		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
		HAL011002	B. WING		05/31/2018	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BECKY RE	EST HOME 1		/ER BUSH CREEK ER, NC 28732	ROAD		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	Buncombe County D	sure Section and the epartment of Social Services survey on May 30-31, 2018.				
D 164	10A NCAC 13F .050 Diabetic Resident	5 Training On Care Of	D 164			
	Diabetic Residents An adult care home as the care of residents unlicensed staff prior insulin as follows: (1) Training shall be nurse, registered pha practitioner. (2) Training shall inco (a) basic facts about in the management of (b) insulin action; (c) insulin storage; (d) mixing, measurin for insulin administra	ig and injection techniques tion; evention of hypoglycemia ncluding signs and unitoring; universal tions; inistration times; and				
	facility failed to assur	and record reviews, the e 3 of 3 medication aides and C) received training by a				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		BERTH TO ATTOT TO BER.	A. BUILDING:			
		HAL011002	B. WING		05	C 5/31/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	EST HOME 1		VER BUSH CREEK IER, NC 28732	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 164	Continued From page	e 1	D 164			
	diabetic residents pri	or to administering insulin.				
	The findings are:					
	Interview with the Resident Care Coordinator (RCC) on 05/31/18 at 8:30am revealed there was one insulin dependent resident in the facility.					
	-Staff A was hired on Aide (MA). -There was documer medication clinical sk -There was documer passed the medication 11/04/08. -There was no docur training on file. -There was documer another assisted livin 10/2014 through 08/2					
		018 Medication ds (MAR) revealed Staff A edications to the residents on				
		A on 05/30/18 at 2:15pm ministering medications to				
	revealed: -She "administered n at the facility. -She was the MA tod -She had "previously assisted living facility	worked as a MA at another				

STATE FORM

	of Health Service Regun TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM		
		HAL011002	B. WING		05	C 05/31/2018	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
BECKY RI	EST HOME 1		VER BUSH CREEK IER, NC 28732	ROAD			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET	
D 164	Continued From page	e 2	D 164				
	her personnel record her previous employe -She had completed previous place of em Refer to the interview	diabetic care training at a ployment. v with the Business Office					
	Manager (BOM) on C Refer to the interview at 8:31am.	v with the RCC on 05/31/18					
	Refer to the interview (RN) on 05/31/18 at	v with the Registered Nurse 12:30pm.					
	Refer to the interview 05/31/18 at 1:17pm.	v with the Administrator on					
	-Staff B was hired on -There was documen medication clinical sk -There was documen passed the medication 06/06/17. -There was no document training on file. -There was document	ntation Staff A completed a kills validation on 05/14/18. Intation Staff A successfully on administration exam on mentation of diabetic care Intation of employment at ing facility as a MA, dates of					
	Review of the May 20 had administered me a routine basis.	018 MAR revealed Staff B edications to the residents on with Staff B on 05/31/18 at					
	1:12pm was unsucce						
	Refer to the interview at 9:40am.	with the BOM on 05/31/18					

STATE FORM

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING		С	
		HAL011002			05	5/31/2018
IAME OF PI	ROVIDER OR SUPPLIER		NDDRESS, CITY, STATE			
BECKY RI	EST HOME 1		ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 164	Continued From page	e 3	D 164			
	Refer to the interview at 8:31am.	with the RCC on 05/31/18				
	Refer to the interview 12:30pm.	/ with the RN on 05/31/18 at				
	Refer to the interview 05/31/18 at 1:17pm.	with the Administrator on				
	-Staff C was hired on -There was documer	ntation Staff C completed a				
	-There was documer	ills validation on 10/18/17. Itation Staff C successfully In administration exam on				
	06/06/17. -There was no docun on file.	nentation of diabetic training				
		nentation of employment eginning work as a MA at the				
	-					
	-	IAR revealed Staff C had tions to the residents on a				
		lent on 05/31/18 at 11:45am iinistered his nighttime ).				
	-	with the RN from the facility's on 05/31/18 at 11:50am				
	Telephone interview 1:11pm was unsucce alth Service Regulation	with Staff C on 05/31/18 at essful.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		HAL011002	B. WING		05	C 05/31/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE			
BECKY RI	EST HOME 1		NER BUSH CREEK IER, NC 28732	ROAD			
		ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN (		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D 164	Continued From page	e 4	D 164				
	Refer to the interview at 9:40am.	with the BOM on 05/31/18					
	Refer to the interview at 8:31am.	with the RCC on 05/31/18					
	Refer to the interview 12:30pm.	with the RN on 05/31/18 at					
	Refer to the interview with the Administrator on 05/31/18 at 1:17pm.						
	Interview with the BOM on 05/31/18 at 9:40am revealed:						
	-	completed by the RN. nployed at the facility for					
	-Prior to hiring the RN completed by a RN c contracted pharmacy	ontracted from the facility's					
	-Prior to hiring the RN task.	I, the RCC completed this					
	care training for Staff	ason there was no diabetic A, B or C. I, the RCC was responsible					
		training needs of the staff.					
	revealed:	C on 05/31/18 at 8:31am					
	-	completed by the RN. nployed at the facility for					
	-Prior to hiring the RN completed by a RN c contracted pharmacy	ontracted from the facility's					
		e reasons the diabetic care					

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STATEMENT	of Health Service Regure of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011002	B. WING		C 05/31/2018	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BECKY R	EST HOME 1		/ER BUSH CREEK	ROAD		
			ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 164	Continued From page	e 5	D 164			
	revealed: -She had been emploit 1½ months. -She was responsible trainings. -She was not aware to had not been comple -She had not received diabetic resident. -She has observed S insulin to the resident Interview with the Adr 1:17pm. -Prior to hiring the RN responsible for auditin assure all staff trainin -The facility had a "ch track staff record requ -"They may need to a on the survey findings -She thought the diab completed for Staff A the contracted pharm	necklist" that was used to uirements. add to the checklist" based s. petic care training had been , B and C by the RN from				
D935	G.S.§ 131D-4.5B(b) / Training and Compet	ACH Medication Aides; ency	D935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirem	aining and Competency				
	home is prohibited fro any unsupervised me that individual has pro	er 1, 2013, an adult care om allowing staff to perform edication aide duties unless eviously worked as a ng the previous 24 months in				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM		
		HAL011002	B. WING		05	C 05/31/2018	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ECKY RI	EST HOME 1		ER BUSH CREEK	ROAD			
		FLETCH	ER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	9 6	D935				
	Department that inclu in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monito bleeding occurs or the exists. (2) A clinical skills eva NCAC 13F .0503 and (3) Within 60 days fro individual must have a. An additional 10-ho developed by the Dep training and instruction	s for Disease Control and on infection control and, if tion practices and pring or testing in which e potential for bleeding aluation consistent with 10A 1 10A NCAC 13G .0503. In the date of hire, the completed the following: pur training program partment that includes n in all of the following:					
	Prevention guidelines applicable, safe inject procedures for monito bleeding occurs or the exists. b. An examination de by the Division of Hea	s of Disease Control and on infection control and, if					
	reviews, the facility fa	observation and record					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL011002	B. WING		C 05/31/2018	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
BECKY RE	EST HOME 1		VER BUSH CREEK IER, NC 28732	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D935	Continued From page 7 completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to residents. The findings are:		D935			
	-Staff A was hired on Aide (MA). -There was documer medication clinical sk -There was documer passed the medication 11/04/08. -There was no docur hour medication train -There was no docur verification prior to be facility. -There was documer another assisted livir 10/2014 through 08/2 Review of the May 2 Administration Recor	mentation of employment eginning work as a MA at the ntation of employment at ng facility as a MA from 20/17.				
		A on 05/30/18 at 2:15pm ministering medications to				
	revealed: -She "administered n at the facility. -She was the MA tod	on 05/30/18 at 4:00pm nedications to the residents" ay (05/30/18). inistering medications since				

Division of Health Service Regulatio STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING			С	
		HAL011002		05	05/31/2018		
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
BECKY RI	EST HOME 1		IER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	e 8	D935				
	her personnel record her previous employe -She had completed training at a previous Refer to the interview Manager (BOM) on 0 Refer to the interview Coordinator (RCC) of Refer to the interview (RN) on 05/31/18 at Refer to the interview	the 15 hour medication aide place of employment. with the Business Office 05/31/18 at 9:40am. with the Resident Care n 05/31/18 at 8:31am. with the Registered Nurse					
	-Staff C was hired on -There was documen medication clinical sk -There was documen passed the medication 06/06/17. -There was no docum hour medication train -There was no docum verification prior to be facility. -There was documen other assisted living f documented.	tation Staff C completed a cills validation on 10/18/17. Intation Staff C successfully on administration exam on nentation of a 5, 10 or 15 ing on file. nentation of employment eginning work as a MA at the itation of employment at two					
	revealed Staff C had the residents on a roo	administered medications to					

STATE FORM

	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY	
	JF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP		
		HAL011002	B. WING		05	C 05/31/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	EST HOME 1	316 LOV	VER BUSH CREEK	ROAD			
		FLETCH	IER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
D935	Continued From page	e 9	D935				
	medications (8:00pm	).					
		with the RN from the facility's on 05/31/18 at 11:50am					
	Telephone interview 1:11pm was unsucce	with Staff C on 05/31/18 at essful.					
	Refer to the interview at 9:40am.	v with the BOM on 05/31/18					
	Refer to the interview at 8:31am.	v with the RCC on 05/31/18					
	Refer to the interview with the RN on 05/31/18 at 12:30pm.						
	Refer to the interview 05/31/18 at 1:17pm.	v with the Administrator on					
	revealed: -Staff trainings were -The RN had been en about 1½ months.	DM on 05/31/18 at 9:40am completed by the RN. mployed at the facility for					
	contracted pharmacy -The RN would secur	contracted from the facility's					
	employer. -Prior to hiring the RI task.	N, the RCC completed this					
	-She did not know re	ason there was no ion for Staff A or Staff C. ason there was no 5, 10 or raining for Staff A or Staff C.					
		N, the RCC was responsible					

Division of Health Service Regulation STATE FORM

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If continuation sheet 10 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
	of connection	IDENTIFICATION NOMBER.	A. BUILDING:				
		HAL011002	B. WING		05	C 05/31/2018	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	EST HOME 1	316 LOW	ER BUSH CREEK	ROAD			
		FLETCH	ER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	e 10	D935				
	to "keep up with" the	training needs of the staff.					
	Interview with the RCC on 05/31/18 at 8:31am revealed: -Staff trainings were completed by the RN. -The RN had been employed at the facility for about 1½ months.						
	-Prior to hiring the RN, the training was completed by a RN contracted from the facility's contracted pharmacy.						
	-She did not know reason there was no employment verification for Staff A or Staff C.						
	verification form to a	anded the employment n owner of Staff C's previous					
		they have not responded. Iministrator" have both called ved no response.					
	Interview with the RN	l on 05/31/18 at 12:30pm					
		byed at the facility for about					
	trainings.	e to complete the staff					
		te with the new employee nent verification form from previous employer.					
		ason there was no ion for Staff A because Staff he same time she was hired.					
	-She did not know re						
	C was hired before s the facility.	he started employment at					
		medication training had to be nent verification could not be					
	Interview with the Ad 1:17pm.	ministrator on 05/31/18 at					

STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL011002	B. WING		05	C 05/31/2018	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ECKV D	EST HOME 1	316 LOV	VER BUSH CREEK	ROAD			
		FLETCH	ER, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	e 11	D935				
	responsible for auditin assure all staff trainin -The facility had a "ch track staff record requ -"They may need to a on the survey findings -She was not aware t verification form or m Staff A, she "thought paperwork". -She, the BOM and th numerous occasions verification form for S -Staff C's medication scheduled because S medical leave, it had schedule trainings wit contracted pharmacy "part time" and now th was in the process of trainings for the staff. -She thought the facil employment verificati (05/31/18).	hecklist" that was used to uirements. add to the checklist" based s. here was no employment edication aide training for they had all of her he RCC had tried on to obtain the employment itaff C. aide training had not been Staff C had been on personal been "a challenge" to th the RN from the because she only worked hat they had hired a RN, she scheduling the necessary lity had received Staff A's on form earlier today e verifcations were obtained					