at for his bed but the sheet bed. neet away. the same problem he did					

STATE FORM

2WMT11

If continuation sheet 2 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	CONSTRUCTION	CON	R
AME OF F	ROVIDER OR SUPPLIER	STREET			1 1/	2/10/2024
	NO NOLIVON ON OUT LIEN		DDRESS, CITY, STATE	E, ZIP CODE		
VILHAM	RIDGE		A 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
D 087	Continued From page 2		D 087			
	initial tour on 12/04/2 -There was not a top his mattress. -There was not a pillo Interview with a third 9:43am revealed: -He had not had a top clean pillowcase for a -He had a pillowcase nose since he had no -The Resident Care O him two or three week for his bed and he tok -The RCC or other far a top sheet, bottom si -He would like the sta and a pillowcase on h Observation of a four initial tour on 12/04/24 -There was no top sh mattress. -He had two pillows of them had a pillowcase Interview with a fourth 9:52am revealed it did linens on his bed. Observation of a fifth initial tour of the faciliti revealed:	resident on 12/04/24 at o sheet, bottom sheet, or a bout a month. but took it off to blow his t been given any tissue. Coordinator (RCC) asked ks ago if he wanted linens d her yes. cility staff never brought him heet, or clean pillowcase. iff to place sheets on his bed his pillow. th resident's room during the 4 at 9:52 am revealed: eet or a bottom sheet on his n his bed and neither of				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 3 of 94

E SUMMARY S	STREET A			(X3) DATE SURVEY COMPLETED R 12/10/2024		
SUMMARY S		TADDRESS, CITY, STATE, ZIP CODE				
SUMMARY S			, 21 00DL			
SUMMARY S		LLE, NC 28805				
X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOLL DIE			PROVIDER'S PLAN OF CORRECTION	N		
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
ntinued From pag	ie 3	D 087				
erview with a fifth 2am revealed: e did not have a l thress because sh shed by staff. e was using the t le she slept. lid not bother her nout any linens be servation of a sixti :42am revealed: ere was no top or dent's bed. e mattress was m rview with a sixth 2am revealed: off had not put she e. e sheets would co noved around in t ervation of a seve be resident had 3 p wcases. ere was a blanket e in a heaping pile rview with a seven by m revealed: e did not know ho sheets put on he e wanted sheets of ere pillows.	resident on 12/04/24 at bottom or top sheet on her he thought it was being hrow blanket to cover up to lay on the plastic mattress ecause she was used to it. In resident's bed on 12/05/24 bottom sheet on the hade of a plastic material. resident on 12/05/24 at bets on his bed in a long ome off the bed as soon as the bed. enth resident's bed on evealed: n or top sheet on the bed. billows on her bed with no con her bed and clothes e on top of the blanket. In th resident on 12/06/24 at w long it had been since she r bed.					
wcases for her be						
	2am revealed: e did not have a i tress because sh hed by staff. e was using the t e she slept. id not bother her out any linens be ervation of a sixt (42am revealed: ere was no top or dent's bed. e mattress was m rview with a sixth am revealed: ff had not put she e sheets would co noved around in the ervation of a sev 6/24 at 2:55pm r ere was no bottor e resident had 3 g wcases. ere was a blanket a in a heaping pill view with a seve pm revealed: e did not know ho sheets put on he e wanted sheets of er pillows. e did not know ho	 a did not have a bottom or top sheet on her tress because she thought it was being hed by staff. a was using the throw blanket to cover up e she slept. id not bother her to lay on the plastic mattress out any linens because she was used to it. ervation of a sixth resident's bed on 12/05/24 evas no top or bottom sheet on the dent's bed. a mattress was made of a plastic material. rview with a sixth resident on 12/05/24 at tam revealed: af had not put sheets on his bed in a long . a sheets would come off the bed as soon as noved around in the bed. ervation of a seventh resident's bed on 6/24 at 2:55pm revealed: are was no bottom or top sheet on the bed. a esident had 3 pillows on her bed with no wcases. are was a blanket on her bed and clothes a in a heaping pile on top of the blanket. view with a seventh resident on 12/06/24 at ppm revealed: a did not know how long it had been since she sheets put on her bed. a wanted sheets on her bed and pillowcases er pillows. a did not know how to get sheets and wcases for her bed and staff did not ask her if wanted some. 	Pain revealed: a did not have a bottom or top sheet on her a did not have a bottom or top sheet on her tress because she thought it was being hed by staff. a was using the throw blanket to cover up e she slept. id not bother her to lay on the plastic mattress out any linens because she was used to it. ervation of a sixth resident's bed on 12/05/24 4/2am revealed: are was no top or bottom sheet on the dent's bed. a mattress was made of a plastic material. view with a sixth resident on 12/05/24 at tam revealed: ff had not put sheets on his bed in a long . e sheets would come off the bed as soon as hoved around in the bed. ervation of a seventh resident's bed on 6/24 at 2:55pm revealed: re was no bottom or top sheet on the bed. resident had 3 pillows on her bed with no wases. rew was a blanket on her bed and clothes a in a heaping pile on top of the blanket. view with a seventh resident on 12/06/24 at pm revealed: a did not know how long it had been since she sheets put on her bed. <	Zam revealed: a did not have a bottom or top sheet on her tress because she thought it was being hed by staff. a was using the throw blanket to cover up e she slept. id not bother her to lay on the plastic mattress out any linens because she was used to it. ervation of a sixth resident's bed on 12/05/24 ervation of a sixth resident's bed on 12/05/24 evan to top or bottom sheet on the dent's bed. ervation of a plastic material. ervation of a sixth resident on 12/05/24 at am revealed: ervation of a sixth resident on 12/05/24 at am revealed: e sheets would come off the bed as soon as noved around in the bed. ervation of a seventh resident's bed on 6/24 at 2:55pm revealed: ervation of a seventh resident on 12/06/24 at prevealed: ervation of a seventh resident on 12/06/24 at prevealed: rew was no bottom or top sheet on the bed. resident had 3 pillows on her bed with no wcases. ervation of a seventh resident on 12/06/24 at prevealed: ervation the seventh resident on 12/06/24 at prevealed: view with a seventh resident on 12/06/24 at prevealed: ervaled sheets on her bed. view with a seventh resident on 12/06/24 at prevealed: ervaled sheets on her bed. view with a seventh resident on 12/06/24 at prevealed: ervaled sheets on her bed. view with a seventh resident on 12/06/24 at prevealed: ervaled sheets on her bed. view with a seventh resident on since	Parmevealed: a did not have a bottom or top sheet on her tress because she thought it was being hed by staff. a was using the throw blanket to cover up e she slept. a was using the throw blanket to cover up e she slept. id not bother her to lay on the plastic mattress out any linens because she was used to it. available to the slept. ervation of a sixth resident's bed on 12/05/24 4/24 4/22m revealed: available to the the slept. am revealed: that resident on 12/05/24 at tam revealed: if had not put sheets on his bed in a long that resident's bed on 6/24 at tam revealed: is sheets would come off the bed as soon as tooved around in the bed. available to the bed. ervation of a seventh resident's bed on 6/24 at 2:56pm revealed: available to the bed. re was no bottom or top sheet on the bed. available to the bed. re was no bottom or top sheet on the bed. available to the bed. re was a blanket on her bed and clothes available to the bed. resident had 3 pillows on her bed with no wcases. available to the bed. rew was no bottom or top sheet on the bed. available to the bed. revealed: did not know how long it had been since she sheets put on her bed. was with a seventh resident on 12/06/24 at pm revealed: avanted sheets on her bed and pillowcases	

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 4 of 94

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE (A. BUILDING: B. WING			E SURVEY IPLETED
	ROVIDER OR SUPPLIER				1:	2/10/2024
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE		
WILHAM	RIDGE	30 DALE ASHEVII	A DRIVE .LE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
D 087	Continued From pag	e 4	D 087			
	9:46am revealed: -There were multiple blankets folded and s -There were no pillow Second observation of 12/06/24 at 3:38pm r -There were no sheet mattress on the bed. -There were 4 black I bed and 1 black laune front of the bed. -There was a pile of o at the foot of the bed. -The resident rummage linens lying in the floor	vs stored in the linen closet. of the fifth resident's room on evealed: ts covering the plastic aundry bags sitting on the dry bag setting on the floor in lirty linens lying on the floor ged through a pile of dirty or at the foot of the bed and heet and applied the dirty				
	a week. -She would like sheet Interview with the eigl 3:50pm revealed: -She had resided at th staff had never chang	evealed: sheets on her bed in about s on her bed. ht resident on 12/06/24 at he facility for 13 years and led the linens on her bed.				
	-Staff never offered to bed so she made her Second interview with					
	12/06/24 at 2:51pm re -A county Ombudsma today and he express having linens for his b	evealed: n had spoken with him ed his concerns about not				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 5 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING			R
	ROVIDER OR SUPPLIER				12/	10/2024
	ROUBER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	211	
PREFIX	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
D 087	Continued From pag	e 5	D 087			
	about his request for	linens				
		linens on 12/06/24 for his				
_	bed.					
	-The RCC did not off	er to put them on for him.				
		op sheet, bottom sheet, and				
	a clean pillowcase					
		resident by offering him				
	some books to make	his bed for him.				
	Conned abaranting					
	on 12/06/24 at 2:51pt	of the third resident's room				
		it, that did not live in the				
	room, placing a pillow					
		en observed to place the				
	comforter on the bed					
	-The resident took six	k books from the other				
	resident for his assist	ance in making his bed.				
	Telephone interview	with a county Ombudsman				
	on 12/06/24 at 4:00pr					
	-She had spoken with	n a resident who expressed				
	concerns about not h 12/06/24.	aving linens on his bed on				
	-She told the RCC wh	no replied she did not know				
	why he did not have a	sheets on his bed.				
		ens to the resident while he				
	was in the hallway.					
		er to put the linens on his				
	bed.	e opposite direction of his				
	room with his walker.					
		man offered to place the				
		attress for him so he would				
	not have to return to I					
	-She did not know if c	other staff came back to his				
	room and put linens of					
		if he was able to put his				
	linens on himself.					
		if he was able to put his				
	linens on himself.					

Division of Health Service Regulation

STATE FORM

6899

2WMT11

If continuation sheet 6 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:			E SURVEY
		HAL011377	B. WING		1:	R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	ID PROVIDER'S PLAN OF COR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE A DEFICIENCY DEFICIENCY DEFICIENCY		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
D 087	Continued From page	e 6	D 087			
	that worked for the fa needed. -Some of the resident bed linens and some so they could change -The bed linens were a resident's shower d -She did not documen changed. -The residents who w beds preferred not to -She did not know on a couch cushion as a -She did not know wh was.	evealed: personal care aide (PCA) cility and she worked as ts asked her to change their residents asked for sheets the bed linens themselves. supposed to be changed on ay. nt when the bed linens were rere missing linens from their have sheets on the beds. e of the residents was using				
	revealed: -All staff were respon- had linens on their be -On shower days, one with the residents' sho could go and change -When it was brought someone did not have would make sure they -There was no one will beds. -She became aware of who did not have linen never went in his roor	e staff member could assist ower while the other staff the linens. to her attention that e linens on their bed, she y got linens. ho had to make their own of a resident on 12/06/24 ns on his bed, but they m because he always came when it was time for his				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 7 of 94

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL F 12/1	ETED
NAME OF P	ROVIDER OR SUPPLIER	30 DALE	ADDRESS, CITY, ST/ E A DRIVE LLE, NC 28805	ATE, ZIP CODE		ULUL T
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 087	1:52pm revealed: -Residents were give did not use them or w -If the linens were soid changing them. -He expected the line twice a week. -There was no docum often linens were bein The facility failed to e provided a clean top sampled resident becomes sleep on plastic mattr dirty linens. One resident that was not changed because staff did not when trying to changed because staff had noo third resident rummag linens on the floor an- sheet to her bed after for about one week. A another resident by g resident would apply staff were not changing was detrimental to the	t a fall risk. ministrator on 12/10/24 at n linens but some of them yould kick them off the bed. iled, staff should be ens to be changed by staff nentation regarding how ng changed. msure residents were and bottom sheet on seven ds. This required residents to resses with no sheets and bet slept on a dirty sheet d or washed in 2 months change her sheets, and e herself she fell on the bed. nged her own sheets t offered assistance, and a ged through a pile of dirty d applied a dirty bottom r not having a bottom sheet A fourth resident bribed		The facility has added "Change of linens" opli the facility quickMA stall be require address unen require for each resident appropriate intervals. also accomplishes the for documentation facility efforts in to linens and other The Administrator Overseeing the imple. of this and will ADI reports at a	R. Nour at at This need of ADLS. 15 mentahas	
	protection in accordan 12/19/24 for this viola CORRECTION DATE			OF this and will ADL reports at a weekly, and will d. Surveys daily unto demonstrates comple	s room 1 state iance.	01/24/2

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 8 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED R 2/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET		700 0005	12/10/2024		
	Noviber on our lieft		DDRESS, CITY, STATE	, ZIP CODE			
NILHAM	RIDGE		LLE, NC 28805				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	0/5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision		D 269				
	care to residents acc plans and attend to a	1 Personal Care and staff shall provide personal ording to the residents' care ny other personal care be unable to attend to for					
	reviews, the facility fa assistance for 2 of 4	as evidenced by: ns, interviews, and record ailed to provide personal care sampled residents (#2 and istance with bathing and					
	The findings are:						
	08/26/24 revealed: -Diagnoses included orthostatic hypotensis bipolar type. -The resident was co -The resident was no -The resident needed dressing.	rbally abusive.					
	08/26/24 revealed: -The resident require bathing, dressing, ea hygiene, and toileting	nbulatory with aid or device					

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 9 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COM	E SURVEY IPLETED R 2/10/2024
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
				, ZIF GODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OPPECTION	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
D 269	Continued From pag	je 9	D 269			
	-The resident was in	dependent with transfers.				
	Observation of Resid	dent #4 on 12/04/24 at				
	9:37am revealed:					
		ting on the side of his bed				
	holding a blanket ac					
		white t-shirt that was stained, pants with dried food sticking				
		a pair of white socks that				
	were soiled to a gray					
	• •	substance matted in the back				
		he back right of his head.				
		was long and uneven, with a				
		nce visible around his mouth.				
	-There was a dime s	ized area of the beard that				
	was black and matte	d.				
		nails on his right hand were				
	long, jagged, and bla					
		nails on his left hand were				
	Contract of the second s	rk in color, and uneven and				
	rough. -Resident #4 smelled	d of body odor				
	-Resident #4 sinelled					
	Interview with Reside	ent #4 on 12/04/24 at 9:37am				
	revealed:					
	-He got "no care" fro					
		red medications to him and				
	provided meals to hi -He was able to trans					
	wheelchair.	ster himself into his				
	-The staff at the facil	ity used to trim his				
		don't do it no more."				
	-"My beard. I hate it					
		eard being so long and				
	uneven.					
		nim with bathing, he took				
	"care of that."					
	and the second	last time he had a shower.				
		hower and he would "take				
	care of it."					

Division of Health Service Regulation

STATE FORM

6899

2WMT11

If continuation sheet 10 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		СОМ	E SURVEY PLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	718 0005		./ 10/2024
				, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 269	Continued From page	e 10	D 269			
	note dated 08/19/24 i supportive care and e in regard to maintaini Review of Resident # dated 08/20/24-10/31 had been offered 32 s of the showers offere Observation of Resid 9:30am revealed: -Resident #4 was wes than the previous day -Resident #4 was wes sweat pants with drie -Resident #4 was wes gray color. -Resident #4's hair, b	44's Resident Refusal forms 1/24 revealed the resident showers and had refused all d. ent #4 on 12/05/24 at aring a cleaner white t-shirt				
	Interview with Reside revealed: -It had been a "long" -The staff who had gi longer worked there. -There was another s there who used to trin hair, but it had been a longer worked there. Interview with a media 12/05/24 at 9:45am residence	ent #4 on 12/05/24 at 9:30am time since he had a shower. ven him the shower no staff person who had worked m his fingernails, beard, and a "long" time and she no cation aide (MA) on				
	care aide (PCA) and residents to appointm -Resident #4 did not v -He always refused to	the PCA transported nents as needed. want to shower.				

Division of Health Service Regulation

STATE FORM

6899

If continuation sheet 11 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		1:	R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
VILHAM	RIDGE	30 DALE	A DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y 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) COMPLETE DATE
D 269	Continued From page	e 11	D 269			
	meals. -His primary care pro his refusals to showe	me out of his room for vider (PCP) was aware of r. of his refusals to shower.				
	(RCC) on 12/05/24 at -She had worked at the 2024. -She had known Resi once since she had w	he facility since January ident #4 to get a shower				
	but Resident #4 would him. -Resident #4 would le clothes twice a week. -The staff were able to	d not let the podiatrist see at the staff change his				
	clothing.					
	12/06/24 at 9:44am re -She was aware of Re	esident #4's refusals of				
	assistance with perso -She was not sure wh comply that would no -She would like for sta everyday "if he would	nat to do to get him to t violate his rights. aff to change his clothes				
		esident #4 walk limited esident #4 utilize his				
	Telephone interview v 12/06/24 at 11:15am -Resident #4's persor	vith Resident #4's MHP on				
	mentioned to her. -Her role with Resider Ith Service Regulation	nt #4 was medication				

Division of Health Service Regulatio STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VILHAM	PIDGE	30 DALE	ADRIVE			
	THE SE	ASHEVI	LE, NC 28805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	()(5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
D 269	Continued From page	ge 12	D 269			
	monogoment not be	hav damel				
	management not be					
	make to staff to assis	recommendations she could				
	make to stall to assi	st with the situation.				
	Interview with the Ad	ministrator on 12/10/24 at				
	1:52pm revealed:					
	•	everything" to get Resident				
	#4 to shower.	,				
	-There had been mu	Itiple attempts from different				
	staff members without	ut success.				
	2. Review of Resider	nt #2's FL2 dated 07/11/24				
		included type 2 diabetes and				
	schizoaffective disord					
	Review of Resident #	#2's current FL2 dated				
	08/26/24 revealed:					
		ed assistance with bathing				
	and dressing.	4 - J				
	-Sight was document	ted as a functional limitation.				
	Review of Resident #					
	08/26/24 revealed the	e resident required limited				
	assistance with bathi	ing.				
	Review of Resident #	#2's August 2024 shower				
		08/20/24-08/31/24 revealed				
		red staff assistance with five				
		e shower, and received				
	assistance with four	showers.				
		#2's September 2024 shower				
		09/01/24-09/30/24 revealed				
		red staff assistance with nine				
		showers, and received				
	assistance with three	e showers.				
	Review of Resident #	#2's October 2024 shower				
		10/01/24-10/31/24 revealed				
	the resident was offer	red staff assistance with nine				

STATE FORM

6899

2WMT11

If continuation sheet 13 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 12/10/2024	
	PROVIDER OR SUPPLIER	STDEET A		700 0000	1 14	10/2024
			DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE ⁻ DATE
D 269	Continued From page	ge 13	D 269			
	showers, refused fiv assistance with four	e showers, and received showers.				
	documentation from the resident was offer showers, refused nir	#2's November 2024 shower 11/01/24-11/30/24 revealed ared staff assistance with 13 he showers, and received				
	11:15am revealed: -He did not feel he re showers. -He knew how to "ba -It had been "awhile" -He washed up in his -He washed his "priv -He had deodorant to	ent #2 on 12/06/24 at equired staff assistance with the himself." ' since his last shower. s bathroom. 'ates" and under his arms.				
	(RCC) on 12/09/24 a -They provided show #2 to make sure "it's -Resident #2 refused -If a staff went to Res assistance with a sho were supposed to co he refused. -She would then go b again and offer to giv -She tried to encoura soda" to get him to ta	vering assistance to Resident done right." I showers "a lot." sident #2 and offered him ower and he refuses, staff ome to her and let her know back and check with him ve him a shower. age him and "give him a ake a shower. howers taken and refusals of				
D 273	10A NCAC 13F .090		D 273			
	10A NCAC 13F .090	2 Health Care				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED		
		HAL011377	B. WING		1	R 12/10/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE				
VILHAM	RIDGE		A DRIVE LLE, NC 28805					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 14	D 273					
	(b) The facility shall to meet the routine at of residents.	assure referral and follow-up nd acute health care needs						
	This Rule is not met FOLLOW-UP TO TYP							
	Based on these finding Violation was not abate continues.	ngs, the previous Type B ated. Non-compliance						
	reviews, the facility fa referral and follow-up care needs for 1 of 3 (Resident #2) related	to missed eye exam tification of the mental health						
	The findings are:							
		2's FL2 dated 07/11/24 ncluded type 2 diabetes and ler.						
	9:30am revealed: -Resident #2 wore gla	sident #2 on 12/04/24 at asses. asses he wore were different						
	diameters in size and -The lenses did not fit -The lenses were held	were of varying thickness. into the wire frame. d onto the wire frame by						
	sides of the glasses. -The wire was stiff and thickness of paperclip							
	-The ends of the wire	wrapped around the frames uded past the wire frames						

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 15 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED R 2/10/2024	
VAME OF PROVIDER OR SUPPLIER		STREET	DDRESS, CITY, STATE	710.0005		12/10/2024	
			A DRIVE	, ZIP CODE			
VILHAM	RIDGE		LLE, NC 28805				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES					
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From page	ge 15	D 273				
	-The right ear piece frame.	was missing from the wire					
		ent #2 on 12/04/24 at 9:31am " he would like to get "setup" o get new glasses.					
local o appoir	Review of Resident local ophthalmology appointment was sc examination on 06/2	heduled for an eye					
	09/10/24 at 9:30am -Resident #2 refused second local ophtha	d to go to an appointment at a					
	reminder revealed R appointment resche	#2's eye appointment tesident #2 had an duled on 12/05/24 at 10:10am ttend the appointment on					
	practice on 12/04/24 -Resident #2 was so their practice on 06/2 a "no show."	with local ophthalmology at 2:04pm revealed: heduled for an eye exam in 26/24 at 2:15pm and he was					
	10/30/24 and it was -Another appointment at 10:45am and it was	nt was scheduled for 11/15/24					
	scheduled for 05/28/ Telephone interview ophthalmology pract revealed:						

STATE FORM

2WMT11

If continuation sheet 16 of 94

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		COM	SURVEY PLETED R /10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A		- 700 0005	1 12	10/2024
			DDRESS, CITY, STATE	=, ZIP CODE		
WILHAM P	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT 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) COMPLETE DATE
D 273	Continued From pag	e 16	D 273			
	12/05/24 at 10:10am -Resident #2 was pre	heduled for an eye exam on aviously scheduled for an eye ut the appointment had been				
	revealed: -He had his last eye of -The last pair of new was "three or four year -He "fell over" and that damaged. -He made his current combining pieces of 3 glasses he had kept. -He denied ever having	eye glasses he had received				
	prior to appointments -His last eye appointn -When Resident #2 g "got bad" and he refu- appointment. -Resident #2 "definite Review of Resident # medication administra	evealed: blems with becoming but to appointments. needed medication to take to help him with his anxiety. nent had to be rescheduled. ot out of the car his anxiety sed to go into the ly" needed new glasses. 2's October 2024 electronic ation record (eMAR) there were no documented needed clonazepam				
		2's November 2024 eMAR there were no documented				

Division of Health Service Regu STATE FORM

6899

2WMT11

DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HAL011377 B. WING			(X3) DATE SURVEY COMPLETED R		
				12	/10/2024
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RIDGE					
SUMMARY S					
D SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CEDED BY FULL DREEN		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From pag	e 17	D 273			
10:58am revealed: -Resident #2 would m when he was anxious -Resident #2 would m hallway when out of h afraid of falling. -Resident #2 had to t prior to going to appo- Once when they had eye appointment, he ophthalmology office parked in the parking Interview with the Re (RCC) on 12/05/24 at -Resident #2 had a fe -Resident #2 would m -She had scheduled affe -Resident #2's was w to fix. -The facility had been	ot come out of his room ang onto the railing in the his room because he was ake a medication for anxiety intments. I taken Resident #2 to an refused to go into the and tried to get into cars lot due to his anxiety. sident Care Coordinator t 11:45am revealed: ear of going out of the facility. efuse to go to an eye exam. appointments for Resident rent ophthalmology offices. earing the glasses he tried				
Telephone interview of care provider (PCP) of revealed: -The facility had notifi getting Resident #2 to -She did not know if to administering the as of medication prior to tal	with Resident #2's primary on 12/06/24 at 9:44am ed her of the difficulty in o eye appointments. he facility had tried needed anti-anxiety				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page administrations of as administrations of as administered to Resident A second interview w 10:58am revealed: -Resident #2 would n when he was anxious -Resident #2 would n hallway when out of h afraid of falling. -Resident #2 had to t prior to going to appor -Once when they had eye appointment, he ophthalmology office parked in the parking Interview with the Res (RCC) on 12/05/24 at -Resident #2 would re -She had scheduled a #2 between two differ -Resident #2's was w to fix. -The facility had been his eye appointments prescription and a pa Telephone interview w care provider (PCP) o revealed: -The facility had notifit getting Resident #2 to -She did not know if tt administering the as r	OF CORRECTION IDENTIFICATION NUMBER: HAL011377 ROVIDER OR SUPPLIER STREET A RIDGE 30 DALE ASHEVII SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES Continued From page 17 administrations of as needed clonazepam administered to Resident #2. A second interview with the MA on 12/06/24 at 10:58am revealed: -Resident #2 would not come out of his room when he was anxious. -Resident #2 would not come out of his room when he was anxious. -Resident #2 would not come out of his room because he was afraid of falling. -Resident #2 had to take a medication for anxiety prior to going to appointments. -Once when they had taken Resident #2 to an eye appointment, he refused to go into the ophthalmology office and tried to get into cars parked in the parking lot due to his anxiety. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed: -Resident #2 would refuse to go to an eye exam. -She had scheduled appointments for Resident #2 between two different ophthalmology offices. -Resident #2 would refuse to go to an eye exam. -She had scheduled appointments for Resident #2 between two different ophthalmology offices. -The facility had been trying to get Resident #2 to his eye appointments so he could get a new prescription and a pair of new glasses. Telephone interview with Resident #2's primary care provider (PCP) on 12/06/24 at 9:44am revealed: -The facility had notified h	OF CORRECTION IDENTIFICATION NUMBER: (x, z) MULTIFIEE IDENTIFICATION NUMBER: A. BUILDING: A. BUILDING: B. WING INCIDENTIFICATION NUMBER: B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 17 D 273 administrations of as needed clonazepam administered to Resident #2. D 273 A second interview with the MA on 12/06/24 at 10:58am revealed: D 273 -Resident #2 would not come out of his room when he was anxious. -Resident #2 would hang onto the railing in the hallway when out of his room because he was afraid of falling. -Resident #2 had to take a medication for anxiety prior to going to appointments. -Once when they had taken Resident #2 to an eye appointment, he refused to go into the ophthalmology office and tried to get into cars parked in the parking lot due to his anxiety. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed: -Resident #2 had a fear of going out of the facility. -Resident #2 would refuse to go to an eye exam. -She had scheduled appointments for Resident #2 between two different ophthalmology offices. -Resident #2 would refuse to go to an eye exam. -She had scheduled appointments for Resident #2 between two different ophthalmology offices. -Resident #2's was wearing the glasses he tried to fix. -The facilit	OF CORRECTION INTERTIGATION NUMBER: INTELLIONS HAL011377 B. WING ROWDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WINTE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDER ASHEVILE, NC 2805 PROVIDERS PLAN OF CROSS-REFERENCED TO T DEFICIENCY WINTE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 17 D 273 D 273 administrations of as needed donazepam administered to Resident #2. D 273 A second interview with the MA on 12/06/24 at 10:58m revealed: -Resident #2 would not come out of his room when he was anxious. D 273 -Resident #2 would hang onto the railing in the hallway when out of his room because he was afraid of falling. Interview with the Resident #2 to an eye appointment, he refused to go into the ophthalmology office and threid to get into cars parked in the parking lot due to his anxiety. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed: -Resident #2 would refutes to go to an eye exam. -She had scheduled appointments for Resident #2 to his eye appointments so he could get a new prescription and a pair of new glasses. -Resident #2's was wearing the glasses he tried to fix. -The facility had been trying to get Resident #2 to his eye appointments so he could get a new prescription and a pair of new glasses. Telephone interview with th	OF CORRECTION INTIDENTIFICATION NUMBER: INSTRUCT NOT NOT THE SUBSTRUCTION INSTRUCT NOT NOT THE SUBSTRUCTION HALO11377 B WING 12 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROUTER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCE B WING RECARD DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LISC DENTIFYING INFORMATION) ID PREFIX REQUILATORY OR LISC DENTIFYING INFORMATION) ID PREFIX REQUILATORY OR LISC DENTIFYING INFORMATION) Continued From page 17 ID Continued From page 17 Basecond Interview with the MA on 12/06/24 at 10.58 mervealed: Resident #2 would not come out of his room when he was anxious. Resident #2 Nad to take a medication for anxiety prior to going to appointments. Once when they had taken Resident #2 to an eye appointments. Once when they had taken Resident #2 to an eye appointments. The addition of the Resident #2 to an eye appointments. The addition of the Resident #2 to an eye appointments. The addition the religition of the facility. Resident #2 would religition the facility. Resident #2 would religition the facility. Resident #2 would religition the facility. The addition to fire of ophing out of the facility. The addition the weak and the gaisse

Division of Health Service Regulat STATE FORM

6899

2WMT11

If continuation sheet 18 of 94

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			TE SURVEY MPLETED	
		HAL011377	B. WING		1	12/10/2024	
NAME OF PROVIDE	R OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
WILHAM RIDGE		30 DALE	A DRIVE				
		ASHEVI	LE, NC 28805				
(X4) ID PREFIX TAG	K (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE		
revea -Resi -Resi floor -Resi floor -Resi #2's o three away feel li -On 1 eye a -They prior -They the aj afraid Telep 12/06 -Resi to trea (an ai being or hel -Leav "acute -Resi (used prior t -Resi to trea (an ai being or hel -Leav "acute -Staff appoi not go -On 1 sidew	dent #2 was a f dent #2 would of acility and hold of dent #2 express was going to "fa dent #2's eye d depth perception dimensions, ind they are from y ke he would fall 2/05/24, Reside ppointment. a daministered a to leaving for the used a wheelc opointment, so f of falling. hone interview y /24 at 11:15am dent #2 was ord at anxiety due to haxiety disorder t in situations wh p may not be av- ing the facility for e anxiety" for Re- dent #2 had an to treat anxiety to leaving for an iew with the Adr m revealed: had taken Resi- ntments and on o in. 2/05/24, Reside alk" outside the	fall risk. come out into the hallway of onto the hand railing. sed to her he felt like the fill in." octor told her it was Resident in (ability to see objects in cluding their size and how far rou) that made the resident ent #2 went to his scheduled in anti-anxiety medication e appointment. hair to take Resident #2 into Resident #2 would not be with Resident #2's MHP on revealed: lered to receive clonazepam to a diagnosis of agoraphobia that involves intense fear of here escape may be difficult vailable). or appointments could trigger esident #2. as needed clonazepam () ordered to be administered	D 273				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 19 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		co	TE SURVEY MPLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIR CODE		2/10/2024
			EA DRIVE	, ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID SUMMARY		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	ECORRECTION	0(5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 19	D 273			
	Resident #2 into goin appointment.	ng inside and completing the				
	procedures manual d -Omissions and refus documented on the e administration record -Resident's provider v consecutive missed/r Review of Resident # revealed:					
	treat schizophrenia) t 8:00am. -There was an order a tablet daily at bedtime -There was an order a treat anxiety) 0.5mg t 12:00pm, and 4:00pm -There was an order a bedtime.	wo tablets every morning at for clozapine 100mg one e. for clonazepam (used to hree times daily at 8:00am, n. for clonazepam 1mg daily at for hydroxyzine (used to				
	-There was an order f	for mirtazapine (used to ng 1/2 tablet (7.5mg) daily at				
	revealed: -There was an entry fr tablet three times dail 12:00pm, and 4:00pm -On 08/30/24 at 12:37	2's August 2024 eMAR or clonazepam 1mg one half y scheduled for 8:00am, 1. 7pm, clonazepam was dministered due to "resident				
	Review of Resident # revealed: Ith Service Regulation	2's September 2024 eMAR				

Division of Health Service Regula STATE FORM

6899

2WMT11

If continuation sheet 20 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	1001 C-0000000-0000000-00	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY IPLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			L/10/2024
				, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OPPECTION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From page	e 20	D 273			
	-There was an entry t	for clozapine 25 mg two				
		g scheduled at 8:00am.				
		for clonazepam 1mg one half				
		ly scheduled for 8:00am,				
	12:00pm, and 4:00pn					
		for hydroxyzine 25mg one				
		cheduled for 8:00am and				
	6:00pm.					
		am, clozapine, clonazepam,				
	and hydroxyzine were	e documented as not				
	administered due to "	'didn't want this am."				
	Review of Resident #2's October 202 revealed:	2's October 2024 eMAR				
		for clonazepam 1mg one half				
		ly scheduled for 8:00am,				
	12:00pm, and 4:00pn					
	-There was an entry f	for clozapine 100mg one				
	tablet at bedtime sch					
	and the second	for hydroxyzine 25mg one				
		cheduled for 8:00am and				
	6:00pm.					
		for mirtazapine 15mg 1/2				
		t bedtime scheduled at				
	6:00pm. -On 10/05/24 at 4:00p					
		dministered due to "resident				
	refused."					
	-On 10/06/24 at 4:00	om. clonazepam was				
		dministered due to "resident				
	refused."					
	-On 10/07/24 at 8:55a					
		dministered due to "resident				
	refused."	The second s				
	-On 10/16/24 at 4:00					
	documented as not a refused."	dministered due to "resident				
		pm, clozapine, hydroxyzine,				
	and mirtazapine were					
	administered due to "					

STATE FORM

6899

.

2WMT11

If continuation sheet 21 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED R
	ROVIDER OR SUPPLIER				1 1/	2/10/2024
	NOVIDER OR SOFFLIER		DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		A DRIVE LE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	DECTION	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 273	Continued From page	e 21	D 273			
		8pm, clonazepam was administered due to "resident				
	refused."					
		pm, clonazepam was administered due to "resident				
		pm, clonazepam was Idministered due to "resident				
	-On 10/22/24 at 12:2	6pm, clonazepam was Idministered due to "resident				
15	refused." -On 10/31/24 at 12:3	1pm, clonazepam was				
	documented as not a refused."	dministered due to "resident				
	Review of Resident # revealed:	[‡] 2's November 2024 eMAR				
	tablets every morning	for clozapine 25 mg two g scheduled at 8:00am.				
	tablet three times dai	for clonazepam 1mg one half ly scheduled for 8:00am,				
	12:00pm, and 4:00pm -There was an entry tablet at bedtime sch	for clonazepam 1mg one				
	-There was an entry	for hydroxyzine 25mg one cheduled for 8:00am and				
	6:00pm. -On 11/02/24 at 8:00a					
15.	hydroxyzine were do administered due to '	resident refused."				
		pm, clonazepam was Idministered due to "resident				
	-On 11/07/24 at 12:00 documented as not a	6pm, clonazepam was Idministered due to "resident				
	refused." -On 11/07/24 at 4:00p	pm, clonazepam was dministered due to "resident				
	refused."	aministered due to resident				

Division of Health Service Regulation STATE FORM

6899

2WMT11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		CON	E SURVEY IPLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET				L/10/2024
			DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMP	
D 273	Continued From pag	e 22	D 273			2
	documented as not a refused." -On 11/18/24 at 6:33	pm, clonazepam was administered due to "resident pm, clonazepam was				
	refused." Review of Resident # 11/25/24 at 4:07pm r	administered due to "resident #2's chart note entry dated evealed the Mental Health "advised about resident n."				
	revealed: -He always took his r -He did not refuse his	ent #2 on 12/05/24 at 9:37am nedications. s medications. for anxiety, "nervousness",				
	Health Provider (MHI revealed: -She was not aware of health medications for -"Generally" Resident -If Resident #2 tells y	t #2 took his medications. ou he has taken his e could not account for why				
	Interview with a medi 12/05/24 at 9:45am re -Resident #2 did not i she administered mei -Resident #2 would c cart to get his medica her in the hallway at t	cation aide (MA) on evealed: refuse medications when dications. ome out to the medication tions as soon as he heard he medication cart. sident Care Coordinator 11:45am revealed:				

STATE FORM

6899

2WMT11

If continuation sheet 23 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	18 7.52	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	i:	COMPLETED	
		HAL011377	B. WING		R 12/10/2024	
AME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE. ZIP CODE	1 16/10/2024	
			EA DRIVE			
WILHAM F	RIDGE		ILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From pag	je 23	D 273			
/	refuse his medication	ine				
/		also refuse medications if he				
)		ng to the dining room.				
1		ed medications to the				
		nt refused a medication for				
	three consecutive do					
		t refuse medications "that				
N	much."					
		dministrator on 12/10/24 at		-	1.	
- 1	1:52pm revealed:	말을 수 있는 것을 가지 않는 것을 수 있다.		taility will continue	Fo	
		cation refusals was to notify		the stand was there is	of	
		ider after three consecutive		attempt new manual		
	doses were missed.			prisoring residents are	-	
	-Residents would "so			con la	Luir	
		ney did not like the MA who		Facility will continue attempt new methods ensuring residents are comforfable going to	() sector	
		ninister their medications.		appointments. Kisidents	WITH	
		was there weekly for them to		and in the St	0.0	
		th her about Resident #2's		MRN Medicarians N	recibire	
	care.			PRN medications sp to appointments with	(1	
	The facility failed to e	_ ensure Resident #2 went to		he revered and ad	Ina isisterto	
	his ophthalmology ap	ppointment after four		cleard par in	shuchling	
		his anxiety when an as		auministere per	, , , , , , , , , , , , , , , , , , ,	
		lication was not administered	,	administered per ins It resident refuses	He	
		s on 10/30/24 and 11/15/24		medication for some	, reason,	
		experienced a problem with		The second		
J		d the primary care provider		this relosal will be		
	was not notified of the			documented as a	Chart	
		her risk of falls for five		oolonichte		
	A hard south all and south a state of the second	was detrimental to the		note since you are	Unagle	
	the second s	velfare of the resident and		to document a PR	Al refuser	
	constituted a Type B	Violation.				
	The facility provided	a plan of protection in		through the med po		
	and the second	a plan of protection in 6. 131D-34 on 12/10/24 for		Administrator to Imple	ment	
	this violation.	. 1010-04 011 12/10/24 10		and review merely so		
				appoint-ments and an	a Oriential	
1.1.1				appoint rent and	1 1/2	
				barriers weekly, at m	ninimuma. Olice	

STATE FORM

6899

2WMT11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	. ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 292	Continued From pag	e 24	D 292			
D 292	10A NCAC 13F .090 Service	4(c)(3) Nutrition And Food	D 292			
	 (c) Menus In Adult C (3) Any substitutions of equal nutritional va daily dietary requirem of this Rule, appropri documented in record to indicate the foods This Rule is not met Based on observation interviews, the facility of menu substitutions served to residents. The findings are: Interview with a resid 12/04/24 at 9:34am r -The food was not ve -There was never a m was going to be served	a made in the menu shall be alue, in order to maintain the ments in Subparagraph (d)(3) ate for therapeutic diets, and ds maintained in the kitchen actually served to residents.				
	revealed the menu co of orange juice, one-l three-fourths cup of co toast, one teaspoon co	ast menu for 12/09/24 onsisted of four ounces (oz.) half cup of cooked cereal or cold cereal, two slices of of margarine, two teaspoons egg, eight oz. of milk and				

Division of Health Service Regulation

STATE FORM

6899

2WMT11

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		COM	E SURVEY IPLETED R 2/10/2024
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
WILHAM F	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF		CORRECTION	0.0
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 292	Continued From page	e 25	D 292			
	eight oz. of coffee.					
	12/09/24 at 8:43am r served one waffle wit	reakfast meal service on evealed the residents were th syrup, two slices of turkey				
	bacon, a fruit cup or applesauce, and eight oz. of apple cider. Interview with residents on 12/09/24 between 8:47am and 8:53am revealed: -They rarely get eggs served at breakfast.					
		eggs for breakfast on				
	breakfast in a long tin	ne.				
	them.	at was going to be served to		26 13		
	-He was not asked if breakfast on 12/09/24					
	12:30pm revealed:	on 12/09/24 at 8:55am and				
		akfast meal for 12/09/24. or the residents according to				
	-He saw cereal on the 12/09/24 and thought	e menu for breakfast for the residents might want				
2.00		ise they sometimes ving cold foods at breakfast. ggs because there were				
	only six and that was	ggs because there were not enough for everyone. Igs he gave turkey bacon				
	and a fruit cup or appl	lesauce instead.				
	-He did not know wha was.	t a menu substitution form				
	-He had only worked a	at the facility for a few een trained to document				
	meal substitutions.					
	Internieus site the Dee	sident Care Coordinator				

Division of Health Service Regulat STATE FORM

6899

2WMT11

If continuation sheet 26 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 12/10/2024		
NAME OF P	ROVIDER OR SUPPLIER	30 DALE	STREET ADDRESS, CITY, STATE, ZIP CODE 30 DALEA DRIVE ASHEVILLE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	BATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
D 292	(RCC) on 12/09/24 a -The cook was new -The cook was new -The cook may not h complete a menu su available in the kitch Interview with the Ac 1:52pm revealed: -They had food deliv once or twice a weel -He was not aware th the menu change for 12/09/24. -The staff should be	at 1:52pm revealed: and still in training. have known he needed to obstitution form. bstitution forms were en. dministrator on 12/10/24 at rered to the facility at least	D 292	Statt to be adequate trained on substitut immediately upon then trained at lea quarterly by the Manager.	trons hires St Kitchen	ō1/24/2	
D 344	10A NCAC 13F .100 (a) An adult care ho the resident's physic for verification or clai medications and trea (1) if orders for admi resident are not date of admission or read (2) if orders are not of (3) if multiple admiss admission or readmi forms are not the sar The facility shall ensi- clarification is docum record.	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 sion forms are received upon ssion and orders on the me. ure that this verification or hented in the resident's as evidenced by: iews and interviews, the re contact with the	D 344				

STATE FORM

2WMT11

If continuation sheet 27 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	R
	ROVIDER OR SUPPLIER	etdeet 4		700 0005	14	10/2024
UNIL OF T	NOVIDER OR OUT LIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM F	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID						
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
D 344	Continued From page	e 27	D 344			
	(Resident #2) related	• 1 of 3 sampled residents to all prescription and dication orders on the				
	The findings are:					
	Review of Resident # 08/26/24 revealed:	2's current FL2 dated				
		type 2 diabetes mellitus and ler.				
	treat pain) 325mg tab	for acetaminophen (used to let with no dosage, route, or				
		for aspirin EC (used to				
		1mg tablet with no dosage,				
	route, or frequency in					
		for atorvastatin (used to				
	treat high cholesterol)					
	dosage, route, or freq	for chlorhexidine (used to				
		riodontal disease) 0.12%				
	rinse with no dosage,					
	instructions.	route, et mequency				
	-There was an order f	or clonazepam (used to				
		let with no dosage, route, or				
	frequency instructions					
		or clozapine (used to treat				
		g tablet with no dosage,				P. 1
	route, or frequency in					
		or clozapine 25mg tablet				
		, or frequency instructions. or diphenhist (used to treat				
		mg capsule with no dosage,				
	route, or frequency ins					
		or famotidine (used to treat				
		ease) 20mg tablet with no				
	dosage, route, or freq					
		or guaifenesin (used to help		*		
		oml solution with no dosage,				

Division of Health Service Regulation STATE FORM

2WMT11

If continuation sheet 28 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R	
		HAL011377	B. WING		1:	2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	ADRIVE			
		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
D 344	Continued From pag	je 28	D 344			
	route or frequency in	notructions				
	route, or frequency in					
		for hydrocortisone (used to				
		ing, and swelling) 1% cream				
		e, or frequency instructions.				
	-There was an order for hydroxyzine (used to treat anxiety) 25mg tablet with no dosage, route,					
	or frequency instruct					
		for hydroxyzine 25mg				
		age, route, or frequency				
_	instructions.	age, route, or nequency				
	CARL MAL STAL DE SACE LE SUEL DOG ET LE	for Imodium A-D (used to	5.60 E.			
		ablets with no dosage, route,				
	or frequency instruct					
		for lisinopril (used to treat				
		high blood pressure) 40mg tablet with no dosage,				
	route, or frequency instructions. -There was an order for loratadine (used to treat					
		t with no dosage, route, or				
	frequency instruction					
		for metformin (used to treat				
		Omg tablet with no dosage,				
	route, or frequency in					
		for metoprolol (used to treat				
		25mg tablet with no dosage,				
1.1	route, or frequency in					
	-There was an order	for milk of magnesia (used				1.54
	to treat constipation)	400,g/5ml suspension with				
		frequency instructions.				
	-There was an order	for mirtazapine (used to				
		ng tablet with no dosage,				
	route, or frequency in					
		for oxcarbazepine (used to				
		g tablet with no dosage,				
	route, or frequency in					
		for senna 8.6mg (used to				
		plet with no dosage, route, or				
	frequency instruction					
		for sodium chloride (used to				
		ody) 1gm tablet with no				
	dosage, route, or frec lth Service Regulation	quency instructions.				

Division of Health Service Regulation

STATE FORM

6899

2WMT11

If continuation sheet 29 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED
					1:	2/10/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	ADRIVE			
_		ASHEVI	LLE, NC 28805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	OPPECTION	
PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOLL)				ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 344	Continued From page	ge 29	D 344			
	-There was an order for triple antibiotic ointment					
	(used to prevent and	treat minor skin infections)				
- 1 - 1	with no dosage, rout	te, or frequency instructions.				
	Interview with the Re	esident Care Coordinator				
	(RCC) on 12/05/24 a	at 11:45am revealed:				
	-The facility had rece	ently changed to a different				
	software program pr	ovided by the facility's				
	contracted pharmac	y to produce new FL2s for the				
	residents.					
	-Resident #2's curre	nt FL2 was completed using				
	the new software pro					
	-Many of the residen	ts had new FL2s completed				
	with the new softwar	e program.				
	the new El 2e erecto	ers were incomplete on all d with the software program.				
	-She had not noticed	I medication orders were				
	incomplete on the ne					
		gnatures from the primary				
	care providers (PCP)) on the new FL2s.				
		with Resident #2's primary				
	revealed:	on 12/06/24 at 9:44am				
	-She signed Residen	t #2's FL2 dated 08/26/24.				
		sed" she had not noticed the				는 문건
	medication orders we					
		ation orders from his prior				
	FL2 dated 07/11/24 v					
		not notify her concerning the				
	FL2.	n orders on Resident #2's				
	Interview with the RC	C on 12/09/24 at 1:51pm				
	revealed she was res	ponsible for notifying the				
	PCP and obtaining cl resident's FL2s.	arification on orders on the				
		ninistrator on 12/10/24 at				
	1:52pm revealed:					

STATE FORM

2WMT11

If continuation sheet 30 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		HAL011377			12/	10/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
WILHAM	RIDGE	30 DALE	EA DRIVE			
- and	1		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
D 344	Continued From pag	e 30	D 344	-TT C III III		
	-The RCC was rospo	onsible for clarifying any		the treitity has	completed	
	medication orders or	the FL2 that were not clear		an update on t	te new	
	and complete.			Software	1 1	01/24/
		o by the FL2 for medication		The facility has an update on the Software mentione	o that	
	orders.			Will now include	medicati	5
		the active medication orders		administration 1915th	letcone_	
	from the pharmacy.	lication orders on the FL2		and other previously	1 ommittee	3
	were an "oversight."	ication orders on the FLZ				
	ererergina			central in this will	be monil	rene d
D 354	10A NCAC 13F .100	3 (c) Medication Labels	D 354	details. This wal monthly by the	Administra	ter.
	10A NCAC 13F .1003	3 Medication Labels				
	(c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.					
	review, the facility fail container had a corre	n, interviews, and record led to ensure the medication ct label for 1 of 1 sampled) with an insulin pen used to		The facility has ad in new labeling that allows for the facility to now its own labels are to be general appropriate interval generations will only by the ad	sevente . Labers and at 15. Luber	

STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL011377		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 12/10/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	IDOF		ADRIVE			
VILHAM F	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 354	Continued From page	e 31	D 354			
	The findings are:					
	Review of Resident #1's current FL2 dated 06/06/24 revealed diagnoses included diabetes mellitus type 2.					
	Review of Resident #1's physician's orders dated 06/06/24 revealed there was an order for Tresiba (a long-acting insulin to treat high blood glucose levels) 100units (u)/milliliters (ml) inject 36u twice daily.					
	Review of Resident #1's physician's order dated 1/30/24 revealed the facility may use another esident's unopened Tresiba 200u/ml inject 18u wice daily in place of 100u/ml until the facility eceived Resident #1's Tresiba from the wharmacy.					
	bservation of Resident #1's medications on and on 12/04/24 at 4:45pm revealed there was o Tresiba 100u/ml available for administration.					
	on hand on 12/05/24 a -There was a Tresiba blacked out with black	pen 200u/ml with a name marker and Resident #1's				
	blacked out with black marker and Resident #1's name handwritten on a piece of paper and taped to the lid. -There was no change of direction label on the pen.					
		entation with instructions of sident #1's Tresiba 200u/ml t.				
1	contracted pharmacy or revealed:	nacist from the facility's on 12/05/24 at 10:47am				
1	-The pharmacy only p medications and would h Service Regulation	rinted labels for d never have handwritten				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 32 of 94

TAG RESIDENT D 354 Continued Resident Tresiba pa -Resident concentra -The phar dispense concentra -The facilit direction s being adm copy of the the pharm updated o Interview W (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi	SUMMARY ST CH DEFICIENC SULATORY OR 4 From page #1's name of en. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u ty should hat ticker on the inistered to e new order acy so that n the eMAR	30 DALL ASHEV ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ADDRESS, CITY, STATE EA DRIVE ILLE, NC 28805 PREFIX TAG D 354	E, ZIP CODE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	12/10/2024 (X5) COMPLETI DATE
(X4) ID (EA PREFIX (EA TAG Resident = D 354 Continued Resident = Tresiba pa -Resident = -Resident = concentra -The phar dispense I concentra -The facilit direction s being adm copy of the the pharm updated o Interview V (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi details of t -The Admi	SUMMARY ST CH DEFICIENC SULATORY OR 4 From page #1's name of en. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u ty should hat ticker on the inistered to e new order acy so that n the eMAR	30 DALL ASHEV ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EA DRIVE ILLE, NC 28805	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
(X4) ID PREFIX TAG(EA REGD 354ContinuedD 354Resident i Tresiba pa -Resident concentra -The phar dispense i concentra -The facili direction s being adm copy of the the pharm updated oInterview V (RCC) on -Resident for adminis -The MAs Tresiba wit to Resider -The Admi details of t	CH DEFICIENC SULATORY OR I From page #1's name of an. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u by should ha ticker on the inistered to be new order acy so that n the eMAR	ASHEV ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ILLE, NC 28805	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
PREFIX TAG (EA REC D 354 Continued Resident : Tresiba pa -Resident concentra -The phar dispense concentra -The facili direction s being adm copy of the the pharm updated o Interview W (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi details of t	CH DEFICIENC SULATORY OR I From page #1's name of an. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u by should ha ticker on the inistered to be new order acy so that n the eMAR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) a 32 on paper and taped it to the a pen was ordered with a l/ml. ot receive an order or 's Tresiba pen with a l/ml. ave placed a change of e Tresiba pen 200u/ml Resident #1 and faxed a with dosage instructions to the medication could be	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
PREFIX TAG (EA REC D 354 Continued Resident : Tresiba pa -Resident concentra -The phar dispense concentra -The facili direction s being adm copy of the the pharm updated o Interview V (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi details of t	CH DEFICIENC SULATORY OR I From page #1's name of an. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u by should ha ticker on the inistered to be new order acy so that n the eMAR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) a 32 on paper and taped it to the a pen was ordered with a l/ml. ot receive an order or 's Tresiba pen with a l/ml. ave placed a change of e Tresiba pen 200u/ml Resident #1 and faxed a with dosage instructions to the medication could be	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
Resident i Tresiba po -Resident concentra -The phar dispense l concentra -The facili direction s being adm copy of the the pharm updated o Interview V (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi details of t	#1's name of an. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u ty should ha ticker on the inistered to be new order acy so that n the eMAR	on paper and taped it to the a pen was ordered with a u/ml. ot receive an order or 's Tresiba pen with a u/ml. ive placed a change of e Tresiba pen 200u/ml Resident #1 and faxed a with dosage instructions to the medication could be	D 354		
Tresiba pa -Resident concentra -The phar dispense concentra -The facili direction s being adm copy of the the pharm updated o Interview v (RCC) on -Resident for adminis -The MAs Tresiba wh to Resider -The Admi details of t	en. #1's Tresib tion of 100u macy did no Resident #1 tion of 200u by should ha ticker on the inistered to e new order acy so that n the eMAR	a pen was ordered with a n/ml. ot receive an order or 's Tresiba pen with a n/ml. we placed a change of e Tresiba pen 200u/ml Resident #1 and faxed a with dosage instructions to the medication could be			
	12/04/24 at #1's Tresiba stration. had borrow hich was a " hit #1. nistrator wo he Tresiba I 1.	ident Care Coordinator 4:45pm revealed: a 100u/ml was not available ed another resident's higher" dose to administer uld have to explain the porrowed to administer to			
revealed: -On 11/30/ on-call pro	24, another vider to use	C on 12/05/24 at 11:45am MA got permission from an another resident's Tresiba ctions to administer Tresiba			
200u/ml inj Tresiba 10 -She did no	ect 18u twi 0u/ml insuli ot place a cl	ce daily since Resident #1's n pen was unavailable. nange of direction sticker			
dosage an medication	d instruction cart.	cause she wrote the is on a sticky note on the at happened to the sticky			
note with the Resident #	ne dosage a 1's Tresiba.	and instructions for			

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 33 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		HAL011377	B. WING		12	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
WILHAM	RIDGE	30 DALE	A DRIVE				
		ASHEVI	LE, NC 28805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	BATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
D 354	Continued From page	ge 33	D 354				
	insulin to administer directions were com	to Resident #1 because the municated by "word of ning shift and were written on					
	3:22pm revealed: -He was made awar that Resident #1 ran	Iministrator on 12/05/24 at e by the RCC on 12/01/24 out of Tresiba and another					
	being substituted. -The facility did not h 200u/ml pen with a c	a different concentration was have to label the Tresiba change of direction sticker for					
- - - - - - - - - - - - - - - - - - -	Tresiba 200u/ml bec instructions by "word	ister 18u twice daily of the ause they passed off the I of mouth" during shift					
		1 permanent MA and the ed medications and used cover shifts.					
	-The agency staff we of mouth" during shif Resident #1 18u of T	ere also instructed by "word t change to administer resiba 200u/ml.					
	kept it on the medica	Resident #1's Tresiba and					
	the administration of Resident #1 when the direction sticker on the	Tresiba 200u/ml 18u to ere was no change of ne pen and the eMAR was					
	twice daily. -The RCC had taken	resiba 100u/ml inject 36u all precautions by writing the ky note and placing the note					
		rt and staff verbally telling					

6899

2WMT11

If continuation sheet 34 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		E SURVEY PLETED	
		HAL011377	B. WING		12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
WILHAM	RIDGE		A DRIVE			
			LE, 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
D 358	Continued From pag	e 34	D 358			
D 358	10A NCAC 13F .100 Administration	4(a) Medication	D 358			
	 (a) An adult care how preparation and administration and non-by staff are in accord (1) orders by a licensiwhich are maintained 	4 Medication Administration me shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner I in the resident's record; and on and the facility's policies		Response on page	52	
F V B	VIOLATION	UNABATED TYPE A2				
		ngs, the previous Type A2 . Non-compliance continues.				
	THIS IS A TYPE B VI	OLATION				
	reviews, the facility fa medications as order residents (#1 and #2) treat high blood suga					
	The findings are:					
	procedures manual d -Medications, prescrip and treatments will be accordance with the p orders.	s medication policies and ated 06/21/23 revealed: otions and non-prescription, administered in prescribing practitioner's at all medications are in				

STATE FORM

2WMT11

If continuation sheet 35 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED R 2/10/2024
AME OF P	ROVIDER OR SUPPLIER	OTDEET A			1 14	2/10/2024
	NOVIDER OR SOFFEIER		DDRESS, CITY, STATE	, ZIP CODE		
VILHAM	RIDGE					
			LE, NC 28805	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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) COMPLET DATE
D 358	Continued From pag	ge 35	D 358			
	the pharmacy, then the medication and docu- information form. -All medication inform the Resident Care C they may follow up w -Any medication that upon the arrival of the medication from the 1. Review of Resident 06/06/24 revealed di mellitus type 2. Review of Resident a 06/06/24 revealed th (a long-acting insulin levels) 100units (u)/r daily. Review of Resident a 11/30/24 revealed th	medication is not delivered by the facility will borrow that ument it on the medication mation forms will be given to coordinator (RCC) so that with the pharmacy. t is borrowed will be replaced he receiving resident's pharmacy. Int #1's current FL2 dated lagnoses included diabetes #1's physician's orders dated here was an order for Tresiba to treat high blood glucose milliliters (ml) inject 36u twice #1's physician's order dated e facility may use another				
	resident's unopened	Tresiba 200u/ml inject 18u ff 100u/ml until the facility				
	received Resident #					
	pharmacy.					
	medication administr revealed:	#1's October 2024 electronic ration record (eMAR)				
	36u twice daily at 8:0 -There was documer	for Tresiba 100u/ml inject 00am and 6:00pm-8:00pm. ntation Tresiba 100u/ml 36u				
	was administered tw 6:00pm-8:00pm from	ice daily at 8:00am and 1 10/01/24-10/31/24.				
	Review of Resident # revealed:	#1's November 2024 eMAR				

STATE FORM

2WMT11

If continuation sheet 36 of 94
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COM	E SURVEY IPLETED
ME OF PROVIDER OR SUPPLIEI			700 0005	1 14	2/10/2024
		ADDRESS, CITY, STATE	:, ZIP CODE		
LHAM RIDGE		EA DRIVE LLE, NC 28805			
X4) ID SUMMAI	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	
PREFIX (EACH DEFIC TAG REGULATOR	IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358 Continued From	page 36	D 358			
36u twice daily at -There was docu was administered 6:00pm-8:00pm f -There was docu was administered 11/30/24 at 6:00p -There was no do 36u was administ 6:00pm-8:00pm, 6:00pm-8:00pm, -There was no do Tresiba was not a 6:00pm-8:00pm, 6:00pm-8:00pm, 6:00pm-8:00pm, 6:00pm-8:00pm, 6:00pm-8:00pm, 6:00pm-8:00pm, 6:00pm-8:00pm, 18u twice daily at -There was an en 36u twice daily at -There was an en 36u twice daily at -There was an en sugars (FSBS) fo at bedtime. -There was docur at 7:30am, 11:30a the results rangin -There was docur was administered 6:00pm-8:00pm fr -There was no do 18u was administered	Accumentation Tresiba 100u/ml ered on 11/28/24 at 11/29/24 at 8:00am or and 11/30/24 at 8:00am. Accumentation regarding why administered on 11/28/24 at 11/29/24 at 8:00am or and 11/30/24 at 8:00am. Accumentation regarding why administered on 11/28/24 at 11/29/24 at 8:00am or and 11/30/24 at 8:00am. Accumentation for the second accumentation for the second accume				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 37 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
_		HAL011377	B. WING		R 12/10/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
VILHAM I	RIDGE	30 DALE	A DRIVE			
		ASHEVII	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	TION SHOULD BE C	
D 358	Continued From page	e 37	D 358			
	hand on 12/04/24 at 4:45pm revealed there was no Tresiba 100u/ml available for administration.					
	Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 4:45pm revealed:					
	-Resident #1's Tresiba 100u/ml was not available					
	for administration. -The MAs had borrowed another resident's					
		"higher" dose to administer				
	to Resident #1.					
		ould have to explain the borrowed to administer to				
	Telephone interview	with a pharmacist from the				
		harmacy on 12/05/24 at				
	-Resident #1's Tresib					
		on 08/29/24 in the quantity he quantity of 21ml, and				
	10/09/24 in the quant	ity of 21ml and would last				
	approximately 30 day					
	towards the end of No	a would have run out				
	-The facility had to re					
		edication was in low supply				
		t had been received for a s Tresiba since 10/09/24.				
	Second observation of	of Resident #1's medications				
		at 10:32am revealed:				
		pen with a name blacked and Resident #1's name				
	handwritten on a piec	e of paper and taped to the				
	lid.	the Tree line and				
	-The concentration or 200u/ml.	n the Tresiba pen was				
		e of direction label on the				
	pen.					

Division of Health Service Regulation STATE FORM

6899

2WMT11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	IDENTIFICATION NUMBER: A. BUILDING:		CON	E SURVEY IPLETED R	
NAME OF F	ROVIDER OR SUPPLIER	STREET	T ADDRESS, CITY, STATE, ZIP CODE				
				, ZIP CODE			
WILHAM	RIDGE	30 DALE ASHEVIL	LE, NC 28805				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHO		SHOULD BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 38	D 358				
	from the facility's con 12/05/24 at 10:47am -The pharmacy only p medications and wou Resident #1's name of Tresiba pen. -Resident #1's Tresib concentration of 1000 -The pharmacy did no Tresiba pen with a co -Insulin pens should no control purposes. -She would never reac convert the dosage of Tresiba 100u/ml inject Tresiba pen with Res and taped to the lid w 200u/ml. -The dosage of Resid to be changed if the f 200u/ml along with me instructions on the eM #1's Tresiba was adm accurately. -The facility should had direction sticker on the being administered to copy of the new orde the pharmacy so that updated on the eMAF -The facility requeste Tresiba 100u/ml the emails of the solution -The facility requeste	revealed: printed labels for lid never have handwritten on paper and taped it to the a pen was ordered with a u/ml. of dispense Resident #1's oncentration of 200u/ml. never be shared for infection commend for the MAs to f Resident #1's ordered at 36u twice daily with the ident #1's name handwritten with a concentration of dent #1's Tresiba would have facility staff used the pen with redication and dosage MAR to make sure Resident ninistered and documented ave placed a change of the Tresiba pen 200u/ml o Resident #1 and faxed a r with dosage instructions to the medication could be R. r received a fax with a new 's Tresiba. d a refill for Resident #1's evening of 12/04/24. msed a refill for Resident					

6899

2WMT11

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
	HALU11377	D. WING		12/10/2024	
ME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
ILHAM RIDGE	30 DALE	EA DRIVE			
	ASHEVI	LLE, NC 28805			
REFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		SHOULD BE	(X5) COMPLET DATE
D 358 Continued From pag	e 39	D 358			
revealed: -On 11/30/24, another on-call provider to us insulin pen with instru 200u/ml inject 18u tw Tresiba 100u/ml insu -The MA who got per resident's Tresiba for responsible for reque #1's Tresiba from the -The entry on Reside changed from Tresiba daily to Tresiba 200u -Sometimes she adm medications and she 200u/ml pen to Reside she administered 360 on Resident #1's eM/ -The facility's policy a medications from oth medications were un -Resident #1's Tresiba had to be requested for contracted pharmacy -She was responsible cart and requested re weeks when they we -She did not call the pro- Resident #1's Tresiba they were given perm to use another reside Review of an electrom note for Resident #1' 11/30/24 at 5:44pm m -A MA documented R Tresiba 100u/ml and Tresiba 200u/ml avai	esting a refill for Resident pharmacy. nt #1's eMAR was not a 100u/ml inject 36u twice /ml inject 18u twice daily. inistered Resident #1's injected Tresiba 18u of the lent #1 and documented that u of the 100u/ml twice daily AR. allowed borrowing er residents when available. a was not on a cycle-fill and for refill from the facility's e for auditing the medication affills for medications every 2 re in low supply. oharmacy to see why a was not delivered because nission by an on-call provider ont's Tresiba pen. hic triage communication s on-call provider dated evealed: tesident #1 was out of				

STATE FORM

6899

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	CONSTRUCTION	CON	TE SURVEY IPLETED R 2/10/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			2/10/2024
				E, ZIP CODE		
WILHAM F	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORDECTION	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 40	D 358			
	arrival for Resident # pharmacy. -The MA responded b the pharmacy was clo -The provider asked i doses. -The MA responded, #1's Tresiba ran out t reported to her on sh -The provider asked y scheduled. -The MA responded a -The provider asked y blood sugar reading y -The MA responded 2 -The provider ordered inject 18u twice daily	back Monday (12/02/24) and osed for the weekend. if Resident #1 missed any no. She thought Resident hat morning and it was not ift change. what time the next dose was at 6:00pm. what Resident #1's current was.				
	the end of November -The facility told her the by the pharmacy and Telephone interview w care provider (PCP) of revealed: -She was not notified #1 ran out of Tresiba -She was not notified dosage or concentrat administered to Resid	f her Tresiba for 2 days at 2024. hey got her Tresiba refilled was administering it to her. with Resident #1's primary on 12/06/24 at 9:42am by the facility that Resident				
	conversation on the e	up the encounter of the electronic triage note dated here the on-call provider				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 41 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
		HAL011377	B. WING	1:	2/10/2024	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ILHAM F		30 DALE	ADRIVE			
	NDGE	ASHEVI	LE, NC 28805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD ULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				COMPLET DATE
D 358	Continued From pag	e 41	D 358			
	ordered the substitut	ion until Resident #1's				
		d be delivered by the				
	pharmacy on 12/02/2					
		cility to call and get Resident				
		ation of Tresiba 100u/ml				
		s possible from a pharmacy				
	so that no mistakes w					
	administering Tresiba	a to Resident #1.				
	-The order for the Tre	esiba 200u/ml inject 18u				
	twice daily should ha					
	- manager in the second s	eMAR could have been				
	and the second se	ect dosage instructions and				
	concentration.					
		cility to put a change of				
	direction sticker on th	e borrowed Tresiba pen and				
	update the eMAR wit	h the correct concentration				
	and units to be admir					
		ave been administered twice				
		ly and that would have				
	-	blood sugar levels requiring				
	emergency room me	dical attention.				
		ministrator on 12/05/24 at				
		at 1:53pm revealed:				
	-The RCC also wrote					
		Resident #1's Tresiba and				
	kept it on the medica					
		e by the RCC on 12/01/24 out of Tresiba and another				
		out of Tresiba and another a different concentration was				
	being substituted.	a undrent concentration was				
		ave a policy that included to		*		
		u/ml pen with a change of				
	direction sticker for R					
		ster 18u twice daily of the				
		ause they passed off the				
		of mouth" during shift				
	change.	5				
	•	1 permanent MA and the				
	RCC, who also admi					

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 42 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE (A. BUILDING: B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/10/2024	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
				e, zip code		
VILHAM	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 358	Continued From page	je 42	D 358			
	currently and used a shifts. -The agency staff we of mouth" during shift Resident #1 18u of T -He saw no issues we the administration of Resident #1 when the direction sticker on the still documented as T twice daily. -The RCC had taken instructions on a stice on the medication can each other at the char- -The facility would have resident's Tresiba 200 Resident #1 and would the Tresiba since Ref was 100u/ml. -He was responsible concentration on the Tresiba 200u/ml injer one else knew how to -The RCC or MAs we requesting refills for the -The RCC did not fact to change Resident # 18u twice daily becard when the MA got the on-call provider. Observation of Resident hand on 12/05/24 at of Tresiba 100u/ml differences.	gency staff daily to cover ere also instructed by "word ft change to administer Tresiba 200u/ml. with safety concerns related to Tresiba 200u/ml 18u to ere was no change of the pen and the eMAR was Tresiba 100u/ml inject 36u all precautions by writing the ky note and placing the note of ange of shift. ave to request a refill for the 10u/ml that was borrowed for uld cover the cost to pay back sident #1's concentration for changing the dose and eMAR for Resident #1's ct 18u twice daily because no o. ere responsible for				
	hand on 12/05/24 at of Tresiba 100u/ml d the facility's contracte date of 12/04/24.	12:03pm there were 7 pens elivered to the facility from				

STATE FORM

6899

2WMT11

If continuation sheet 43 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COM	E SURVEY IPLETED
	ROVIDER OR SUPPLIER	OTDEET A			1 12	2/10/2024
NAME OF P	NOVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		A DRIVE LE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 358	Continued From page	e 43	D 358			
	revealed diagnoses ir schizoaffective disord	ncluded type 2 diabetes and er.				
	revealed there was an	t #2's FL2 dated 07/11/24 n order for clonazepam) 1mg one tablet at bedtime.				
	(MHP) prescription da	2's mental health provider ated 09/03/24 revealed tablet at bedtime quantity				
		2's August 2024 electronic ttion record (eMAR) from /ealed:				
	tablet daily at bedtime	or clonazepam 1mg one e scheduled for 6:00pm. g was documented as rrences out of 12				
	-On 08/31/24, the clor	nazepam was documented ue to "other read chart				
		2's August 2024 charting was no entry for 08/31/24.				
	Review of Resident #	2's September 2024 eMAR				
	tablet daily at bedtime -The clonazepam 1mg administered 28 occu	or clonazepam 1mg one e scheduled for 6:00pm. g was documented as rrences out of 30				
	opportunities. -On 09/01/24, the clor documented as not ac read chart note." -On 09/02/24, the clor	dministered due to "other				
	documented as not ac "medication on order	dministered due to				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 44 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		HAL011377	B. WING		1	2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM I	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ODDECTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 44	D 358			
	Review of Resident # charting notes reveal 09/01/24.	2's September 2024 ed there was no entry for				
~	Count Sheet (CSCS) clonazepam 1mg 1/2 dispensed 07/15/24 q revealed:	uantity of 30 half tablets				
	documented as admin	om, clonazepam 0.5mg was				
	revealed: -There was an entry fr tablet daily at bedtime -The clonazepam was administered 30 occur opportunities. -On 10/21/24 at 7:06p					
8	revealed: -There was an entry fit tablet daily at bedtime -The clonazepam was administered 30 occu opportunities. -On 11/15/24 at 9:17p	rrences out of 30 om, the clonazepam was owed from" as needed				
	Review of Resident # 06/27/24-11/19/24 for tablet daily as needed	clonazepam 0.5mg one				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 45 of 94

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COL	TE SURVEY MPLETED R 2/10/2024
	PROVIDER OR SUPPLIER				11	2/10/2024
	ROUDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (-
PREFIX	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)			ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 45	D 358			
	documented as admi -On 11/03/24 no doci 0.5mg was documen -On 11/04/24 no doci 0.5mg was documen -On 11/15/24 no doci 0.5mg was documen Review of Resident # 10/01/24-10/11/24 fo (0.5mg) tablets dispendent half tablets revealed clonazepam 0.5mg watching wa	pm, clonazepam 0.5mg was inistered. umented time, clonazepam ted as administered. umented time, clonazepam ted as administered. umented time, clonazepam ted as administered. #2's CSCS dated r clonazepam 1mg 1/2 tab ensed 09/03/24 quantity of 30 on 10/04/24 at 6:00pm, vas documented as #2's CSCS dated r clonazepam 1mg 1/2 tab ensed 10/03/24 quantity of 30 on 10/27/24 at 6:00pm,				
	hand on 12/04/24 at -There was one bubb clonazepam 1mg witi -The pharmacy label 1mg one tablet at bea -The dispense date w tablets. Telephone interview w facility's contracted p 3:44pm revealed: -The pharmacy provinguantity dispensed to administration for inw	ble pack labeled "bedtime" of h one tablet remaining. directions were clonazepam dtime. vas 11/04/24 quantity of 30 with a pharmacist from the harmacy on 12/05/24 at ded a CSCS for each b be used to document the				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 46 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	COM	E SURVEY IPLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE			10/2024
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID		STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN		FCORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
D 358	Continued From page 46		D 358			
	 2 358 Continued From page 46 tablets of clonazepam 1mg for Resident #2 on 09/03/24, 10/03/24, and 11/04/24. Each delivery provided a 30 day supply of the bedtime dose. The pharmacy provided a CSCS form with each bubble pack of the clonazepam 1mg tablets. Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed: The entries on the CSCS dated 11/03/24 and 11/04/24 were documented "borrowed" by her. She borrowed clonazepam 0.5mg from Resident #2's as needed bubble pack. She borrowed the daily medication because she did not have a supply of clonazepam 1mg tablets available to administer. She had not realized at the time the strength of the clonazepam in the as needed bubble pack was 0.5mg instead of 1mg. 					
	revealed: -The facility "sometin clonazepam. -This usually occurre	ent #2 on 12/04/24 at 9:30am nes" ran "short" of his d when it was time for the nedications to arrive from the				
	Telephone interview health provider (MHF revealed: -Resident #2 was ord to treat anxiety due to (an anxiety disorder to being in situations who or help may not be at -There was a potentia	al for increased anxiety when eceive clonazepam as				

STATE FORM

6899

2WMT11

If continuation sheet 47 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	CONSTRUCTION	COM	E SURVEY PLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			
				-, 21° 000E		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 47	D 358			
	any increased anxiet	у.				
	1:52pm revealed: -Their contracted pha emergency supply of discretion. -Their medication pol aides (MAs) to borrow -The MAs were requir medications to the RC -The MAs were not pr documented on the C -The MAs had received importance of docume and include a date an -The eMAR was the p facility's medication and b. Review of Residen revealed there was an 0.12% rinse (used to and swelling of the gu	icy allowed the medication v out of stock medications. red to report any borrowed CC. aying attention when they SCS. ed training on the enting CSCS entries legibly d time. prevailing record of the dministration policy. t #2's FL2 dated 07/11/24 n order for chlorhexidine reduce the inflammation				
	swish and spit 15ml b scheduled at 8:00am -The chlorhexidine wa administered 59 occur opportunities. Review of Resident #2 revealed:	2's September 2024 administration record or chlorhexidine 0.12% rinse y mouth twice daily and 6:00pm. as documented as rrences out of 60 2's October 2024 eMAR or chlorhexidine 0.12% rinse				

Division of Health Service Re STATE FORM

6899

2WMT11

If continuation sheet 48 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		TE SURVEY IPLETED
		HAL011377	B. WING		12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RIDGE	30 DALE	ADRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 358	Continued From page	e 48	D 358			
	scheduled at 8:00am -The chlorhexidine w administered 61 occu opportunities.	as documented as				
	revealed:	and 6:00pm. as documented as				
	12/01/23-12/05/24 rev	or chlorhexidine 0.12% rinse by mouth twice daily and 6:00pm. as documented as				
	documented as borro -On 12/04/24 at 8:04a documented as borro -On 12/04/24 at 5:57p documented as borro	am, chlorhexidine was wed. om, chlorhexidine was wed. om, chlorhexidine was				
	Review of Resident # 08/20/24 -12/05/24 re -On 12/02/24 at 6:20p documented as borroo -On 12/03/24 at 7:35a documented as borroo order." -On 12/05/24 at 7:21a	2's chart note entries dated				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 49 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE (A. BUILDING: B. WING		COM	E SURVEY PLETED R 2/10/2024
IAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE			
				-, ZIF CODE		
VILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN O		PECTION	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
D 358	Continued From pag	e 49	D 358			
	hand on 12/04/24 at no chlorhexidine ava Interview with Reside	lent #2's medications on 3:56pm revealed there was ilable. ent #2 on 12/04/24 at 2:39pm to go to a dental appointment				
	revealed: -He received the chlor -The chlorhexidine w and mouth. -Prior to the morning	ent #2 on 12/06/24 at 9:27am orhexidine that morning. as used to clean his teeth of 12/06/24, he had not kidine in "two weeks."				
	care provider (PCP) o revealed: -She did not prescrib Resident #2.	with Resident #2's primary on 12/06/24 at 9:49am e the chlorhexidine for hlorhexidine would help keep e mouth.				
	facility's contracted p 10:27am revealed: -The current order for twice daily. -They dispensed bott Resident #2 on 05/29 on 12/05/24.	with a pharmacist at the harmacy on 12/06/24 at r chlorhexidine 0.12% 15ml des of chlorhexidine to 9/24, 06/25/24, 08/09/24, and exidine was a 17-day supply eiving it twice daily.				
	(RCC) on 12/09/24 a -She removed Reside	sident Care Coordinator t 1:51pm revealed: ent #2's chlorhexidine cation cart on 12/02/24.				

2WMT11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	discontinuing the med -She had borrowed c another resident's su Resident #2. Interview with the Adr 1:52pm revealed: -He did not know why documented administ there did not seem to sent from the pharma -The RCC was respon- medication carts to er- ordered were available -The eMAR should re- administered. -Their contracted pha- emergency supply of discretion. -They had extra stock took over managemen- the MAs had been uss chlorhexidine. -The MAs must have of chlorhexidine for R resident because the was used up. -Their medication poli- borrow out of stock m- -They did not have a si- back the resident who borrowed. -The MAs were requir- medications to the RC medication.	2's PCP had discussed dication. hlorhexidine solution from pply to administer to ministrator on 12/10/24 at r the medication aides (MAs) tration of chlorhexidine when have been enough supply rey. nsible for checking the nsure the medications le for administration. flect the medication rmacy could do a partial or a medication at their of medications when they nt of the facility and perhaps ing from previous stock of borrowed the last few doses esident #2 from another "back log" of chlorhexidine icy allowed the MAs to redications. specific policy on how to pay	D 358			
	administered as order	red when Resident #1 was resident's Tresiba 200u/ml				

STATE FORM

2WMT11

If continuation sheet 51 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE S COMPL	ETED
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	12/1	0/2024
WILHAM	RIDGE		EA 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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358	with no change of dim insulin pen, the entry were not changed on 100u/ml 36u was doo twice daily with no wa administered the corr placing Resident #1 a dosage with each inje seriously low blood su emergency room eva Resident #2 was adm ordered to treat anxie needed dose of clona ordered clonazepam for 5 instances betwee placing Resident #2 a experiencing increase detrimental to the hea #1 and #2 and constit The facility provided a accordance with G.S. this violation. THE CORRECTION ID VIOLATION SHALL N 2025. 10A NCAC 13F .1004 Administration 10A NCAC 13F .1004 (j) The resident's mare; (2) name of the medic	ection sticker affixed to the and dose/concentration the eMAR, and Tresiba umented as administered ay to tell if Resident #1 was ect dosage of Tresiba at risk of receiving twice the ection that would cause ugar levels requiring an luation and treatment. inistered a medication as ty by administering an as zepam 0.5mg instead of the 1mg scheduled at 6:00pm en 08/20/24-11/19/24 t an increased risk of ed anxiety. This failure was lith and safety of Resident utes a Type B Violation. 	D 367	The facility has fire corrected errors in a medication procovernes at the facility. The has worked with Providers to establish improved oversight p to ensure medication advance. The facility worked prompty as advance. The facility worked prompty as advance their st crotering process as reconfigure their to provide for bet ordering of an edicat the Administrator sh review all medicated have short supplis be ordeved for in advance.	the st process facility all n an process s are nd in y hos macy weantines mod to system to any to y will m	,

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 52 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			TE SURVEY MPLETED
-		HAL011377	B. WING	1	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
WILHAM I	RIDGE		EA DRIVE			
	018445245		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 367	Continued From pag	e 52	D 367			
	 (4) instructions for ac or treatment; (5) reason or justificat medications or treater documenting the ress (6) date and time of at (7) documentation of medications or treater omission, including re (8) name or initials of the medication or treesignature equivalent documented and mail administration record This Rule is not met Based on observation reviews, the facility far medication administer for 3 of 3 sampled re and #3) including accord long-acting insulin to (#1), a medication us a steroid cream used and irritation (#3). The findings are: 1. Review of Resider 06/06/24 revealed dia mellitus type 2. 	dministering the medication ation for the administration of nents as needed (PRN) and ulting effect on the resident; administration; any omission of nents and the reason for the efusals; and, f the person administering atment. If initials are used, a to those initials is to be intained with the medication I (MAR). as evidenced by: ns, interviews, and record ailed to ensure the electronic ation records were accurate sidents (Resident #1, #2, curate documentation of a treat high glucose levels ted to treat anxiety (#2), and I to reduce skin inflammation				
	(a long-acting insulin	to treat high blood glucose hilliliters (ml) inject 36u twice				
	Review of Resident #	1's physician's order dated				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 53 of 94

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		CON	E SURVEY IPLETED R 2/10/2024
	ROVIDER OR SUPPLIER			700 0000		2/10/2024
UNITE OF T	NOVIDEN ON SOFFEIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 367	Continued From page	e 53	D 367			
	resident's unopened	e facility may use another Tresiba 200u/ml inject 18u f 100u/ml until the facility 's Tresiba from the				
	electronic medication (eMAR) revealed:	1's 12/01/24-12/04/24 administration record				
	36u twice daily at 8:0 -There was no entry f 18u twice daily at 8:0	for Tresiba 100u/ml inject 0am and 6:00pm-8:00pm. for Tresiba 200u/ml inject 0am and 6:00pm-8:00pm. to check fingerstick blood				
	sugars (FSBS) four til at bedtime.	mes daily before meals and				
		tation FSBS were checked 4:30pm, and 8:00pm with om 108-236				
	-There was document was administered twice	tation Tresiba 100u/ml 36u ce daily at 8:00am and				
	6:00pm-8:00pm from -There was document was administered on	tation Tresiba 100u/ml 36u				
		nentation Tresiba 200u/ml				
	6:00pm-8:00pm from 8:00am on 12/04/24.	12/01/24-12/03/24 or at				
		ent #1's medications on 1:45pm revealed there was or administration.				
	(RCC) on 12/04/24 at -Resident #1's Tresiba	sident Care Coordinator 4:45pm revealed: a 100u/ml was not available				
	for administration. -The MAs had borrow					
	Tresiba which was a " to Resident #1. Ith Service Regulation	'higher" dose to administer				

Division of Health Service Reg STATE FORM

6899

2WMT11

If continuation sheet 54 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	E SURVEY PLETED
	ROVIDER OR SUPPLIER	OTDEET			12/10/2024	
	NOVIDEN ON BOILFEIER		ADDRESS, CITY, STATE	E, ZIP CODE		
VILHAM F	RIDGE					
	SUMMADY S	TATEMENT OF DEFICIENCIES	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 367	Continued From pag	e 54	D 367			
	-The Administrator w details of the Tresiba Resident #1.	rould have to explain the borrowed to administer to				
	facility's contracted p 9:35am revealed: -Resident #1's Tresib previously dispensed of 21ml, 09/23/24 in t 10/09/24 in the quant approximately 30 day -Resident #1's Tresib towards the end of Ne -The facility had to re pharmacy when a me or out and no request refill for Resident #1's Second observation of on hand on 12/05/24 -There was a Tresiba out with black marker handwritten on a piece lid. -The concentration or 200u/ml instead of Re 100u/ml.	I on 08/29/24 in the quantity the quantity of 21ml, and tity of 21ml and would last /s with each refill. a would have run out ovember 2024. quest refills from the edication was in low supply t had been received for a s Tresiba since 10/09/24. of Resident #1's medications at 10:32am revealed: pen with a name blacked and Resident #1's name the of paper and taped to the in the Tresiba pen was				
	from the facility's cont 12/05/24 at 10:47am i -Resident #1's Tresiba concentration of 100u -The pharmacy did no	revealed: a pen was ordered with a /ml. t dispense Resident #1's				
	The dosage of Reside	ncentration of 200u/ml. ent #1's Tresiba would have acility staff used the pen with				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 55 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	CO	R R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	710.0005		2/10/2024
				E, ZIP GODE		
WILHAM I	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES				
PREFIX	(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	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 367	Continued From page	e 55	D 367			
	200u/ml along with m instructions on the eff #1's Tresiba was adm accurately. -The facility should he order with dosage inst that the medication of eMAR. -The pharmacy never order for Resident #1 Interview with the RC revealed: -On 11/30/24, anothe on-call provider to us insulin pen with instru- 200u/ml inject 18u tw Tresiba 100u/ml insul -The MA who got per resident's Tresiba for responsible for reque #1's Tresiba from the -The entry on Resider changed from Tresiba daily to Tresiba 200u/ -Sometimes she adm medications, and she 200u/ml pen to Reside she administered 36u on Resident #1's Tresib- had to be requested f contracted pharmacy. Interview with Reside 10:05am revealed:	hedication and dosage MAR to make sure Resident ninistered and documented ave faxed a copy of the new structions to the pharmacy so ould be updated on the received a fax with a new 's Tresiba. C on 12/05/24 at 11:45am r MA got permission from an e another resident's Tresiba icctions to administer Tresiba icctions to administer Tresiba icce daily since Resident #1's in pen was unavailable. mission to use another Resident #1 was sting a refill for Resident pharmacy. nt #1's eMAR was not a 100u/ml inject 36u twice fml inject 18u twice daily. injected Tresiba 18u of the ent #1 and documented that of the 100u/ml twice daily AR. a was not on a cycle-fill and or refill from the facility's in #1 on 12/06/24 at				
		ney got her Tresiba refilled				
	by the pharmacy and	was administering it to her.				

Division of Health Service Re STATE FORM

6899

2WMT11

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	E SURVEY PLETED R 2/10/2024
JAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
WILHAM RI	DGE		LE, NC 28805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES			000000000	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 367 (Continued From pag	ge 56	D 367			
3- cok k-tt rrb T rr c tt R d s tt - ir o e c T o - p - - tc 1. w # 2. re	3:22pm and 12/10/2 The RCC also wrote direction change for rept it on the medica He was made awar hat Resident #1 ran esident's Tresiba in being substituted. MAs knew to admin fresiba 200u/ml beo hange. He saw no issues whe administration of Resident #1 when the irection sticker on the till documented as wice daily. The RCC had taken he medication ca ach other at the cha He was responsible oncentration on the resiba 200u/ml inje- ne else knew how to The RCC faxed order harmacy changed to The RCC did not fax to change Resident # 8u twice daily becan then the former MA 1's on-call provider.	e by the RCC on 12/01/24 out of Tresiba and another a different concentration was dister 18u twice daily of the sause they passed off the d of mouth" during shift with safety concerns related to f Tresiba 200u/ml 18u to here was no change of the pen and the eMAR was Tresiba 100u/ml inject 36u all precautions by writing the ext and staff verbally telling ange of shift. for changing the dose and eMAR for Resident #1's ct 18u twice daily because no o. ers to the pharmacy and the he orders on the eMAR. x the order to the pharmacy #1's Tresiba 200u/ml inject use she was not working got the order from Resident				

2WMT11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		СОМ	E SURVEY PLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	70.0005	1 12	10/2024
			A DRIVE	E, ZIP CODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	00000000000	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 367	Continued From page	ge 57	D 367			
	revealed there was a 0.12% rinse (used to and swelling of the g	nt #2's FL2 dated 07/11/24 an order for chlorhexidine o reduce the inflammation gums and reduce gum spit 15ml by mouth twice 6:00pm.				
Review of Resident #2's Septer electronic medication administr (eMAR) revealed: -There was an entry for chlorher swish and spit 15ml by mouth the scheduled at 8:00am and 6:00p -The chlorhexidine was docume administered 59 occurrences of opportunities.	n administration record for chlorhexidine 0.12% rinse by mouth twice daily n and 6:00pm. vas documented as					
	revealed:	and 6:00pm. /as documented as				
	revealed:	and 6:00pm. as documented as				
	12/01/23-12/05/24 re	for chlorhexidine 0.12% rinse				

STATE FORM

6899

2WMT11

If continuation sheet 58 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
		HAL011377	B. WING	12	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE					
			LLE, NC 28805			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 367	Continued From pag	je 58	D 367			
	scheduled at 8:00am -The chlorhexidine w administered 10 occ opportunities. -On 12/03/24 at 5:38 documented as borro -On 12/04/24 at 8:04 documented as borro -On 12/05/24 at 5:20 documented as borro -On 12/05/24 at 7:35 documented as borro -On 12/03/24 at 7:35 documented as borro -On 12/05/24 at 7:21 documented as borro Observation of Resident # no chlorhexidine ava Telephone interview w facility's contracted p 10:27am revealed: -The current order for twice daily. -They dispensed bott Resident #2 on 05/25 on 12/05/24.	h and 6:00pm. vas documented as urrences out of 10 Ppm, chlorhexidine was owed. fam, chlorhexidine was owed. 'pm, chlorhexidine was owed. 'pm, chlorhexidine was owed. 'pm, chlorhexidine was owed. #2's chart note entries dated evealed: pm, the medication was owed "waiting on d/c order." am, the medication was owed "temp waiting on d/c am, the medication was owed "waiting on d/c order." lent #2's medications on 3:56pm revealed there was				
	with Resident #2 rece Interview with Reside					

STATE FORM

2WMT11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING	12	/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 367	Continued From pag	e 59	D 367			
	not received the chlo	rhexidine in "two weeks."				
	(RCC) on 12/09/24 a -She removed Resid solution off the media	ent #2's chlorhexidine cation cart on 12/02/24. hlorhexidine solution from				
	1:52pm revealed: -The MAs should onl	ministrator on 12/10/24 at y document administration of en they administered it to the eflect the medication				
	revealed there was a	nt #2's FL2 dated 07/11/24 n order for clonazepam r) 0.5mg three times daily at nd 4:00pm.				
	(MHP) prescription da -Clonazepam 1mg or 30 with five refills. -There was a note or	² 's mental health provider ated 09/03/24 revealed: ne tablet at bedtime quantity the prescription to refill half day #45 with five refills.				
	facility's contracted p 3:44pm revealed: -The pharmacy disper bubble packs of 30 h 1mg for Resident #2 11/04/24. -Each delivery provid	with a pharmacist from the harmacy on 12/05/24 at ensed and delivered three alf tablets of clonazepam on 09/03/24, 10/03/24, and ed a 30 day supply of the evening scheduled doses.				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 60 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY IPLETED
		TALUTION		<u> 1</u> :	2/10/2024	
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	A DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET
D 367	Continued From pag	je 60	D 367			
	Count Sheet (CSCS) form with each bubble pack				
	of the clonazepam for					
	or the olonazepath it	or inventory.				
	Review of Resident :	#2's September 2024 eMAR				
	revealed:					
	-There was an entry for clonazepam 1mg take					
	one half tablet three times daily scheduled at					
	8:00am, 12:00pm, 4:00pm.					
		omg was documented as				
	administered 89 occi	urrences out of 90				
	opportunities from 09					
		0pm, clonazepam 0.5mg				
	was documented as					
	-On 09/27/24 at 4:00	pm, clonazepam 0.5mg was				
	documented as admi					
	-On 09/28/24 at 12:0	0pm, clonazepam 0.5mg				
	was documented as	administered.				
	-On 09/28/24 at 4:00	pm, clonazepam 0.5mg was				
	documented as admi					
	-On 09/29/24 at 12:0	0pm, clonazepam 0.5mg				
	was documented as					
	-On 09/29/24 at 4:00	pm, clonazepam 0.5mg was				
	documented as admi					
		0pm, clonazepam 0.5mg				
	was documented as					
		pm, clonazepam 0.5mg was				
	documented as admi	nistered.				
	Review of Resident #	2's CSCS for clonazepam				
		ed on 09/03/24 quantity of 30				
	half tablets revealed:					
	-Administration dates 09/18/24-09/28/24.	on the CSCS included				
	- 사망 같은 다 여러 같은 것이다. 한국가 가지 않는 것이 많다. 가지 않는 것이다.	nented administration of				
		n 09/27/24 at 12:00pm.				
		n 09/2//24 at 12:00pm. nented administration of				
		n 09/27/24 at 4:00pm.				
		nented administration of				
		n 09/28/24 at 12:00pm.				
		nented administration of			¥	
	Ith Service Regulation	ioniou auminiariation or				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 61 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	COM	TE SURVEY MPLETED R 2/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIR CODE	······································	2/10/2024
			A DRIVE	, ZIP GODE		
WILHAM	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 367	Continued From pag	e 61	D 367			
	-There was no docur clonazepam 0.5mg of -There was no docur clonazepam 0.5mg of -The last entry on the 8:00am. Review of Resident # revealed: -There was an entry for one half tablet three f 8:00am, 12:00pm, 4: -The clonazepam 0.5 administered 81 occu opportunities from 11 -On 11/01/24 at 12:00 was documented as a -On 11/05/24 at 4:00 documented as admi -On 11/20/24 at 12:00 was documented as a Review of Resident # 1mg tablets dispense half tablets revealed: -Administration dates 10/24/24-11/04/24. -There was no docur clonazepam 0.5mg of	ing was documented as urrences out of 90 /01/24-11/30/24. 0pm, clonazepam 0.5mg administered. pm, clonazepam 0.5mg was nistered. 0pm, clonazepam 0.5mg administered. 42's CSCS for clonazepam ad on 10/03/24 quantity of 30 is on the CSCS included mented administration of n 11/01/24 at 12:00pm.				
	12:00pm. Review of Resident #	CSCS was 11/04/24 at 2's CSCS for clonazepam d on 10/03/24 quantity of 30				

STATE FORM

6899

2WMT11

If continuation sheet 62 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		co	TE SURVEY MPLETED R
NAME OF P	ROVIDER OR SUPPLIER			11	2/10/2024	
	NOVIDER OR SOFFLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 367	Continued From pag	e 62	D 367			
	10/24/24-11/15/24. -There was no docur clonazepam 0.5mg o	s on the CSCS included mented administration of on 11/05/24 at 4:00pm. e CSCS was 11/15/24 at				
	1mg tablets dispense half tablets revealed:	#2's CSCS for clonazepam ad on 11/04/24 quantity of 30 s on the CSCS included				
	-There was no docun clonazepam 0.5mg o	nented administration of n 11/20/24 at 12:00pm. e CSCS was 11/27/24 at				
	(RCC) on 12/09/24 at -She called the pharm sending bubble packs tablets quantity 30 wi each card (morning, f -When the pharmacy bubble packs with ad them, she would pull the times of administr bubble packs. -The medication aide	macy and asked them to stop s of clonazepam 1mg half ith administration times on noon, and evening). continued to send the ministration time stickers on the stickers off and just write ration on the top of the s (MAs) had been instructed ming, noon and evening				
	1:52pm revealed: -The eMAR was the p facility's medication a -The MAs were "not p documented on CSC -The MAs had not be	paying attention" when they				

Division of Health Service Regulation

STATE FORM

6899

2WMT11

If continuation sheet 63 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/10/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ET ADDRESS, CITY, STATE, ZIP CODE				
			A DRIVE	, ZIP CODE			
WILHAM I	RIDGE		LLE, NC 28805				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	()(5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 367	Continued From pag	e 63	D 367				
	sheets (morning, nor #2's clonazepam 0.5 -So "we pulled those document on one CS times of clonazepam -He had trained the M document CSCS ent -He also trained the M the accuracy of the c substances on the m oncoming MA at the 12/29/23 revealed: -Diagnoses included high blood pressure. -He was intermittently Review of Resident # revealed an order da triamcinolone 0.1% c twice daily with a stop Review of Resident # revealed: -There was an order 1 0.1% apply to affecte -The RCC documente triamcinolone cream 11/02/24, 11/04/24, 1 11/21/24 at 8:00am. -The RCC documente triamcinolone cream	on, and evening) for Resident mg scheduled doses. " and asked the MAs to just SCS for all administration 0.5mg for Resident #2. MAs on how to properly ries. MAs to count off and verify counts of all controlled edication cart with the end of their shifts. It #3's current FL2 dated chronic lung disease and y disoriented. (3's physician orders ted 04/15/24 for ream apply to affected area to date of 12/28/24. (3's November 2024 eMAR for triamcinolone cream					
	11/07/24, 11/22/24 ar Review of Resident # eMAR revealed:	nd 11/23/24 at 6:00pm. 3's December 1-5, 2024,					
	-The RCC documente	ed she administered the					

Division of Health Service Reg STATE FORM

6899

2WMT11

If continuation sheet 64 of 94

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377		(X2) MULTIPLE C A. BUILDING: B. WING	CON	R R 2/10/2024			
	ROVIDER OR SUPPLIER	STDEET A					
UNITE OF T	NOVIDEN ON SOFFEIER		DDRESS, CITY, STATE	, ZIP CODE			
WILHAM	RIDGE	30 DALE					
			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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE	
D 367	Continued From page	e 64	D 367				
	triamcinolone cream 12/03/24 at 6:00pm.	0.1% to Resident #3 on					
	administration on 12/	3's available medications for 04/24 revealed there was a 0.1% cream for Resident					
	revealed:	nt #3 on 12/04/24 at 4:38pm					
	pointed to his groin. -Some staff offered h	ash in his "private area" and im the medicated cream and					
	some did not. -Staff would give him self-administer it.	the cream and he would					
	(RCC) on 12/05/24 at	nistered Resident #3's					
	-Anytime she offered Resident #3, he woul	the triamcinolone cream to d refuse it.					
	have the triamcinolon	he pharmacy recently to le cream 0.1% removed edication administration					
	record (eMAR) becau -Any documentation s	se Resident #3 refused it.					
	was an error.						
	Interview with the Adr 1:52pm revealed: -He was not aware th	ninistrator on 12/10/24 at					
	erroneously documer was being administer	ting triamcinolone cream ed to Resident #3.					
	-The eMAR documen medications that are a						

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 65 of 94

STATEMENT	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		HAL011377		12	/10/2024	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
WILHAM F	RIDGE		EA DRIVE LLE, NC 28805			
(X4) ID SUMMARY		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
D 375	Continued From pag	e 65	D 375			
D 375	10A NCAC 13F .100 Medications	5(a) Self-Administration Of	D 375			
	Medications (a) An adult care how who are competent a self-administer their r requirements are me (1) the self-administer physician or other per prescribe medication documented in the re (2) specific instruction	medications if the following at: ation is ordered by a erson legally authorized to is in North Carolina and				
	interviews, the facility sampled residents (# physician order to sel related to treat gastric	ns, record reviews, and / failed to ensure 3 of 3				
	The findings are:					
	to Resident Self-Adm dated 06/21/23 revea -A resident must be c able to self-administe -The medication to be ordered by a physicia	competent and physically				

6899

2WMT11

If continuation sheet 66 of 94

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING		R	
	ROVIDER OR SUPPLIER	-	ADDRESS, CITY, STATE		12	2/10/2024
WILHAM F	RIDGE		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 375	Continued From page	e 66	D 375			
	1) Review of Resident #7's current FL2 dated 06/06/24 revealed: -Diagnoses included schizoaffective disorder and gastric esophageal reflux disease (GERD). -There was no information listed regarding his orientation.					
	initial tour on 12/04/2 -There was a plastic (used to treat GERD) -The plastic bottle of indicated there were tablets.	lent #7's room during the 4 at 9:26am revealed: bottle of calcium carbonate o n his bedside table. calcium carbonate label 72 chewable 1000mg calcium carbonate was mpty.				
	revealed: -He had to take the c help with his heartbur -The last time he tool was last week.	ent #7 on 12/04/24 at 9:26am alcium carbonate tablets to m. < a calcium carbonate tablet bught him the calcium				
		7's physician orders for calcium carbonate. to self-administer calcium				
	Interview with a medi 12/04/24 at 2:40pm re -Resident #7 did not I self-administer calciu -She was not aware h his room. -She was not aware h	evealed: have orders to m carbonate. ne had calcium carbonate in				

Division of Health Service Re STATE FORM

6899

2WMT11

If continuation sheet 67 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		СОМ	E SURVEY PLETED R 2/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			-/ 10/202-
				, ZIP CODE		
WILHAM	RIDGE		LE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(3/5)
PREFIX		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 375	Continued From page	ge 67	D 375			
	calcium carbonate ir	his room				
	-She did not always give medication to the					
	residents in their roc					
	 And Report of Control and Annual Control of Control 2014;17(1) 	ve medication in the hallway,				
		ch, or residents may come to				
	the medication cart when it was time for their					
	medication administ	ration.				
	Interview with the Re	esident Care Coordinator				
	(RCC) on 12/04/24 a					
	-Resident #7 did not					
	self-administer calci					
	-She was not aware	the calcium carbonate was in				
	his room.					
		walk to the medication cart				
		his medications to be	10			
	administered.	and the factility of				
	provider (PCP).	see the facility primary care				
		ok Resident #7 to all his				
		ts outside the facility.				
						40
		ministrator on 12/10/24 at				
	1:52pm revealed:					
	-In order for a reside	An and the second se				
		P had to write an order for it. order for a resident to				
		cations, there was not an				
		ted to verify the resident				
		urately self-administer the				
	medication.	,				
		was not a medication				
		a physician's order to				
	self-administer since medication.	it was an over-the-counter				
		ent #8's current FL2 dated				
	06/06/24 revealed:	Deskinger I. II.				
		Parkinson's disease and				
-	anxiety. Ith Service Regulation					

STATE FORM

2WMT11

If continuation sheet 68 of 94

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	сом	E SURVEY PLETED	
				12	2/10/2024	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
VILHAM I	RIDGE		A DRIVE _LE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	• • • • • • • • • • • • • • • • • • • •	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
D 375	Continued From pag	e 68	D 375			
	-He had intermittent	disorientation.				
	Poviow of a modical	report from a local hospital				
		aled Resident #8 had				
		sion (a type of high blood				
		e arteries in the lungs and				
		o moderate emphysema				
	(chronic lung disease	e).				
	Observation of Resid	dent #8's room during the				
		24 at 10:01am revealed:				
	-There was a nebuliz	er machine in his room.				
		unopened vials of a liquid				
	medication beside th	e nebulizer.				
	Interview with Reside	ent #8 on 12/04/24 at				
	10:01am and 12/05/2	24 at 11:45am revealed:				
		oblems, so he took medicine				
	for it when he neede	I D TALLY WE DESCRIPTION				
	 He could self-admin treatments. 	ister his breatning				
	-He had a breathing	treatment with the				
	medication about a v					
	Review of Resident	#8's physician orders				
	revealed:					
	-The original order da	ated 07/07/23 for I (used to treat various lung				
		inhale 1 vial via nebulizer				
	once daily as needed					
		so indicated Resident #8				
		the nebulized medication.				
		dated 05/02/24 indicating				
	Resident #8's as nee					
	Ipratropium/Albutero	I had not been used in the				
		on the order for the PRN				
	_	to be discontinued on				
- 1 - N	05/06/24.					

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 69 of 94

	f Health Service Regu OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	СОМ	E SURVEY PLETED	
AME OF PR	OVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE			/10/2024
			EA DRIVE			
ILHAM R	IDGE		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 375	Continued From page	e 69	D 375			
	Interview with a MA or revealed: -Resident #8 could no medications. -She was not aware h room. -He usually came out his medication. Interview with the RC revealed: -Resident #8 did not h that he could self- adi -She was not aware h for his nebulizer in his Interview with the Adr 1:52pm revealed: -The staff had been in room and had not see medication vials for th -Resident #8 should room to self-administed discontinued. 3) Review of Resider 12/29/23 revealed: -Diagnoses included high blood pressure. -He was intermittently Review of Resident # revealed: -An order dated 04/15 cream apply to affected -There was a stop data	on 12/04/24 at 2:40pm ot self-administer his he had medication in his it to the medication cart for C on 12/04/24 at 2:49pm have any PRN medication minister. he had four medication vials s room. ministrator on 12/10/24 at h and out of Resident #8's en the nebulizer or the four he nebulizer. not have medications in his er that have been int #3's current FL2 dated chronic lung disease and y disoriented. G'24 for triamcinolone 0.1% ed area twice daily.				

STATE FORM

6899

2WMT11

If continuation sheet 70 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		HAL011377	B. WING	12/10/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	RIDGE		A DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLE DATE
D 375	Continued From page	ge 70	D 375			
	administration on 12/04/24 revealed there was a tube of triamcinolone 0.1% cream for Resident #3.					
	revealed: -He used to have a monitor pointed to his groin. -Staff would give him self-administer it. -He refused the trian because the rash was	ent #3 on 12/04/24 at 4:38pm rash in his "private area" and n the cream and he would ncinolone cream recently as healed. e triamcinolone cream in a				
	revealed: -Resident #3 did not self-administer medi -Resident #3 came t medication when it v -She gave him the tr self-administer. -She had never adm cream to Resident # where the "affected a Interview with the Ref revealed Resident # self-administer any p creams. Interview with the Act 1:52pm revealed: -He was not aware to triamcinolone cream self-administer.	cations. o the medication cart for his vas time to administer them. iamcinolone cream to inistered the triamcinolone 3 and she did not know area" was. CC on 12/05/24 at 12:09pm 3 did not have an order to prescribed medicated dministrator on 12/10/24 at he MA was giving the to Resident #3 to have a self-administration		Facility Will conduct room sweeps to residents harboring medications for se that are not ino in their medical This process will overseen by the	any	

STATE FORM

6899

2WMT11

If continuation sheet 71 of 94

STATEMEN	of Health Service Regu of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011377	B. WING	12	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WILHAM F	RIDGE					
0	CUMMADY CT		LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 377	Continued From page	e 71	D 377			
D 377	10A NCAC 13F .1006	6(a) Medication Storage	D 377			
	 (a) Medications that stored in the resident safe and secure man care home's medicati procedures. This Rule is not met Based on observation 	ns, record reviews, and				
		named to ensure ored in a safe and secure npled residents (#7 and #8).				
	Storage of Medication self-adminstered med	s Medication Policies or ns dated 06/21/23 revealed dications that are kept in a e stored in a safe and				
		nt #7's current FL2 dated agnoses included gastric sease (GERD).				
	tour on 12/04/24 at 9	ent #7's room during initial :26am revealed there was a um carbonate (used to treat le table.				
	carbonate in his room -She did not always g residents in their roor	evealed: Resident #7 had calcium n. give medication to the				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 72 of 94
STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		The second se	LETED
		HAL011377		12/	10/2024	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
WILHAM	RIDGE		EA DRIVE LLE, NC 28805			
	STIMMADA S	TATEMENT OF DEFICIENCIES				1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 377	Continued From page 72		D 377			
	on the smoking porc the medication cart v medication administr	h, or residents may come to when it was time for their ration.				
	(RCC) on 12/04/24 a -She was not aware carbonate in his roor	Resident #7 had calcium n. walk to the medication cart				
	1:52pm revealed: -The facility offered a use if they had medic they wanted to keep -He had not been aw out on Resident #7's	are medications were sitting				
	06/06/24 revealed: -Diagnoses included anxiety.	ent #8's current FL2 dated Parkinson's disease and				
	dated 09/23/24 revea pulmonary hypertens pressure affecting the	report from a local hospital aled Resident #8 had sion (a type of high blood e arteries in the lungs and o moderate emphysema				
	tour on 12/04/24 at 1 -There was a nebuliz -He had a cup with 4 beside the nebulizer.	er machine in his room. vials of a liquid medication				

Division of Health Service Regulation STATE FORM

6899

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/10/202			
NAME OF P	ROVIDER OR SUPPLIER	30 DALE	DDRESS, CITY, ST EA DRIVE LLE, NC 28805		12/10/202	-		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLET DATE
D 377	10:01am and 12/05/2 -He had breathing pr medication in the via nebulizer. -He did not lock his n -He used his lock box Interview with a medi 12/04/24 at 2:40pm r -She was not aware with four Ipratropium disease) vials in his r -She did not always g residents in their room Interview with the Re (RCC) on 12/04/24 a not aware Resident # Ipratropium/Albuterol Interview with the Ad 1:52pm revealed: -The facility offered a use if they had medic they wanted to keep	ent #8 on 12/04/24 at 24 at 11:45am revealed: oblems, so he used the Is and placed it in his nedications up in his room. x to secure his valuables. ication aide (MA) on revealed: Resident #8 had a nebulizer /Albuterol (used to treat lung room. give medication to the ms. sident Care Coordinator t 3:02pm revealed she was 48 had a nebulizer with four vials in his room. ministrator on 12/10/24 at Il residents a locked box for cations or other valuables in their rooms. are medications were sitting	D 377	Facility will conduct Weekly room Sweet to ensure adequate Storage of Self-ac Medications. Improper Storage of wedication Storage of wedication Storage of wedication Storage of wedication Storage of wedication	ng A			
D 392	10A NCAC 13F .1008 (a) An adult care hor controlled substances receipt, administration controlled substances	8 (a) Controlled Substances B Controlled Substances me shall assure a record of s by documenting the n, and disposition of s. These records shall be esident's record in the facility	D 392	Contract and facility reprimand residents to with the contract. Process to be overs by the Administrat	Accordonce Fhis	e e		

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 74 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			
		DENTITION TONIEN	A. BUILDING:		СОМ	PLETED
		HAL011377	B. WING	12	R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
VILHAM	RIDGE	30 DALI	EA DRIVE			
		ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FILEFIX		N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 74		D 392			
	and in such an order reconciliation of cont	that there can be accurate rolled substances.				
	This Rule is not met	as evidenced by:				
		ns, interviews, and record				
		ailed to ensure a readily				
	retrievable record that receipt and administr	at accurately reconciled the				
		sampled residents (#2 and				
		olled substance for anxiety				
	(#2 and #8).					
	The findings are:					
	Review of the facility	's medication policies and				
	procedures manual o	lated 06/21/23 revealed:				
	and the set of the set	ontrolled substances will be cility and will be available for				
	President and the second se	nentation will be kept in the				
		eceipt of the controlled				
	substance by the pha	armacy will be maintained.				4 - 5 - 5
		will be maintained within the				
	facility for a minimum	n of five years.				
	1. Review of Resider	nt #2's FL2 dated 07/11/24				
	and the second sec	ncluded type 2 diabetes and				
	schizoaffective disor	der.				
	a. Review of Resider	nt #2's FL2 dated 07/11/24				
	revealed there was a	an order for clonazepam				
	(used to treat anxiety	/) 1mg daily at bedtime.				
	Review of Resident	#2's August 2024 electronic				
	medication administr 08/20/24-08/31/24 re	ration record (eMAR) from evealed:				
		for clonazepam 1mg take				
	one tablet at bedtime	e scheduled at 6:00pm.				
	-There were 12 docu alth Service Regulation	mented administrations of				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 75 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL011377	B. WING		12	R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		-	
		30 DALE	EA DRIVE				
WILHAM	RIDGE	ASHEVI	LLE, NC 28805				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET	
D 392	Continued From pag	je 75	D 392				
	clonazepam from 08	/20/24-08/31/24.					
	Review of Resident #2's Controlled Substance						
) for clonazepam 1mg tablets					
		24 quantity of 31 tablets					
	revealed:						
	-Administration dates	s on the CSCS included					
	08/01/24-08/30/24.						
		0pm, two doses were signed		÷			
		e dose was documented as					
	as administered on the C	SCS, one dose documented				- 1. T	
	as auministered on t	THE EMAR.					
	Review of Resident #2's charting notes dated						
	08/20/24-09/10/24 revealed there was no entry						
	concerning the borrowed clonazepam dose on						
	08/27/24.						
		#2's mental health provider					
		lated 09/03/24 revealed:					
	30 with five refills.	ne tablet at bedtime quantity					
		n the prescription to refill half					
		day #45 with five refills.					
		with a pharmacist at the					
		oharmacy on 12/05/24 at					
		esident #2's clonazepam 1mg					
	daily at bedtime reve						
		ided a Controlled Substance) for each quantity dispensed					
		ent the administration for					
	inventory control.						
		as for clonazepam 1mg					
	quantity of 30 tablets						
		ity 30 clonazepam 1mg					
		sed in one bubble pack a				1151	
	30-day supply.	ity 30 clonazepam 1mg					
		sed in one bubble pack a					
	alth Service Regulation						

Division of Health Service Regulat STATE FORM

6899

2WMT11

If continuation sheet 76 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
		HAL011377	B. WING	12	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE	30 DALI	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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From pag	e 76	D 392			
		ty 30 clonazepam 1mg ed in one bubble pack a				
	revealed:	#2's November 2024 eMAR				
	one tablet at bedtime	for clonazepam 1mg take e scheduled at 6:00pm. Imented administrations of				
		#2's CSCS for clonazepam ed on 11/04/24 quantity of 30				
		s on the CSCS included				- 6
	-On 11/05/24 at 6:00	pm, one tablet documented				
		lets documented remaining.				
		pm, one tablet documented				
1101		lets documented remaining.				
		pm, one tablet documented lets documented remaining.				
		pm, one tablet documented				
		lets documented remaining.				
		pm, one tablet documented				
		lets documented remaining.				
	-On 11/10/24 at 6:00	pm, one tablet documented				
		lets documented remaining.				
		pm, one tablet documented				
		lets documented remaining.				
		pm, one tablet documented				
		lets documented remaining. pm, one tablet documented				
		lets documented remaining.				
1 - D -		pm, one tablet documented				
		lets documented remaining.				
		pm, one tablet documented				
		lets documented remaining.				
	-On 11/16/24 at 6:00	pm, one tablet documented				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 77 of 94

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/10/2024	
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			
			., 211 0002		
/ILHAM RIDGE		LLE, NC 28805			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(VE)
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 392 Continued From page	9 77	D 392			
-On 11/17/24 at 6:00p administered, 17 table -On 11/18/24 at 6:00p administered, 16 table -On 11/19/24 at 6:00p administered, 17 table -On 11/20/24 at 6:00p administered, 15 table -On 11/21/24 at 6:00p administered, 15 table -On 11/22/24 at 6:00p administered, 13 table -On 11/23/24 at 6:00p administered, 13 table -On 11/24/24 at 6:00p administered, 11 table -On 11/25/24 at 6:00p administered, 10 table -On 11/26/24 at 6:00p administered, 9 tablet -On 11/27/24 at 6:00p administered, 7 tablet -On 11/28/24 at 6:54p administered, 7 tablet -On 11/28/24 at 6:54p administered, 5 tablet -On 11/28/24 at 6:54p administered, 5 tablet -On 11/29/24 at 6:00p administered, 5 tablet -On 11/29/24 at 6:00p administered, 5 tablet -On 11/29/24 at 6:00p administered, 3 tablet -On 11/20/24 at 6:00p	ets documented remaining. om, one tablet documented ets documented remaining.				

STATE FORM

6899

2WMT11

If continuation sheet 78 of 94

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
		HAL011377	B. WING			R /10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	PIDCE	30 DALE	A DRIVE			
	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 78		D 392			
		et documented remaining. pm, one tablet documented ets remained.				
	revealed:	ent #2 on 12/04/24 at 9:30am nes" ran "short" of his				
		d when it was time for the nedications to arrive from the				
	(RCC) on 12/10/24 a	esident Care Coordinator t 10:40am revealed: e for auditing the CSCS				
	when she worked as	m when she had time or a medication aide (MA). set schedule to audit the				
	1:52pm revealed:	Interview with the Administrator on 12/10/24 at 1:52pm revealed:				
	-CSCS audits consis	s on resident CSCS entries. ted of looking for missed legible, time and dates, and				
		igh an entry that was in error. the CSCS entries on				
	properly document o -The MAs were supp	osed to do a count of every				
	to handing off the ke the oncoming shift M					
	substance bubble pa	uld visualize each controlled				
		the staff tried to figure out				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 79 of 94

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		COM	SURVEY PLETED
		HAL011377		12	12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE		EA DRIVE			
			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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 79		D 392			
	why the count was off. -He did not keep track of the MAs who would					
		controlled substance count				
	-The issues with the entries were a "docu	discrepancies on the CSCS mentation issue."				
		nt #2's FL2 dated 07/11/24 an order for clonazepam				
	(used to treat anxiety	(used to treat anxiety) 0.5mg three times daily at 8:00am, 12:00pm, and 4:00pm.				
		#2's August 2024 electronic ration record (eMAR) from				
	-There was an entry	for clonazepam 1mg take s daily scheduled at 8:00am,				
		mented administrations of /20/24-08/31/24.				
	Count Sheet (CSCS)	#2's Controlled Substance) for clonazepam 1mg tablets 24 quantity of 31 half tablets				
	-Administration dates 08/20/24-08/28/24.	s on the CSCS included				
	out on the CSCS, on "borrowed" on the CS	0pm, two doses were signed e dose was documented as SCS, one dose documented				
		he eMAR. 0pm, two doses were signed e dose was documented as				
		SCS, one dose documented				
		0pm, two doses were				
	documented as "born dose documented as	rowed" on the CSCS, one administered on the eMAR.				
	-On 08/23/24 at 12:0	0pm, two doses were				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 80 of 94

STATEMEN	of Health Service Regi T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 12/10/2024	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			10/2024
	NOVIDEN ON OUT FIEN					
WILHAM I	RIDGE		LLE, NC 28805			
(X4) ID SUMMARY STATEM		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COP	RRECTION	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
D 392	Continued From page 80		D 392			
	signed out on the CS	SCS, one dose was				
		rowed" on the CSCS, one				
		administered on the eMAR.				
		Opm, two doses were				
	signed out on the CS	• Martin Contraction and Contr				
		rowed" on the CSCS, one				
	dose documented as	administered on the eMAR.				
	-On 08/27/24 at 12:0	0pm, two doses were				
	signed out on the CS					
		rowed" on the CSCS, one				
		administered on the eMAR.				
	-The entry on 08/20/2					
		Resident Care Coordiantor				
	(RCC).					
	-The entries on 08/1/24, 08/22/24, 08/23/24,					
	08/26/24, and 08/27/ medication aide (MA	24 were documented by one).				
		#2's charting notes dated				
- 1 ° -		evealed there were no entries				
		wed clonazepam doses on				
	08/20/24, 08/21/24, 08/21/24, 0	08/23/24, 08/26/24, and				
	Review of Resident #	#2's mental health provider				
		ated 09/03/24 revealed:				
		ne tablet at bedtime quantity				
	30 with five refills.					
		n the prescription to refill half				
	tablets three times a	day #45 with five refills.				
	Telephone interview	with a pharmacist at the				
		harmacy on 12/05/24 at				
		esident #2's clonazepam 1mg				
	1/2 tablet three times					
		ded a Controlled Substance				
) for each quantity dispensed				
		ent the administration for				
	inventory control.	a for donazonam 1mz				
	alth Service Regulation	s for clonazepam 1mg				_

STATE FORM

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		COMF	SURVEY PLETED		
		HAL011377	B. WING		12/10/2024			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE				
WILHAM I	RIDGE		EA DRIVE LLE, NC 28805					
(X4) ID	SUMMARY S				CORDECTION			
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL						ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 81		D 392					
		s with five refills. ved the pharmacy to refill If tablets three times a day						
	revealed:	#2's October 2024 eMAR for clonazepam 1mg take						
	half tablet three time 12:00pm, 4:00pm.	s daily scheduled at 8:00am, imented administrations of						
		#2's CSCS for clonazepam ed on 10/03/24 quantity of 30						
	-Administration dates	half tablets revealed: -Administration dates on the CSCS included						
	service and the service services and	am, one tablet documented						
		lets documented remaining. opm, one tablet documented						
		lets documented remaining.						
		am, one tablet documented						
		lets documented remaining.						
	-On 10/25/24 at 12:0	00pm, one tablet documented						
		lets documented remaining.						
		one tablet documented						
		lets documented remaining.)am, one tablet documented						
		lets documented remaining.						
		00pm, one tablet documented						
		lets documented remaining.						
		pm, one tablet documented						
	administered, 22 tab	lets documented remaining.						
		am, one tablet documented						
		lets documented remaining.						
		00pm, one tablet documented						
		lets documented remaining.						
		opm, one tablet documented lets documented remaining.						
	alth Service Regulation	neta documented remaining.						

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 82 of 94

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING		12/10/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ILHAM R	IDGE	30 DALE	EA DRIVE			
	IDGE	ASHEVI	LLE, NC 28805			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLET
D 392	Continued From pag	je 82	D 392			
	-On 10/27/24 at 6:00	opm, one tablet documented				
		lets documented remaining.				
		am, one tablet documented				
		lets documented remaining.				
		00pm, one tablet documented				
		lets documented remaining.				
	-On 10/28/24 at 4:00	pm, one tablet documented				
		lets documented remaining.				
	-On 10/29/24 at 8:00	am, one tablet documented				
	administered, 16 tab	lets documented remaining.				
	-On 10/29/24 at 12:0	00pm, one tablet documented				
	administered, 15 tab	lets documented remaining.				
	-On 10/29/24 at 4:00	pm, one tablet documented				
	administered, 14 tab	lets documented remaining.				
	-On 10/30/24 at 8:00	am, one tablet documented				
	administered, 13 tab	lets documented remaining.				
	-On 10/30/24 at 12:0	0pm, one tablet documented				
	administered, 12 tab	lets documented remaining.				
	-On 10/30/24 at 4:00	pm, one tablet documented				
		lets documented remaining.				
		am, one tablet documented				
1.1.1		lets documented remaining.				
		opm, one tablet documented				
		ets documented remaining.				
	-On 11/01/24 at 8:00	am, one tablet documented				
		ets documented remaining.				
		pm, one tablet documented				
		ets documented remaining.				
		am, one tablet documented				
		ets documented remaining.				
		Opm, one tablet documented				
		ets documented remaining.				
		pm, one tablet documented				
		ets documented remaining. am, one tablet documented				
		ets documented remaining.				
		Opm, one tablet documented				
		ets documented remaining.				
		am, one tablet documented				
	-OII 11/04/24 at 0.00		1			

Division of Health Service Regulation STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL011377	B. WING	12	R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE		A DRIVE LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page 83		D 392			
	-On 11/04/24 at 12:0 administered, 0 table	00pm, one tablet documented ets remained.				
	revealed:	lent #2 on 12/04/24 at 9:30am mes" ran "short" of his				
	-This usually occurred when it was time for the monthly cycle fill of medications to arrive from the pharmacy.					
	Interview with the medication aide (MA) on 12/06/24 at 9:08am revealed: -She was the MA who documented "borrowed" on					
	Resident #2's CSCS 08/21/24, 08/22/24, 08/27/24. -She did not remem	8 entries for 12:00pm on 08/23/24, 08/26/24, and ber the circumstances as to				
	why she wrote "born	owed."				
	(RCC) on 12/10/24 a	esident Care Coordinator at 10:40am revealed: le for auditing the CSCS				
	-She would audit the when she worked as	em when she had time or s a MA. set schedule to audit the				
	CSCS entries.	set schedule to addit the				
Pr:	1:52pm revealed:	dministrator on 12/10/24 at				
	expected the MA to situation.	wed a medication, he notify the RCC about the				4
	progress note of wh medication from and	ected to make a note in the ere they borrowed the I which resident it was given				
		s on resident CSCS entries. sted of looking for missed				

STATE FORM

6899

2WMT11

If continuation sheet 84 of 94

	of Health Service Reg OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY
		HAL011377	B. WING		R 12/10/2024	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		30 DALE	A DRIVE			
WILHAM F	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET
D 392	Continued From page	je 84	D 392			
	doses, entries being	legible, time and dates, and				
		ugh an entry that was in error.				
		the CSCS entries on				
	12/03/24 or 12/04/24					
	-He had trained the	MAs and RCC on how to				
	properly document of	properly document on CSCS entries.				
3 1	The MAs were supposed to do a count of every					
	controlled substance on the medication cart prior					
	o handing off the keys to the medication cart to					
		ne oncoming shift MA.				
- 1 - A		The MAs who performed the controlled				
	substance count should visualize each controlled					
	substance bubble pack and compare the					
	· · · · · · · · · · · · · · · · · · ·	amounts on those carts with the CSCS counts.				
	If the count was off, the staff tried to figure out					
1.1	why the count was o					
		ck of the MAs who would				
		controlled substance count				
	verification for any g					
1.1		discrepancies on the CSCS				2.11
	entries were a "docu					
		nt #2's FL2 dated 07/11/24				
		an order for clonazepam				
		y) 0.5mg one tablet daily as				
		ive prior to leaving for				
	appointments/outing	S.				
		dent #2's medications on				
200	hand on 12/04/24 at					
		ble pack of clonazepam				
	0.5mg tablets with q					
		clonazepam 0.5mg one				
		ed for anxiety given prior to				
	leaving for appointm	ents/outings. was 06/20/24 quantity of 30.				
	- me dispense date	was ourzorzą quantity of 30.				
		#2's Controlled Substance				
) for clonazepam 0.5mg				
	tablets dispensed or	06/20/24 quantity of 30				

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 85 of 94

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COM	R
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
				, ZIF CODE		
VILHAM F	RIDGE		LLE, NC 28805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	()(5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLE DATE
D 392	Continued From page	ge 85	D 392			
	clonazepam 0.5mg anxiety give prior to appointments/outing -There was no docu on the handwritten la -There was no date was 8:33am, and the -Administration date and ended on 11/19 -On 09/15/24 at 12:0 documented as "bor -On 09/16/24 no time was documented as "bor -On 09/16/24 no time was documented as "bor -On 11/03/24 no time was documented as "bor -On 11/08/24 no time documented as "bor -On 11/08/24 no time was documented as "bor -On 11/12/24 no time was documented as "bor -On 11/15/24 no time was documented as "bor -On 11/16/24 no time was documented as "bor	vritten label with directions one tablet daily as needed for leaving for gs. mented prescription number abel. on the first entry, the time e starting count was 27. s began 09/15/24 at 12:00pm /24 at 7:00am. 00pm, one tablet was rowed." 00pm, one tablet was rowed." e documented, one tablet "borrowed." 00pm, one tablet was rowed." e documented, one tablet "borrowed." e documented, one tablet "borrowed." e documented, one tablet was rowed." e documented, one tablet was rowed." e documented, one tablet "borrowed." e documented, one tablet				
	Interview with the Re (RCC) on 12/04/24 a -She did not know w	esident Care Coordinator				

STATE FORM

6899

STATEMEN	of Health Service Reg T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING		COMP	R
				70.0005	1 12	/10/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE ASHEVIL	LE, NC 28805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLET DATE
D 392	Continued From pag	je 86	D 392			
	-The pharmacy "usu pharmacy label with controlled substance -She did not know w was not included in t as needed clonazep -"Borrowed" entries of clonazepam 0.5mg 0 not have a supply of the scheduled doses (MA) would take a do supply instead. -They had trouble ge	zepam 0.5mg tablets. ally" provided a CSCS with a each bubble pack of es. hy the prescription number he handwritten label on the am 0.5mg bubble pack. on Resident #2's as needed CSCS meant the resident did clonazepam to administer for a so the medication aides ose from the as needed etting prescriptions for tepam from his mental health				
Tell pha -Th cloi any app 06/ -Th cor -Th pre Re CS nee app qua -Ao -Th one leat -Or	pharmacy on 12/04/2 -The pharmacy dispection clonazepam 0.5mg of anxiety give prior to 1 appointments/outing: 06/20/24.	s for Resident #2 on with each bubble pack of vided would have a				
	CSCS for clonazepa needed for anxiety g appointments/outing quantity of 30 tablets -Administration dates -The label directions one tablet daily as ne leaving for an appoint -On 06/27/24 no time	s dispensed on 06/20/24 revealed: s were 06/27/24-07/07/24. were clonazepam 0.5mg eeded for anxiety give prior to				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 87 of 94

STATEMENT	of Health Service Regi of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	HAL011377		B. WING	12	/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
D 392	Continued From pag	ue 87	D 392			
	documented remaini					
		e documented, one tablet administered, 28 tablets				
	documented remaini					
		e documented, one tablet				
		administered, 27 tablets				
	documented remaini					
	2 Poviour of Posido	ent #8's current FL2 dated				
	06/06/24 revealed:	ent #o's current FLZ dated				
		Parkinson's disease and				
	anxiety.				1	
	-He was intermittent	ly confused.				
	06/06/24 revealed a	#8's physician's orders dated n order for clonazepam (used ng tablet three times daily				
	administration record	#8's electronic medication d (eMAR) for October 2024				
	revealed:	lonazepam 0.5mg tablet tid				
	at 8:00am, 1:00pm,					
		sed or refused during the				
	month.					
	Review of Resident 2024 revealed:	#8's eMAR for November				
	-Documentation of c	lonazepam 0.5mg tablet tid				
	at 8:00am, 1:00pm,					
	-No doses were mis month.	sed or refused during the				
	1-5, 2024, revealed:					
	-Documentation of c	lonazepam 0.5mg tablet tid				
	at 8:00am, 1:00pm,					
	-No doses were mis	sed or refused during the first				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 88 of 94

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		COMF	SURVEY
		HAL011377	B. WING			R /10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	IDOF	30 DAL	EA DRIVE			
WILHAM F	RIDGE	ASHEVI	LLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page	je 88	D 392			
	five days of the mon	th.				
	Count Sheet (CSCS -The clonazepam 0.1 as administered on 7 -The clonazepam 0.1 as administered on 7 -There was no docur or the 6:00pm dose administered on 10/7 -The clonazepam 0.1 as administered on 7 -The clonazepam 0.1 as administered on 7 -There was no docur of clonazepam was 7 -The clonazepam 0.1	21/24. 5mg tablet was documented 10/24/24 at 1:00pm. 5mg tablet was documented 10/24/24 at 6:00pm. mentation the 8:00am dose administered on 10/24/24. 5mg tablet was documented 10/27/24 at 4:00pm although				
	2024 revealed: The clonazepam 0.5 administered on 11/7 and 6:00pm.	#8's CSCS for November img was documented as 17/24 at 12:00pm, 1:00pm mentation the 8:00am dose				
	of clonazepam was a -The clonazepam 0.4 administered on 11/7 -There was no docum of clonazepam was a -The clonazepam 0.4 administered on 11/2 and 6:00pm. -The clonazepam 0.4 administered on 11/2	administered on 11/17/24. 5mg was documented as 18/24 at 1:00pm and 6:00pm. mentation the 8:00am dose administered on 11/18/24. 5mg was documented as 21/24 at 8:00am, 12:00pm, 5mg was documented as				
	administered on 11/2					

Division of Health Service Regulation STATE FORM

6899

STATEMEN	of Health Service Regi T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011377	B. WING	12	R /10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	PIDCE	30 DALE	EA DRIVE			
WILHAM I	RIDGE	ASHEVI	LLE, NC 28805			*
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV		(X5) COMPLET
TAG	REGULATORY OR					DATE
D 392	Continued From pag	e 89	D 392			
	administered on 11/2	22/24 at 6:00pm				
	the second se	mentation the 8:00am dose				
		administered on 11/22/24.				
		5mg was documented as				
	administered on 11/2	5				
	and the second	5mg was documented as				
		23/24 at 12:00pm and				
		3:00pm.				
		omg was documented as				
		administered on 11/23/24 at 1:00pm				
		ong was documented as				
	administered on 11/28/24 at 1619 (4:19pm).					
		omg was documented as				
	adminstered on 11/3					
		omg was documented as				
	"borrowed" on 11/30/	/24 at 6:00pm.				
	- Standard Broch (Construction - Co	#8's CSCS for December				
		no errors in documentation of				
	administration of clor	nazepam 0.5mg tid.				
		#8's medication variance				
		24 revealed the clonazepam				
	0.5mg was given time	ely tid.				
	contract contract in the second	#8's medication variance				
	report for November					
	clonazepam 0.5mg w	vas given timely tid.				
	Review of Resident #	#8's medication variance				
		1-5, 2024 revealed the				
	clonazepam 0.5mg w					
		sident Care Coordinator				
		de (MA) on 12/10/24 at				
	9:32am and 10:40am					
		hy the documentation of the				
	a de la company de la comp	SCS was not in order for the				
		esident #8's clonazepam was				
	administered.					
	-Sometimes her and	other MAs forget to sign the				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 90 of 94

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
НА		HAL011377	HAL011377 B. WING		R 12/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
WILHAM	RIDGE	30 DALE	A DRIVE			
		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 392	Continued From page	e 90	D 392			
	CSCS after administe	aring Resident #8's				
		Ild document the medication				
		when they were counting				
		nt #8's clonazepam was				
		of a shift and compared it to				
	the CSCS.	a chine and compared it to				
	-On 10/21/24, 11/21/2	24, and 11/23/24, her and				
	another MA documented on Resident #8's					
	clonazepam CSCS th	clonazepam CSCS that the scheduled 1:00pm				
		dose was administered, but Resident #8's				
	clonazepam was only	lonazepam was only administered once and the				
_		ented was supposed to be				
	locumented at a different time or on a different					1.1.1
	late.					
		ny there were 2 doses of				
		nted as administered on				
	11/23/24 at 12:00pm					
	-She thought one dos					
		prrowed dose administered				
		ho did not have clonazepam				
	not documented as b	er and the clonazepam was				
	-Resident #8 had 2 de					
		SCS on 11/30/24 at 6:00pm				
		written next to one of the				
	doses.	whiten heat to one of the				
		ich resident the "borrowed"				
	dose of clonazepam					
		y had to document the				
	medication as borrow					
	-All controlled substar	nces were counted at the				
	end of each shift and	compared to the CSCS.				
	-When there was a di	screpancy between the				
		a controlled substance and				
		CS, the MA coming on shift				
		accept the keys to the				
	medication cart and n					
	-She was notified befo					
		available did not match				
	what was documented	d on the CSCS and most of				

Division of Health Service Regulation STATE FORM

6899

2WMT11

If continuation sheet 91 of 94

TATEMENT OF DEFIND ND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	HAL011377		B. WING		12	2/10/2024
AME OF PROVIDER	OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ILHAM 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 392 Contin	ued From page	e 91	D 392			
the tim docum -The fa allowe for oth -Her a auditin availat them to -She a the am admini set sch Intervie -She o 1:00pn during -Some medica busy ir -She a the cor -She a schedu and do 1:00pn docum CSCS	the it was becau acility's policy for d for controlled er residents if it and the Adminis g the number of ble on the med to the CSCS. Udited t	Ise someone forgot to ation on the CSCS. or borrowing medications I substances to be borrowed the medication was needed. trator were responsible for of controlled substances ication cart and comparing CS and compared them to lled substances available to had time, but there was no on 12/10/24 at 9:45am ed Resident #8's scheduled because she did not work revening medication pass. Thelped her administer ints when the RCC was not inted the declination of a GCS after she administered nee medications. esident #8's 1:00pm m on 11/21/24 and 11/23/24 declination on the CSCS at now why the RCC also azepam on Resident #8's ministrator on 12/10/24 at or borrowing medications ncluding controlled rowed from one resident and her resident if a medication				

STATE FORM

2WMT11

If continuation sheet 92 of 94

STATEMEN	of Health Service Regi of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	(X2) MULTIPLE C A. BUILDING: B. WING	ONSTRUCTION	СОМ	E SURVEY PLETED
	ROVIDER OR SUPPLIER			7000005	12	2/10/2024
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WILHAM I	RIDGE		EA DRIVE LLE. NC 28805			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					()(5)
PREFIX TAG	(EACH DEFICIENC		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 392	Continued From page	e 92	D 392		A state of the second sec	
	another resident but who the medication w -The MAs were supp note in the other reside medication was borror medication administre -He audited the CSC about every other day facility experienced a and the MAs docume administered to reside since they could not to -The CSCS were mean to only use a single li out. -He last audited the C 12/04/24. -The issues with the of entries were a "docur -The facility used to h on a cycle fill from the of controlled substances supply stock was low -He did not know why run out and some cor be borrowed from oth -The RCC was respon audits to check for me request refills from the controlled substances -The facility did not ha	osed to document in a chart dent's record when a bwed and document the ared on the electronic ation record (eMAR). S for missed documentation y since 09/27/24 when the power outage for 5 days ented the medications ents on notebook paper use the eMAR. ssy, and he instructed staff ne when marking a mistake CSCS on 12/03/24 or discrepancies on the CSCS mentation issue." have controlled substances e pharmacy and had months ces in stock so he stopped ow MAs must request the s to be refilled when the v some medications would throlled substances had to her residents. nsible for medication cart edications in low supply and e pharmacy including s. ave a policy regarding when				
	controlled substances documented on the C -The MAs were never	s were supposed to be				
		controlled substance was				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011377	- 25 - 26		(X3) DATE S COMPL F 12/1	ETED
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE		012024
WILHAM RIDGE		EA DRIVE ILLE, NC 28805			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLET DATE
legible and to chec remaining of the m compare it to the a	age 93 tructed to make the CSCS is the documented amount edication on the sheet and ctual amount remaining of the ce at the change of shifts.	D 392	Facility has made to the procovement PCP discovery, phane coordination and sy and the decomentar Process. Administration how overseeing this duily to ensure of At such time the demanstrates competently the duily review of drop binck down every othe day.	process, nacy skans, nion (13 s process camplicance e staff	01/2-1/2