STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011188	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 5	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey on February 10-11, 2015.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls, ceilings, and floors were clean and in good repair in the dining room, kitchen, living room, and 2 of 4 bathrooms used by the residents (bathrooms # 2 and #3) and 1 of 9 resident rooms (Room #12). The findings are: Observation of Room 12 on 2/10/15 at 9:15am during facility tour revealed: -A triangular area behind the door and adjacent to the dresser was covered in a thick layer of grey dust. This area was roughly 10 inches long along the wall and 6 inches wide against the dresser. -There was no housekeeping checklist posted on the door to Room 12. An interview with the resident who lived in Room #12 on 2/10/15 at 9:15am revealed: -Staff provides housekeeping assistance in the bedroom. -There is usually a checklist posted on the	D 074		

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D 074	Continued From page 1 bedroom door detailing the cleaning task, which staff completed them, and when. -Housekeeping has not been provided in his bedroom since "last month sometime" . Observation of the dining room on 2/10/15 at 12:06pm revealed: - Dust balls covering the top of the wall to the left of the main entryway. - A thick layer of grey dust covering the top of a cork board hanging on the wall left of the main entryway. - An area approximately 3 feet long of abraded sheetrock with various areas of peeling paint on the wall left of the main entryway. -A thin layer of gray dust covering the top edges of the ceiling fan blades. - Various areas of dried splatters and spills on the wall behind the coffee maker. Observation of the kitchen on 2/10/15 at 12:09pm revealed: - An uncovered, exposed outlet to the right of the refrigerator. - Pieces of the "popcorn" finish on the ceiling was hanging down around the fire alarm. - A layer of dust on the wall above the refrigerator, hanging down approximately 1/2 - 1 inches. Observation of the living room on 2/10/15 at 12:15pm revealed: - Muliple dried, sticky spots on the floor in various places. - Food crumbs and a soda can pop top on the floor near the couch. - A small wastebasket without a bag, full of soiled briefs, orange peels and other various pieces of garbage. - An open, empy commerical cookie wrapper and a can of furniture polish on an end table.	D 074		

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D 074	Continued From page 2 Observation of bathroom #3 on 2/11/15 at 8:50am revealed: - Light to dark gray splotches on the shower floor and walls. - Deteriorated caulking along the shower entrance. - Broken corner guards on each side of the outer shower wall with exposed, jagged edges. - Two rough, exposed areas on the wall to the left of the toilet where the toilet paper holder had been removed and placed closer to the toilet. Observation of bathroom #2 on 2/11/15 at 8:55am revealed: - An area of black scuff marks on the wall outside of the shower approximately 3 feet in length. - Areas of light to dark gray splotches on the shower floor and walls. - Areas of scattered black splotches along the top of the shower wall. Interviews with the Administrator on 2/10/15 at 3:58pm and 2/11/15 at 9:00am revealed: - Facility staff was responsible for assuring the home was cleaned on a regular basis. - There was a cleaning schedule posted in the kitchen. - Staff were to check off the various cleaning tasks when they were completed. - She knew 2 weeks ago that the dining room was in need of repair but forgot to schedule repairs. - She thought the showers could be cleaned with a commercial abrasive agent and a household cleaning eraser. Review of the facility cleaning schedule for February 2015 revealed: - Cleaning duties were divided up into tasks according to the day of the week.	D 074		

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D 074	Continued From page 3 - Staff were to sign and date the log after the tasks were complete. - Cleaning tasks for the resident bedroms were divided up according to rooms and days of the week, as follows: - Resident rooms 1, 2, and 3 were to be cleaned every Monday. - Resident rooms 4, 5, and 6 were to be cleaned every Tuesday. - Resident rooms 7, 8, and 9 were to be cleaned every Wednesday. - Resident rooms 10, 11 and 12 were to be cleaned every Thursday. - Staff had initaled that rooms 1 though 9 had been cleaned the first week of February. - There were no staff initials that rooms 10, 11 or 12 had been cleaned in February. - Cleaning tasks for the kitchen and dining room were most recently initialed by staff on 2/5/15. - There were no scheduled cleaning tasks listed on the facility cleaning schedule for the living room or the common bathrooms. Review of the facility's county Health Department inspection dated 3/3/14 revealed no demerits.	D 074		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration 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;	D 367		

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D 367	Continued From page 4 (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 observation, interview and record review the facility failed to assure accurate documentation of medication administration for 1 of 3 residents regarding Clindaymycin (used to treat infections) and oxycodone with APAP 5mg/325mg (used to treat pain.) The findings are: (1) Review of Resident #2's FL2 dated 1/20/15 revealed: - The resident was admitted on 5/27/14. - Diagnoses included "migraine," major depression, obesity, anxiety, and post-traumatic stress disorder. - A physician's order for oxycodone/APAP, 5mg/325mg one every day as needed for headache pain. Observation of Resident #2's medication on hand on 2/10/15 at 2:05pm included a bubble card of oxycodone/APAP with 20 tablets remaining. Review of Resident #2's controlled drug record on 2/10/15 at 2:05pm revealed:	D 367		

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- A bubble card of 30 oxycodone tablets had been dispensed on 11/25/14.
- The first tablet had been administered on 1/27/15.
- Staff had documented there were 22 oxycodone tablets remaining.
- Staff had initialed that resident #2 had received one oxycodone tablet as follows:
  - 1/27/15 (29)
  - 1/28/15 (28)
  - 2/1/15 (27)
  - 2/4/15 (26)
  - 2/5/15 (25)
  - 2/6/15 (24)
  - 2/8/15 (23)
  - 2/9/15 (22)

Review of Resident #2's electronic Medication Administration Record (eMAR) for January 2015 revealed staff had initialed Resident #2 received one oxycodone tablet on 1/27/15 and 1/28/15.

Review of Resident #2's eMAR for February 2015 revealed staff had initialed Resident #2 received oxycodone as follows:
- 2/4/15 "2x"
- 2/6/15
- 2/8/15
- 2/9/15 "2x"
- 2/10/15

Interviews with the Medication Aide (MA) on 2/10/15 at 2:18pm and 2/11/15 at 10:38am revealed:
- Resident #2 takes oxycodone "every day."
- Resident #2 only received one oxycodone tablet per day per the physician's order.
- The documentation of "2x" was a "computer mistake" but he could not correct it because once information was documented in the eMAR,

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D 367	Continued From page 6	D 367		

staff were unable to make changes.
- He had administered one oxycodone tablet to Resident #2 on 2/7/15 but did not "sign out" the oxycodone tablet on the eMar or on the controlled substance log.
- Narcotics are counted by staff "whenever the shift is over or keys are exchanged."
- He did not realize the amount of oxycodone on the controlled substance log was different from the amount remaining in the bubble card until the surveyor brought it to his attention.

Interview with Resident #2 on 2/10/15 at 3:40pm revealed:
- He did not take oxycodone every day.
- When he took oxycodone, he only took it one time per day.
- Medication staff never offered him more than one tablet at a time.
- He would not have taken more than one oxycodone tablet a day because he was only supposed to receive one tablet per day per his physicians' order.

2. Record review on 2/10/15 revealed a subsquent physician's order dated 1/29/15 for Clindamycin 300mg four times a day for 7 days for a dental abcess.

Observation of medications on hand for Resident #2 on 2/10/15 at 2:05pm revealed a partially used bubble card of Clindaycin with 26 punched out bubbles and 2 intact bubbles which each contained 1 capsule of Clindamycin.

Review of Resident #2's eMAR's for January 2015 and February 2015 revealed:
- Staff had initialed Resident #2 had received Clindamycin per physician's order from 1/29/15 through 2/5/15.

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D 367	Continued From page 7 - Staff had initialed Resident #2 had received Clindamycin on 1/29/15 at 4:00pm and 8:00pm. Interviews with Medication Aide A on 2/10/15 at 2:05pm and 2/11/15 at 10:38am revealed: - Resident #2 received his first dose of Clindamycin at 8:00am on 1/30/15. - There were 2 doses of Clindamycin left over because it had been delivered by the pharmacy "too late" on 1/29/15. - The Clindamycin should have been coded on the eMar as not yet received from the pharmarcy. - He did not know Resident #2 had missed any doses of Clindamycin until the surveyor brought it to his attention. Interview with Resident #2 on 2/10/15 at 3:40pm revealed: - His physician had prescribed Clindamycin for a tooth abcess. - He thought he had received all ordered doses of Clindamycin. - His tooth abcess had "cleared up pretty quick." Interview with a representative from Resident #2's prescribing dentist' office on 2/11/15 at 10:25am revealed: - Resident #2's dentist had prescribed Clindamycin for Resident #2 as a "temporary fix" for a tooth abcess until a tooth extraction could be performed. - Although he had missed 2 doses of Clindamycin, Resident #2 "should be fine" if the tooth abcess had cleared up. Review of the facility's Medication Policies and Procedures revealed: - MAR's were to be signed by the staff responsible for administering medication. - MAR's were to be signed after each and every	D 367		

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D 367	Continued From page 8 dose for each and every resident. Interview with the Administrator on 2/11/15 at 11:15am revealed: - She expected "perfection" from staff when it came to medication administration. - Staff should call her or the Property Manager immediately when they realize they have made a documentation error on the eMar. - Documentation errors on the eMAR can be corrected by her or the Property Manager. - She would discuss with staff the importance of being accurate when counting narcotics before the count sheet is signed.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an accurate reconciliation record for one controlled medication prescribed for 2 of 3 sampled residents with controlled medication (Resident #2 and Resident #3). The findings are: 1. Review of Resident #2's FL2 dated 1/20/15 revealed: - The resident was admitted on 5/27/14. - Diagnoses included "migraine," major	D 392		

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D 392	Continued From page 9	D 392		

depression, obesity, anxiety, and post-traumatic stress disorder.
- A physician's order for oxycodone/APAP, 5mg/325mg one every day as needed for headache pain.

Observation of Resident #2's medication on hand on 2/10/15 at 2:05pm included a bubble card of oxycodone/APAP containing 20 tablets.

Review of Resident #2's controlled drug record on 2/10/15 at 2:05pm revealed:
- A bubble card of 30 oxycodone tablets had been dispensed on 11/25/14.
- The first tablet had been administered on 1/27/15.
- Staff had documented there were 22 oxycodone tablets remaining.
- Staff had initialed that Resident #2 had received one oxycodone tablet as follows:
    - 1/27/15 (29)
    - 1/28/15 (28)
    - 2/1/15 (27)
    - 2/4/15 (26)
    - 2/5/15 (25)
    - 2/6/15 (24)
    - 2/8/15 (23)
    - 2/9/15 (22)

Review of Resident #2's electronic Medication Administration Record (eMAR) for January 2015 revealed staff had initialed Resident #2 received one oxycodone tablet on 1/27/15 and 1/28/15.

Review of Resident #2's eMAR for February 2015 revealed staff had initialed Resident #2 received oxycodone as follows:
- 2/4/15 "2x"
- 2/6/15
- 2/8/15

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D 392	Continued From page 10 - 2/9/15 "2x" - 2/10/15 Interviews with the Medication Aide (MA) on 2/10/15 at 2:18pm and 2/11/15 at 10:38am revealed: - Resident #2 takes oxycodone "every day." - Resident #2 only received one oxycodone tablet per day per the physician's order. - The documentation of "2x" was a "computer mistake" but he could not correct it because once information was documented in the eMAR, staff were unable to make changes. - He had administered one oxycodone tablet to Resident #2 on 2/7/15 but did not "sign out" the oxycodone tablet on the eMar or on the controlled substance log. - Narcotics are counted by staff "whenever the shift is over or keys are exchanged." - He did not realize the amount of oxycodone on the controlled substance log was different from the amount remaining in the bubble card until the surveyor brought it to his attention. Interview with the Administrator on 2/11/15 at 11:15am revealed: - Staff should call her or the Property Manager immediately when they realize they have made a documentation error on the eMar. - Documentation errors on the eMAR can be corrected by her or the Property Manager. - She would discuss with staff the importance of being accurate when counting narcotics before the count sheet is signed. 2. Review of Resident #3's FL2 dated 2/6/15 revealed: - Diagnoses include schizoaffective disorder, diabetes, and polydipsia. - A physician's order for Clonazepam 1mg every	D 392		

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D 392	Continued From page 11 morning. Review of Resident #3's medication on hand 2/10/15 revealed there were 26 doses of the Clonazepam 1mg pills remaining in the bubble pack card. Review of Resident #3's controlled substance sheet on 2/10/15 revealed the following: - Medication Aide B administered Clonazepam 1mg on 2/5/15 and documented there were 31 doses remaining. - Medication Aide A administered a dose of Clonazepam 1mg on 2/6/15, skipped the next line on the controlled substance sheet and documented there were 29 doses remaining instead 30. -Medication Aide A administered the doses on 2/7/15, 2/8/15, 2/9/15, and 2/10/15 on the subsequent lines, and the count remained disrupted during that time. - Medication Aide A documented there were 25 Clonazepam pills on hand for 2/10/15. Interview with Medication Aide A on 2/10/15 at 2:30pm revealed he did not know how controlled substance count became inaccurate. Interview with the Property Manager on 2/10/15 at 2:35pm revealed: - The count became inaccurate when Medication Aide A skipped a line when documenting the Clonazepam on 2/6/15. -She corrected the count and drew a single line with ink through the blank line 3. Review of the facility's Medication Policies and Procedures revealed control sheets were to be signed after each dose of controlled medication by staff and the count maintained.	D 392		

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