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 **08/25/2021**

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 a follow-up survey on 08/24/21 to 08/25/21 with an exit conference via telephone on 08/25/21.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation has been abated. Based on observation, interview, and record review, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (Resident #1) a medication used to treat infection was not administered as prescribed. The findings are: Review of Resident #1's current FL2 dated 08/09/21 revealed: -Diagnoses included abscess of left buttock. -There was an order for cefdinir 300mg 1 capsule every 12 hours for 9 days. Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for cefdinir 300mg 1 capsule every twelve hours for 9 days scheduled at 8:00am and 8:00pm.	{D 273}		

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

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{D 273}	Continued From page 1	{D 273}		

-The cefdinir was documented as administered twice daily starting 08/09/21 at 5:00pm through 08/18/21 at 8:00am for 15 occurrences out of 18 opportunities.
-On 08/09/21 at 5:00pm and 08/17/21 at 8:00am, cefdinir was documented as not administered due to staff were waiting on the medication to arrive from the pharmacy.
-On 08/18/21 at 8:00am, cefdinir was documented as not administered due to "resident refused."

Observation of Resident #1's medications on hand on 08/24/21 at 2:40pm revealed there was no cefdinir remaining.

Telephone interview with a medication aide (MA) on 08/25/21 at 10:30am revealed:
-She had documented the cefdinir entry on 08/17/21 at 8:00am on Resident #1's eMAR as waiting on the medication to arrive from the pharmacy.
-"Maybe" the cefdinir had been "out" and she had documented not administering the medication because they were waiting on the medication to arrive from pharmacy.
-She did not know why she had documented on the eMAR Resident #1 refused cefdinir on 08/18/21 at 8:00am.
-Resident #1 "never" refused his medications when she administered medications.
-She had been trained to document refusals in the eMAR and inform the next shift of the refusal.
-She knew she was supposed to notify the primary care provider (PCP) of medication refusals, but she did not notify the PCP.

Telephone interview with the facility's contracted pharmacy representative on 08/25/21 at 11:15am revealed:

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{D 273}	Continued From page 2 -They received the prescription for Resident #1's cefdinir 300mg 1 capsule every 12 hours for 9 days on 08/09/21. -They dispensed cefdinir 18 capsules to the facility on 08/09/21. -They had not received any cefdinir back from the facility for Resident #1. Interview with Resident #1 on 08/25/21 at 11:09am revealed: -He had never refused his antibiotic. -The antibiotic was prescribed to him in the hospital to treat an abscess and an urinary tract infection. -He remembered the MA telling him the cefdinir was "out." -He "tried" to tell the MA he had more doses to take of the cefdinir. Telephone interview with Resident #1's primary care provider (PCP) on 08/25/21 at 2:00pm revealed: -She did not know the resident had missed three doses of the cefdinir. -The cefdinir was prescribed for an abscess. -The abscess was "healing." -She had not seen any signs of reinfection. -There was a risk of Resident #1 developing a resistant bacteria strains to cefdinir and of wound infection preventing delayed wound healing when a course was not completed as prescribed. -However, in this case they had ordered a 9 day course and the resident received 7 days which was normally how cefdinir would be ordered to prevent resistant bacteria. Interview with the Administrator on 08/25/21 at 12:00pm revealed she excepted the MAs to notify the prescriber of any medication that was not administered as ordered.	{D 273}		

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{D 273}	Continued From page 3 Review of facility's refusal of medication policy revealed: -Document refusal per the MAR guide. -Upon first refusal of a medication the director/designee shall notify the physician and in addition shall ask for clarification of how often to notify for future refusals. -Ensure staff observe the resident and report any effect which may result from refusal. -Document notification and follow-up orders/recommendations.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders for 2 of 3 sampled residents (#2, #3) regarding orders for weekly weights and 1 of 3 for weekly blood pressures (#2) were implemented. The findings are: 1. Review of Resident #2's current FL2 dated 07/19/21 revealed diagnoses included bipolar disorder, diabetes type II, and schizoaffective disorder.	D 276		

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D 276	Continued From page 4 a. Review of Resident #2's primary care provider (PCP) order dated 06/23/21 revealed record blood pressure weekly on Thursdays from 8:00am to 9:00am. Review of Resident #2's PCP order dated 07/05/21 revealed record blood pressure weekly on Thursdays from 8:00am to 9:00am. Review of Resident #2's current FL2 dated 07/19/21 revealed record blood pressure weekly on Thursdays from 8:00am to 9:00am. Review of Resident #2's August 2021 eMAR revealed: -There was an entry to record blood pressure weekly. -There were no documented blood pressures from 08/01/21 to 08/24/21. -On 08/05/21, there was no documented blood pressure due to resident refused. Review of Resident #2's record revealed the resident's blood pressure on 08/25/21 at 9:35am was documented as 121/70. Telephone interview with one medication aide (MA) on 08/25/21 at 10:30am revealed: -The blood pressure cuff had not worked for a month. -She had not been able to check blood pressures for the residents who had orders. -"Some" of the MAs would document blood pressure readings from a previous blood pressure checks on the eMAR though they did not actually check the blood pressures. Interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am revealed: -She started her role as the RCC about two	D 276		

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weeks prior.
-The staff had not notified her the blood pressure monitor was not working.
-There was a case of blood pressure monitoring equipment that worked stored in the office.

Interview with the Administrator on 08/25/21 at 12:00pm revealed:
-She started in her role as Administrator on 08/09/21.
-Staff did not tell her the blood pressure monitor was not working.
-Staff should check blood pressure for residents as ordered and document the results in the eMAR.

Telephone interview with Resident #2's PCP on 08/25/21 at 2:01pm revealed she wanted the resident to receive weekly blood pressure checks because the resident was taking multiple blood pressure medications.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

b. Review of Resident #2's primary care provider (PCP) order dated 06/23/21 revealed record weight weekly on Thursdays from 8:00am to 9:00am and notify PCP and office of a variance of 5% or more.

Review of Resident #2's PCP order dated 07/05/21 revealed record weekly weight on Thursdays from 8:00am to 9:00am and notify PCP and office of a variance of 5% or more.

Review of Resident #2's current FL2 dated 07/19/21 revealed record weekly weight on Thursdays from 8:00am to 9:00am and notify

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D 276	Continued From page 6 PCP and office of a variance of 5% or more. Review of Resident #2's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry to record weight weekly and notify PCP and office of a variance of 5% or more. -On 07/01/21, there was no documented weight due to "need new scale wouldn't record weight." -On 07/08/21, there was documented weight of 173.6lbs. -There were no other documented weights for July 2021. Review of Resident #2's August 2021 eMAR revealed: -There was an entry to record weight weekly and notify PCP and office of a variance of 5% or more. -There were no documented weights from 08/01/21 to 08/24/21. -On 08/05/21, there was no documented weight due to "resident refused." Review of Resident #2's record revealed the resident's weight was documented as 167.6lbs on 08/25/21 at 9:35am. Interview with one Medication Aide (MA) on 08/24/21 at 11:12am revealed there was an order for weights for Resident #1, but she had not been doing them. Interview with the same MA on 08/24/21 at 3:30pm revealed: -There was not a working scale and she notified the office. -The scale had not been working for several weeks.	D 276		

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-The office brought a new scale about 1 week ago.
-The new scale worked properly.

Telephone interview with a second MA on 08/25/21 at 10:30am revealed:
-She had not been weighing residents.
-The scale they used to weigh residents had been "messed up."
-The heavier residents could not be weighed accurately on the scale.
-She did not let the facility administration know the scale was not working.

Interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am revealed:
-She started her role as the RCC about two weeks prior.
-The office was notified the scale was not working about 1 week ago.
-The scale was replaced and currently worked.
-The scale was capable of accurately weighing someone over 250lbs.

Interview with the Administrator on 08/25/21 at 12:00pm revealed:
-She started in her role as Administrator on 08/09/21.
-If an order to weigh a resident was in the eMAR, she expected staff to weigh the resident and document the weight.
-If something was wrong with the scale, she expected staff to report it to her.
-Staff had reported the problem with the scale to the office and a new scale was sent within the last week.

Telephone interview with Resident #1's primary care provider (PCP) on 08/25/21 at 2:01pm revealed the resident had orders for weekly

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weights because there was a time when the resident was not eating well.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

2. Review of Resident #3's current FL2 dated 8/10/21 revealed a diagnoses of arthritis, osteopenia, coronary artery disease, vertigo, obesity and type 2 diabetes.

Review of Resident #3's primary care provider (PCP) dated 8/10/21 revealed an order to record weight weekly and notify the PCP and office of a 5% variance.

Review of Resident #3's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to record weight weekly notify PCP and office of 5% variance.
-On 08/04/21, 08/11/21, and 08/18/21 there were documented weights of 300lbs.
-The weights were all documented by the same medication aide (MA).

Interview with a medication aide (MA) on 8/24/21 at 3:30pm revealed:
-She has not weighed Resident #3.
-There was not a working scale and she notified the office.
-The scale had not been working for several weeks.
-The office brought a new scale about 1 week ago which works properly.

Interview with the Resident Care Coordinator (RCC) on 8/24/21 at 10:30am revealed the office was notified that the scale was not working about

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1 week ago and it was replaced.

Review of Resident #3's record revealed the resident's weight was documented as 274.2lbs on 08/25/21 at 9:00am.

Interview with Resident #3 on 8/25/21 at 9:25am revealed she had never been weighed by any MA's at this facility prior to the weight taken "today" (08/25/21).

Telephone interview with a second MA on 8/25/21 at 10:30am revealed:
-The scale would not register, so she documented the last known weight on the eMAR and copied that weight for each week.
-She did not notify the office that the scale was not working.

Interview with the Administrator on 08/25/21 at 12:00pm revealed:
-She started in her role as Administrator on 08/09/21.
-If an order to weigh a resident was in the eMAR, she expected staff to weigh the resident and document the weight.
-If something was wrong with the scale, she expected staff to report it to her.
-Staff had reported the problem with the scale to the office and a new scale was sent within the last week.

{D 358} 10A NCAC 13F .1004(a) Medication Administration {D 358}

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

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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 TYPE A2 VIOLATION

Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues.

THIS IS A TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure medications were administered according to the ordered parameters for 1 of 3 sampled residents (Resident #3) related to medications used to treat high blood pressure.

The findings are:

Review of Resident #3's current FL2 dated 08/10/21 revealed diagnoses included coronary artery disease, vertigo, and type 2 diabetes.

Review of Resident #3's Resident Register revealed an admission date of 07/28/21.

1. Review of Resident #3 physician's orders dated 08/10/21 revealed:
-There was an order for hydrochlorothiazide (used to treat high blood pressure) 25 mg daily hold for systolic blood pressure (maximum pressure your heart exerts while beating) less than 100 or pulse less than 55.
-There was an order to record blood pressures weekly.

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{D 358}	Continued From page 11 a. Review of Resident #3's August 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydrochlorothiazide 25mg 1 tablet daily hold for systolic blood pressure less than 100 scheduled at 8:00am. -The hydrochlorothiazide was documented as administered daily from 08/01/21 to 08/24/21. -On 08/02/21, there was a documented blood pressure reading of 121/68. -On 08/11/21, there was a documented blood pressure reading of 122/78. -On 08/18/21, there was a documented blood pressure reading of 122/78. -There was no documentation of blood pressure checks prior to administration of hydrochlorothiazide for 08/01/21 to 08/24/21. Observation of the medication cart on 08/24/21 at 3:30pm revealed one wrist blood pressure monitor and one upper arm blood pressure monitor. Review of Resident #3's record revealed a documented blood pressure of 104/86 taken on 08/25/21 at 9:00am. Interview with a Medication Aide (MA) on 08/24/21 at 3:30pm revealed: -The MA had never taken Resident #3's blood pressure, because the blood pressure monitor did not work. -There were two blood pressure monitors in the medication cart, but neither monitor was functioning. -She had not requested a replacement blood pressure monitor from management. -There was no drop-down box on the eMAR to record the blood pressure before administering the hydrochlorothiazide.	{D 358}		

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-The staff who entered orders into the eMAR were responsible for setting up the drop-down box in the eMAR for the blood pressure readings.

Interview with Resident #3 on 08/24/21 at 3:45pm revealed:
-She had never had her blood pressure taken while residing at this facility.
-She was recently taken to the hospital for extreme dizziness and was prescribed a medication to help with the dizziness.
-She was not aware of the physician order to hold her blood pressure medication if her blood pressure was low.
-She was certain no one had taken her blood pressure before administering any medication.

Telephone interview with a second MA on 08/25/21 at 10:30 revealed:
-She could not find a blood pressure monitor on the medication cart.
-She did not take the blood pressures for Resident #3 prior to administering hydrochlorothiazide daily.
-She did record the blood pressure for Resident #3 weekly on the eMAR.
-She copied the last recorded blood pressure on the eMAR instead of taking Resident #3's current blood pressure.
-She did not ask management for a replacement blood pressure monitor.

Interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am revealed:
-The MAs had not notified the office the blood pressure monitors were not functioning.
-She checked the wrist blood pressure monitor and it was working properly.
-There was a case of blood pressure monitors in the office.

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-Management did not know what staff needed if the staff did not tell them.

Interview with the Office Manager on 8/25/21 at 11:45am revealed the staff failed to notify her that the blood pressure monitors were not functioning.

Refer to the telephone interview with the primary care physician's office triage nurse on 08/24/21 at 2:45pm.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

b. Review of Resident #3's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for hydrochlorothiazide (used to treat high blood pressure) 25mg 1 tablet daily hold for pulse less than 55 scheduled at 8:00am.
-The hydrochlorothiazide was documented as administered daily from 08/01/21 to 08/24/21.
-There was no documentation of pulse rates prior to administration of hydrochlorothiazide for 08/01/21 to 08/24/21.

Review of Resident #3's record revealed a documented pulse rate of 85 on 08/25/21 at 9:00am.

Interview with a Medication Aide (MA) on 08/24/21 at 3:30pm revealed:
-The MA had never taken Resident #3's pulse.
-The physician order to hold the hydrochlorothiazide for a pulse less than 55 was on the eMAR.
-There was no drop-down box on the eMAR to record the pulse before administering the hydrocholorathiazide.
-The staff who entered orders into the eMAR

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were responsible for setting up the drop-down box in the eMAR for the pulse rate.

Interview with Resident #3 on 08/24/21 at 3:45pm revealed:
-She had never had her pulse rate taken while residing at this facility.
-She had recently been taken to the hospital for extreme dizziness and was prescribed a medication to help with the dizziness.
-She was not aware of the physician order to hold her blood pressure medication if her pulse rate was low.
-She was certain no one had taken her pulse before administering any medication.

Telephone interview with a second MA on 08/25/21 at 10:30 revealed she did not take the pulse rate for Resident #3 prior to administering hydrochlorothiazide daily.

Refer to the telephone interview with the primary care physician's office triage nurse on 08/24/21 at 2:45pm.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

2. Review of Resident #3 physician's orders dated 08/10/21 revealed there was an order for lisinopril (used to treat high blood pressure) 20 mg 1 tablet at bedtime hold for systolic blood pressure (maximum pressure your heart exerts while beating) less than 100 or pulse less than 55.

a. Review of Resident #3's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lisinopril 20mg 1 tablet at

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bedtime hold for systolic blood pressure less than 100 scheduled at 8:00pm.
-The lisinopril was documented as administered at bedtime from 08/01/21 to 08/24/21 with the exception of 08/20/21 at 8:00pm due to "resident refused."
-There was no documentation of blood pressure checks prior to administration of lisinopril for 08/01/21 to 08/24/21.

Observation of the medication cart on 08/24/21 at 3:30pm revealed one wrist blood pressure monitor and one upper arm blood pressure monitor.

Review of Resident #3's record revealed a documented blood pressure of 104/86 taken on 08/25/21 at 9:00am.

Interview with a Medication Aide (MA) on 08/24/21 at 3:30pm revealed:
-The MA had never taken Resident #3's blood pressure, because the blood pressure monitor did not work.
-There were two blood pressure monitors in the medication cart, but neither monitor was functioning.
-She had not requested a replacement blood pressure monitor from management.
-There was no drop-down box on the eMAR to record the blood pressure before administering the lisinopril.
-The staff who entered orders into the eMAR were responsible for setting up the drop-down box in the eMAR for the blood pressure readings.

Interview with Resident #3 on 08/24/21 at 3:45pm revealed:
-She had never had her blood pressure taken while residing at this facility.

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-She was recently taken to the hospital for extreme dizziness and was prescribed a medication to help with the dizziness.
-She was not aware of the physician order to hold her blood pressure medication if her blood pressure was low.
-She was certain no one had taken her blood pressure before administering any medication.

Telephone interview with a second MA on 08/25/21 at 10:30 revealed:
-She could not find a blood pressure monitor on the medication cart.
-She did not take the blood pressures for Resident #3 prior to administering lisinopril daily.
-She did record the blood pressure for this resident weekly on the eMAR.
-She copied the last recorded blood pressure on the eMAR instead of taking the resident's current blood pressure.
-She did not ask management for a replacement blood pressure monitor.

Interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am revealed:
-The MAs had not notified the office the blood pressure monitors were not functioning.
-She checked the wrist blood pressure monitor and it was working properly.
-There was a case of blood pressure monitors in the office.
-Management did not know what staff needed if the staff did not tell them.

Interview with the Office Manager on 8/25/21 at 11:45am revealed the staff failed to notify her that the blood pressure monitors were not functioning.

Refer to the telephone interview with the primary care physician's office triage nurse on 08/24/21 at

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2:45pm.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

b. Review of Resident #3's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lisinopril (used to treat high blood pressure) 20mg 1 tablet at bedtime hold for pulse less than 55 scheduled at 8:00pm.
-The lisinopril was documented as administered at bedtime from 08/01/21 to 08/24/21 with the exception of 08/20/21 at 8:00pm due to "resident refused."
-There was no documentation of pulse rates prior to administration of lisinopril from 08/01/21 to 08/24/21.

Review of Resident #3's record revealed a documented pulse of 85 taken on 08/25/21 at 9:00am.

Interview with a Medication Aide (MA) on 08/24/21 at 3:30pm revealed:
-The MA had never taken Resident #3's pulse.
-There was no drop-down box on the eMAR to record the pulse rate before administering the lisinopril.
-The staff which entered orders into the eMAR were responsible for setting up the drop-down box in the eMAR for the pulse rate checks.

Interview with Resident #3 on 08/24/21 at 3:45pm revealed:
-She had never had her pulse taken while residing at this facility.
-She was recently taken to the hospital for extreme dizziness and was prescribed a medication to help with the dizziness.

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-She was not aware of the physician order to hold her blood pressure medication if her pulse rate was low.
-She was certain no one had taken her pulse rate before administering any medication.

Telephone interview with a second MA on 08/25/21 at 10:15 revealed:
-She only administered afternoon medications.
-She would expect a drop-down box on the eMAR to enter a pulse rate if that was a parameter for administering a medication.
-She did not remember taking a pulse for Resident #3.

Telephone interview with a third MA on 08/25/21 at 10:30 revealed she did not take check a pulse rate for Resident #3 prior to administering lisinopril daily.

Refer to the telephone interview with the primary care physician's office triage nurse on 08/24/21 at 2:45pm.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

____

Telephone interview with the primary care physician's office triage nurse on 08/24/21 at 2:45pm revealed:
-The parameters for the blood pressure medications were accurate due to the resident's diagnosis of hypertension.
-The physician would expect these parameters to be followed.

Interview with the Administrator on 08/25/21 at 12:00pm revealed:
-It was the facility's policy to administer medications as they were prescribed.

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{D 358}	Continued From page 19 -If there were required vital signs on the eMAR for a medication to be administered, she expected staff to check the vital sign and document the information in the eMAR prior to administering the medication. ____________________ The facility failed to check Resident #3's blood pressure and pulse rate as ordered prior to administering blood pressure medications twice a day which increased the residents risk for dizziness. This failure was detrimental to the health, safety, and welfare of Resident #3 and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 9, 2021.	{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, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration	{D912}		

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{D912}	Continued From page 20 and infection prevention. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered according to the ordered parameters for 1 of 3 sampled residents (Resident #3) related to medications used to treat high blood pressure.[Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (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-4.4 A(b) Adult Care Home Infection Prevention Requirements (Unabated 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	{D932}		

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{D932}	Continued From page 21 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 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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This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not 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.

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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 revealed:
-Sharing of glucometers was strictly prohibited.
-Prior to checking a resident's blood sugar, ensure that the name on the glucometer and zippered case match the resident who is having their sugar checked.

Observation of the facility's medication cart on 08/24/21 at 2:10pm revealed:
-There were five zippered cases containing Brand A glucometers in the top drawer.
-Hand written on each case was a different resident's name.

1. Review of Resident #1's current FL2 dated 08/09/21 revealed there was an order for fingerstick blood sugar (FSBS) testing three times a day with meals.

Review of Resident #1's FL2 dated 06/23/21 revealed:
-Diagnoses included diabetes mellitus type 2 and acute diastolic congestive heart failure.
-There was an order for FSBS testing three times a day with meals.

Observation of Resident #1's FSBS testing supplies on 08/24/21 at 2:10pm revealed:
-There was a zippered case labeled with Resident #1's name in a compartment in the top drawer of

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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 Brand A glucometer's history on 08/24/21 at 3:17pm revealed:
-Powering the glucometer on revealed the screen showed a current date of 08/24 and time of 2:36am (an approximate delay of 13 hours and 41 minutes).
-There was no year displayed with the date on the glucometer screen.
-There were 36 FSBS readings in the memory dated 08/11 to 08/23 with a range of 114-361.
-On 08/23 at 3:38am, there was a FSBS of 196 with a value of 198 documented on 08/24/21 at 4:30pm on the eMAR.
-On 08/22 at 3:22am, there was a FSBS of 261 with a value of 192 documented on 08/22/21 at 4:30pm on the eMAR.
-On 08/21 at 5:08am, there was a FSBS of 161 with a value of 234 documented on 08/21/21 at 4:30pm on the eMAR.
-On 08/18 at 7:21pm, there was a FSBS of 185 with a value of 287 documented on 08/19/21 at 8:00am on the eMAR.
-On 08/17 at 4:00am, there was a FSBS of 210 with a value of 217 documented on 08/18/21 at 8:00am on the eMAR and a value of 210 documented on 08/17/21 at 4:30pm.
-On 08/16 at 4:09am, there was a FSBS of 218 with a value of 218 documented on 08/17/21 at 8:00am on the eMAR and a value of 218 documented on 08/16/21 at 4:30pm.
-On 08/15 a 5:17am, there was a FSBS of 308 with no corresponding FSBS value documented on the eMAR.
-On 08/13 at 7:19am, there was a FSBS of 114

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with no corresponding FSBS value documented on the eMAR.
-On 08/13 at 4:17am, there was a FSBS of 161 with no corresponding FSBS value documented on the eMAR.

Review of Resident #1's August 2021 eMAR revealed:
-There was an entry to check and record FSBS with meals scheduled at 8:00am, 12:00pm, and 4:30pm.
-The FSBS results were documented as completed three times daily from 08/11/21 at 12:00pm to 08/24/21 at 8:00am.
-There were no FSBS results documented for 08/15/21 at 4:30pm and on 08/16/21 at 12:00pm.
-The FSBS range was 133-361.

Review of Resident #1's Brand A glucometer's history and August 2021 eMAR revealed 28 out of 36 FSBS readings in the glucometer memory corresponded to the documented FSBS values on Resident #1's August 2021 eMAR.

Interview with Resident #1 on 08/24/21 at 12:30pm revealed:
-The staff kept his glucometer on the medication cart.
-The staff performed FSBS testing for him.
-He had gotten a new glucometer at the end of May 2021.
-He did not know if staff used his glucometer to check his FSBS or not.

Refer to the interview with one Medication Aide (MA) on 08/24/21 at 4:30pm.

Refer to the telephone interview with a second MA on 08/25/21 at 10:04am.

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Refer to the telephone interview with a third MA on 08/25/21 at 10:30am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

2. Review of Resident #2's current FL2 dated 07/09/21 revealed:
-Diagnoses included bipolar disorder, diabetes type II, and schizoaffective disorder.
-Check and record FSBS (fingerstick blood sugar) tests twice daily at 8:00am and 8:00pm and notify the primary care provider (PCP) for FSBS greater than 500 or less than 80.

Observation of Resident #2's FSBS testing supplies on 08/25/21 at 9:16am 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 Brand A glucometer's history on 08/24/21 at 3:00pm revealed:
-Powering the glucometer on revealed the screen showed a current date of 08/24 and time of 2:56pm (an approximate delay of 4 minutes).
-There was no year displayed with the date on the glucometer screen.
-There were 31 FSBS readings in the memory dated 08/10 to 08/24 with a range of 68-315.
-21 out of 31 FSBS readings in the glucometer memory corresponded to the documented FSBS values on Resident #2's August electronic

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	HAL011372	A. BUILDING: ______ B. WING ______	R-C 08/25/2021

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
{D932}	Continued From page 27 Medication Administration Record (eMAR). -On 08/22 at 9:12am, there was a FSBS of 295 with no corresponding value documented on the eMAR. -On 08/20 there were no FSBS values in the glucometer history, a value of 126 was documented on 08/20/21 at 8:00pm on the eMAR and a value of 131 was documented on 08/20/21 at 8:00am on the eMAR. -On 08/18 at 8:33pm, there was a FSBS of 112 with a value of 211 documented on 08/18/21 at 8:00pm on the eMAR. -On 08/18 at 8:54am, there was a FSBS of 249 with a value of 177 documented on 08/18/21 at 8:00am -On 08/17 at 8:19pm, there was a FSBS of 171 with a value of 177 documented on 08/17/21 at 8:00pm on the eMAR. -On 08/17 at 8:40am, there was a FSBS of 172 with no value documented on 08/17/21 at 8:00am on the eMAR due to "resident refused." -On 08/14 there was no FSBS values in the glucometer history for morning, a value of 124 was documented on 08/14/21 at 8:00am on the eMAR. -On 08/12 at 8:00pm, there was a FSBS value of 135 with no corresponding value documented on the eMAR. -On 08/12 at 8:30am, there was a FSBS value of 161 with a value of 265 documented on 08/12/21 at 8:00am on the eMAR. Review of Resident #2's August 2021 eMAR revealed: -There was an entry to check and record FSBS twice daily scheduled at 8:00am and 8:00pm. -The FSBS results were documented as completed twice daily from 08/01/21 at 8:00am to 08/24/21 at 8:00am. -There were no FSBS results documented for	{D932}		

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08/17/21 at 8:00am.
-The FSBS range was 70-344.

Review of Resident #2's Brand A glucometer's history and August 2021 eMAR revealed 21 out of 31 FSBS readings in the glucometer memory corresponded to the documented FSBS values on Resident #2's August electronic Medication Administration Record (eMAR).

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Refer to the interview with one Medication Aide (MA) on 08/24/21 at 4:30pm.

Refer to the telephone interview with a second MA on 08/25/21 at 10:04am.

Refer to the telephone interview with a third MA on 08/25/21 at 10:30am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

3. Review of Resident #3's current FL-2 dated 8/10/21 revealed diagnoses included type 2 diabetes.

Review of Resident #3's physician order dated 8/10/21 revealed check blood glucose twice daily once before breakfast and once before bedtime.

Observation of Resident #3's FSBS testing supplies on 08/24/21 at 3:40pm revealed:
-There was a zippered case labeled with Resident

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(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
{D932}	Continued From page 29	{D932}		

#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 Brand A glucometer's history on 08/24/21 at 3:40pm revealed:
-Powering the glucometer on revealed the screen showed a current date of 06/13 and time of 6:41am (an approximate delay of 72 days and 9 hours and 1 minute).
-There was no year displayed with the date on the glucometer screen.
-There were 37 FSBS readings in the memory dated 05/25 to 06/12 with a range of 34-300.
-On 08/22/21 at 8:00am, there was a documented FSBS of 295 on the eMAR with no corresponding value in the glucometer history.
-On 08/17/21 at 8:00am, there was a documented FSBS of 191 on the eMAR with no corresponding value in the glucometer history.
-On 08/12/21 at 8:00pm, there was a documented FSBS of 135 on the eMAR with no corresponding value in the glucometer history.
-On 08/12/21 at 8:00am, there was a documented FSBS of 161 on the eMAR with no corresponding value in the glucometer history.

Review of Resident #3's August 2021 eMAR revealed:
-There was an entry to check and record FSBS twice daily scheduled at 8:00am and 8:00pm.
-The FSBS results were documented as completed twice daily from 08/01/21 at 8:00am to 08/24/21 at 8:00am.
-There were no FSBS results documented for 08/20/21 at 8:00pm.
-The FSBS range was 130-300.

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Review of Resident #3's Brand A glucometer's history and August 2021 eMAR revealed 34 out of 37 FSBS readings in the glucometer memory corresponded to the documented FSBS values on Resident #3's August electronic Medication Administration Record (eMAR).

Interview with Resident #3 on 08/24/21 at 4:25pm revealed:
-Staff checked her FSBS's twice daily at 8:00am and 8:00pm.
-She did not know what glucometer staff used to check her FSBS.

Refer to the interview with one Medication Aide (MA) on 08/24/21 at 4:30pm.

Refer to the telephone interview with a second MA on 08/25/21 at 10:04am.

Refer to the telephone interview with a third MA on 08/25/21 at 10:30am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am.

Refer to the interview with the Administrator on 08/25/21 at 12:00pm.

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Interview with a Medication Aide (MA) on 08/24/21 at 4:30pm revealed:
-She did not share glucometers between residents.
-Residents with orders for FSBS testing each had their own glucometer stored in the medication cart.
-All of the glucometers were clearly labeled on the storage pouch and on the glucometers to prevent

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glucometers from getting mixed up.
-She did not know why the values in the glucometer history did not match the eMAR documentation.

Telephone interview with a second MA on 08/25/21 at 10:04am revealed:
-Residents with orders for FSBS testing had their own glucometers.
-She did not share glucometers between residents.
-She recorded FSBS readings in the eMAR as soon as she did them to prevent errors with recording the test values into the eMAR.
-She cleaned the resident's glucometer before and after use with an alcohol wipe.
-She would not check a resident's FSBS multiple times unless their blood sugar was "super high" or "super low" when she checked it.
-She could not explain why there were extra readings in the glucometers that did not match the resident's eMAR documentation.

Telephone interview with a third MA on 08/25/21 at 10:30am revealed:
-She had been received training to never share glucometers.
-There were glucometers available for every resident with orders for FSBS testing.
-The glucometer history readings should match the eMAR.
-"Maybe" residents were refusing to have their FSBS checked and staff were just "going by" the last FSBS result.
-The MA's get in hurry and just "throw" the glucometers into the drawer instead of placing them in the appropriately labeled zippered case.
-Then an MA who follows if in a "hurry" might accidentally use the wrong glucometer, because the names were written on the bottom of all the

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glucometers and was not visible from the top of the glucometer.

Interview with the Resident Care Coordinator (RCC) on 08/25/21 at 11:25am revealed:
-She had just been hired as the RCC about two weeks prior.
-She found out "yesterday" (08/24/21) they were going to be auditing glucometer histories against eMAR entries.
-She did not know when the glucometers had last been audited.

Interview with the Administrator on 08/25/21 at 12:00pm revealed:
-She had been hired as the Administrator on 08/09/21.
-The staff had compared glucometer histories against the eMAR entries in July 2021 and the values matched.
-The MAs had been trained never to share glucometers.
-All of the glucometers were clearly labeled.
-It would be difficult for staff to get the glucometers mixed up.
-She could not explain how the glucometer histories were not matching up to the eMAR entries.
-Going forward she and the RCC would be auditing the glucometer's weekly.

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The facility failed to implement infection control procedures consistent with CDC guidelines resulting 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.

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{D932}	Continued From page 33 ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/21 for this violation.	{D932}		