STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHMOND HILL REST HOME # 3	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey with an onsite visit on 05/26/21 and 05/27/21 and a desk review on 05/28/21 and 06/01/21 with an exit conference via telephone on 06/01/21.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) were tested for Tuberculosis (TB) disease upon hire. The findings are: 1.Review of Staff A's, Medication Aide (MA), personnel record revealed: -There was no documented date of hire. -There was no documentation of a completed TB skin test. Interview with Staff A on 05/27/21 at 2:41pm revealed she was responsible for administering medications to the residents, cooking, and	D 131		

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providing assistance with activities of daily living (ADLs).

Interview with Staff A on 06/01/21 at 12:29pm revealed:
-She was hired in late February 2021 or early March 2021.
-She completed a TB skin test at a local urgent care on the same day she had completed pre-employment drug testing.
-She did not have documentation of the TB skin test.
-She was not sure if the local urgent care kept records of TB skin testing.

Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am.

Refer to the interview with the Business Office Manager (BOM)/Supervisor-in-Charge (SIC) on 05/27/21 at 4:44pm.

Refer to the telephone interview with the Administrator on 05/27/21 at 11:45am.

2. Review of Staff C, Housekeeper, personnel record on 05/27/21 revealed:
-There was a hire date of 03/23/21.
-There was no documentation of a TB skin test completed upon hire.

Interview with Staff C on 05/27/21 at 2:45pm revealed:
-He was hired about 3 months ago as a medication aide (MA)/personal care aide (PCA)/cook and transportation staff.
-His responsibilities were to assist residents with activities of daily living (ADLs), cook meals and transport the residents to and from appointments.

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D 131	Continued From page 2 Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am. Refer to the interview with the Business Office Manager (BOM)/Supervisor-in-Charge (SIC) on 05/27/21 at 4:44pm. Refer to the telephone interview with the Administrator on 05/27/21 at 11:45am. _____ Telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am revealed: -He was responsible for administering the staff and resident's TB skin test for the facility. -The Administrator was responsible for notifying him if a staff member or resident needed a TB skin test. -He visited the facility in the past 2 to 3 weeks and had administered a TB skin test but did not remember if it was a resident or staff member. Interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm revealed: -The Administrator started working in April 2021. -The Administrator was responsible for notifying the Nurse Consultatnt for the MAs who required a TB skin test. -The Administrator was responsible for ensuring all required training and requirements were completed when the facility hired a new staff member. Interview with the Administrator on 05/27/21 at 11:45am revealed: -She was responsible for making sure all staff received a TB skin test upon hire.	D 131		

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D 131	Continued From page 3 -She knew all staff received the first step TB skin test upon hire but she could not find the documentation. -She remembered a recommendation to stop completing TB skin test during the coronavirus pandemic but did not know if the recommendation had changed. -She had not resumed obtaining a TB skin test for newly hired staff.	D 131		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) were competency validated for Licensed Health Professional Support (LHPS) tasks who provided care for one resident who had an order	D 161		

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for compression hose and fingerstick blood sugar checks (FSBS).

The findings are:

Review of Staff A's, Medication Aide (MA), personnel record on 05/27/21 revealed:
-There was no documented date of hire.
-There was documentation Staff A had passed the state approved medication aide written exam on 10/31/17.
-There was no documentation Staff A had completed the competency validated medication clinical skills checklist.
-There was no documentation Staff A was competency validated to assist with compression hose or collect FSBS.

Review of a resident's April 2021 electronic Medication Administration Record (eMAR) revealed Staff A had collected FSBS for a resident for 11 out of 23 opportunities.

Review of a resident's May 2021 eMAR revealed Staff A had applied compression hose for a resident 12 out of 26 opportunities.

Interview with Staff A on 05/26/21 at 3:55pm revealed:
-She started working in the facility in late February 2021 or early March 2021.
-She administered medications to the residents and assisted with other activities of daily living (ADLs) as needed.
-She remembered the Nurse Consultant (RN) completing the competency validated LHPS checklist soon after she started working at the facility.
-She did not have the documentation that it was completed.

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-The Administrator should have the documentation.

Telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am revealed:
-He was responsible for completing the LHPS competency checklist for new staff at the facility.
-The Administrator was responsible for notifying him if the facility had a staff member that needed to complete the checklist.
-He did not keep records of the staff at the facility that he had competency validated to perform LHPS tasks.
-He did not remember the last time he had completed a LHPS competency checklist for staff at the facility.

Interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm revealed:
-The Administrator started working in April 2021.
-The LHPS training and check off was to ensure competency in the LHPS tasks.
-The Administrator was responsible for notifying the Nurse Consultant for the staff who required the LHPS training and competency check off.
-The Administrator was responsible for ensuring the staff had all of the required LHPS training and check off completed prior to performing the LHPS tasks.

Telephone interview with the Administrator on 06/01/21 at 2:41pm revealed:
-Staff A was hired as a MA on 02/19/21.
-She was "sure" Staff A had completed the LHPS competency validation checklist.
-She could not find the documentation showing Staff A had completed the competency validation checklist.

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D 161	Continued From page 6 -She was trying to get the staff training documents organized so she could find Staff A's LHPS competency validation checklist.	D 161		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of the adult care homes to protect each resident's right	D 176		

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D 176	Continued From page 7 to receive adequate and appropriate care and services and to be free of neglect as related to the management of facilities, infection prevention and control program, and staff qualifications. The findings are: Interview with a resident on 05/26/21 at 9:25am revealed: -There was no staff member in the building. -The MA had been out of the building for about 20 minutes. -He thought the MA had gone to another building to help give medications. -He was administered his medications before the MA had left the building. -He was not sure how to find where the MA was. -He had to wait on the MA to return to the building if he needed anything. Interview with a second resident on 05/26/21 at 9:30 am revealed: -The MA was not in the facility and she did not know where she was. -She complained of pain, an 8 out of 10 on the pain scale and wanted her prescribed pain medication but had to wait until the MA got back in the building in order to get it. -She "just knew" she would have to wait or walk to another building if she needed anything except in an emergency then send someone for help or call 911. -There were issues with staffing over the past month, but more so in the last week with getting staff to give medications. -She had to wait several times over the past week for her medication or received them late. Interview with the MA on 05/26/21 at 10:00am revealed:	D 176		

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D 176	Continued From page 8 -She was the MA assigned to this facility. -She administered her morning medications to the residents in the facility and then went to building #2 to administer morning medications. -She left the facility at approximately 8:30am. -She was gone approximately an hour to give medications in sister facility. -There were many times over the past month, but more so over the past week she had to administer medications in more than one facility during her 7:00am - 7:00pm shift. -The Administrator was responsible for the residents while she was out of the facility. -She called the Administrator and was instructed leave and administer medications to a sister facility and the Administrator would come up and watch the residents. -The Administrator was not in the facility when she left. -There was no other staff in the facility while she was gone. -If the residents needed something while she was gone they were to get the Administrator or come and get her. -She was usually gone for a 1 hr. to 1-1/2 hr. -The residents could call 911 in an emergency by using the facility phone. -She was not provided a two-way telecommunication device by the Administrator. -She did have her personal cell phone. -The residents did not have her personal cell phone number or it was not written down for easy access for them to use. -She gave the resident pain medication after she returned to the facility about an hour later. -The residents would have to wait until she returned to receive any medication because the Administrator could not administer medications. A second interview with the second resident on	D 176		

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D 176	Continued From page 9 05/26/21 at 10:15am revealed she received her pain medication about 20 minutes ago and her pain was still 8 out of 10 on the pain scale. Interview with a third resident on 05/27/21 at 3:00pm revealed: -There have been a few occasions during May 2021 when staff were not in the building at all times. -On 05/24/21 there was no staff for his building to administer medications so he had to wait for medications while the staff member gave medications in the other buildings first. -He did not get his medications on time that day. -He was instructed to call for help if he needed it, but the phone in the facility was "spotty at best" and did not work every time. -The only number he had to call was 911. -He could not call the staff if he needed them because he did not know their numbers so he would have to go find them. Interview with a fourth resident on 05/27/21 at 3:20pm revealed: -There had been 2 occasions this week staff were not in the building and did not know where the staff was. -There were 2 occasions this month he was told by the staff what building they would be in. -If he needed staff he would have to go find them or walk down to the office (approximately 50 yards away) where the Administrator was. -There were two other occasions in the past week where he did not receive his medications on time or eat on time and he had to go look for staff and found them in another building. -He was told by the Administrator to call 911 if it was an emergency like if he or someone else got hurt or needed help. -The building was locked every night at 8:00pm	D 176		

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and if you went out you could not get back in unless you rang the door bell and someone let you back in.
-He was concerned if he left the building in the middle of the night to get help, he could not get back in

Interview with a MA on 05/27/21 at 3:30pm revealed:
-The doors to the facility were locked at 10:00pm every night and the alarm was set.
-If you went out the doors at night after the doors were locked and the alarm was set then alarm would sound.
-If you were out after 10:00pm and the doors were locked, in order to get back in the doorbell would have to be rung.
-The residents were told by the Administrator that after 10:00pm the residents would have to go to a hotel or stay with family or friends.
-The residents all knew they need to be back in the facility before 10:00pm.
-If the residents required assistance, or medications when a staff member was not in the facility, then they were to wait until the staff member got back in the facility or come and get us.
-The resident could call 911 if needed but they have always been able to find staff because we would be in one of the other buildings.
-She left the facility unattended because she would be in sister facility giving medications.
-She would be out of the facility administering medications in sister facility 1-2 hours tops.
-She has been one of two MAs in the facility several times this past 2 weeks and had to leave facility unattended to administer medications to a sister facility.

Interview with a fifth resident on 05/27/21 at

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D 176	Continued From page 11 4:00pm revealed: -There has been times there were no staff in the building. -The last time was on 05/26/21 in the morning because the MA went to another building to give medications. -Because there were no staff in the facility and if she needed to talk or needed something she would go find the MA in one of the other sister facilities. -She could not call the staff because there was no number to call them. Interview with a sixth resident on 05/27/21 at 4:15pm revealed: -The facility only had a MA and no PCA. -Over the past week the MA had to go to other buildings to give medications. -Over the past week he had received his medications late either in the evenings or in the mornings depended on where the MA went first. -On 05/23/21, after the doors were locked at 10:00pm, he woke up in the middle of the night and there was no staff in the building. -He could not go find them because the door would automatically lock behind him. -He did not need anything at that time but it did concern him if something would have happened he would have to call 911. -On 05/24/21 there was no staff in the building until after 8:00am when the Business Office Manager (BOM) came in to give the morning medication late. Interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm revealed: -The Administrator started working in April 2021. -The Administrator was responsible for notifying the Consultant Nurse for the MAs who required	D 176		

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the training.
-The Administrator was responsible for ensuring the medication aides (MAs) had all of the required qualifications prior to administering medications.

Interview with the Administrator on 05/26/21 at 9:15am revealed:
-She was responsible for being in the facility while the medication aide (MA) went to building #2 to administer medications.
-She was working on other duties in the office.
-There was no personal care aide (PCA) in the facility while the MA was gone.
-There was supposed to be someone in the facility at all times.
-If the residents needed anything, they could come and get her.

Interview with the Administrator on 05/26/21 at 4:00pm revealed:
-She had issues with staffing of the past month more so the past 2 weeks.
-She had 2-3 MAs giving medications in all 5 buildings daily.
-She was supposed to have a MA in each of the 5 buildings and 3-5 personal care aides (PCA) to share, that way there would be a MA in each building at all times.
-On Sunday, 05/23/21 at 8:00pm a staff member called in for the 8:00am shift on 05/24/21.
-Between 05/23/21 at 8:00pm and 8:00am there were several staff that called out for their shifts on 05/24/21.
-There was a staff member that did not call or show up for her shift on 05/24/21, 8:00am to 8:00pm.
-She was responsible for staffing 5 buildings with at least a MA in each building.
-On 05/24/21, she staffed the 5 buildings with the Business Office Manager (BOM) and the Activity

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Director (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself.
-On 05/24/21, all the residents were brought up to the front porches of two sister facilities.
-Because there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked lunch and supper out on the grills, and everyone enjoyed a cookout day.
-It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did.

Non-compliance was found in the following rule areas:

1. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) were tested for Tuberculosis (TB) disease upon hire [Refer to Tag D0131 10 NCAC 13F .0406(a) Test for Tuberculosis (Standard Deficiency)].

2. Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) were competency validated for Licensed Health Professional Support (LHPS) tasks who provided care for one resident who had an order for compression hose and fingerstick blood sugar checks (FSBS) [Refer to Tag D0161 10 NCAC 13F .0504(a) Competency Validation for Licensed Health Professional Support Tasks (Standard Deficiency)].

3. Based on observations and interviews, the facility failed to ensure that at no time residents were left alone in the home without a qualified

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D 176	Continued From page 14 staff and the Administrator or Administrator-in-Charge (AIC) was within 500 feet of the home with means of two-way communication [Refer to Tag D0177 10 NCAC 13F .0601(b)3 Management of Facilities with a Capacity or Census of Seven to Thirty Residents (Type A1 Violation)]. 4. 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 10 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors [Refer to Tag 0612 10 NCAC 13F .1801 Infection Prevention and Control Program (Standard Deficiency)]. 5. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) who administered medications to residents had completed the competency validated medication clinical skills, the 5, 10, or 15-hour state approved medication administration training course, and successfully passed the state medication aide examination as required [Refer to Tag D935 G.S. 131D-4.5B(b) Adult Care Home Medication Aide Training and Competency (Standard Deficiency)]. _____ The Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statues of adult care homes in order to protect each resident's rights to receive adequate and appropriate care and series and to be free of neglect. The Administrator failed to ensure 2 of 3	D 176		

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D 176	Continued From page 15 sampled staff (Staff A and C) were tested for Tuberculosis (TB) disease upon hire, failed to ensure 1 of 3 sampled staff (Staff A) were competency validated for Licensed Health Professional Support (LHPS) tasks who provided care for one resident who had an order for compression hose and fingerstick blood sugar checks (FSBS), failed to ensure there was no time the residents were left alone in the home without a qualified staff, 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 10 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors, and failed to ensure 2 of 3 sampled staff (Staff A and B) had completed the competency validated medication clinical skills, the 5, 10, or 15-hour state approved medication administration training course. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility failed to provide a Plan of Protection in accordance with G.S. 131D-34. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 1, 2021.	D 176		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities With A Capacity Or 10A NCAC 13F .0601 Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (b) At all times there shall be one administrator or administrator-in-charge who is directly	D 177		

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D 177	Continued From page 16 responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions in Paragraph (c) of this Rule, one of the following arrangements shall be used to manage a facility with a capacity or census of 7 to 30 residents: (1) The administrator is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; (2) An administrator-in-charge is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; or (3) When there is a cluster of licensed homes, each with a capacity of 7 to 12 residents, located adjacently on the same site, there shall be at least one staff member, either live-in or on a shift basis in each of these homes. In addition, there shall be at least one administrator or administrator-in-charge who is within 500 feet of each home with a means of two-way telecommunication with each home at all times and directly responsible for assuring that all required duties are carried out in each home. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to ensure that at no time residents were left alone in the home without a qualified staff and the Administrator or Administrator-in-Charge (AIC) was within 500 feet of the home with means of two-way communication.	D 177		

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D 177	Continued From page 17 The findings are: Observation outside of the facility on 05/26/21 at 9:15am revealed the Administrator walked out of the office approximately 50 yards up to the front parking area of building #2 which was located across from building #3. Interview with the Administrator on 05/26/21 at 9:15am revealed: -She was responsible for being in the facility while the medication aide (MA) went to building #2 to administer medications. -She was working on other duties in the office. -There was no personal care aide (PCA) in the facility while the MA was gone. -There was supposed to be someone in the facility at all times. -If the residents needed anything, they could come and get her. Observation inside of the facility on 05/26/21 from 9:20am to 9:36am revealed: -There were 6 residents inside the building. -There were 3 of the 6 residents in the building asleep in their rooms. -There were 3 resident outside the building smoking in the smoking area. -There were no staff located in the building. Interview with a resident on 05/26/21 at 9:25am revealed: -There was no staff member in the building. -The MA had been out of the building for about 20 minutes. -He thought the MA had gone to another building to help give medications. -He was administered his medications before the MA had left the building.	D 177		

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-He was not sure how to find where the MA was.
-He had to wait on the MA to return to the building if he needed anything.

Interview with a second resident on 05/26/21 at 9:30 am revealed:
-The MA was not in the facility and she did not know where she was.
-She complained of pain, an 8 out of 10 on the pain scale and wanted her prescribed pain medication but had to wait until the MA got back in the building in order to get it.
-She "just knew" she would have to wait or walk to another building if she needed anything except in an emergency then send someone for help or call 911.
-There were issues with staffing over the past month, but more so in the last week with getting staff to give medications.
-She had to wait several times over the past week for her medication or received them late.

Interview with the MA on 05/26/21 at 10:00am revealed:
-She was the MA assigned to this facility.
-She administered her morning medications to the residents in the facility and then went to building #2 to administer morning medications.
-She left the facility at approximately 8:30am.
-She was gone approximately an hour to give medications in sister facility.
-There were many times over the past month, but more so over the past week she had to administer medications in more than one facility during her 7:00am - 7:00pm shift.
-The Administrator was responsible for the residents while she was out of the facility.
-She called the Administrator and was instructed leave and administer medications to a sister facility and the Administrator would come up and

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watch the residents.
-The Administrator was not in the facility when she left.
-There was no other staff in the facility while she was gone.
-If the residents needed something while she was gone they were to get the Administrator or come and get her.
-She was usually gone for a 1 hr. to 1-1/2 hr.
-The residents could call 911 in an emergency by using the facility phone.
-She was not provided a two-way telecommunication device by the Administrator.
-She did have her personal cell phone.
-The residents did not have her personal cell phone number or it was not written down for easy access for them to use.
-She gave the resident pain medication after she returned to the facility about an hour later.
-The residents would have to wait until she returned to receive any medication because the Administrator could not administer medications.

A second interview with the second resident on 05/26/21 at 10:15am revealed she received her pain medication about 20 minutes ago and her pain was still 8 out of 10 on the pain scale.

Interview with a third resident on 05/27/21 at 3:00pm revealed:
-There have been a few occasions during May 2021 when staff were not in the building at all times.
-On 05/24/21 there was no staff for his building to administer medications so he had to wait for medications while the staff member gave medications in the other buildings first.
-He did not get his medications on time that day.
-He was instructed to call for help if he needed it, but the phone in the facility was "spotty at best"

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and did not work every time.
-The only number he had to call was 911.
-He could not call the staff if he needed them because he did not know their numbers so he would have to go find them.

Interview with a fourth resident on 05/27/21 at 3:20pm revealed:
-There had been 2 occasions this week staff were not in the building and did not know where the staff was.
-There were 2 occasions this month he was told by the staff what building they would be in.
-If he needed staff he would have to go find them or walk down to the office (approximately 50 yards away) where the Administrator was.
-There were two other occasions in the past week where he did not receive his medications on time or eat on time and he had to go look for staff and found them in another building.
-He was told by the Administrator to call 911 if it was an emergency like if he or someone else got hurt or needed help.
-The building was locked every night at 8:00pm and if you went out you could not get back in unless you rang the door bell and someone let you back in.
-He was concerned if he left the building in the middle of the night to get help, he could not get back in

Interview with a MA on 05/27/21 at 3:30pm revealed:
-The doors to the facility were locked at 10:00pm every night and the alarm was set.
-If you went out the doors at night after the doors were locked and the alarm was set then alarm would sound.
-If you were out after 10:00pm and the doors were locked, in order to get back in the doorbell

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D 177	Continued From page 21 would have to be rung. -The residents were told by the Administrator that after 10:00pm the residents would have to go to a hotel or stay with family or friends. -The residents all knew they need to be back in the facility before 10:00pm. -If the residents required assistance, or medications when a staff member was not in the facility, then they were to wait until the staff member got back in the facility or come and get us. -The resident could call 911 if needed but they have always been able to find staff because we would be in one of the other buildings. -She left the facility unattended because she would be in sister facility giving medications. -She would be out of the facility administering medications in sister facility 1-2 hours tops. -She has been one of two MAs in the facility several times this past 2 weeks and had to leave facility unattended to administer medications to a sister facility. Interview with a fifth resident on 05/27/21 at 4:00pm revealed: -There has been times there were no staff in the building. -The last time was on 05/26/21 in the morning because the MA went to another building to give medications. -Because there were no staff in the facility and if she needed to talk or needed something she would go find the MA in one of the other sister facilities. -She could not call the staff because there was no number to call them. Interview with a sixth resident on 05/27/21 at 4:15pm revealed: -The facility only had a MA and no PCA.	D 177		

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-Over the past week the MA had to go to other buildings to give medications.
-Over the past week he had received his medications late either in the evenings or in the mornings depended on where the MA went first.
-On 05/23/21, after the doors were locked at 10:00pm, he woke up in the middle of the night and there was no staff in the building.
-He could not go find them because the door would automatically lock behind him.
-He did not need anything at that time but it did concern him if something would have happened he would have to call 911.
-On 05/24/21 there was no staff in the building until after 8:00am when the Business Office Manager (BOM) came in to give the morning medication late.

Interview with the Administrator on 05/26/21 at 4:00pm revealed:
-She had issues with staffing of the past month more so the past 2 weeks.
-She had 2-3 MAs giving medications in all 5 buildings daily.
-She was supposed to have a MA in each of the 5 buildings and 3-5 personal care aides (PCA) to share, that way there would be a MA in each building at all times.
-On Sunday, 05/23/21 at 8:00pm a staff member called in for the 8:00am shift on 05/24/21.
-Between 05/23/21 at 8:00pm and 8:00am there were several staff that called out for their shifts on 05/24/21.
-There was a staff member that did not call or show up for her shift on 05/24/21, 8:00am to 8:00pm.
-She was responsible for staffing 5 buildings with at least a MA in each building.
-On 05/24/21, she staffed the 5 buildings with the Business Office Manager (BOM) and the Activity

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Director (AD) who were MAs and could administer medications to the residents, a personal care aide (PCA) for assistance and herself.
-On 05/24/21, all the residents were brought up to the front porches of two sister facilities.
-Because there were only 4 staff for a total of approximately 50 residents with in all 5 sister facilities, the 4 staff cooked lunch and supper out on the grills, and everyone enjoyed a cookout day.
-It was "not the best they could do at the time", but under the circumstances of only 4 staff for approximately 50 residents, that was what they did.
-The MAs or PCAs did not have means of two-way telecommunication with the home, they use their personal cell phone which they could call or text each other.
-The residents did not have access to the staff's personal cell phone numbers.
-Any resident who required assistance could come to the office or to one of the other buildings.
-In the event of an emergency the residents could call 911, if staff could not be located.

Interview with the Owner on 05/27/21 at 4:00pm revealed:
-There should always be a staff member inside the facility to help care for the residents at all times.
-The Business Office Manager (BOM)/Supervisor, the Administrator, and the Resident Care Coordinator (RCC) was responsible for making sure there was a staff member in each building at all times.
-He did not know the residents in the facility were left alone for a period of time during the morning on 05/26/21.
-If a resident left the building during the night after

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D 177	Continued From page 24 the alarm was set then the alarm would go off. -The alarm would alert the staff that a resident had went out of the facility. -When the alarm was triggered then the doors unlock. -He thought the residents could get back in the facility if needed if a staff member was not in the facility. _____ The Administrator failed to ensure there was no time the residents were left alone in the home without a qualified staff and the Administrator or Administrator-in-Charge (AIC) was within 500 feet of the home with means of two-way communication which caused all the residents being left alone in the home for up to two hours at a time with no means of communicating with staff which resulted in one resident not receiving a pain medication when in severe pain; late meals and late medications; residents having to resort to calling 911 themselves if there was an emergency; and one resident not going to search for staff when in need for fear of being locked out of a facility and having to stay with friends or at a hotel if after 10:00pm. This failure resulted in serious neglect to the residents and constituted a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/27/21. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 1, 2021.	D 177		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 25 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure a Medication Administration Record (MAR) w available for documenting the administration of medications for 1 out of 3 sampled residents. The findings are: Review of Resident #3's current FL2 dated revealed diagnoses of schizoaffective disorder bipolar type, suicidal ideations, auditory hallucinations, major depressive disorder, mild intellectual disability disorder and prediabetes. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 05/11/21.	D 367		

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D 367	Continued From page 26 Review of Resident #3's signed physician ordered dated 05/10/21 revealed: -There was a physician's order for buspirone 5mg two times a day (a medication used to treat anxiety). -There was a physician's order for divalproex extended release 500mg at bedtime (a medication used to treat seizures and bipolar disorder). -There was a physician's order for gabapentin 500mg three times a day (a medication used to treat seizures and nerve pain). -There was a physician's order for Invega 234mg injected every 3 weeks (a medication used to treat schizoaffective disorder). -There was a physician's order for lisinopril 10mg every day (a medication used to treat high blood pressure). -There was a physician's order for loratadine 10mg every day (a medication used to treat allergies). -There was a physician's order for meloxicam 15mg every day (a medication used to treat arthritis). -There was a physician's order for nicotine patch 14mg/24hr patch (a medication used to help stop smoking). -There was a physician's order for Paliperidone extended release 6mg at bedtime (a medication used to treat schizoaffective disorder). -There was a physician's order for prazosin 5mg, 2 capsules at bedtime (a medication used to treat high blood pressure). -There was a physician's order for quetiapine 100mg at bedtime (a medication used to treat bipolar disorder). -There was a physician's order for benadryl 25mg every 4 hours as needed (PRN) for allergic reaction.	D 367		

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D 367	Continued From page 27 -There was a physician's order for clearlax powder 17gm in 8oz of water every day PRN for constipation. -There was a physician's order for imodium 2mg PRN with each loose stool. -There was a physician's order for maalox 200-200-20mg/ml, 30ml up to 4 times a day PRN indigestion/heartburn. -There was a physician's order for melatonin 5mg at bedtime PRN for sleep. -There was a physician's order for milk of magnesia 400mg/5ml 2 times a day PRN for constipation. -There was a physician's order for quetiapine 50mg PRN for anxiety every 4 hours, not to exceed 4 doses. -There was a physician's order for Robitussin DM 100mg/10ml, 10ml every 6 hours PRN cough. -There was a physician's order for trazodone 50mg at bedtime PRN for sleep. -There was a physician's order for Tylenol ES 500mg every 6 hours PRN for minor discomfort/headache. Review of Resident #3's May 2021 Medication Administration Record (MAR) revealed there was no MAR available for review. Review of the facility's Electronic Medical Record policy revealed: -The orders were inputted to the electronic MAR by the contracted pharmacy and received in the facility daily. -The medication aide (MA) would compare the eMAR to the current doctor's orders and immediately correct any errors. -If for some reason a hand written MAR must be completed, there must be written orders from the physician.	D 367		

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D 367	Continued From page 28 Interview with a MA on 05/26/21 at 10:50am revealed: -Resident #3 came to the facility on 05/11/21. -Resident #3 had medications, an FL2 and physician orders with her when she arrived to the facility. -She was not the MA on duty when Resident #3 arrived at the facility on 05/11/21. -The MA on duty at that time was responsible for faxing the orders to the pharmacy to be entered in the eMAR system. -The MA was responsible for completing a paper MAR with Resident #3's medications on them if needed. -On 05/21/21 was the first time she administered medications to Resident #3. -There were no medications listed in the eMAR for her to document as administered. -The Supervisor was responsible for making sure the medications were approved in the eMAR system so she could document the medications as administered. -There were no paper MARs or an eMAR to document she administered Resident #3's medications. -The facility did not have paper MARs to use. -On 05/21/21 she reported the lack of paper MARs and no eMAR for Resident #3 to the BOM who was also the Supervisor. -The BOM/Supervisor told her, "she would handle it". -On 05/21/21 later that day she informed the Administrator about not having the MARs for documentation of medication she administered. -The Administrator told her to continue to administer the medication according to the instructions on the medication bubble pack. -She was not given anything to document the medications she administered to Resident #3. -There should have been something to document	D 367		

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the medications administered on even if it was notebook paper.
-She administered the medications the same way as the other MA by reading the instructions on the medication bubble pack without documenting it on paper.

Interview with a second MA on 05/27/21 at 9:47am revealed:
-She faxed Resident #3's orders to the pharmacy on 05/11/21.
-She did not fill out a paper MAR for Resident #3's medications because the facility did not have paper MARs to use.
-She reported the issue to the BOM on 05/11/21 after Resident #3 arrived to the facility.
-She was instructed by the Administrator and the BOM/Supervisor to administer the medications to Resident #3 according to the instructions on the medication bubble pack.

Telephone interview with Resident #3's contracted pharmacy representitive on 05/26/21 at 11:55am revealed:
-The medications for Resident #3 were entered into the eMAR system on 05/11/21.
-It was the responsibility of the facility staff to approve the orders in the eMAR system in order to document administration of the medications administered.
-A paper MAR should have been used to document the medications administered to Resident #3 during the month of May 2021 until the medications were approved by the facility staff and a new eMAR was generated.
-The records indicated there were multiple phone calls made to the facility on 05/13/21, 05/21/21 and 05/24/21 related to Resident #3's medications not approved in Resident #3's pharmacy profile.

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-The pharmacy had documented Resident #3's mediations in Resident #3's pharmacy profile.
-The facility staff were responsible for approving Resident #3's pharmacy profile in order to allow the facility staff to document the administration of Resident #'3 medications in the eMAR system.
-As of 05/26/21, Resident #3's medications were not approved or documented as administered in the eMAR system.

Interview with the BOM on 05/26/21 at 12:44pm revealed:
-She had not approved Resident #3's orders in the eMAR for administration because she thought she had already completed that task.
-The MA was responsible for faxing all orders to the pharmacy.
-The pharmacy was responsible for entering the orders into the eMAR system.
-She and the MAs were responsible for approving all of the orders in the eMAR system.
-The MAs were aware they could approve the orders in the eMAR for administration.
-After the approval was completed then the MAs could administer the medications and document them in the eMAR.
-If there was a new order faxed after the eMAR was updated, then the MAs were responsible for hand writing all new orders on a paper MAR.
-All medications administered to a resident must be documented on a paper MAR or in the eMAR.
-There should never be a medication administered without documentation.

Interview with the Administrator on 05/26/21 at 3:48pm revealed:
-The MAs were responsible for faxing the orders to the pharmacy.
-After the pharmacy entered the orders into the eMAR system the MAs or the BOM was

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D 367	Continued From page 31 responsible for approving the orders for administration. -The MAs were responsible for completing a hand written MAR for all of the orders until the orders showed up in the eMAR. -The MAs were responsible for administering the medications according to the orders on the paper MAR or in the eMAR and documenting the administration of the medications afterwards. -The policy was to document all medications on a paper MARs or in the eMAR after administration. -She was not aware Resident #3's medications were administered with out a paper MAR or the eMAR and that they were not documented as administered. -She did not instruct the MAs to just follow the package directions.	D 367		
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:	D 612		

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D 612	Continued From page 32 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 10 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors. The findings are: Review of the current CDC guideline for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 03/29/21 revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. 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 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 infection control policy dated 03/29/21 revealed: -Visitors must cooperate with the facility's screening process at each visit and attest to not having signs or symptoms or current diagnosis of	D 612		

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D 612	Continued From page 33 COVID-19, if they have had a COVID-19, they must provide documentation that they no longer meet CDC criteria for transmission-based precautions. -Any individuals with symptoms of COVID-19 infection will not be permitted to visit with a resident. -The visitor should call the facility staff prior to entry for the staff to meet the visitor outside the facility for screening. -The screening process includes the visitor questionnaire, temperature, and other screenings as may be recommended by the CDC or the NCDHHS. Observation on 05/26/21 at 9:15am revealed two surveyors entered the facility with no COVID-19 screening or temperature checks and there were no screening questionnaire or thermometer located near the entrance. Observations of the entry hall on 05/26/21 at 9:40am revealed: -A medication aide (MA) entered the building and proceeded down the hall towards the surveyors. -She did not screen either surveyor and did not have any supplies used for screening with her. Observation of the Nurse Consultant entering the facility on 05/26/21 at 11:00am revealed he was not screened upon entering the facility. Interview with the MA on 05/26/21 at 11:10am revealed: -Usually visitors stop at the office and get screened prior to visiting the facility. -The office was located approximately 100 feet from the facility. -If a provider comes to the facility, they were screened when they entered the facility. -She was not being screened when she entered	D 612		

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the facility to begin her shift.
-The surveyors should have been screened when they entered the facility.

Interview with the Business Office Manager (BOM)/Supervisor on 05/26/21 at 12:35pm revealed:
-All visitors should be directed to the office to be screened and not in the facility.
-The office was located down the road from the facility.
-All visitors to the facility passed the office on the way to the facility.

Telephone interview with a Registered Nurse from the local health department on 05/27/21 at 10:22am revealed:
-All facilities should screen visitors by checking their temperatures and completing a questionnaire upon entry into the facility.
-The facility should be following the guidelines from the CDC and the NCDHHS.

Interview with the Administrator on 05/26/21 at 1:07pm revealed:
-She did not know visitors still needed to be screened before they entered the facility.
-She was told by someone from the county that they did not have to follow guidelines because no one had tested positive for COVID-19.
-She could not remember who she had talked to.
-She assumed the facility could stop screening visitors.
-The facility had screened visitors until early March 2021.

Interview with the Owner on 05/26/21 at 10:51am revealed:
-All visitors should be screened prior to entering the facility.

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D 612	Continued From page 35 -Most visitors "usually" go by the office first and were screened. -Each building should have a visitor log and questionnaires available to properly screen all visitors. -He did not know the facility did not have supplies available in the building to screen the visitors, including a thermometer and the questionnaire.	D 612		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect related to the management of facilities with a capacity or census of seven to thirty residents. The findings are: 1. Based on observations and interviews, the facility failed to ensure that at no time residents were left alone in the home without a qualified staff and the Administrator or Administrator-in-Charge (AIC) was within 500 feet of the home with means of two-way communication. [Refer to Tag D0177, 10A NCAC 13F .0601(a) Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the	D914		

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D914	Continued From page 36 management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of the adult care homes to protect each resident's right to receive adequate and appropriate care and services and to be free of neglect as related to the management of facilities, infection prevention and control program, and staff qualifications. [Refer to Tag D0176, 10A NCAC 13F .0601(a) Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A	D935		

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D935	Continued From page 37 NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) who administered medications to residents had completed the competency validated medication clinical skills, the 5, 10, or 15-hour state approved medication administration training course, and successfully passed the state medication aide examination as required. The findings are: 1. Review of Staff A's, Medication Aide (MA), personnel record on 05/27/21 revealed: -There was no documented date of hire. -There was documentation Staff A had passed the state approved medication aide written exam on 10/31/17. -There was no documentation Staff A had completed the competency validated medication clinical skills checklist.	D935		

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D935	Continued From page 38 Review of a resident's May 2021 electronic Medication Administration Record (eMAR) revealed Staff A had documented medications were administered to the resident. Interview with Staff A on 05/27/21 at 2:57pm revealed: -She started working at the facility in late February or March of 2021. -She completed the Medication Administration Skills Validation Checklist with the Nurse Consultant (RN) from the facility's contracted pharmacy after she had started working in the facility. -The Administrator should have the paper work in the office. -She was usually the only staff member in the facility while she was working. -She administered medications to the residents. Telephone interview with the Administrator on 06/01/21 at 2:41pm revealed: -She was responsible for making sure all MAs completed the required training upon hire to the facility. -Staff A was hired as a MA on 02/19/21. -She was "sure" Staff A had completed the Medication Administration Skills Validation Checklist with the RN prior to administering medications in the facility. -She could not find the documentation showing Staff A had completed the competency validation checklist. -She was "trying" to find the documentation but she had not organized the staff training documentation. Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am.	D935		

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D935	Continued From page 39 Refer to the interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm. 2.Review of Staff B's, Medication Aide (MA), personnel record revealed: -Staff B was hired on 07/26/19. --There was documentation Staff B had passed the state approved medication aide written exam on 08/08/06. -There was no documentation of completion of the 5, 10, or 15-hours medication aide training. Review of a resident's May 2021 electronic Medication Administration Record (eMAR) revealed Staff A had documented medications were administered to the resident. Interview with Staff B on 05/27/21 at 10:02am revealed: -She worked as a MA in the facility. -She did not remember completing the 5, 10, or 15-hour medication aide training while working at the current facility. -She worked as a MA at another facility beginning in 2018 and thought she had completed the training at the previous facility. -She told the Administrator she had worked at a previous facility and was told she did not have to complete the training because of the prior experience. Telephone Interview with the Administrator on 06/01/21 at 2:41pm revealed: -She was responsible for making sure all MAs completed the required training upon hire to the facility. -She had completed the Employment Verification Form for Staff B because she had previously	D935		

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RICHMOND HILL REST HOME # 3	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
D935	Continued From page 40 worked as a MA at another facility in 2018 and 2019. -She did not know if Staff B had worked as a MA prior to 2013. -She did not know the employment verification process should only be completed for staff that had worked as a MA prior to October 2013. Refer to the telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am. Refer to the interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm. _____ Telephone interview with the Nurse Consultant (RN) from the facility's contracted pharmacy on 05/28/21 at 8:20am revealed: -He provided the 5, 10, and 15-hour medication training and was responsible for completing the competency validated medication clinical skills checklist for the MAs. -The Administrator was responsible for notifying him if the facility had a MA that needed to complete the training. -He had completed some training for the facility in the past 2 to 3 months but he did not keep records of which MAs had completed the training. Interview with the Business Office Manager (BOM)/Supervisor on 05/27/21 at 4:44pm revealed: -The Administrator started working in April 2021. -The Administrator was responsible for notifying the Consultant Nurse for the MAs who required the training. -The Administrator was responsible for ensuring the medication aides (MAs) had all of the required qualifications prior to administering medications.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011374	A. BUILDING: _____ B. WING _____	06/01/2021

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