STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 1	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 completed a follow-up survey from 10/12/21 - 10/13/21.	{D 000}		
{D 292}	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide substitutions of equal nutritional value for 6 of 6 residents. The findings are: Review of the regular diet menu for the lunch meal on 10/12/21 revealed residents were to receive sweet and sour pork cutlet (3 ounces pork cutlet and one-half cup pineapple), one-half cup rice, one-half cup oriental vegetables, one cup spinach salad, one tablespoon of vinegar and oil, one slice whole grain bread, one teaspoon margarine, one-half cup vanilla pudding and one cup of 2% milk. Observation of the lunch meal on 10/12/21 served at 12:25pm revealed: -The lunch meal was served to six residents in the dining room.	{D 292}		

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{D 292}	Continued From page 1 -The lunch meal served was one baked drumstick, corn and mashed potatoes. Interview with a Medication Aide (MA) on 10/12/21 at 12:32pm and 3:52pm revealed: -Third shift staff was supposed to take out any meat from the freezer that was supposed to be served for lunch. -When she came in to work on 10/12/21 there was no pork in the refrigerator. -Chicken drumsticks were thawing in the refrigerator, so that is what she cooked for lunch. -There was no rice to be served, but the residents had some "one or two days ago", so she did not want to serve it again so soon. -There were only one or two packages of vegetables in the freezer and that would not have been enough to serve the residents. -There were no pineapple chunks in the food storage area. -They did not have fresh spinach for a salad, only frozen spinach. -There was whole grain bread in the freezer, but none that was thawed. -There was no vanilla pudding in the food storage area. -She chose to serve corn and mashed potatoes with the baked chicken drumstick for lunch on 10/12/21. -She did not use a measuring device to determine the amount of corn or mashed potatoes given to each resident. -Each resident received one baked chicken drumstick. -She only had ingredients to serve what was on the menu 50% of the time. Interview with the Administrator on 10/12/21 at 4:10pm revealed: -Grocery shopping based on the menu was done	{D 292}		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 292}	Continued From page 2 on Fridays every week. -If foods on the menu were not available, an appropriate substitution of equal nutritional value should be made. -She was not aware of the substitution made for the lunch meal on 10/12/21. -The substituted lunch meal on 10/12/21 was not of equal nutritional value to what was on the regular diet menu for 10/12/21. Interviews with three residents on 10/13/21 between 10:00am and 10:15am revealed: -The staff did not follow the posted menu. -They usually had to ask what was going to be served for lunch and dinner. -The weekly menu was posted in the dining room, but the print was so small they could not read it. -They didn't care what they had to eat and always ate whatever she was served. -They ate a lot of potatoes and rice. -It is unhealthy for them to eat all those starches. -Staff used to serve a lot of vegetables, but they did not anymore.	{D 292}		
{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: Based on observations, interviews, and record	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

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

reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#1) related to administering a medication used to lower blood pressure and administering an incorrect dosage of a medication used to treat elevated blood sugar levels.

The findings are:

Review of Resident #1's current FL-2 dated 08/10/21 revealed:
-Diagnoses included diabetes type 2, hypertension, coronary artery disease.
-There was a medication order for lisinopril (used to treat high blood pressure) 20mg take one tablet at bedtime and hold if the systolic blood pressure (SBP) was less than 100.
-There was a medication order for Ozempic (used to decrease elevated blood sugar levels) inject 0.5mg subcutaneously weekly.

a. Review of Resident #1's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lisinopril 20mg take 1 tablet at bedtime and hold if SBP was less than 100.
-Lisinopril 20mg was documented as administered from 08/01/21 through 08/19/21 and 08/21/21 through 08/31/21.
-Lisinopril 20mg was documented as not administered with reason being resident refused.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for lisinopril 20mg take 1 tablet at bedtime and hold if SBP was less than 100.
-Lisinopril 20mg was documented as administered from 09/01/21 through 09/14/21,

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 1	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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{D 358}	Continued From page 4	{D 358}		

and 09/16/21 through 09/30/21.
-Lisinopril 20 was documented as not administered on 09/15/21.
-On 09/06/21 the blood pressure was documented as 78/67.
-On 09/17/21 the blood pressure was documented as 90/75.

Review of Resident #1's October 2021 eMAR revealed:
-There was an entry for lisinopril 20mg take 1 tablet at bedtime and hold if SBP was less than 100.
-Lisinopril 20mg was documented as administered from 10/01/21 through 10/06/21, 10/09/21 through 10/11/21.
-Lisinopril 20mg was documented as not administered on 10/07/21 and 10/08/21.

Interview with the Administrator on 10/12/21 at 4:20pm revealed:
-She did not know why a MA administered lisinopril to Resident #1 with the SBP less than 100 on 09/06/21 and 09/17/21 when there was an order to hold the medication.
-She had reeducated the MAs the last week of September 2021 because the MAs were documenting blood pressure medications as administered without documenting the blood pressures of residents.
-She expected MAs to adhere to the facility's Medication Administration Policy and not administer blood pressure medications to residents that have an order with parameters and the blood pressure was outside the parameters.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 10/13/21 at 3:59pm revealed:
-The facility did not notify her of Resident #1

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 5	{D 358}		

being administered lisinopril on 09/06/21 with a blood pressure of 78/67 or again on 09/17/21 with a blood pressure of 90/75.
-She expected the facility staff to notify her of medication administration errors.
-Administering lisinopril to Resident #1 with a SBP less than 100 would place her at increased risk for falls or cause Resident #1 to pass out.

Attempted telephone interview with a medication aide (MA) on 10/13/21 at 11:05am was unsuccessful.

b. Review of Resident #1's record for physician's orders revealed:
-There was an order on 08/31/21 to increase Ozempic use to inject 1mg subcutaneously weekly.
-There was no order available for review for an order to decrease Ozempic use to inject 0.5mg subcutaneously weekly dated 09/07/21.

Review of Resident #1's endocrinologist progress note dated 10/12/21 revealed Resident #1 was supposed to be administered Ozempic 0.5mg subcutaneously weekly.

Observation of Resident #1's medications on hand on 10/12/21 at 2:45pm revealed Ozempic 1mg was available for administration.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for Ozempic inject 1mg subcutaneously weekly.
-There was documentation Ozempic 1mg was administered on 09/08/21, 09/15/21, 09/22/21, and 09/29/21.

Review of Resident #1's October 2021 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

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{D 358}	Continued From page 6	{D 358}		

revealed:
-There was an entry for Ozempic inject 1mg subcutaneously weekly.
-There was documentation Ozempic 1mg was administered on 10/06/21.

Telephone interview with Resident #1's endocrinologist on 10/13/21 at 9:46am revealed:
-A physician's order was given to the facility on 09/07/21 to change the dosage of Resident #1's Ozempic from 1mg to 0.5mg weekly due to a "reaction" to the 1mg that caused gastrointestinal upset with diarrhea and dehydration.
-He expected the facility to call and clarify the medication order change if the order was not clear which dosage of Ozempic to administer to Resident #1.
-Resident #1 could experience additional symptoms of gastrointestinal upset including nausea, vomiting, diarrhea with dehydration and cause low blood sugar levels.

Interview with the Administrator on 10/13/21 at 9:56am revealed:
-The Resident Care Coordinator (RCC) was responsible for faxing new physician orders to the pharmacy.
-The RCC would compare the newest physician orders with the medications entered into the eMAR system and verify the medication orders were correct.
-She did not know how the RCC missed faxing Resident #1's medication dosage change order for Ozempic to the facilities contracted pharmacy.
-After the RCC faxed new medication orders to the pharmacy she would save the fax sheet indicating the fax was successful and staple it to the medication order.
-She did not have an order or a fax sheet indicating the fax was successful for Resident

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{D 358}	Continued From page 7 #1's Ozempic 0.5mg ordered on 09/07/21. Telephone interview with the facility's contracted pharmacy on 10/13/21 at 10:00am revealed the pharmacy never received an order from 09/07/21 to decrease Resident #1's Ozempic from 1mg to 0.5mg. Attempted telephone interview with the RCC on 10/13/21 at 11:05am was unsuccessful.	{D 358}		
{D 612}	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was not abated. Non-compliance continues. Based on observations, interviews, and record	{D 612}		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

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{D 612}	Continued From page 8 reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 8 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of visitors, staff, and residents and staff wearing the required personal protective equipment (PPE) appropriately. The findings are: Review of the current CDC guidelines for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 04/27/21 revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Staff should continue to wear a face mask in long term facilities regardless of vaccination status. -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. Review of the NC Department of Health and Human Services (NC DHHS) COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Review of the NC DHHS guidelines for the prevention and spread of the Coronavirus Disease in LTC facilities dated 05/05/21 revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19	{D 612}		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 612}	Continued From page 9 pandemic included screening anyone entering a healthcare facility for signs and symptoms of COVID-19. -Establishing a process to ensure visitors entering the facility are assessed for symptoms of COVID-19. Review of the facility's undated COVID-19 policy revealed: -Posting signage for visitors regarding screening and restricting procedures. -Screening visitors and criteria for restricting visitors who exhibit signs of illness. -A face mask was to be worn while working in the facility and use of personal protective equipment (PPE) was to be worn appropriately. -All staff will be screened for fever and respiratory symptoms at the start of each shift by checking a temperature and documented along with the absence of shortness of breath, new or change in cough, and sore throat. Observation upon entrance to the facility on 10/12/21 at 8:45am revealed: -The night shift medication aide (MA) checked a temperature of the survey team but did not complete COVID-19 screening questions or record the temperatures taken. -The night shift MA was wearing a face mask pulled down below her nose covering the mouth and chin. -There was a notebook labeled "COVID-19 Health care visitor checklist all visitors must complete" at the entrance. Interview with the third shift MA on 10/12/21 at 8:45am revealed: -There were currently 8 residents residing at the facility and 1 resident had been admitted to the hospital who tested positive for COVID-19.	{D 612}		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 1	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 612}	Continued From page 10 -Two residents tested positive for COVID-19 and the facility had been on quarantine for the last 2 weeks. -All residents tested negative on 10/11/21 and were no longer quarantined. Review of the COVID-19 health care and visitor checklist log on 10/12/21 at 8:57am revealed the last entry for temperatures checked and the COVID-19 screening questions was last completed on 07/16/21. Observation of the third shift MA on 10/12/21 at 9:02am revealed she continued to wear a face mask pulled down below her nose and only covering the mouth. Interview with a resident on 10/12/21 at 9:12am revealed: -She tested positive for COVID-19 about 2 weeks ago and had just "come off" quarantine. -Staff did not check her temperature until she tested positive for COVID-19 and her temperature was only checked once after testing positive. Interview with a second resident on 10/12/21 at 9:41am revealed: -Staff checked her temperature for "awhile" but "now that ceased". -The last time staff checked her temperature was about a week ago. Observation of the third shift MA on 10/12/21 at 10:00am revealed she was still wearing her facemask pulled down below her nose and only covering her mouth a chin. Interview with the third shift MA on 10/12/21 at 10:00am revealed:	{D 612}		

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 612}	Continued From page 11 -She worked third shift at the facility but had stayed to work part of first shift until the Administrator arrived to take her place. -The facility's policy regarding wearing PPE during the COVID-19 pandemic was to wear a face mask covering the mouth and nose, and a face shield. -She wore her face mask pulled down below her nose because it fogged up her face shield. -She knew she was supposed to wear the face mask covering her mouth and nose while working in the facility. -She did not document the survey teams' temperatures in the visitor log book that were taken upon entrance to the facility because she "forgot". -The visitor log book also contained COVID-19 screening questions which she "forgot" to ask the survey team because the facility had been quarantined for the last 2 weeks and no visitors were allowed. -The Primary Care Provider (PCP) visited the facility on 10/11/21 but was not screened at the facility because she was screened at the main office before entering the facility. -The resident's temperatures and respirations were taken and documented in the computer at 8:00am, 2:00pm, 8:00pm, and 2:00am daily. Observation on 10/13/21 at 8:45am revealed: -The MA was completing the morning medication pass upon entrance in the facility. -A temperature was not checked on the survey team and no COVID-19 screening questions were asked. Interview with the MA on 10/13/21 at 11:14am revealed: -She self-screened for COVID-19 by checking her temperature at the beginning of her shift but did	{D 612}		

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{D 612}	Continued From page 12	{D 612}		

not document it anywhere.
-Visitors were supposed to have their temperatures checked by staff and answer the COVID-19 screening questions located in the visitors log book located at the entrance of the facility.
-She did not check the temperatures of the survey team or ask COVID-19 screening questions because she was performing the morning medication pass when the survey team entered, and she "forgot" afterwards.

Interview with the Administrator on 10/13/21 at 12:40pm revealed:
-Staff were required to self-screen for signs and symptoms of COVID-10 and check a temperature but they were not required to document it anywhere.
-There were currently no visitors allowed at the facility since September 30, 2021 due to the COVID-19 outbreak at the facility.
-The facility's contracted health care personnel were required to check in at the office first, have a temperature taken, and screened for signs and symptoms of COVID-19 before visiting residents at the facility but the information was not documented anywhere.
-Most of the residents were screened daily for signs and symptoms of COVID-19.
-She did not know why one of the resident's did not have a temperature checked daily or COVID-19 screening questions were asked since she was one of the first residents to test positive for COVID-19.
-She could not find any documented temperatures or screening questions asked for the resident who tested positive for COVID-19.
-The visitor's log had not been updated since 07/16/21 since a tree had fallen on the facility and the residents were moved to other sister facilities

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	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 612}	Continued From page 13 during the repairs and had only been back in the facility for 2 weeks which were then placed on quarantine due to two resident's testing positive for COVID-19. -She did not know why staff did not ask the survey team COVID-19 screening questions on 10/12/21 and document the temperatures in the visitors log book. -She did not know why staff did not check the temperatures or ask the COVID-19 screening questions of the survey team and document them in the visitors log book on 10/13/21. -Staff knew they were supposed to screen all visitors for COVID-19. -Staff knew they were supposed to wear a face mask covering the mouth and nose and were expected to wear all PPE appropriately. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS) for infection prevention during the COVID-19 pandemic related to screening of staff, residents, and visitors and a staff member wearing a face mask inappropriately inside the facility during the COVID-19 pandemic with a recent outbreak of COVID-19. The facility's failure to follow the guidance related to infection prevention for COVID-19 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 10/13/21 for this violation.	{D 612}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R-C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D912}	Continued From page 14 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 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 infection prevention requirements. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 8 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of visitors, staff, and residents and staff wearing the required personal protective equipment (PPE) appropriately. [Refer to Tag 612 10A NCAC 13F .1801 Infection Prevention and Control (Type B Violation)].	{D912}		