STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 completed a follow-up survey on 12/07/21 and 12/08/21 with an exit conference via phone on 12/08/21.	{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 previously Unabated Type B Violation has not been abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1 and #2) related to medications used to treat diabetes. The findings are: 1. Review of Resident #2's current FL2 dated 07/19/21 revealed: -Diagnoses included diabetes, bipolar, and schizoaffective disorder. -There was a physician's order for Lantus (a long	{D 358}		

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{D 358}	Continued From page 1 acting insulin used to stabilize blood glucose) inject 16 units subcutaneously daily. Review of a physician's order dated 11/02/21 revealed: -There was a physician's order to discontinue Lantus inject 16 units subcutaneously daily. -There was a physician's order to start Levemir (used to treat diabetes) inject 14 units subcutaneously at bedtime 30 days with two refills. Review of Resident #2's December 1-7, 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Levemir inject 14 units subcutaneously at bedtime scheduled at 8:00pm. -The Levemir was documented as administered on 12/01/21 at 8:00pm. -There was documentation the Levemir was discontinued with a stop date of 12/01/21. -FSBS ranged from 94 to 223. Review of Resident #2's record revealed there was no physician's order to discontinue Levemir. Review of Resident #2's medications on hand on 12/07/21 at 12:35pm revealed there was no Levemir available to administer. Interview with Resident #2 on 12/07/21 at 9:35am revealed he did not remember getting his insulin recently. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/07/21 at 12:55pm revealed: -The physician's order for Levemir was "active" in the pharmacy computer system.	{D 358}		

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{D 358}	Continued From page 2 -The pharmacy did not have a physician's order to discontinue the Levemir. -Someone from the facility had called the pharmacy today and reported someone at the facility had changed the stop date for the Levemir to 12/01/21. -The pharmacy was not able to see any changes the facility made to the eMAR. Telephone interview with a medication aide on 12/08/21 at 9:47am revealed: -She did not know Resident #2's Levemir was discontinued off the eMAR. -The MAs were not responsible for approving orders for the eMAR or processing physician orders for the residents. -She did not remember what Resident #2's FSBS were in the past week. Interview with the Administrator on 12/07/21 at 1:35pm revealed: -She administered medications in the facility when needed. -The pharmacy had entered a discontinuation order on the eMAR for Levemir. -The discontinuation order for Levemir was approved by the previous Owner because the physician's order was for 30 days. -The previous Owner was working at the facility to help with processing physician's orders. -The pharmacy was responsible for entering all discontinuation orders before the facility could approve the order for the eMAR. -The only staff that could approve orders for the eMAR was the previous Resident Care Coordinator (RCC), the previous Owner, and herself. -The Levemir was sent back to the pharmacy because she thought it was discontinued. -She or the Owner were responsible for auditing	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

the medication carts every "couple of weeks."
-New physician orders were compared to the eMAR before the order was approved.
-She did not make changes to the eMAR unless she sent the change to the pharmacy first.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/07/21 at 3:57pm revealed:
-She did not know the facility had discontinued Resident #2's Levemir.
-Resident #2 was not supposed to stop his Levemir and it should be administered to him daily.
-Resident #2 was at an increased risk for hyperglycemia which could result in diabetic ketoacidosis (DKA).
-DKA (when the body does not have enough glucose for energy and starts breaking down fats; when fats are broken down they produce ketones that makes the body acidic) was a life-threatening condition and would be considered an emergency.

2. Review of Resident #1's current FL2 dated 11/29/21 revealed:
-Diagnoses included diabetes, hypertension, chronic pain, vascular dementia, and peripheral neuropathy.
-There was a physician's order for insulin aspart (a short acting insulin used to manage blood glucose) 100 unit/ml inject 6 units subcutaneously three times daily with meals to treat diabetes.

Review of Resident #1's physician's order dated 11/29/21 revealed a physician's order to monitor fingerstick blood sugars (FSBS) three times daily with insulin and hold insulin if FSBS was less than 100.

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{D 358}	Continued From page 4 Review of Resident #1's November 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for insulin aspart 100 unit/ml inject 6 units subcutaneously 3 times daily scheduled at 7:30am, 12:00pm and 4:30pm. -The insulin aspart was documented as administered three times daily from 11/20/21 to 11/30/21. -There was no entry to hold insulin aspart if FSBS was less than 100. -There was no documentation of FSBS readings. Review of Resident #1's December 2021 eMAR revealed: -There was a computer-generated entry for insulin aspart 100 unit/ml inject 6 units subcutaneously 3 times daily scheduled at 7:30am, 12:00pm, and 4:30pm. -Insulin aspart was not documented as administered from 12/01/21 to 12/07/21. -There was documentation that the insulin was not administered because it was "arriving from pharmacy." -There was no documentation of FSBS readings. Observation of Resident #1's medication on hand on 12/07/21 at 12:45pm revealed the insulin aspart 100 unit/ml was available on the medication cart with a fill date of 11/19/21. Interview with Resident #1 on 12/07/21 at 9:18am revealed he was not administered his insulin over the past weekend (12/03/21-12/05/21). Telephone interview with a representative from the facility's contracted pharmacy on 12/10/21 at 1:20pm revealed: -A physician's order for insulin apart 100 unit/ml	{D 358}		

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{D 358}	Continued From page 5	{D 358}		

pen (17-day supply) for Resident #1 was processed on 11/19/21.
-The medication was delivered to the facility on 11/19/21 at 8:43pm.
-The pharmacy received a physician's order on 11/30/21 for Resident #1 to check FSBS three times a day and hold if FSBS was less than 100.
-The pharmacy entered the physician's order in the computer for the facility to approve for the eMAR.
-The pharmacy received an order on 12/06/21 for a glucometer and supplies for Resident #1.
-The pharmacy did not have a physician's order for the facility to discontinue the insulin aspart.

Telephone interview with Resident #1's Nurse Practitioner (NP) on 12/7/21 at 4:08pm revealed:
-She evaluated Resident #1 for the first time on 11/29/21.
-She did not know the facility stopped administration insulin to Resident #1 after she had wrote the order on 11/29/21 to check FSBS three times daily and hold if FSBS was less than 100.
-She called the facility on 12/03/21 and asked the Administrator about Resident #1's FSBS.
-The Administrator told her the facility did not have a glucometer for Resident #1 and could not check his FSBS.
-She faxed an order to the pharmacy on 12/06/21 for the glucometer and supplies.
-She was "very" concerned that Resident #1 could be having high blood glucose levels because no one was checking his FSBS and he was not administered his insulin for an extended period of time.
-Resident #1 was at an increased risk for hyperglycemia which could result in diabetic ketoacidosis (DKA).
-DKA (when the body does not have enough

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{D 358}	Continued From page 6 glucose for energy and starts breaking down fats; when fats are broken down they produce ketones that makes the body acidic) was a life-threatening condition and would be considered an emergency. Confidential interview with a medication aide (MA) revealed: -She has never administered insulin without obtaining a FSBS. -She knew it was dangerous to administer insulin to a resident without monitoring their FSBS. -She administered Resident #1 insulin, but she felt uncomfortable administering it without a glucometer. Interview with the Administrator on 12/07/21 at 10:00am revealed: -The insulin aspart was available for administration, but there was no glucometer to record FSBS. -Resident #1's NP wrote an order dated 11/29/21 to check the resident's FSBS three times daily and hold if the FSBS was less than 100. -The order to check the FSBS was on the same physician's order as the order for the insulin aspart 100 units/ml. -The resident did not have a glucometer so the staff could not check his FSBS. -The insulin was not administered to Resident #1 because the staff would not know to hold the insulin or not since they could not check the resident's FSBS. _____ The facility failed to administer medications as prescribed by a licensed physician for 2 of 3 sampled residents (#1 and #2) related to a resident (#2) missing his long acting insulin and a resident (#1) missing a short acting insulin for multiple days putting the residents at risk for	{D 358}		

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{D 358}	Continued From page 7 hyperglycemia which could result in a life threatening condition called DKA (when the body does not have enough glucose for energy and starts breaking down fats; when fats are broken down they produce ketones that makes the body acidic). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/21 for this violation.	{D 358}		
{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 2 of 3 sampled residents (#1 and #2) related to medications used to treat diabetes	{D912}		

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{D912}	Continued From page 8 [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated 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 of Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#2, #3, #4) 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 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.	{D932}		

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{D932}	Continued From page 9 c. Accessibility of infection control devices and 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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{D932}	Continued From page 10 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 of Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#2, #3, #4) 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 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 online user manual for Brand A glucometer revealed: -Users should follow the guidelines for prevention of blood-borne transmittable disease in a healthcare setting. -There were no disinfection instructions provided for multi-person use.	{D932}		

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{D932}	Continued From page 11 Review of the facility's diabetic testing policy 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 12/07/21 at 9:15am revealed: -There were three zippered cases containing Brand A glucometers in the top drawer. -Each case had a different resident's name typed and labeled on the front of the case. -The zippered cases were not stored inside zip-locked bags. 1.Review of Resident #2's FL2 dated 07/19/21 revealed: -Diagnoses included diabetes. -There was a physician's order to check and record FSBS twice daily and notify provider if greater than 500 or less than 80. Observation of Resident #2's FSBS testing supplies on 12/07/21 at 10:00am revealed: -There was a zippered case with Resident #2's name printed on a sticker attached to the outside	{D932}		

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{D932}	Continued From page 12	{D932}		

case in the top drawer of the medication cart.
-There was a Brand A glucometer inside the zippered case with the resident's name printed on a sticker and labeled on the back of the glucometer.

Review of FSBS values recorded in the history of Resident #2's glucometer from 11/01/21 to 12/07/21 revealed:
-When the glucometer was powered on, the date was 04/15 and the time was 5:54pm (the actual date was 12/07/21 at 10:32am).
-The FSBS values recorded in the glucometer were not consistent with FSBS readings documented on the resident's November 20201 electronic Medication Administration Record (eMAR).
-There were five FSBS readings documented in the history of Resident #2's glucometer but not on his November 2021 eMAR.
-The readings were 125 at 1:56am on 03/16 (actual date 11/07/21), 138 at 8:02pm on 03/19 (actual date 11/10/21), 559 at 3:41am and 550 at 2:32am on 03/12 (actual date 11/12/21), and 130 at 3:58pm on 03/25 (actual date 11/16/21).
-There was no documentation for a reading of 169 on 11/07/21 and 135 on 11/16/21 (both FSBS values were documented on Resident #2's November 2021 eMAR).

Review of Resident #2's November 2021 eMAR revealed:
-There was a computer-generated entry to check FSBS twice daily scheduled at 8:00am and 8:00pm.
-There was a reading of 169 documented at 8:00am on 11/07/21.
-There was a reading of 135 documented at 8:00pm on 11/16/21.
-There was no documentation in the eMAR of a

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{D932}	Continued From page 13 reading of 125 on 11/07/21, 138 on 11/10/21 (FSBS reading was documented on Resident #4's November 2021 eMAR), 559 and 550 on 11/12/21, and 130 on 11/16/21 (all five FSBS readings were documented in the history of Resident #2's glucometer). Refer to the telephone interview with a second MA on 12/08/21 at 10:34am. Refer to the telephone interview with the Nurse Practitioner (NP) at 3:57pm on 12/08/21. Refer to the interview with the Administrator on 12/07/21 at 1:35pm. 2. Review of Resident #3's current FL2 dated 08/30/21 revealed: -Diagnoses included diabetes. -There was a physician's order to check fingerstick blood sugars (FSBS) once daily on Monday, Wednesday, and Friday. Observation of Resident #3's FSBS testing supplies on 12/07/21 at 10:00am revealed: -There was a zippered case with Resident #3's name printed on a sticker attached to the outside case in the top drawer of the medication cart. -There was a Brand A glucometer inside the zippered case with the resident's name printed on a sticker and labeled on the back of the glucometer. Review of FSBS values recorded in the history of Resident #3's glucometer from 11/01/21 to 12/07/21 revealed: -The date and time on the glucometer when powered on was 12/07/21 at 12:12pm (actual time was the same). -There was no documentation of a FSBS reading	{D932}		

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 12/08/2021

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{D932}	Continued From page 14 of 128 on 12/03/21 (reading documented on Resident #3's December 2021 eMAR). Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry to check FSBS daily on Monday, Wednesday, and Friday scheduled at 8:00am. -There was reading of 128 documented at 8:00am on 12/03/21 (reading was not documented in the history of Resident #3's glucometer). Refer to the telephone interview with a second MA on 12/08/21 at 10:34am. Refer to the telephone interview with the Nurse Practitioner (NP) at 3:57pm on 12/08/21. Refer to the interview with the Administrator on 12/07/21 at 1:35pm. 3. Review of Resident #4's current FL2 dated 07/19/21 revealed: -Diagnoses included diabetes. -There was a physician's order to check and record FSBS every Monday, Wednesday, and Friday, contact provider if greater than 250 or less than 70. Observation of Resident #4's FSBS testing supplies on 12/07/21 at 10:00am revealed: -There was a zippered case with Resident #4's name printed on a sticker attached to the outside case in the top drawer of the medication cart. -There was a Brand A glucometer inside the zippered case with the resident's name printed on a sticker and labeled on the back of the glucometer.	{D932}		

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{D932}	Continued From page 15 Review of FSBS values recorded in the history of Resident #4's glucometer from 11/01/21 to 12/07/21 revealed: -The date and time on the glucometer when powered on was 04/15/21 at 12:20pm (actual time was 12/07/21 at 12:10pm). -There was no documentation of a FSBS reading of 138 on 03/19/21 (actual date 11/10/21). -The FSBS reading of 138 was documented on Resident #4's November 2021 electronic Medication Administration Record (eMAR). Review of Resident #4's November 2021 eMAR revealed: -There was a computer-generated entry to check FSBS daily on Monday, Wednesday, and Friday scheduled at 8:00am. -There was reading of 138 documented at 8:00am on 11/10/21 (reading was not documented in the history of Resident #4's glucometer bu was documented in the history of Resident #2's glucometer that was reviewed on 12/07/21). Refer to the telephone interview with a second MA on 12/08/21 at 10:34am. Refer to the telephone interview with the Nurse Practitioner (NP) at 3:57pm on 12/08/21. Refer to the interview with the Administrator on 12/07/21 at 1:35pm. _____ Telephone interview with a second MA on 12/08/21 at 10:34am revealed: -She was responsible for administration medications in the facility. -She was not responsible for auditing the eMARs or the glucometers.	{D932}		

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{D932}	Continued From page 16 -She made sure she used each resident's personal glucometer when she checked FSBS in the facility. -She did not know why there were extra FSBS readings in the glucometer or why all the documented FSBS readings on the eMAR were not on each resident's glucometer. Telephone interview with the Nurse Practitioner (NP) at 3:57pm on 12/08/21 revealed: -The facility staff should not be sharing glucometers between residents. -It was very dangerous to use the same glucometer on multiple residents because it increased the risk of infection and the risk of transmitting bloodborne pathogens. -She thought the facility had corrected this problem. -It was important for the facility to accurately document all FSBS to ensure the glucometers were not being shared. Interview with the Administrator on 12/07/21 at 1:35pm revealed: -The MAs should not be sharing glucometers between residents in the facility. -The MAs were responsible for making sure they used each resident's assigned glucometer when they checked a FSBS for a resident. -The MAs had recently been retrained by a nurse consultant from the pharmacy on the importance of not sharing glucometers. -The MAs were trained to check the name on the glucometer with the resident's name on the eMAR prior to checking a FSBS to ensure they were using the correct glucometer. -She or the Owner were responsible for auditing the glucometers. -The last audit of the glucometers was "about two weeks ago."	{D932}		

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{D932}	Continued From page 17 -They had found some readings on the glucometers that were not documented on a resident's eMAR. -She had the pharmacy add an entry on all diabetic resident's eMAR for the documentation of any additional readings that were checked on a resident. _____ The facility failed to implement infection control procedures consistent with the Centers for Disease Control (CDC) guidelines resulted in 3 residents having fingerstick blood sugar (FSBS) readings on their electronic Medication Administration Records (eMAR) that was not documented on their assigned glucometer showing glucometers were shared between residents increasing their risk of infection and contracting a bloodborne pathogen disease. This failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/21 for this violation.	{D932}		