Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011372	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an follow-up survey on 10/07/21 and 10/08/21 with an exit conference via telephone on 10/08/21.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previous Unabated Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#2) related to medications used to treat high blood pressure, prevent blood clots, and to treat pain. The findings are: 1. Review of Resident #2's current FL2 dated 07/19/21 revealed diagnoses included hypertension, cardiomyopathy, degenerative disc disease, and diabetes type II.	{D 358}	Complete Chart reviews on a monthly basis by designated staff member. Medications that may be missing will be ordered immediately by designated staff. Electronic MAR monitored daily. Vitals will be completed by med tech staff and monitored by designated staff on a daily basis. all medical and Lab appointments are scheduled by the administrator. Staff instructed to call administrator if any medications has been missed due not being available at scheduled time. Reviewed with med tech	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melanie Scruggs — TITLE: Administrator — (X6) DATE: 11/10/2021

STATE FORM 6899 8TCY13 If continuation sheet 1 of 30

Reviewed and Acknowledged
Date: 11/22/21 CS

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(D 358)	Continued From page 1 a. Review of Resident #2's current FL2 dated 07/19/21 revealed there was an order for eplerenone (a potassium sparing diuretic used to treat high blood pressure) 25mg one tablet every day. Telephone interview with a representative from the facility's contracted pharmacy on 10/07/21 at 11:50am revealed: -A 15-day supply of eplerenone was last dispensed for Resident #2 on 08/31/21. -The 15-day supply would have run out on 09/15/21. -The pharmacy was unable to fill the eplerenone after 08/31/21 because, the resident's insurance would not pay for the medication. -The pharmacy sent a prior authorization request to the primary care provider (PCP). -The insurance company continued to deny coverage of the medication. -The facility staff requested a refill on 10/02/21. -The pharmacy responded to the refill request with a faxed note on 10/05/21 explaining they had not been sending the medication due to the cost ($101.13). -Facility staff were advised to contact the pharmacy if they wanted the medication to be sent as a private pay price plan medication. -The pharmacy had not received a response from the facility. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for eplerenone 25 mg one tablet every day scheduled at 8:00am. -The eplerenone was documented as administered daily from 09/02/21 to 09/30/21. -On 09/01/21, the eplerenone was documented	(D 358)	staff.	11/1/21

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(D 358)	Continued From page 2 as not administered due to "physically unable to take." -On 09/02/21, the eplerenone was documented as not administered due to arriving from pharmacy. Review of Resident #2's blood pressure readings on the September 2021 eMAR ranged from 131/82 to 156/74. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for eplerenone 25mg one tablet every day scheduled at 8:00am. -The eplerenone was documented as administered daily from 10/01/21 to 10/06/21. -On 10/02/21, the eplerenone was documented as administered with the following note "This medication is out but has been ordered from the Pharmacy." -On 10/03/21, the eplerenone was documented as administered with the following pass note "medication ordered yesterday." -On 10/07/21, the eplerenone was documented as not administered due to "medication requires prior authorization not received by the pharmacy." Review of Resident #2's blood pressure readings on the October eMAR revealed a blood pressure of 148/84 on 10/05/21. Observation of Resident #2's medications on hand on 10/07/21 at 12:40pm there was no eplerenone available. Interview with the Resident Care Coordinator (RCC) on 10/07/21 at 12:35pm revealed: -She administered Resident #2's morning medications on 10/07/21 and the eplerenone was not available.	(D 358)		

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{D 358}	Continued From page 3 -She asked Resident #2 on 10/07/21 if he wanted to pay for the eplerenone and the resident did not want to pay for it. -She had planned to contact Resident #2's PCP today (10/07/21) to ask for an alternative to eplerenone. -She had not yet contacted the PCP. Interview with the Administrator on 10/07/21 at 4:20pm revealed residents were responsible for paying for their medications. Interview with the RCC on 10/08/21 at 9:35am revealed: -The MAs were supposed to reorder a medication when the medication supply was at the blue strip on the bubble pack. -She realized the eplerenone was out for Resident #2 "yesterday" (10/07/21). -Then she remembered receiving the payment denial from the pharmacy. -She contacted Resident #2's PCP on 10/07/21 to notify her the resident was out of the medication. -The PCP discontinued the eplerenone and ordered another diuretic medication for the resident. Telephone interview with Resident #2's PCP on 10/08/21 at 2:52pm revealed: -She was aware of the prior authorization denial by Resident #2's insurance company for the eplerenone. -She was unaware the resident had been out of the medication since mid-September until "yesterday" (10/07/21). -By reading the cardiology notes, she believed the medication had been prescribed to treat hypertension. b. Review of Resident #2's physician's order	{D 358}		

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(D 358)	Continued From page 4 dated 09/10/21 revealed: -The resident's INR (a blood test used to monitor individuals who are being treated with the blood thinning medication warfarin) was within therapeutic range. -There was an order to administer warfarin (used to treat and prevent blood clots) 3mg one tablet on Mondays, Tuesdays, Thursdays, Fridays, Saturdays, and Sundays. -There was an order to administer warfarin 1.5mg on Wednesdays. Review of Resident #2's physician's order dated 09/24/21 revealed: -The resident's INR was 3.6. -There was an order for warfarin 1.5mg "today" (09/24/21). -The resume warfarin 3mg daily except 1.5mg on Wednesdays. -Recheck INR in 2 weeks on 10/07/21 at 2:20pm. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for warfarin 3mg take one tablet six times weekly on Monday, Tuesday, Thursday, Friday, Saturday, and Sunday scheduled at 6:00pm. -There was an entry for warfarin 3mg take one-half tablet once weekly on Wednesday scheduled at 6:00pm. -On 09/21/21, the warfarin was documented as not administered due to arriving from the pharmacy. -On 09/24/21, warfarin 3mg was documented as administered instead of warfarin 1.5mg. -On 09/26/21, the warfarin was documented as not administered due to arriving from the pharmacy.	(D 358)		

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(D 358)	Continued From page 5 Review of Resident #2's physician order dated 10/07/21 revealed: -The resident's INR was 3.4. -There was an order for warfarin 3mg daily on Mondays, Tuesdays, Thursdays, Saturdays, and Sundays. -There was an order for warfarin 1.5mg daily on Wednesdays and Fridays. -Recheck INR on 10/22/21 at 2:20pm. Observation of Resident #2's medications on hand on 10/07/21 at 12:40pm revealed there was no warfarin available for administration. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for warfarin 3mg take one tablet six times weekly on Monday, Tuesday, Thursday, Friday, Saturday, and Sunday scheduled at 6:00pm. -There was an entry for warfarin 3mg take one-half tablet once weekly on Wednesday scheduled at 6:00pm. -On 10/07/21, the warfarin was not administered due to arriving from the pharmacy. Telephone interview with the facility's pharmacy representative on 10/07/21 at 11:50am revealed: -The pharmacy dispensed and 14 tablets of warfarin 3mg strength tablets on 09/10/21 which was a two week supply ending 09/24/21. -On 09/21/21, a refill request was received from the facilty for warfarin. -There were two 3mg tablets and one-half of a 3mg tablet sent on 09/22/21 at 9:06pm to supply the medication until the next INR scheduled on 09/24/21. -The pharmacy did not receive a new INR result and warfarin order until 09/26/21 at 7:37pm. -The pharmacy dispensed 9 tablets of warfarin	(D 358)		

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(D 358)	Continued From page 6 3mg tablets the next day (09/27/21) and was delivered to the facility at 3:16pm. Interview with Resident #2 on 10/07/21 at 2:25pm revealed he had not had his warfarin medication for "three days in a row." Interview with the RCC on 10/08/21 at 10:05am revealed Resident #2 did not get his warfarin on 10/07/21, because it did not arrive from the pharmacy until after 9:00pm. Observation of Resident #2's medications on hand on 10/08/21 at 11:04am revealed: -There were two bubble packs of warfarin 3mg tablets. -There was one bubble pack which contained 11 tablets of warfarin 3mg (none of the tablets had been used) with a fill date of 10/07/21. Telephone interview with a representative from the facility's contracted pharmacy on 10/08/21 at 11:35am revealed: -The pharmacy received Resident #2's INR result and warfarin order on 10/07/21 at 4:34pm. -The pharmacy had the warfarin order ready to sent out by 7:30pm. -The warfarin was delivered to the facility on 10/07/21 at 9:31pm. Interview with the Administrator on 10/08/21 at 12:05pm revealed: -She was not aware Resident #2 had missed doses of warfarin. -Staff had not given the warfarin on the evening of 10/07/21 "if she had to guess" because the timing was out of the hour before hour after window for administration. -The staff had not called her to ask about administering the warfarin when it came in.	(D 358)		

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{D 358}	Continued From page 7 -Resident #2's INR appointments were going to have to be scheduled for earlier in the day, so there was enough time to get the order to the pharmacy early enough so the pharmacy could process the order and get it to the facility in time for administration at 6:00pm. Telephone interview with Resident #2's primary care provider (PCP) on 10/08/21 at 2:52pm revealed: -The warfarin was ordered to prevent chronic blood clots. -The INR range to prevent blood clots should be from 2.0 to 3.0. -Resident #2's INR on 10/07/21 was 3.4 so missing the dose of warfarin on 10/07/21 was "okay" since the INR was still above the goal of 3.0 c. Review of Resident #2's current FL2 dated 07/19/21 revealed an order for oxycodone/acetaminophen 5/325mg take one tablet three times daily at 8:00am, 2:00pm, and 8:00pm. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for oxycodone/acetaminophen 5/325mg take one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -The oxycodone/acetaminophen 5/325mg was documented as administered three times daily from 09/01/21 to 09/30/21 with exception of 2 occurrences on 09/15/21 at 2:00pm and 8:00pm. -On 09/15/21 at 2:00pm the oxycodone/acetaminophen 5/325mg was documented as not administered due to "physically unable to take."	{D 358}		

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(D 358)	Continued From page 8 -On 09/15/21 at 8:00pm the oxycodone/acetaminophen 5/325mg was documented as not administered due to "withheld per doctor/registered nurse orders." Review of text message communication between the Resident Care Coordinator (RCC) and Resident #2's primary care provider (PCP) on 09/15/21 at 2:54pm revealed a request was made of the PCP to send a refill request for oxycodone/acetaminophen 5/325mg to the pharmacy. Attempted review of Resident #2's controlled substance count sheet (CSCS) for oxycodone/acetaminophen 5/325mg dated 09/01/21 to 09/15/21 revealed the CSCS was not available. Interview with the RCC on 10/08/21 at 9:35am revealed she was unable to find the CSCS for Resident #2's oxycodone/acetaminophen 5/325mg for 09/01/21 to 09/15/21. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for oxycodone/acetaminophen 5/325mg take one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -The oxycodone/acetaminophen 5/325mg was documented as administered three times daily from 10/01/21 to 10/07/21. Observation of Resident #2's medications on hand on 10/07/21 at 12:40pm revealed: -There were 25 tablets of oxycodone/acetaminophen available for use. -There were 90 tablets of oxycodone/acetaminophen dispensed on	(D 358)		

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{D 358}	Continued From page 9 09/15/21. Interview with Resident #2 on 10/07/21 at 11:25am revealed: -He took oxycodone/acetaminophen 5/325mg three times a day for pain in his lower back. -There were four vertebra in his lower back with no cartilage between them. Telephone interview with a representative from the facility's contracted pharmacy on 10/07/21 at 11:50am revealed: -There were 90 tablets (a 30 day supply) of oxycodone/acetaminophen 5/325mg dispensed on 08/16/21. -The oxycodone/acetaminophen 5/325mg was received by the Administrator on 08/16/21 at 3:08pm. -A hard prescription was received to refill the oxycodone/acetaminophen 5/325mg for Resident #2 on 09/15/21 at 4:00pm. -The request was processed and 90 tablets of oxycodone/acetaminophen 5/325mg were dispensed and signed for by facility staff as received on 09/15/21 at 8:43pm. Interview with the Resident Care Coordinator (RCC) on 10/07/21 at 12:35pm and on 10/08/21 at 9:35am revealed: -On 09/15/21, Resident #2's oxycodone/acetaminophen had not been available. -She had to request a hard prescription for a refill from the PCP. Interview with the Administrator on 10/08/21 at 9:40am and 12:05pm revealed: -She did not know why there had not been enough oxycodone/acetaminophen supply available to finish scheduled doses for Resident	{D 358}		

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(D 358)	Continued From page 10 #2 on 09/15/21 until the new supply could be delivered from the pharmacy. -She had not had any issues with missing medications. The facility failed to administer a medication used to treat hypertension for 22 days. The facility also failed to administer a medication used to prevent blood clots. This failure was detrimental to the health, safety, and welfare of Resident #2 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/07/21 for this violation.	(D 358)		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record of administration and disposition of a controlled substance for 1 of 1 sampled resident (Resident #2) with an order for a controlled substance. The findings are: Review of Resident #2's current FL2 dated	D 392	Designated Staff reviews control sheets every monday. old control sheets are stored in appropriate boxes within the main office.	11/1/21

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D 392	Continued From page 11	D 392		

07/19/21 revealed diagnoses included degenerative disc disease.

Review of Resident #2's current FL2 dated 07/19/21 revealed an order for oxycodone/acetaminophen 5/325mg take one tablet three times daily at 8:00am, 2:00pm, and 8:00pm.

Review of text message communication between the Resident Care Coordinator (RCC) and Resident #2's primary care provider (PCP) on 09/15/21 at 2:54pm revealed a request was made of the PCP to send a refill request for oxycodone/acetaminophen 5/325mg to the pharmacy.

Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxycodone/acetaminophen 5/325mg take one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-The oxycodone/acetaminophen 5/325mg was documented as administered three times daily from 09/01/21 to 09/30/21 with exception of 2 occurrences on 09/15/21.
-On 09/15/21 at 2:00pm the oxycodone/acetaminophen 5/325mg was documented as not administered due to physically unable to take.
-On 09/15/21 at 8:00pm the oxycodone/acetaminophen 5/325mg was documented as not administered due to withheld per doctor/registered nurse orders.

Review of Resident #2's controlled substance count sheet (CSCS) for oxycodone/acetaminophen 5/325mg dated

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D 392	Continued From page 12 09/01/21 to 09/15/21 revealed the CSCS was not available. Interview with the Resident Care Coordinator (RCC) on 10/07/21 at 12:35pm and on 10/08/21 at 9:35am revealed: -On 09/15/21, Resident #2's oxycodone/acetaminophen had not been available. -She had to request a script for a refill from the PCP. -She had been unable to find the CSCS for Resident #2's oxycodone/acetaminophen 5/325mg for 09/01/21 to 09/15/21. Telephone interview with a representative from the facility's contracted pharmacy on 10/07/21 at 11:50am revealed: -There were 90 tablets (a 30 day supply) of oxycodone/acetaminophen 5/325mg dispensed on 08/16/21. -The oxycodone/acetaminophen 5/325mg was received by the Administrator on 08/16/21 at 3:08pm. -A hard script was received to refill the oxycodone/acetaminophen 5/325mg for Resident #2 on 09/15/21 at 4:00pm. -The request was processed and 90 tablets of oxycodone/acetaminophen 5/325mg were dispensed and signed for by facility staff as received on 09/15/21 at 8:43pm. Interview with the Administrator on 10/08/21 at 9:40am and 12:05pm revealed: -She had been unable to find the CSCS for Resident #2's oxycodone/acetaminophen 5/325mg tablets dated 09/01/21 to 09/15/21. -The pharmacy provided a CSCS with each new bubble pack of controlled medication. -When the bubble pack was empty for a	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011372	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 392	Continued From page 13 controlled medication, the CSCS was to be brought to the office by the RCC or a medication aide. -She had "no idea what happened" to Resident #2's oxycodone/acetaminophen 5/325mg CSCS for 09/01/21 to 09/15/21. -She had looked through the office and the shred box and could not find it. -The CSCS might have gotten mixed in with other documents and had not yet been found.	D 392		
(D912)	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related medication administration and adult care home infection prevention requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#2) related to medications used to treat high blood pressure, prevent blood clots, and to treat pain. [Refer to Tag 358, 10A NCAC 13F .1004(a)	(D912)	Designated Med Techs will monitor Vitals and meds as ordered by physician. Office Staff will monitor electronic MAR on a daily basis. 11/1/21	

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{D912}	Continued From page 14 Medication Administration (Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#1, #2, #3) with orders for fingerstick blood sugar (FSBS) monitoring resulting in the sharing of glucometers between residents.[Refer to Tag 932, G.S. 131D-4.4A(b) Adult Care Home Infection Prevention Requirements (Unabated Unabated Type B Violation)].	{D912}		
{D932}	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and	{D932}	CBG logs are monitored by designated staff on a monthly basis and reviewed by management.	10/28/21

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(D932)	Continued From page 15 supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	(D932)		

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RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 16	(D932)		

This Rule is not met as evidenced by:
FOLLOW-UP TO CONTINUING TYPE B VIOLATION

Based on these findings, the previously Unabated Type B Violation has not been abated.

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#1, #2, #3) with orders for fingerstick blood sugar (FSBS) monitoring resulting in the sharing of glucometers between residents.

The findings are:

Review of the CDC guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Review of the manufacturer's on-line user manual for Brand A glucometer revealed:
-Users should follow the guidelines for prevention of blood-borne transmittable diseases in a healthcare setting.
-There were no disinfection instructions provided for multi-person use.

Review of the facility's diabetic testing policy

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 17 revealed: -Sharing of glucometers was strictly prohibited. -Each individual resident will have their own glucometer and it will be labeled with their name. -Individual glucometers are kept inside the zippered glucometer bag and the glucometer bag should be labeled with the resident's name. -The glucometer bag should be stored inside a zip-lock bag also labeled with the resident's name. -Prior to checking a resident's blood sugar, ensure that the name on the glucometer, zippered bag, and zip-lock bag match the resident who is having their sugar checked. -Notify the Supervisor whenever you have a glucometer, glucometer bag or zip-lock bag that does not have a label with the residents' name. Observation of the facility's medication cart on 10/07/21 at 12:35pm revealed: -There were four zippered cases containing Brand A glucometers in the top drawer. -Handwritten on each case was a different resident's name. -The zippered cases were not stored inside zip-lock bags. 1. Review of Resident #1's current FL2 dated 08/09/21 revealed: -Diagnoses included abscess of left buttock. -There was an order for lispro insulin (used to treat high blood sugar) 12 units three times a day with meals hold for FSBS less than 100. -There was an order for Lantus (used to treat high blood sugar) 34 units daily at bedtime hold for FSBS less than 100. Review of Resident #1's primary care provider (PCP) order dated 09/27/21 revealed monitor FSBS three times a day before meals.	(D932)		

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PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 18 Observation of Resident #1's FSBS testing supplies on 10/07/21 at 2:46pm revealed: -There was a zippered case labeled with Resident #1's name in a compartment in the top drawer of the medication cart. -There was a Brand A glucometer inside the zippered case. -The Brand A glucometer was labeled on the back with Resident #1's name. Review of Resident #1's glucometer's use history Brand A revealed: -The date on the glucometer when powered on was 02/13 and the time was 9:21pm (the actual date and time was 10/07/21 at 2:48pm, a difference of 235 days, 17 hours, and 27 minutes). -On 02/09, there were six readings in the glucometer's history, 201 at 11:55pm (actual date 10/03/21 at 5:22pm) , 188 at 6:50pm (actual date 10/03/21 at 12:17pm), 339 at 4:07pm (actual date 10/03/21 at 9:34am), 241 at 2:07am (actual date 10/02/21 at 7:34pm), 183 at 2:03am (actual date 10/02/21 at 7:30pm), 155 at 12:05am (actual date 10/02/21 at 5:32pm). -The actual date for the recordings on 02/09 were 10/02/21 and 10/03/21. Review of Resident #1's October 2021 electronic Medication Administration Record (eMAR) FSBS readings for 10/02/21 and 10/03/21 revealed: -There was a reading of 201 at 4:30pm on 10/03/21. -There was a reading of 188 at 12:00pm on 10/03/21. -There was a reading of 250 at 8:00am on 10/03/21; this reading was not in Resident #1's glucometer's history. -There was a reading of 183 at 8:00pm on	(D932)		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 19	(D932)		

10/02/21.
-There was a reading of 155 at 4:30pm on 10/02/21.
-There was a reading of 137 at 11:30am on 10/02/21; this reading was not in Resident #1's glucometer's history.
-There was no documentation for the readings of 339 and 241.

Review of Resident #1's glucometer history for 02/08 (actual date 10/02/21) revealed:
-There was a reading of 134 at 5:44pm (actual time 11:11am); this reading was not documented on Resident #1's eMAR.
-There was a reading of 258 at 3:28pm (actual time 8:55am); this reading was not documented on Resident #1's eMAR.

Review of Resident #1's glucometer history for 02/04 (actual date 09/28/21) revealed there was a reading for 216 at 2:49pm (actual time 8:16am); this reading was not documented on Resident #1's eMAR.

Interview with a medication aide (MA) on 10/07/21 at 4:10pm revealed:
-She used the glucometer that was in the resident's labeled pouch to check the resident's FSBS's.
-She recorded the FSBS result in the resident's eMAR right after she checked it.
-She did not know why there would be extra FSBS readings in Resident #1's glucometer.
-She had documented FSBS results on the eMAR for Resident #1 on 10/2/21 and 10/03/21.
-Resident #1 had never asked her to check his FSBS at times other than when it was scheduled.
-She only checked Resident #1's FSBS when it came up on the eMAR.

Division of Health Service Regulation

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RICHMOND HILL REST HOME # 5	55 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 20 Refer to the interview with the Administrator on 10/07/21 at 3:50pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/08/21 at 10:05am. Refer to the telephone interview with the Owner on 10/08/21 at 4:10pm. 2. Review of Resident #2's current FL2 dated 07/19/21 revealed: -Diagnoses included diabetes type II. -There was an order for fingerstick blood sugar (FSBS) tests every Monday, Wednesday, and Friday at 12:00pm contact PCP if greater than 250 or less than 70. Observation of Resident #2's FSBS testing supplies on 10/07/21 at 4:26pm revealed: -There was a zippered case labeled with Resident #2's name in a compartment in the top drawer of the medication cart. -There was a Brand A glucometer inside the zippered case. -The Brand A glucometer was labeled on the back with Resident #2's name. Review of Resident #2's glucometer's history Brand A revealed: -The date on the glucometer when powered on was 02/13 and the time was 10:37pm (the actual date and time was 10/07/21 at 4:26pm, a difference of 235 days, 17 hours, and 49 minutes). -There was no year displayed with the date on the glucometer screen. -The first result shown on the glucometer screen was 120 on 02/12 at 6:28pm (observed 10/07/21 at 4:26pm). -The following 13 FSBS results were shown	(D932)		

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[D932]	Continued From page 21 consecutively on the glucometer following the result of 120: 224 at 7:28am on 02/08 (plus 235 days, 17 hours, and 49 minutes=10/01 at 3:17pm) 116 at 6:03pm on 02/07 (plus 235 days, 17 hours, and 49 minutes=10/01 at 11:52am) 128 at 6:11pm on 01/31 (plus 235 days, 17 hours, and 49 minutes=09/24 at 11:59am) 131 at 5:44pm on 01/27 (plus 235 days, 17 hours, and 49 minutes=09/20 at 11:33am) 151 at 6:14pm on 01/24 (plus 235 days, 17 hours, and 49 minutes=09/17 at 12:03pm) 130 at 7:24pm on 01/22 (plus 235 days, 17 hours, and 49 minutes=09/15 at 1:13pm) 137 at 6:16pm on 01/20 (plus 235 days, 17 hours, and 49 minutes=09/13 at 12:05pm) 126 at 3:22pm on 01/17 (plus 235 days, 17 hours, and 49 minutes=09/10 at 9:11am) 126 at 5:56pm on 01/15 (plus 235 days, 17 hours, and 49 minutes=09/08 at 11:44am) 193 at 2:33pm on 01/12 (plus 235 days, 17 hours, and 49 minutes=09/05 at 8:22am) 267 at 1:20am on 01/12 (plus 235 days, 17 hours, and 49 minutes=09/04 at 7:09pm) 104 at 5:41pm on 01/10 (plus 235 days, 17 hours, and 49 minutes=09/03 at 11:29am) 126 at 6:09pm on 01/08 (plus 235 days, 17 hours, and 49 minutes=09/01 at 11:58am) Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for FSBS checks every Monday, Wednesday, and Friday scheduled at 12:00pm. -There were 10 of 13 FSBS results and 3 refusals. -There was a reading of 126 on 01/15 at 5:56pm (actual time 09/08 at 11:44am); this reading was not documented on Resident #2's eMAR.	(D932)		

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(D932)	Continued From page 22 -There was a reading of 193 on 01/12 at 2:33pm (actual time 09/05 at 8:22am); this reading was not documented on Resident #2's eMAR. -There was a reading of 267 on 01/12 at 1:20am (actual time 09/04 at 7:09pm): this reading was not documented on Resident #2's eMAR. -Documentation of FSBS of 127 on eMAR on 09/29/21 at 12:00pm was not in the glucometer. -Documentation of FSBS of 128 on eMAR on 09/24/21 at 12:00pm was not in the glucometer. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for FSBS checks every Monday, Wednesday, and Friday scheduled at 12:00pm. -There were 3 of 3 FSBS results. -There was a reading of 224 on 02/08 at 7:28am (actual time 10/02/21 at 1:17am); this reading was not documented on Resident #2's eMAR. -Documentation of FSBS of 121 on eMAR on 10/04/21 at 12:00pm was not in the glucometer. Refer to the interview with the Administrator on 10/07/21 at 3:50pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/08/21 at 10:05am. Refer to the telephone interview with the Owner on 10/08/21 at 4:10pm. 3. Review of Resident #3's current FL2 dated 07/19/21 revealed diagnoses included diabetes type II. Review of Resident #3's primary care provider (PCP) order dated 07/26/21 revealed there was an order to check and record Resident #3's FSBS's twice daily and notify PCP for FSBS	(D932)		

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(D932)	Continued From page 23 greater than 500 or less than 80. Review of Resident #3's PCP order dated 09/08/21 revealed monitor Resident #3's FSBS's two times a day and notify of FSBS less than 80 or greater than 500. Observation of Resident #3's FSBS testing supplies on 10/07/21 at 3:09pm revealed: -There was a zippered case labeled with Resident #3's name in a compartment in the top drawer of the medication cart. -There was a Brand A glucometer inside the zippered case. -The Brand A glucometer was labeled on the back with Resident #3's name. Review of Resident #3's glucometer's history Brand A revealed: -The date on the glucometer when powered on was 02/13 and the time was 9:42pm (the actual date and time was 10/07/21 at 3:09pm, a difference of 235 days, 17 hours, and 27 minutes). -There was no year displayed with the date on the glucometer screen. -The first result shown on the glucometer screen was 442 on 02/13 at 2:42pm (observed 10/07/21 at 3:20pm). -The following 12 FSBS results were shown consecutively on the glucometer following the result of 442: 327 at 1:43am on 02/13 (plus 235 days, 17 hours, and 27 minutes=10/06 at 7:10pm) 294 at 1:36pm on 02/12 (plus 235 days, 17 hours, and 27 minutes=10/06 at 7:03am) 331 at 7:50am on 02/10 (plus 235 days, 17 hours, and 27 minutes=10/04 at 1:17am) 384 at 3:28pm on 02/08 (plus 235 days, 17 hours, and 27 minutes=10/02 at 8:55am)	(D932)		

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RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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(D932)	Continued From page 24 269 at 1:36pm on 02/07 (plus 235 days, 17 hours, and 27 minutes=10/01 at 7:03am) 359 at 1:55am on 02/07 (plus 235 days, 17 hours, and 27 minutes=09/30 at 7:22pm) 361 at 1:46pm on 02/06 (plus 235 days, 17 hours, and 27 minutes=09/30 at 7:13am) 408 at 2:10am on 02/05 (plus 235 days, 17 hours, and 27 minutes=09/28 at 7:37pm) 409 at 2:49pm on 02/04 (plus 235 days, 17 hours, and 27 minutes=09/28 at 8:16am) 176 at 12:56pm on 02/03 (plus 235 days, 17 hours, and 27 minutes=09/27 at 6:23am) 148 at 1:44pm on 02/02 (plus 235 days, 17 hours, and 27 minutes=09/26 at 7:11am) 299 at 2:38pm on 02/01 (plus 235 days, 17 hours, and 27 minutes=09/25 at 8:05am) Review of Resident #3's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for FSBS checks twice daily notify PCP of FSBS less than 80 or greater than 500 scheduled at 8:00am and 8:00pm. -There were 51 of 58 FSBS results and 1 refusal. -There was a reading of 361 on 02/06 at 1:46pm (actual time 09/30 at 7:13am); this reading was not documented on Resident #3's eMAR. -There was a reading of 408 on 02/05 at 2:10am (actual time 09/28 at 7:37pm); this reading was not documented on Resident #3's eMAR. -There was a reading of 171 on 01/31 at 2:22am (actual time 09/23 at 7:49pm); this reading was not documented on Resident #3's eMAR. -There was a reading of 82 on 01/31 at 2:21am (actual time 09/23 at 7:48pm); this reading was not documented on Resident #3's eMAR. -There was a reading of 195 on 01/20 at 1:07am (actual time 09/12 at 6:34pm); this reading was not documented on Resident #3's eMAR. -There was a reading of 67 on 01/19 at 10:23am	(D932)		

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	HAL011372	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

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{D932}	Continued From page 25 (actual time 09/12 at 3:50am); this reading was not documented on Resident #3's eMAR. -There was a reading of 174 on 01/19 at 2:57pm (actual time 09/12 at 8:24am); this reading was not documented on Resident #3's eMAR. -There was a reading of 245 on 01/19 at 2:43am (actual time 09/11 at 8:10pm); this reading was not documented on Resident #3's eMAR. -There was a reading of 148 on 01/18 at 3:26pm (actual time 09/11 at 8:53am); this reading was not documented on Resident #3's eMAR. -Documentation of FSBS of 261 on eMAR on 09/30/21 at 8:00am was not in the glucometer. -Documentation of FSBS of 189 on eMAR on 09/29/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 206 on eMAR on 09/29/21 at 8:00am was not in the glucometer. -Documentation of FSBS of 398 on eMAR on 09/28/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 179 on eMAR on 09/26/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 246 on eMAR on 09/25/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 189 on eMAR on 09/24/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 136 on eMAR on 09/23/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 198 on eMAR on 09/23/21 at 8:00am was not in the glucometer. -Documentation of FSBS of 222 on eMAR on 09/21/21 at 8:00pm was not in the glucometer. -Documenation of FSBS of 202 on eMAR on 09/19/21 at 8:00am was not in the glucometer. -Documentation of FSBS of 226 on eMAR on 09/18/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 262 on eMAR on 09/13/21 at 8:00am was not in the glucometer. -Documentation of FSBS of 169 on eMAR on 09/12/21 at 8:00pm was not in the glucometer. -Documentation of FSBS of 245 on eMAR on	{D932}		

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(D932)	Continued From page 26	(D932)		

09/11/21 at 8:00pm was not in the glucometer.
-Documentation of FSBS of 148 on eMAR on 09/11/21 at 8:00am was not in the glucometer.
-Documentation of FSBS of 185 on eMAR on 09/10/21 at 8:00pm was not in the glucometer.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for FSBS checks twice daily notify PCP of FSBS less than 80 or greater than 500 scheduled at 8:00am and 8:00pm.
-There were 13 of 13 FSBS results.
-There was a reading of 269 on 02/07 at 1:36pm (actual time 10/01 at 7:03am); this reading was not documented on Resident #3's eMAR.
-Documentation of FSBS of 258 on eMAR on 10/05/21 at 8:00pm was not in the glucometer.
-Documentation of FSBS of 226 on eMAR on 10/05/21 at 8:00am was not in the glucometer.
-Documentation of FSBS of 231 on eMAR on 10/04/21 at 8:00pm was not in the glucometer.
-Documentation of FSBS of 289 on eMAR on 10/04/21 at 8:00am was not in the glucometer.
-Documentation of FSBS of 339 on eMAR on 10/03/21 at 8:00am was not in the glucometer.
-Documentation of FSBS of 241 on eMAR on 10/02/21 at 8:00pm was not in the glucometer.
-Documentation of FSBS of 225 on eMAR on 10/01/21 at 8:00pm was not in the glucometer.
-Documentation of FSBS of 263 on eMAR on 10/01/21 at 8:00am was not in the glucometer.

Interview with the Administrator on 10/07/21 at 3:51pm revealed:
-Resident #3 asked her to check his FSBS at "off times."
-She did not always document extra FSBS checks for Resident #3.

Interview with a medication aide (MA) on

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{D932}	Continued From page 27 10/07/21 at 4:10pm revealed: -She used the glucometer that was in the resident's labeled pouch to check FSBS's. -She recorded the FSBS result in the resident's eMAR right after she checked it. -She did not know why there would be extra FSBS readings in Resident #3's glucometer. -She had documented FSBS results on the eMAR for Resident #3 on 10/2/21 and 10/03/21. -Resident #3 had never asked her to check his FSBS at times other than when it was scheduled. -She only checked Resident #3's FSBS when it came up on the eMAR. Refer to the interview with the Administrator on 10/07/21 at 3:50pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/08/21 at 10:05am. Refer to the telephone interview with the Owner on 10/08/21 at 4:10pm. _____ Interview with the Administrator on 10/07/21 at 3:50pm revealed: -The Owner and the Resident Care Coordinator (RCC) had been "personally" checking the glucometer histories against the resident's eMARs. -The same medication aides (MAs) had been administering medications and checking FSBS in the facility. -The MAs had all been trained to never share glucometers. -She did not believe the MAs were sharing. -She did not know why there were extra readings in the glucometer histories which were not documented on the eMAR or in the residents charts. -"I guess" the MAs were not documenting all of	{D932}		

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(D932)	Continued From page 28 the FSBS's they checked for residents. Interview with the Resident Care Coordinator (RCC) on 10/08/21 at 10:05am revealed: -The last time the glucometers in the facility were audited was on 09/28/21. -She and the Owner performed the audit on 09/28/21. -She and the Owner had noticed some of the entries were "off" but they were not "big" discrepancies like multiple back to back wrong entries. Telephone interview with the Owner on 10/08/21 at 4:10pm revealed: -Staff had been checking the glucometer histories "more often." -He had assisted with auditing the glucometers in the facility. -He felt the extra values in the glucometer histories were from staff checking resident FSBS "multiple times" and not recording them on the eMARs. -He had noticed variations between glucometer history readings and the eMARs which appeared to be documentation errors when he and the RCC had audited the glucometers (example: a glucometer reading of 260 but documented on the eMAR as 262). The facility failed to implement infection control procedures consistent with Centers for Disease Control (CDC) guidelines resulted in 3 residents receiving fingerstick blood sugar checks with glucometers which had been shared which increased the risk of exposure to contracting bloodborne pathogen diseases. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation.	(D932)		

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{D932}	Continued From page 29 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/13/21 for this violation.	{D932}		