1-17-2021

If continuation sheet 1 of 18

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011372	B. WING		R 12/08/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	FE, ZIP CODE	
RICHMON	D HILL REST HOME #	5	MOND HILL ROAI LLE, NC 28806	D	
(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 T DEFICIENC	ION SHOULD BE COMPLETI THE APPROPRIATE DATE
{D 000}	Initial Comments		{D 000}		
	Buncombe County I completed a follow-	nsure Section and the Department of Social Services up survey on 12/07/21 and it conference via phone on	R fo	or the MAR. per Adm	or approving med orde nin 1/18/22 @ 5:20pm
{D 358}	<ul> <li>(a) An adult care he preparation and adr prescription and nor by staff are in according to the staff are in according to the staff are maintained (2) rules in this Section and procedures.</li> <li>This Rule is not me</li> </ul>	04 Medication Administration ome shall assure that the ninistration of medications, n-prescription, and treatments dance with: nsed prescribing practitioner ed in the resident's record; and tion and the facility's policies	{D 358}	Rece will Review all phi orders weeks ensure that of match mare. discriptionsy be handled the phannacly and	ysican y to ideus Anur
	Type B Violation has Based on observation reviews, the facility is medications as order practitioner for 2 of 3 #2) related to medicate The findings are:	ons, interviews, and record failed to administer ered by a licensed prescribing 3 sampled residents (#1 and eations used to treat diabetes.			
	07/19/21 revealed: -Diagnoses included schizoaffective disor	ent #2's current FL2 dated d diabetes, bipolar, and rder. cian's order for Lantus (a long			

8TCY14

RH

STATE FORM Administrativ me 0

Reviewed and Acknowledged 01/18/22

# Division of Health Service Regulation

.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			
		HAL011372	B. WING		12	R 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
RICHMON	ND HILL REST HOME # 5		IMOND HILL ROAD ILLE, NC 28806			
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	acting insulin used to inject 16 units subcut Review of a physicia revealed: -There was a physici Lantus inject 16 units -There was a physici (used to treat diabete subcutaneously at be refills. Review of Resident # electronic Medication (eMAR) revealed: -There was a comput Levemir inject 14 uni bedtime scheduled a -The Levemir was do on 12/01/21 at 8:00p -There was documen discontinued with a s -FSBS ranged from 9 Review of Resident # 12/07/21 at 12:35pm Levemir available to Interview with Reside revealed he did not re recently. Telephone interview of facility's contracted p 12:55pm revealed:	<ul> <li>a stabilize blood glucose) taneously daily.</li> <li>n's order dated 11/02/21</li> <li>an's order to discontinue a subcutaneously daily.</li> <li>an's order to start Levemir as bipet 14 units</li> <li>b addime 30 days with two</li> <li>42's December 1-7, 2021</li> <li>b Administration Record</li> <li>currented entry for ts subcutaneously at t 8:00pm.</li> <li>currented as administered m.</li> <li>tation the Levemir was top date of 12/01/21.</li> <li>44 to 223.</li> <li>42's record revealed there rder to discontinue Levemir.</li> <li>42's medications on hand on revealed there was no administer.</li> <li>ent #2 on 12/07/21 at 9:35am emember getting his insulin</li> <li>with a pharmacist from the harmacy on 12/07/21 at</li> </ul>	{D 358}	DEFICIENC	7)	

STATE FORM

6099

8TCY14

If continuation sheet 2 of 18

Division of	of Health Service Regu	ation			FORM	APPROVED
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 12/08/2021	
		HAL011372	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
RICHMON	ID HILL REST HOME # 5		MOND HILL ROA			
		ASHEVII	LE, NC 28806			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	2	{D 358}			
	-The pharmacy did not to discontinue the Lew -Someone from the far pharmacy today and of facility had changed th to 12/01/21. -The pharmacy was not the facility made to the Telephone interview wi 12/08/21 at 9:47am re- -She did not know Re- discontinued off the ei- -The MAs were not re- orders for the eMAR of orders for the resident -She did not remember were in the past week Interview with the Adm 1:35pm revealed: -She administered mer when needed. -The pharmacy had ei- order on the eMAR for -The discontinuation of approved by the previous physician's order was -The previous Owner help with processing p -The pharmacy was re- discontinuation orders approve the order for -The only staff that co eMAR was the previous	At have a physician's order remir. Incility had called the reported someone at the ne stop date for the Levemir ot able to see any changes e eMAR. With a medication aide on evealed: sident #2's Levemir was MAR. sponsible for approving or processing physician ts. er what Resident #2's FSBS an ininistrator on 12/07/21 at edications in the facility intered a discontinuation r Levemir. order for Levemir was ous Owner because the for 30 days. was working at the facility to obysician's orders. esponsible for entering all a before the facility could the eMAR. uld approve orders for the	{U 336}			

Division of Health Service Regulation STATE FORM

-The Levemir was sent back to the pharmacy because she thought it was discontinued. -She or the Owner were responsible for auditing

6899

8TCY14

If continuation sheet 3 of 18

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011372	B. WING		12	R 2/08/2021
AME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
	D HILL REST HOME # 5		MOND HILL ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	PRESTION	-
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
{D 358}	Continued From page	e 3	{D 358}			
	the medication carts	every "couple of weeks."				
	-New physician order	s were compared to the				
	eMAR before the ord	er was approved.				
	she sent the change	anges to the eMAR unless to the pharmacy first.				
	Telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/07/21 at 3:57pm revealed:					
		e facility had discontinued				
	-Resident #2 was not Levemir and it should	-Resident #2 was not supposed to stop his Levemir and it should be administered to him				
	daily. -Resident #2 was at a					
	ketoacidosis (DKA).	could result in diabetic				
	glucose for energy ar	r does not have enough nd starts breaking down fats;				
	when fats are broken	down they produce ketones				
	that makes the body a condition and would b emergency.	acidic) was a life-threatening				
		t #1's current FL2 dated				
	-Diagnoses included chronic pain, vascula	diabetes, hypertension, r dementia, and peripheral				
	neuropathy. -There was a physicia (a short acting insulin	an's order for insulin aspart				
	(a short acting insulin ducose) 100 unit/mi	used to manage blood nject 6 units subcutaneously				1
	three times daily with	meals to treat diabetes.				
	11/29/21 revealed a p	1's physician's order dated hysician's order to monitor				
	fingerstick blood suga with insulin and hold i 100.	ars (FSBS) three times daily insulin if FSBS was less than				

STATE FORM

.

6899

If continuation sheet 4 of 18

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011372	B. WING	12	R 12/08/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL ROAD LE, NC 28806			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	E CORRECTION	()(5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
(D 358}	Continued From page	e 4	{D 358}			
	(eMAR) revealed: -There was a comput insulin aspart 100 uni subcutaneously 3 tim 7:30am, 12:00pm and -The insulin aspart was administered three tin 11/30/21. -There was no entry to was less than 100. -There was no docum Review of Resident # revealed: -There was a comput insulin aspart 100 uni subcutaneously 3 tim 7:30am, 12:00pm, an -Insulin aspart was no administered from 12 -There was documen not administered beca pharmacy." -There was no docum Observation of Resident on 12/07/21 at 12:45g aspart 100 unit/ml wa medication cart with as Interview with Reside revealed he was not a the past weekend (12)	Administration Record er-generated entry for t/ml inject 6 units es daily scheduled at d 4:30pm. as documented as mes daily from 11/20/21 to to hold insulin aspart if FSBS mentation of FSBS readings. d's December 2021 eMAR er-generated entry for t/ml inject 6 units es daily scheduled at d 4:30pm. to documented as /01/21 to 12/07/21. tation that the insulin was ause it was "arriving from mentation of FSBS readings. ent #1's medication on hand om revealed the insulin is available on the a fill date of 11/19/21. nt #1 on 12/07/21 at 9:18am administered his insulin over t/03/21-12/05/21).				
	1:20pm revealed:	d pharmacy on 12/10/21 at or insulin apart 100 unit/ml				

STATE FORM

8TCY14

If continuation sheet 5 of 18

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011372	B. WING		1;	R 2/08/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 5		MOND HILL ROAD LLE, NC 28806			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF COP	RECTION	(ME)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
{D 358}	Continued From page	e 5	{D 358}			
	11/19/21 at 8:43pm. -The pharmacy recei 11/30/21 for Residen times a day and hold -The pharmacy enter the computer for the eMAR. -The pharmacy recei a glucometer and sug -The pharmacy did no for the facility to disco Telephone interview of Practitioner (NP) on -She evaluated Resid 11/29/21. -She did not know the administration insulin had wrote the order of three times daily and 100. -She called the facilit Administrator about F -The Administrator to have a glucometer for check his FSBS. -She faxed an order to for the glucometer ar -She was "very" cond could be having high because no one was	21. delivered to the facility on ved a physician's order on t #1 to check FSBS three if FSBS was less than 100. ed the physician's order in facility to approve for the ved an order on 12/06/21 for oplies for Resident #1. ot have a physician's order ontinue the insulin aspart. with Resident #1's Nurse 12/7/21 at 4:08pm revealed: dent #1 for the first time on e facility stopped to Resident #1 after she on 11/29/21 to check FSBS hold if FSBS was less than y on 12/03/21 and asked the Resident #1 and could not r Resident #1 and could not to the pharmacy on 12/06/21 ad supplies. cerned that Resident #1				
	period of time. -Resident #1 was at a hyperglycemia which ketoacidosis (DKA).					

STATE FORM

6899

8TCY14

If continuation sheet 6 of 18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011372	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		Сом	E SURVEY IPLETED R 2/08/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
				, ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL ROAD LE, NC 28806			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			CORRECTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
{D 358}	Continued From page	96	{D 358}			
	when fats are broken	nd starts breaking down fats; down they produce ketones acidic) was a life-threatening be considered an				
	revealed: -She has never admin obtaining a FSBS. -She knew it was dan to a resident without n -She administered Re	with a medication aide (MA) nistered insulin without gerous to administer insulin monitoring their FSBS. esident #1 insulin, but she ministering it without a				
	10:00am revealed: -The insulin aspart wa administration, but the record FSBS. -Resident #1's NP wr to check the resident' and hold if the FSBS -The order to check the physician's order as the aspart 100 units/ml. -The resident did not staff could not check -The insulin was not as because the staff wool	ere was no glucometer to ote an order dated 11/29/21 s FSBS three times daily was less than 100. ne FSBS was on the same he order for the insulin have a glucometer so the				
	prescribed by a licens sampled residents (# resident (#2) missing	his long acting insulin and a a short acting insulin for				

STATE FORM

6899

8TCY14

If continuation sheet 7 of 18

OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(, ).	TE SURVEY MPLETED	
				12/08/2021	
D HILL REST HOME # 5			AD		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
hyperglycemia which threatening condition does not have enoug starts breaking down down they produce ka acidic). This failure w safety, and welfare of constitutes a Type B	could result in a life called DKA (when the body h glucose for energy and fats; when fats are broken etones that makes the body as detrimental to the health, the residents and violation.	{D 358}	12		
G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations. This Rule is not met Based on observation reviews, the facility fa received care and set appropriate, and in co federal and state laws as related medication care home infection p The findings are: 1. Based on observat reviews, the facility fa	ation of Residents' Rights ave the following rights: d services which are e, and in compliance with tate laws and rules and as evidenced by: as, interviews, and record iled to ensure residents vices which were adequate, mpliance with relevant s and rules and regulations administration and adult revention requirements.	{D912}	All didbetics will be given her gencose meters, Staffed will be retrained on USE and infection control. meters will be moniton werenzy by pcc.	(-17-2	
	ROVIDER OR SUPPLIER D HILL REST HOME # 5 SUMMARY STI (EACH DEFICIENC' REGULATORY OR L Continued From page hyperglycemia which threatening condition does not have enough starts breaking down down they produce ke acidic). This failure was safety, and welfare of constitutes a Type B V The facility provided a accordance with G.S. this violation. G.S. 131D-21 (2) Deck G.S. 131D-21 Deckar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations. This Rule is not met a Based on observation reviews, the facility fa received care and ser appropriate, and in co federal and state laws as related medication care home infection p The findings are: 1. Based on observat reviews, the facility fa	APP CORRECTION       HAL011372         Import of the state of the sta	OPE CORRECTION       INPETITION NUMBER:       (A. BUILDING;         HAL011372       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST/ 95 RICHMOND HILL RO/ ASHEVILLE, NC 28806         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 7       (D 358)         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.       (D 912)         G.S. 131D-21(2) Declaration of Residents' Rights       (D912)         G.S. 131D-21 Declaration of Residents' Rights       (D 912)         C.S. 131D-21 Declaration of Residents' Rights       (D 912)         G.S. 131D-21 Declaration of Residents' Rights       (D 912)         G.S. 131D-21 Declaration of Residents' Rights       (D 912)         G.S. 131D-21 Declaration of Residents' Rights       (D 912)         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 fi	PF CORRECTION       Image: Description in NUMBER       Down the fact of the construction in NUMBER       Down the construction in NUMBER       Down the construction in NUMBER       A BULDING:	

6899

8TCY14

If continuation sheet 8 of 18

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
			A, BUILDING:			
		HAL011372	B. WING		R 12/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL RO	AD		
			LLE, NC 28806			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLET DATE
{D912}	Continued From page	e 8	{D912}			
	[Refer to Tag 358, 10 Medication Administr Type B Violation)].	A NCAC 13F .1004(a) ation (Unabated Unabated				
	reviews, the facility fa infection control polic Centers of Disease C (CDC) guidelines to e control procedures fo 3 of 3 sampled diabe orders for fingerstick monitoring resulting i between residents [R 131D-4.4A(b) Adult C	n the sharing of glucometers lefer to Tag 932, G.S. Care Home Infection lents (Unabated Unabated				
{D932}	G.S. 131D-4.4A (b) A Requirements	CH Infection Prevention	{D932}	All nesidents will be	2	
	G.S. 131D-4.4A Adul Prevention Requirem	t Care Home Infection ents		All residents will be given new glucose meters. Glucose	_	
	hepatitis B, hepatitis pathogens, each adu the following, beginni (1) Implement a writt consistent with the fe Control and Prevention control that addresse a. Proper disposal of to puncture skin, much tissues, and proper di patient care items that residents. b. Sanitation of room	t transmission of HIV, C, and other bloodborne It care home shall do all of ng January 1, 2012: en infection control policy deral Centers for Disease on guidelines on infection s at least all of the following: single-use equipment used cous membranes, and other isinfection of reusable at are used for multiple s and equipment, including agents, and schedules.		meters. Eilucose meters with be mon werklig by REC.	tonen	I~{7-

STATE FORM

6899

8TCY14

If continuation sheet 9 of 18

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE COMF	LETED
		HAL011372	B. WING		12	R /08/2021
ame of F	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	ND HILL REST HOME # 5		MOND HILL ROAD LLE, NC 28806			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFY (EACH CORRECTIVE ACTION		SHOULD BE	(X5) COMPLE DATE
{D932}	<ul> <li>c. Accessibility of infasupplies.</li> <li>d. Blood and bodily f</li> <li>e. Procedures to be a home staff is expose fluids of another persisignificant risk of transhepatitis C, or other f</li> <li>f. Procedures to prohwith exudative lesion engaging in direct repotential for contact fequipment, or device dermatitis until the co (2) Require and mon facility's infection corr (3) Update the infect necessary to prevent</li> </ul>	ection control devices and luid precautions. followed when adult care d to blood or other body son in a manner that poses a insmission of HIV, hepatitis B, bloodborne pathogens. hibit adult care home staff as or weeping dermatitis from sident care that involves the between the resident, as and the lesion or bodition resolves. itor compliance with the htrol policy.	{D932}			

STATE FORM

8TCY14

If continuation sheet 10 of 18

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		HAL011372	B. WING	1:	2/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL ROAD LLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
{D932}	Continued From page	e 10	{D932}			
	This Rule is not met FOLLOW-UP TO CO VIOLATION					
	Based on these findings, the previously Unabated Type B Violation has not been abated.					
	reviews, the facility fa infection control polic Centers of Disease C (CDC) guidelines to a control procedures fo 3 of 3 sampled diabe orders for fingerstick	ns, interviews, and record illed to implement a written y consistent with the Federal control and Prevention ensure proper infection r the use of glucometers for tic residents (#2, #3, #4) with blood sugar (FSBS) n the sharing of glucometers				
	The findings are:					
	revealed: -The CDC recommendevices should not be -If the glucometer is tresident, it should be the manufacturer's in -If the manufacturer of	uidelines for infection control ds blood glucose monitoring e shared between residents. o be used for more than one cleaned and disinfected per structions. loes not list disinfection ometer should not be shared				
	for Brand A glucomet -Users should follow of blood-borne transm healthcare setting.	the guidelines for prevention				

STATE FORM

6899

8TCY14

If continuation sheet 11 of 18

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVE COMPLETED	
		HAL011372	B. WING		12	2/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 5		MOND HILL ROAD LLE, NC 28806			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(Y5)
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{D932}	Continued From page	e 11	{D932}			
	revealed: -Sharing of glucometer -Each individual reside glucometer and it will -Individual glucometer should be labeled wite -The glucometer bag zip-lock bag also labeled name. -Prior to checking a mention ensure that the name zippered bag, and zip resident who is havin -Notify the Superviso glucometer, glucome does not have a labe Observation of the fan 12/07/21 at 9:15am mention -There were three zip Brand A glucometers -Each case had a diffand labeled on the from -The zippered cases zip-locked bags. 1.Review of Resident revealed: -Diagnoses included -There was a physicial record FSBS twice dag greater than 500 or labeled Supplies on 12/07/21	p-lock bag match the g their sugar checked. r whenever you have a ter bag or zip-lock bag that I with the residents' name. cility's medication cart on evealed: opered cases containing in the top drawer. ferent resident's name typed ont of the case. were not stored inside t #2's FL2 dated 07/19/21 diabetes. an's order to check and aily and notify provider if ess than 80. ent #2's FSBS testing at 10:00am revealed: d case with Resident #2's				

STATE FORM

6899

8TCY14

If continuation sheet 12 of 18

OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
HAL011372		B. WING	12	R 12/08/2021	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
D HILL REST HOME # 5					
SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (	CORRECTION	(2/5)
(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 12	{D932}			
-There was a Brand A zippered case with th	A glucometer inside the e resident's name printed on				
Resident #2's glucom 12/07/21 revealed: -When the glucomete was 04/15 and the tin	eter from 11/01/21 to r was powered on, the date ne was 5:54pm (the actual				
-The FSBS values rea were not consistent w documented on the rea	corded in the glucometer /ith FSBS readings esident's November 20201				
(eMAR). -There were five FSB the history of Resider his November 2021 e	S readings documented in at #2's glucometer but not on MAR.				
(actual date 11/07/21 (actual date 11/10/21 2:32am on 03/12 (act	), 138 at 8:02pm on 03/19 ), 559 at 3:41am and 550 at ual date 11/12/21), and 130				
at 3:58pm on 03/25 (a -There was no docum 169 on 11/07/21 and values were documer	actual date 11/16/21). nentation for a reading of 135 on 11/16/21 (both FSBS nted on Resident #2's				
revealed:					
FSBS twice daily sch 8:00pm.	eduled at 8:00am and				
8:00am on 11/07/21.					
8:00pm on 11/16/21.					
	ROVIDER OR SUPPLIER ID HILL REST HOME # 5 SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page case in the top drawe -There was a Brand A zippered case with th a sticker and labeled glucometer. Review of FSBS valu Resident #2's glucom 12/07/21 revealed: -When the glucomete was 04/15 and the tin date was 12/07/21 at -The FSBS values re- were not consistent w documented on the re- electronic Medication (eMAR). -There were five FSB the history of Resider his November 2021 e -The readings were 1 (actual date 11/07/21 (actual date 11/10/21 2:32am on 03/12 (act at 3:58pm on 03/25 (a- There was no docum 169 on 11/07/21 and values were documer November 2021 eMA Review of Resident # revealed: -There was a comput FSBS twice daily sch 8:00pm. -There was a reading 8:00pm on 11/16/21.	DF CORRECTION       HAL011372         HAL011372         ROVIDER OR SUPPLIER         STREET A         STREET HOME # 5         STREET HOME # 5         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 12         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.         -There was no documentation for a reading of 169 on 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 11/12/12), 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 Resid	DF CORRECTION       IDENTIFICATION NUMBER:       (2,2) MULTIPLE C         A. BUILDING:       HAL011372       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         BUILLI REST HOME # 5       95 RICHMOND HILL ROAD ASHEVILLE, NC 28806         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 12       (D case in the top drawer of the medication cart.       ID TAG         -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.       (D 207/21 revealed:         When the glucometer from 11/01/21 to 12/07/21 revealed:       -When the ducumeter 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 11/10/21), 158 at 3:41am and 550 at 2:32am 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.	PF CORRECTION     Image: Contract of the image: Contreat of the image: Contract of the image: Contract of the i	OPRECORRECTION       Image: Construction Number       Image: Cons

STATE FORM

6899

8TCY14

If continuation sheet 13 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION HAL011372		(A) HOUDENOOT EIENOEIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		B. WING	12	R 2/08/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL ROAD			
(¥4) ID	CUMMADY OT		LLE, NC 28806			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D932}	Continued From page	ə 13	{D932}			
TAG REGULATORY OR LSC IDEM		07/21, 138 on 11/10/21 ocumented on Resident eMAR), 559 and 550 on 11/16/21 (all five FSBS nented in the history of neter). e interview with a second 0:34am. e interview with the Nurse 57pm on 12/08/21. with the Administrator on t #3's current FL2 dated diabetes. an's order to check ars (FSBS) once daily on , and Friday. ent #3's FSBS testing at 10:00am revealed: d case with Resident #3's	{D932}			
	case in the top drawe -There was a Brand A	r of the medication cart. Slucometer inside the e resident's name printed on				
	Resident #3's glucom 12/07/21 revealed: -The date and time or powered on was 12/0	es recorded in the history of eter from 11/01/21 to n the glucometer when 7/21 at 12:12pm (actual				
	time was the same). -There was no docum	nentation of a FSBS reading				

STATE FORM

6899

8TCY14

If continuation sheet 14 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011372		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	12	R /08/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	D HILL REST HOME # !	J	MOND HILL ROAD			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	COMPLE DATE
{D932}	Continued From pag	je 14	{D932}			
	of 128 on 12/03/21 ( Resident #3's Decer	reading documented on nber 2021 eMAR).				
	Review of Resident a electronic Medication (eMAR) revealed:	#3's December 2021 n Administration Record				
	-There was a compu FSBS daily on Mond scheduled at 8:00am					
	8:00am on 12/03/21	of 128 documented at (reading was not istory of Resident #3's				
	Refer to the telephor MA on 12/08/21 at 1	ne interview with a second 0:34am.				
	Refer to the telephor Practitioner (NP) at 3	ne interview with the Nurse 3:57pm on 12/08/21.				
	Refer to the interview 12/07/21 at 1:35pm.	v with the Administrator on				
	07/19/21 revealed:	nt #4's current FL2 dated				
	record FSBS every N	diabetes. ian's order to check and Monday, Wednesday, and der if greater than 250 or less				
	than 70.	3				
	supplies on 12/07/21	dent #4's FSBS testing at 10:00am revealed:				
	name printed on a st	ed case with Resident #4's iicker attached to the outside er of the medication cart.				
	-There was a Brand	A glucometer inside the ne resident's name printed on				
	glucometer.					

STATE FORM

6699

8TCY14

If continuation sheet 15 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011372		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	12	R / <b>08/2021</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	D HILL REST HOME # 5	95 RICH	MOND HILL ROAD			
			LE, NC 28806			
(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)		SHOULD BE COMPLE	
{D932}	Continued From pag	e 15	{D932}			
	Resident #4's glucon 12/07/21 revealed: -The date and time o powered on was 04/' time was 12/07/21 at -There was no docur of 138 on 03/19/21 (a -The FSBS reading of Resident #4's Noven Medication Administr Review of Resident # revealed: -There was a comput FSBS daily on Monda scheduled at 8:00am -There was reading of 8:00am on 11/10/21 documented in the hi glucometer bu was d Resident #2's glucom 12/07/21). Refer to the telephon Practitioner (NP) at 3	nentation of a FSBS reading actual date 11/10/21). of 138 was documented on ober 2021 electronic ration Record (eMAR). ter-generated entry to check ay, Wednesday, and Friday of 138 documented at (reading was not story of Resident #4's ocumented in the history of neter that was reviewed on the interview with a second 0:34am.				
	Telephone interview 12/08/21 at 10:34am -She was responsible	revealed:				
	medications in the fac					

STATE FORM

6899

8TCY14

If continuation sheet 16 of 18

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
	HAL011372		B. WING	12	2/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
RICHMON	ID HILL REST HOME # 5		MOND HILL ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
{D932}	Continued From page	9 16	{D932}			
	the facility. -She did not know wh readings in the glucor	when she checked FSBS in y there were extra FSBS neter or why all the adings on the eMAR were				
	(NP) at 3:57pm on 12 -The facility staff shou glucometers between -It was very dangerou glucometer on multipl increased the risk of i transmitting bloodborn -She thought the facil problem. -It was important for th	Id not be sharing residents. Is to use the same e residents because it infection and the risk of ne pathogens. ity had corrected this the facility to accurately e ensure the glucometers				
	1:35pm revealed: -The MAs should not between residents in -The MAs were respo- used each resident's they checked a FSBS -The MAs had recentil consultant from the pl of not sharing glucom -The MAs were traine glucometer with the re eMAR prior to checkir were using the correct -She or the Owner we the glucometers.	nsible for making sure they assigned glucometer when for a resident. y been retrained by a nurse narmacy on the importance eters. d to check the name on the esident's name on the ng a FSBS to ensure they				

STATE FORM

6699

8TCY14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011372			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		сом	E SURVEY PLETED
				12	12/08/2021	
			DDRESS, CITY, STATE,	ZIP CODE		
RICHMON	D HILL REST HOME # 5		MOND HILL ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(147)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
{D932}	Continued From page	e 17	{D932}			

STATE FORM

6899

8TCY14

If continuation sheet 18 of 18