

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Highland Farms		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Tabernacle Road Black Mountain, NC 28711	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046</p> <p>Based on observations, record review, and staff interviews the facility failed to provide competent nursing staff when 2 of 4 nursing staff (Nurse #1 and Medication Aide #1) were not educated on the facility's glucometer disinfection policy and procedures.</p> <p>Findings included:</p> <p>a. An observation was conducted on 8/21/24 at 4:30 PM of Nurse #1 performing a blood glucose check. After performing the blood glucose check Nurse #1 returned the glucometer to the top drawer of the medication cart without disinfecting the glucometer.</p> <p>An interview with was conducted on 8/21/24 at 4:40 PM with Nurse #1. She said she had not cleaned the glucometer after performing the blood glucose check because she had not been aware that she needed to do so. Nurse #1 said she had worked at the facility for about 3 months and that she had not received education or training on glucometer disinfection.</p> <p>Nurse #1's employee file revealed there was no record of education on glucometer disinfection.</p> <p>b. An interview was conducted with Medication Aide #1 on 8/22/23 at 9:44 AM. She said that she had worked at the facility as a Medication Aide for about a year and a half. Medication Aide #1 said she was assigned to the back [NAME] hall and that she currently did not have any residents on her assigned hall who received capillary blood glucose checks. She said that glucometers were assigned for individual resident use and were labeled with the resident's name. Medication Aide #1 said glucometers were stored in the top drawer of the medication cart. She said that during her orientation on the medication cart she had been told to clean glucometers after each use. Medication Aide #1 said that she had been told she could use a disinfectant wipe or an alcohol wipe to clean the glucometer. Medication Aide #1 said she used an alcohol prep pad to wipe off the glucometer after using it. She said she used the alcohol prep pad because it was right there on the medication cart and convenient.</p> <p>Medication Aide #1's employee file revealed there was no record of education on glucometer disinfection.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The DON stated she was unable to provide training records on glucometer disinfection for Nurse #1 and Medication Aide #1. She said there were not records Nurse #1 or Medication Aide #1 had received training on glucometer disinfection. The DON stated that nursing staff should be educated during new hire orientation and annually on glucometer disinfection procedures. The DON explained the Staff Development Coordinator completed new hire orientation and nurse education. She said that education on glucometer disinfection was currently not in place. The DON stated that education on glucometer disinfection had used to be part of the facility's new hire nurse orientation, and she was unsure how it had fallen out of the orientation process.</p> <p>The Staff Development Coordinator (SDC) was unavailable for interview.</p> <p>An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator stated that education on glucometer disinfection should be completed during new hire orientation. She said there had been a turnover in the SDC position and that may be why the education on glucometer disinfection had been missed in the new hire orientation process.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50046</p> <p>Based on observations, record review, and staff interviews the facility failed to implement their policy and procedures for glucometer disinfection when Nurse #1 failed to disinfect a resident (Resident #201) glucometer after performing a capillary blood glucose test. This deficient practice occurred for 1 of 1 resident (Resident #201) reviewed for infection prevention and control.</p> <p>The findings included:</p> <p>The facility policy dated 5/29/24 and entitled Glucometer Disinfection read in part: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne disease to resident and employees.</p> <p>The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions.</p> <p>The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV) (blood borne virus), Hepatitis C (blood borne virus), and Hepatitis B (blood borne virus).</p> <p>Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use.</p> <p>The glucometer User Instruction Manual read in part: Clean the outside of the meter with a damp cloth only. Dirt, dust, blood, control solution, or water entering the meter could cause damage. Do not store your meter or test strips near bleach or cleaners that contain bleach.</p> <p>An observation was completed on 8/21/22 at 4:40 PM of Nurse #1 performing a blood glucose test for Resident #201. Nurse #1 removed the glucometer from the top drawer of her medication cart. The glucometer was stored in the manufacturer's zippered storage bag and labeled with Resident #201's name. Nurse #1 gathered supplies (an alcohol pad, lancet, and test strips). Nurse #1 was accompanied as she carried the glucometer and supplies down to Resident #201's room. After entering the room, the nurse put the glucometer and supplies down on the resident's bed. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #1 discarded the trash and lancet, and returned to the medication cart with the glucometer. She placed the glucometer back into the manufacturer's zippered storage bag and zipped the bag closed and returned the glucometer to the top drawer of the medication cart. There were disinfectant wipes present in the bottom drawer of the medication cart.</p> <p>An interview was performed with Nurse #1 on 8/21/24 at 4:30 PM. Nurse #1 said that glucometers were for individual use and not shared. Nurse #1 stated that she had never been told she needed to clean/ disinfect the glucometer after it had been used. Nurse #1 said she had not received any education from the facility on glucometer cleaning/ disinfection procedures. Nurse #1 stated that she had not cleaned/disinfected the glucometer after performing Resident #201's because it was an individual glucometer, and she had not been aware that she needed to do so.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was performed with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The Director of Nursing stated that glucometers needed to be disinfected after each use regardless of if they were for individual use because they were touched by staff and could cause the transmission of blood borne pathogens. The DON explained that the manufacturer instructions for the current glucometer the facility used said to clean the glucometer with a damp cloth, because the glucometer was intended for home use. She said that the facility should clean/ disinfect glucometers per manufacturer instructions and that the facility should use a glucometer that could be cleaned/ disinfected according to manufacture instructions using an environmental protective agency (EPA) approved product that was effective against blood borne pathogens.</p> <p>An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator stated that glucometers should be disinfected after each use. She said an EPA approved disinfectant should be used to disinfect the glucometer after each use to kill blood borne pathogens.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046</p> <p>Based on record review, resident and staff interviews the facility failed to administer a pneumococcal vaccine to a resident who had consented for the vaccine to be administered. This deficient practice occurred for 1 of 5 residents reviewed for Pneumococcal Immunizations (Resident #18).</p> <p>The findings included:</p> <p>Resident #18 was admitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Assessment (MDS) dated [DATE] revealed Resident #18 was cognitively intact. It was not documented on the MDS that she had received the pneumonia vaccine.</p> <p>Review of Resident #18's medical record revealed a form titled Resident Vaccine Consent Form. The pneumococcal vaccine was marked under the section entitled check vaccines consented to be given. The vaccine consent signature section indicated verbal consent was provided by Resident #18's family during a video conference and was dated 7/18/24.</p> <p>Review of Resident #18's medical record revealed there was no documentation that a pneumococcal vaccine had been administered. There was no prior pneumococcal immunization history documented in Resident #18's medical record.</p> <p>Review of the standing orders attached to Resident #18's August 2024 physician orders revealed there was a standing order that read: May give pneumococcal vaccine on admission according to acceptable standards of clinical practice or unless medically contraindicated.</p> <p>An interview was conducted on 8/21/24 at 3:53 PM with Resident #18. She said she remembered the pneumococcal vaccine being offered to her and the consent form being completed. She said she had probably received a Pneumonia Vaccine in the past but that she did not recall when. Resident #18 said she had wanted the newest pneumococcal vaccine and that she was waiting on the facility to give it.</p> <p>An interview with the Director of Nursing (DON) was conducted on 8/22/24 at 10:52 AM. The DON said there was no record that a pneumonia vaccine had been administered to Resident #18 while at the facility. The DON said the facility did not have any past pneumonia vaccine history for Resident #18. The DON explained she expected the pneumococcal vaccine to be offered to residents on admission and a consent/ declination form to be completed. The DON stated the Infection Preventionist (IP) was responsible for obtaining immunization history of residents, offering immunizations, and completing the immunization consent/ declination form with residents/ families on admission and annually. The DON explained once consent for the pneumococcal vaccine was obtained, she expected the vaccine to be given to the resident ideally by the next day. The DON stated she thought the IP had been bogged down with other things and had not communicated well. She explained that the IP had made changes to the immunization process that she had thought would be okay. The DON said the IP had not discussed or communicated the changes with her and that the pneumococcal vaccine being administered for Resident #18 had been missed.</p> <p>The IP was currently on leave and unavailable for interview.</p> <p>(continued on next page)</p>		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator said the pneumococcal vaccine should be offered to residents on admission. The Administrator said if Resident #18 had wanted the pneumococcal vaccine that the vaccine should had been administered to her. She said there was an issue with the process that Resident #18's pneumococcal vaccine being given had been missed.		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046</p> <p>Based on record review, resident and staff interviews the facility failed to offer and provide a COVID-19 vaccine to 1 of 5 residents reviewed for COVID-19 immunizations (Resident #42).</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on [DATE].</p> <p>The admission Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #42 had moderate cognitive impairment.</p> <p>Review of Resident #42's medical record revealed he had last received a COVID-19 vaccine prior to admission on 6/16/22. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #42.</p> <p>An interview was conducted on 8/21/24 at 3:40 PM with Resident #42. He stated that the facility had not discussed or offered the COVID-19 vaccine with him since his admission to the facility. Resident #42 said that it had been more than a year since he had last received a COVID-19 vaccine. He said he had not received the newest recommended COVID-19 vaccine. Resident #42 said that if he was able to get the COVID-19 vaccine at the facility he wanted to receive it.</p> <p>An interview was conducted with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The DON said there was no record of where the COVID-19 vaccine had been offered to Resident #42. The DON explained she expected the COVID-19 vaccine to be offered to residents on admission and a consent/ declination form to be completed. The DON stated the Infection Preventionist (IP) was responsible for obtaining immunization history of residents, offering immunizations, and completing the immunization consent/ declination form with residents/ families on admission and annually. The DON explained once consent for the COVID-19 vaccine was obtained, the facility would coordinate with the pharmacy for the vaccine to be administered. The DON stated she thought the IP had been bogged down with other things and had not communicated well. She explained that the IP had made changes to the immunization process that she had thought would be okay. The DON said the IP had not discussed or communicated the changes with her and that the COVID-19 vaccine being offered to Resident #42 had been missed.</p> <p>The IP was on leave during the survey and unavailable for interview.</p> <p>An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator said the COVID-19 vaccine should be offered to residents on admission. The Administrator said if Resident #42 had wanted a COVID-19 vaccine then the vaccine should had been administered to him.</p>		