STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011372	A. BUILDING: _____ B. WING _____	R 04/05/2022

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 and follow-up survey and complaint investigation with an onsite visit of 03/30/22 to 03/31/22, a desk review 04/01/22, 04/04/22 and a telephone exit on 04/05/22. The complaint investigation was initiated on 03/24/22 by the Buncombe County Department of Social Services.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately for 1 of 3 sampled residents (Resident #1) who displayed agitated, cursing, yelling, talking to the wall, laughing at inappropriate times, confused, hands shaking uncontrollably, sweating and hallucinating, which required an immediate emergency response. The findings are:	D 271		

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D 271	Continued From page 1 Review of Resident #1's current FL2 dated 08/30/21 revealed diagnoses included schizoaffective disorder and diabetes. Telephone interview with the Administrator on 04/05/22 at 11:15am revealed: -There was no written emergency policy/procedure. -All staff, upon hire were trained on the facility's emergency procedures. -In the event of a resident emergency situation such as, but not limited to, complaints or display of increased behaviors, staff were to call 911/Emergency Medical Services (EMS) for evaluation, treatment and potential transportation of a resident to a hospital. -If a personal representative declines EMS, the personal representative must complete a Declination of EMS Release Form. -Call the resident's primary care physician (PCP) for further recommendations in case of refusal and notification of event. -Complete and incident/accident report. -Document the incident in the resident's progress notes. Review of Resident #1's facility charting notes revealed: -On 03/21/22, at 11:18pm, the medication aide (MA) documented Resident #1 was talking to himself. -On 03/24/22, at 3:41pm, the MA documented Resident #1 was talking to the Adult Home Specialist (AHS) and Resident #1 was acting "out of sorts" so she gave him an as needed (PRN) antipsychotic medication. -On 03/24/22, at 9:35pm the Resident Care Coordinator (RCC) documented staff called the Mental Health Provider (MHP) on 03/21/22.	D 271		

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-On 03/24/22, at 9:35am the RCC, upon her return to the facility, on 03/21/22, she noticed Resident #1 was acting out of sorts.
-On 03/24/22, the RCC documented she left a message with the MHP to return her call on 03/21/22.
-On 03/24/22, the RCC documented, on 03/22/22, she called 911 for Resident #1 to be evaluated and resident refused to go.
-On 03/24/22, the RCC documented, on 03/22/22, she called Resident #1's family member and the family member took Resident #1 out for a bit and then brought Resident #1 back to the facility.
-On 03/24/22, the RCC documented, on 03/24/22, the staff called the MHP and left another message regarding Resident #1's continued behavioral issues.
-On 03/24/22, the RCC documented, she spoke to AHS on 03/24/22 about Resident #1 refusal, 911 called again and Resident #1 refused at first but stated he would go.

Review of Resident #1's Behavioral Health hospitalization record dated 03/24/22 to 03/30/22 revealed:
-On 03/24/22, he was admitted for a full evaluation with symptoms of being hyperverbal, anxious, and distressed.
-On 03/24/22, his admission diagnoses included schizoaffective disorder, and bipolar type.
-On 03/25/22, during Resident #1's initial assessment he displayed poor concentration, was confused with memory cloudiness, brief crying spells, brief laughing spells, intermittence full body tremors that escalated as interview progressed, hyperverbal, and with brief episodes of obsessive compulsive disorder (OCD) by counting fingers with thumbs and not able to stop until physician held his hands.

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-On 03/30/22, the reason for admission was for anxiety and psychosis in the context of poor compliance with medications.
-He became tearful with labile affect (characterized by rapid changes in emotion unrelated to external events or stimuli), felt confused and disoriented, and thought something was wrong with his medication treatment although he reported he was taking all the medications given to him at the facility by the staff and felt someone was stealing some of his medications.
-On 03/31/22, he was discharged back to the facility.

Interview with the Resident Care Coordinator (RCC) on 03/30/22 at 8:30am and by telephone on 04/05/22 at 11:15am revealed:
-On 03/11/22, she went on vacation after completing a medication cart audit of Resident #1's medications.
-She returned to the facility on 03/21/22 to find out that Resident #1 ran out of his clozaril.
-On 03/21/22, upon return to the facility, she notified the Administrator that Resident #1 did not receive his clozaril from 03/17/22 to 03/21/22 and was displaying symptoms of hallucinations and increased anxiety.
-On 03/21/22, she left a message on Resident #1's MHP voicemail explaining what happened and she did not receive a call back.
-She did not think to call 911 because she left a message for the MHP.
-On 03/22/22, she told the MA to call 911, and Resident #1 and his family member refused to be transported to the hospital.
-Resident #'1 family member told her that she would "take care of it".
-On 03/22/22, Resident #1's family member left the facility with Resident #1 and it was her

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understanding Resident #1's family member would take Resident #1 to the hospital but it was later that night on 03/22/22, she found out by text from the MA that Resident #1's family member took him out to eat and calmed him down some.
-On 03/23/22, around noon, she called the MHP and left a "more urgent" voicemail, but in hindsight she should have called 911 because she did not receive a return call from the MHP.
-She was the only MA for all 4 buildings and Resident #1 was still displaying hallucinations and increased anxiety, but she became so busy she did not follow-up after leaving a voicemail with the MHP.
-On 03/24/22, around lunch time, she called the MHP and left another voicemail.
-On 03/24/22, around 3:00pm, she received a report from the staff, Resident #1 was having issues with another resident and she instructed the MA to call 911.
-On 03/24/22,911 was called and Resident #1 was sent out to the hospital.

Interview with a MA on 03/31/22 at 7:35am revealed:
-On 03/17/22, she administered Resident #1's last clozaril.
-On 03/21/22, Resident #1 was hallucinating, agitated, episodes of crying at one minute then laughing the next and talking to the walls so she let the Administrator and RCC know.
-She knew Resident #1 was out of clozaril on 03/17/22 and Resident #1's hallucinations, talking to self and episodes of crying/laughing were symptoms of Resident #1 being without his clozaril and needed to go to the ER.
-She did not call 911 because the RCC and Administrator was aware of Resident #1's symptoms and she thought the RCC and Administrator was handling it.

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-Hindsite, in her opinion, at anytime from 03/21/22 to 03/24/22, she, a MA, the RCC or Administrator could have called 911 based on Resident #1 displaying symptoms of hallucinations, talking to self, tremors or episodes of laughing and crying because those were signs and symptoms of Resident #1 going without his clozaril and needed to be evaluated by a physician especially after not receiving a return call from the MHP on 03/21/22.

Telephone interview with Resident #1's MHP on 03/31/22 at 9:04am revealed:
-She saw Resident #1 last on 02/28/22.
-On 02/28/22, Resident #1 reported having increased anxiety off and on since December 2021, so she increased his clozaril from 150mg a night to 200mg at night.
-The next communication regarding Resident #1 was from the AHS on 03/25/22 informing her Resident #1 was in the hospital for an increase in Resident #1's psychosis because of running out of his clozaril.
-Clozaril was a medication used to treat Resident #1's schizoaffective disorder, it was an antipsychotic and could not be stopped suddenly.
-If Resident #1 missed 2 doses then he needed to be reevaluated and restarted based on his lab work, how long he was on the medication, any previous complications while on the clozaril, and current medical condition and if all of those thing were good then she could titrate him faster than if there were issues.
-When Resident #1 missed more than 1 dose of clozaril, it put Resident #1 at a severe risk of developing increased anxiety and hallucinations which in turn put him at a greater risk of harm to self.
-It was her expectation for Resident #1 to receive his clozaril in order to help prevent an increase in

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Resident #1's psychosis, increase risk of harm to self and hospitalization.
-If Resident #1 displayed symptoms such as hallucinations, episodes of crying then laughing, talking to self or objects, increased sweating or hand or body tremors, call 911 and send out for evaluation.

Interview with the Adult Home Specialist (AHS) on 03/31/22 at 2:22pm revealed:
-On 03/24/22, around 10:00am, she was at the facility when a personal care aide (PCA) informed her Resident #1 was agitated, cursing, yelling, talking to the wall, laughing at inappropriate times, confused, hands shaking uncontrollably, sweating and hallucinating because Resident #1 missed his clozaril over the past several days.
-On 03/24/22, the PCA informed her, on 03/22/22, Resident #1 refused to go to the hospital for an assessment
-On 03/24/22, around 11:00am, she observed Resident #1 yelling, agitated and cursing in the bathroom.
-There was no one addressing Resident #1's behaviors at the time on 03/24/22.
-On 03/24/22, she spoke to the RCC and suggested Resident #1 needed to go to the hospital.

Interview with Resident #1 on 03/31/22 at 4:55pm revealed:
-Recently he began to have hallucinations, increased anxiety, times when he would cry and then laugh at nothing, and talk to the walls, and he knew at that point he was not receiving his clozaril so he tried to tell the Administrator and the RCC but felt he was "backed into a corner" and no one was listening.
-He became scared.
-His clozaril helped keep his voices and other

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symptoms of his psychosis under control.
-The staff told his family member the behaviors were because he had an argument with the personal care aide (PCA) not because he missed several doses of clozaril.
-He refused to go to the ER the first time because he was in a "fog" and the "voices" were louder and telling him to not go to the ER.
-The staff told him the second time if he did not go to the ER he could not stay at the facility.

Interview with Resident #1's family member on 03/31/22 at 5:10pm revealed:
-She did not know Resident #1 was hallucinating, talking to self, having episodes of crying then laughing, increased sweating or increased anxiety since 03/21/22.
-On 03/23/22, she was called by the PCA related to Resident #1 and the PCA was in an argument and Resident #1 was agitated and the staff wanted him to go to the ER.
-Resident #1 refused to go to the ER and after the PCA explained about the argument she decided to come and get Resident #1 and take Resident #1 for a ride.
-On 03/23/22, she picked up Resident #1 that afternoon just to remove him from the situation and that did calm him down some.
-He still had issues with rapid talking, increased anxiety, and uncontrollable crying but related it to the argument.
-Resident #1 was unable to tell her exactly how he felt.
-On 03/23/22, she took him back to the facility after supper.
-The staff did not relay any information about Resident #1's behaviors or missing his clozaril.
-She felt Resident #1 and herself depended on the staff to report the correct and full issue regarding Resident #1, like on 03/23/22 when she

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was notified the staff called 911 because Resident #1 and a staff member was in an argument so she and Resident #1 refused to go to the ER based on the fact it was probably a one time thing.
-She would not have refused for Resident #1 to go to the ER if she knew Resident #1's increased anxiety and behaviors that day were caused by Resident #1 not getting his clozaril.
-She did not know until 03/24/22 Resident #1 did not receive his clozaril when the MA told her Resident #1 was to go to the ER or be discharged.

Interview with the Administrator on 03/30/22 at 4:52pm and by telephone on 04/05/22 at 10:13am revealed:
-On 03/11/22, The RCC completed a medication cart audit on Resident #1, before the RCC left on vacation and informed her that Resident #1 would be out of clozaril in a few days.
-She was not aware Resident was out of the clozaril on 03/17/22 until a MA told her on 03/21/22.
-On 03/17/22, the MA informed another MA Resident #1 was out of clozaril via a person to person text instead of using the required group text, so she was not made aware.
-She knew missed doses of clozaril would cause Resident #1 to exhibit symptoms of hallucinations, increased anxiety, and excessive talking.
-On 03/21/22, Resident #1 displayed symptoms of hallucinating, increased anxiety and excessive talking so she called Resident #1's family member because Resident #1 was upset with a staff member.
-When Resident #1 ran out of clozaril on 03/17/22 and began having increased symptoms of his psychosis on 03/21/22, the RCC should have

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D 271	Continued From page 9 called 911 especially after no return call from the MHP. _____ The staff failed to respond immediately by calling 911/Emergency Medical Services (EMS) for evaluation, treatment and potential transportation to a hospital in regard to a resident demonstrating hallucinations, increased anxiety, episodes of crying and laughing, talking to the wall, increased sweating and hand and body tremors resulting in a 3 day delay of treatment. Resident #1 experienced an increase in his psychosis and required a restart of his antipsychotic medication and monitoring during a 7 day hospitalization. This failure resulted in serious neglect and harm to Resident #1 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/22. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 6, 2022.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure contact with the Mental Health Provider (MHP) for 1 of 3 sampled residents (Residents #1) related to obtaining required lab work to refill an antipsychotic	D 273		

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medication, and refill of an antipsychotic medication resulting in a 7 day hospital stay.

The finding are:

Review of Resident #1's current FL2 dated 08/30/21 revealed diagnoses included schizoaffective disorder and diabetes.

a. Review of Resident #1's current FL2 dated 08/30/21 revealed an order for clozaril (an antipsychotic used to treat schizophrenia) 100mg, 1-1/2 tablets (150mg), every night.

Review of Resident #1's subsequent signed physician's order dated 02/28/22 revealed an order for clozaril 200mg every night.

Observations of Resident #1's medications on hand on 03/30/22 at 4:08pm revealed there was no clozaril available for administration.

Interview with a second MA on 03/31/22 at 7:35am revealed:
-On 03/17/22, she administered Resident #1's last clozaril.
-She could not order the clozaril because there were no labs on file for Resident #1.
-She did not contact the lab when Resident #1 ran out of clozaril on 03/17/22 because the RCC, Administrator or another MA was responsible for getting the contracted lab to get Resident #1's labs for his clozaril.
-When Resident #1 was down to the last 2-3 clozaril, the MAs were to contact the Administrator or the RCC for a lab draw and refill.

Interview with the Resident Care Coordinator (RCC) on 03/30/22 at 8:30am and by telephone on 04/05/22 at 11:15am revealed:

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-On 03/11/22, she went on vacation after completing a medication cart audit of Resident #1's medications.
-She informed the Administrator and the medication aides (MA) to make sure Resident #1's clozaril was refilled before he ran out of medication.
-If Resident #1 missed more than two doses he could display symptoms of hallucinations, become very anxious and would require medical attention immediately.
-On 03/17/22, a MA texted her cell phone stating the MA gave the last dose of clozaril on 03/17/22.
-On 03/17/22, she reported to the Administrator, Resident #1 received his last clozaril on 03/17/22 and to notify the pharmacy and get a refill before his next dose was due on 03/18/22 at 8:00pm.
-She returned to the facility on 03/21/22 to find out that Resident #1 ran out of his clozaril on 03/17/22 and after notifying the Administrator Resident #1 did not receive clozaril 03/17/22 to 03/21/22 and was displaying symptoms of hallucinations and increased anxiety.
-The RCC did not notify the MHP Resident #1 ran out of clozaril on 03/17/22 until she returned to work on 03/21/22 and did not call the Administrator.
-On 03/21/22, she left a message on Resident #1's Mental Health Provider's (MHP) voicemail explaining what happened and she did not receive a call back.

Review of Resident #1's March 2022 eMAR revealed:
-An entry for clozaril 100mg, 2 tablets (200mg), every night scheduled to be administered at 8:00pm, documented as administered 03/01/22 to 03/21/22.
-On 03/22/22 and 03/23/22, 100mg, 2 tablets (200mg), every night was documented as not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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administered, awaiting pharmacy.
-On 03/24/22 to 03/31/22 was blank.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/31/22 at 9:48am revealed:
-There was a subsequent order dated 02/28/22 for clozaril 100mg, 2 tablets (200mg), every night.
-On 03/01/22, clozaril 100mg, 14 tablets (7 doses) was dispensed to the facility and to begin on 03/01/22 to 03/07/22 and Resident #1 would have been out of the clozaril on 03/08/22.
-On 03/12/22, clozaril 100mg, 14 tablets (7 doses) was dispensed to the facility and to begin on 03/12/22 to 03/18/22 and Resident #1 would have been out of the clozaril on 03/19/22.
-According to Resident #1's dispense record, Resident #1 ran out of clozaril on 03/08/22 to 03/11/22 and missed 9 of 23 doses. 17 out of 31 doses for the month of March 2022.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/30/22 at 3:09pm revealed:
-In order for a resident to receive clozaril, the pharmacy must have a copy of the resident's current lab work.
-If more than two doses were missed, the pharmacy cannot refill the clozaril.
-Missing 2 or more doses of clozaril could lead to a significant risk of Resident #1 displaying symptoms such as; hallucinations, delusions, repetitive words/rambling, odd behavior, disorganized thinking and problems with communication.

Review of Resident #1's facility charting notes revealed:
-On 03/21/22, upon the RCC's return to the facility she noticed Resident #1 was acting out of

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sorts, she left a message with the MHP to return her call.
-On 03/24/22, at 9:35pm the RCC documented staff called the MHP.

Review of staff group text messages revealed on 03/17/22, a MA sent a text message to another MA, informing about Resident #1 was out of clozaril.

Telephone interview with Resident #1's MHP on 03/31/22 at 9:04am revealed:
-She saw Resident #1 last on 02/28/22.
-Clozaril was a medication used to treat Resident #1's schizoaffective disorder, it was an antipsychotic and could not be stopped suddenly.
-The only communication documented in Resident #1's record at the office regarding Resident #1 was from the AHS on 03/25/22 informing her Resident #1 was in the hospital for an increase in psychosis because the facility ran out of his clozaril.
-The facility did not inform her Resident #1 ran out of his clozaril in March 2022.
-If Resident #1 missed 2 doses he would need to be reevaluated and restarted based on his lab work, how long he was on the medication, any previous complications while on the clozaril, and current medical condition and if all of those thing were good then she could titrate him faster than if there were issues.
-When Resident #1 missed more than 1 dose of clozaril, it put Resident #1 at a severe risk of developing increased anxiety and hallucinations which in turn put him at a greater risk of harm to self.
-The facility should have been focused on getting the blood work completed monthly by the hospital as planned and Resident #1 would have received his Clozaril without delay.

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D 273	Continued From page 14 -It was her expectation for Resident #1 to receive his lab work, and not to miss his clozaril in order to help prevent an increase in Resident #1's psychosis, increase risk of harm to self and hospitalization. Interview with Resident #1 on 03/31/22 at 4:55pm revealed: -In March 2022, he began to have the same symptoms, and he knew at that point he was not receiving his clozaril so he tried to tell the Administrator and the RCC but felt he was "backed into a corner" and no one was listening. -He became scared. -His clozaril helped keep his voices and other symptoms of his psychosis under control. -He felt he was not getting his clozaril many times December 2021 to March 2022 and his mania was worse, but when he asked the MAs, he was told that he was getting the clozaril. -He did not know what to do because he depended on the MAs to give him the clozaril. Interview with the Administrator on 03/30/22 at 4:52pm and by telephone on 04/05/22 at 10:13am revealed: -On 03/11/22, The RCC completed a medication cart audit on Resident #1, before the RCC left on vacation and informed her that Resident #1 required a refill on clozaril within a few days or Resident #1 would be out of clozaril. -She was not aware Resident was out of the clozaril on 03/17/22 until a MA told her on 03/21/22. -On 03/17/22, the MA informed another MA Resident #1 was out of clozaril via a person to person text instead of using the required group text, so she was not made aware. -It was her responsibility to check about Resident #1's clozaril the day after the RCC left for	D 273		

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vacation to ensure the clozaril was refilled. and to notify the MHP about the medication not filled as ordered.
-She knew missed doses of clozaril would cause Resident #1 to exhibit symptoms of hallucinations, increased anxiety, and excessive talking.
-On 03/21/22, when the MA told her Resident #1 was out of clozaril she reviewed Resident #1 eMAR and the medication was documented as administered.
-On 03/21/22, Resident #1 displayed symptoms of hallucinating, increased anxiety and excessive talking so she called Resident #1's family member.
-She did not notify the MHP when the RCC told her to while the RCC was out of the facility.
-She did not notify the MHP on 03/21/22 when the MA informed her Resident #1 was out of clozaril or that Resident #1 displayed symptoms of psychosis.
-She did not notify the MHP on 03/23/22, after finding out that Resident #1's family member did not take Resident #1 to the ER on 03/22/22.
-She was ultimately responsible for making sure Resident #1's labs were ordered, clozaril was refilled and that he did not run out, and that the physician was notified of Resident #1's psychosis and refusal to go to the ER.

b. Telephone interview with Resident #1's MHP on 03/31/22 at 9:04am revealed:
-The original order for Resident #1's clozaril 100mg, 1-1/2 tablets every night dated 02/19/18.
-Along with that order, Resident #1 was entered into the Risk Evaluation and Mitigation Strategies (REMS, a drug safety program that the FDA can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks; re: fda.gov/drug

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safety and availability) system which meant, the lab would complete the blood work, enter the results in the REMS system, and the pharmacy would check for completion of the blood work and results prior to refill of the clozaril.

Telephone interview with a representative from Resident #1's hospital lab on 03/31/22 at 11:34am revealed:
-An absolute neutrophil count (a blood test used to identify the number of neutrophil's, a common white blood cell type, in the body) (ANC) was required to be drawn on a monthly basis in order for Resident #1 to receive his clozaril.
-Resident #1 was to have his labs drawn which included an ANC on a monthly basis.
-According to their records, Resident #1 received lab work on 03/24/22 while Resident #1 was a patient in the hospital.
-All lab work was sent to the MHP.

Telephone interview with a representative from the facility's contracted lab on 03/31/22 at 11:02am revealed:
-Resident #1 received an ANC lab draw on 03/11/22.
-It was the responsibility of the facility staff to call and set up an appointment for Resident #1's lab draws and to bring Resident #1 to them.
-It was the responsibility of the facility staff to request a copy of the blood work and send to the pharmacy or MHP.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/31/22 at 9:48am revealed:
-On 03/08/22, the facility staff requested a refill of Resident #1's clozaril.
-A pharmacy staff member informed the facility staff member the pharmacy needed a copy of

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Resident #1's blood work in order to refill the clozaril and the pharmacy would dispense a 3 day supply of the clozaril to give the facility staff additional time to provide the results of Resident #1's blood work.
-On 03/11/22, the facility staff again requested a refill of Resident #1's clozaril without a copy or proof of Resident #1's blood work.
-On 03/11/22, the pharmacy dispensed a second 3 day supply of clozaril and a second request for the copy of Resident #1's blood work.
-There were no more requests for refills of Resident #1's clozaril after 03/11/22.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/30/22 at 3:09pm revealed:
-In order for a resident to receive clozaril, the pharmacy must have a copy of the resident's current lab work that documented if a resident's ANC was low which is a sign of neutropenia.
-If the lab work was not completed the pharmacy could not dispense clozaril unless Resident #1 was out of the clozaril and the resident only missed one dose.
-If more than two doses were missed, the pharmacy could not refill the clozaril.
-Neutropenia which is one of the serious side effects of clozaril could cause Resident #1 to be susceptible to serious infections which could lead to death and that is why the lab work was required prior to refills.

Interview with the Resident Care Coordinator (RCC) on 03/30/22 at 8:30am and by telephone on 04/05/22 at 11:15am revealed:
-On 03/11/22, she went on vacation after completing a medication cart audit of Resident #1's medications.
-Resident #1 required a lab draw and a refill of his

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clozaril within 3 days after she left.
-She informed the Administrator and the medication aides (MA) to make sure Resident #1's lab was drawn which included the ANC before Resident #1 ran out of medication.
-She returned to the facility on 03/21/22 to find out from a MA, that Resident #1 did not receive his lab work.
-She did not know why the Administrator did not contact the MHP about the lab work not completed.
-On 04/04/22, she found out Resident #1's ANC blood work was completed on 03/11/22 but the Administrator did not request a copy of the blood work to send to the pharmacy.
-It was the responsibility of the Administrator to send the blood work to the pharmacy while she was out of the facility.

Interview with a second MA on 03/31/22 at 7:35am revealed:
-On 03/17/22, she notified the MA who was responsible for getting the lab work and clozaril ordered for Resident #1.
-She could not order the clozaril because there were no labs on file for Resident #1.
-When Resident #1 was down to the last 2-3 clozaril, she contacted the Administrator or the RCC for a lab draw and refill.
-On 03/21/22, Resident #1 was hallucinating, agitated, episodes of crying at one minute then laughing the next and talking to the walls and there was no clozaril on the medication cart, so she let the Administrator and RCC know.

Telephone interview with Resident #1's MHP on 03/31/22 at 9:04am revealed:
-She saw Resident #1 last on 02/28/22.
-On 02/28/22, she wrote a subsequent standing order for the hospital lab to draw Resident #1's

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labs when necessary but the facility did not give her a fax number, she could send the order to.
-The hospital lab had the standing order already in place but still did not receive a fax number from the facility for the facility.
-The next communication regarding Resident #1 was from the AHS on 03/25/22 informing her Resident #1 was in the hospital for an increase in psychosis because the facility ran out of his clozaril and the pharmacy could not refill clozaril without the required lab work.
-The facility should have been focused on getting the blood work completed monthly by the hospital as planned and Resident #1 would have received his Clozaril without delay.
-It was her expectation for Resident #1 to receive his lab work, and not to miss his clozaril in order to help prevent an increase in Resident #1's psychosis, increase risk of harm to self and hospitalization.

Interview with the Administrator on 03/30/22 at 4:52pm and by telephone on 04/05/22 at 10:13am revealed:
-On 03/11/22, The RCC completed a medication cart audit on Resident #1, before the RCC left on vacation and informed her that Resident #1 required a lab draw in a few days or Resident #1 would be out of clozaril.
-It was her responsibility to check about Resident #1's clozaril the day after the RCC left for vacation to ensure the blood work was completed and if not notify the MHP for instructions since the labs were not completed and the clozaril could not be refilled.
-She knew clozaril was to be given every day and Resident #1 could not miss more than one dose because it would have to be restarted by the physician at that point.
-She knew if the labs were not completed the

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D 273	Continued From page 20 Resident #1 missed doses of clozaril and would cause Resident #1 to exhibit symptoms of hallucinations, increased anxiety, and excessive talking. _____ The facility failed to ensure contact with the MHP after Resident #1's blood work was not completed, resulting in clozaril not being refilled and missed doses, and a resident demonstrated hallucinations, increased anxiety, episodes of crying and laughing, talking to the wall, increased sweating and hand and body tremors resulting in an increase in his psychosis and required a restart of his antipsychotic medication and monitoring during a 7 day hospitalization. This failure resulted in serious risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/30/22. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 6, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

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D 358	Continued From page 21 TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (Residents #1) related to an antipsychotic medication used to treat schizophrenia. The findings are: Review of the facility's undated Medication Administration Policy and Procedure revealed medications are to be administered and documented on the Medication Administration Record. Review of Resident #1's current FL2 dated 08/30/21 revealed: -Diagnoses included schizoaffective disorder and diabetes. -A order for clozaril (an antipsychotic used to treat schizophrenia) 100mg, 1-1/2 tablets (150mg), every night. Review of Resident #1's subsequent physician's order dated 02/28/22 revealed clozaril 200mg every night. Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed: -An entry for clozaril 100mg, 2 tablets (200mg), every night scheduled to be administered at 8:00pm. -Clozaril was documented as administered 03/01/22 to 03/21/22. -On 03/22/22 and 03/23/22, 200mg, the clozaril was documented as not administered, awaiting pharmacy.	D 358		

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D 358	Continued From page 22 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/31/22 at 9:48am revealed: -There was a subsequent order dated 02/28/22 for clozaril 100mg, 2 tablets (200mg), every night. -On 03/01/22, clozaril 100mg, 14 tablets (7 doses) was dispensed to the facility. -On 03/12/22, clozaril 100mg, 14 tablets (7 doses) was dispensed to the facility. Observation of Resident #1's medications on hand on 03/30/22 at 4:08pm revealed there was no clozaril was available for administration. Interview with the Resident Care Coordinator (RCC) on 03/30/22 at 8:30am revealed: -On 03/11/22, she went on vacation after completing a medication cart audit of Resident #1's medications. -Resident #1 required a lab draw and a refill of his clozaril within 3 days after she left. -She informed the Administrator and the medication aides (MA) to make sure Resident #1's lab was drawn and his clozaril was refilled before he ran out of medication. -If Resident #1 missed more than two doses he could display symptoms of hallucinations, become very anxious and would require medical attention immediately. -On 03/17/22, a MA texted her cell phone stating the MA gave the last dose of clozaril on 03/17/22. -On 03/17/22, she reported to the Administrator, Resident #1 received his last clozaril on 03/17/22 and to notify the pharmacy and get a refill before his next dose was due on 03/18/22 at 8:00pm. -She returned to the facility on 03/21/22 to find out from a MA that Resident #1 did not receive his lab work, ran out of his clozaril on 03/17/22 and after notifying the Administrator Resident #1	D 358		

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did not receive his clozaril 03/17/22 to 03/21/22 and was displaying symptoms of hallucinations and increased anxiety.
-On 04/04/22, she found out that Resident #1's ANC blood work was completed on 03/11/22 but the Administrator did not request a copy of the blood work to send to the pharmacy.
-It was the responsibility of the Administrator to send the blood work to the pharmacy while she was out of the facility.

Telephone interview with Resident #1's MHP on 03/31/22 at 9:04am revealed:
-She did not receive a call from the facility Resident #1 ran out of his clozaril in March 2022.
-She was under the impression Resident #1 received his clozaril daily otherwise she would not have increased his dosage 02/28/22 due to Resident #1's report of increased psychosis.
-Clozaril was a medication used to treat Resident #1's schizoaffective disorder, it was an antipsychotic and could not be stopped suddenly.
-If Resident #1 missed 2 doses then he needed to be reevaluated and restarted based on his lab work, how long he was on the medication, any previous complications while on the clozaril, and current medical condition and if all of those things were good then she could titrate him faster.

Interview with Resident #1 on 03/31/22 at 4:55pm revealed:
-With his mania worsening and the staff telling him he was getting his clozaril, when he saw his MHP he explained what he was feeling and the MHP increased his clozaril.
-He did not know what to do because he took all of the medications the MAs gave him and depended on the MAs to follow the MHP orders.

Interview with the Administrator on 03/30/22 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24 4:52pm and by telephone on 04/05/22 at 10:13am revealed: -She was not aware Resident was out of the clozaril on 03/17/22 until a MA told her on 03/21/22. -On 03/17/22, the MA informed another MA Resident #1 was out of clozaril via a person to person text instead of using the required group text, so she was not made aware. -It was her responsibility to check about Resident #1's clozaril the day after the RCC left for vacation to ensure the blood work and clozaril was refilled. -She knew clozaril was to be given every day and Resident #1 could not miss more than one dose because it would have to be restarted by the physician at that point. -She knew missed doses of clozaril would cause Resident #1 to exhibit symptoms of hallucinations, increased anxiety, and excessive talking. -On 03/21/22, when the MA told her Resident #1 was out of clozaril she reviewed Resident #1 eMAR and the medication was documented as administered. -On 03/21/22, Resident #1 began to display symptoms of hallucinating, increased anxiety and excessive talking and was ultimately sent to the emergency room (ER) on 03/24/22. -She did not check back after every notification or request related to Resident #1 to see if Resident #1's labs were completed, clozaril ordered, or if Resident #1 was sent to the ER after displaying symptoms of psychosis. -She was ultimately responsible for making sure Resident #1's labs were ordered, clozaril was refilled and that he did not run out, and that the physician was notified of Resident #1's psychosis and refusal to go to the ER.	D 358		

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D 358	Continued From page 25 The facility failed to ensure medications were administered as order, resulting in Resident #1 not receiving his clozaril causing him to experience hallucinations, increased anxiety, episodes of crying and laughing, talking to the wall, increased sweating, hand and body tremors requiring a restart of his antipsychotic medication and monitoring during a 7 day hospitalization. This failure resulted in serious risk for physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/30/22. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 6, 2022.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the scheduled times as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1, and #2). The findings are: Review of the facility's undated Medication	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 26	D 364		

Administration Policy and Procedure revealed medications were to be administered one hour before or one hour after the scheduled administration time.

1. Review of Resident #1's current FL2 dated 08/30/21 revealed:
-Diagnoses included schizoaffective disorder and diabetes.
-An order for fish oil 1000mg three times a day.
-An order for metformin 500mg, 2 tablets, two times a day.
-An order for preservision areds, 1 capsule, two times a day.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 02/01/22 - 03/30/22 revealed:
-There was an entry for fish oil 1000mg three times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 03/10/22, 03/11/22, 03/15/22, and 03/21/22.
-There was an entry for fish oil 1000mg three times a day at 2:00pm and documentation of administration at 2:00pm on 02/03/22, 02/06/22, 02/10/22, 02/12/22, 02/24/22, 02/28/22, 03/01/22, 03/04/22, 03/07/22, 03/10/22, 03/15/22, 03/19/22, and 03/24/22.
-There was an entry for fish oil 1000mg three times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/03/22, 02/04/22, 02/07/22, 02/18/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/18/22, 03/19/22, and 03/20/22.
-There was an entry for metformin 500mg, 2 tablets, two times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22,

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D 364	Continued From page 27 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 03/10/22, 03/11/22, 03/15/22, and 03/21/22. -There was an entry for metformin 500mg, 2 tablets, two times a day at 5:00pm and documentation of administration at 5:00pm on 02/01/22, 02/02/22, 02/04/22, 02/08/22, 02/11/22, 02/12/22, 02/14/22, 02/15/22, 02/16/22, 02/18/22, 02/20/22, 02/22/22, 02/23/22, 02/24/22, 02/25/22, 03/01/22, 03/02/22, 03/04/22, 03/05/22, 03/08/22, 03/09/22, 03/11/22, 03/15/22, 03/17/22, 03/18/22, 03/19/22, 03/20/22, 03/21/22, 03/22/22, and 03/24/22. -There was an entry for preservision areds, 1 capsule, two times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 03/10/22, 03/11/22, 03/15/22, and 03/21/22. -There was an entry for preservision areds, 1 capsule, two times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/03/22, 02/04/22, 02/07/22, 02/18/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/18/22, 03/19/22, and 03/20/22. Review of Resident #1's Medication Variance Report for 02/01/22 - 03/30/22 revealed: -Fish oil, metformin and preservision areds were scheduled to be administered at 8:00am and were documented as administered on 02/01/22 at 9:30am, 02/06/22 at 9:46am, 02/07/22 at 9:25am, 02/12/22 at 9:22am, 02/13/22 at 9:11am, 02/14/22 at 9:52am, 02/15/22 at 9:16am, 02/16/22 at 9:29am, 02/17/22 at 10:12am, 02/20/22 at 9:55am, 03/10/22 at 9:11am, 03/11/22 at 10:57am, 03/15/22 at 9:41am, and 03/21/22 at 9:14am. -The scheduled 8:00am medications were administered late 14 out of 58 days. -Fish oil was scheduled to be administered at	D 364		

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2:00pm and was documented as administered on 02/03/22 at 12:55pm, 02/06/22 at 4:03pm, 02/10/22 at 12:52pm, 02/12/22 at 12:45pm, 02/24/22 at 12:56pm, 02/28/22 at 3:07pm, 03/01/22 at 12:34pm, 03/04/22 at 12:29pm, 03/07/22 at 3:09pm, 03/10/22 at 12:34pm, 03/15/22 at 12:23pm, 03/19/22 at 12:37pm, and 03/24/22 at 11:50am.
-The scheduled 2:00pm medication was administered late 7 out of 58 days and early 7 out of 58 days.
-Metformin was scheduled to be administered at 5:00pm and was documented as administered at 5:00pm on 02/01/22 at 9:30am, 02/06/22 at 9:46am, 02/07/22 at 9:25am, 02/12/22 at 9:22am, 02/13/22 at 9:11am, 02/14/22 at 9:52am, 02/15/22 at 9:16am, 02/16/22 at 9:29am, 02/17/22 at 10:12am, 02/20/22 at 9:55am, 03/01/22 at 3:36pm, 03/02/22 at 3:35pm, 03/04/22 at 6:57pm, 03/05/22 at 7:21pm, 03/08/22 at 3:53pm, 03/09/22 at 3:25pm, 03/11/22 at 3:01pm, 03/15/22 at 3:39pm, 03/17/22 at 3:45pm, 03/18/22 at 3:52pm, 03/19/22 at 3:18pm, 03/20/22 6:47pm, 03/21/22 at 2:34pm, 03/22/22 at 3:42pm, and 03/24/22 at 3:44pm.
-The scheduled 5:00pm medication was administered late 7 out of 58 days and early 24 out of 58 days.
-Fish oil, and preservision areds were scheduled to be administered at 8:00pm and were documented as administered on 02/01/22 at 10:29pm, 02/03/22 at 6:54pm, 02/04/22 at 9:57pm, 02/07/22 at 6:38pm, 02/18/22 at 9:06pm, 02/23/22 at 9:04pm, 02/27/22 at 6:44pm, 02/28/22 at 6:36pm, 03/04/22 at 6:57pm, 03/18/22 at 6:48pm, 03/19/22 at 6:13pm, and 03/20/22 at 6:47pm.
-The scheduled 8:00pm medications were administered late 9 out of 58 days and early 8 out

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D 364	Continued From page 29 of 58 days. Refer to telephone interview with the facility's contracted physician on 03/31/22 at 9:20am. Refer to interview with a medication aide (MA) on 03/30/22 at 5:31pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 04/05/22 at 11:30am. Refer to telephone Interview with the Administrator on 04/05/22 at 11:15am. 2. Review of Resident #2's current FL2 dated 08/30/21 revealed: -Diagnoses included type 2 diabetes, hypertension, dyslipidemia, chronic obstructive pulmonary disease, cardiomyopathy and degenerative disc disease. -An order for wellbutrin 150mg two times a day. -An order for carvedilol 3.125mg two times a day. -An order for namenda 10mg two times a day. -An order for oxycodone 5/326mg three times a day. -An order for gabapentin 300mg four times a day. Review of Resident #2's eMAR for 02/01/22 - 03/30/22 revealed: -There was an entry for wellbutrin 150mg two times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 02/24/22, 03/07/22, 03/10/22, 03/11/22, 03/15/22, 03/16/22, and 03/21/22. -There was an entry for wellbutrin 150mg two times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/04/22, 02/07/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22,	D 364		

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D 364	Continued From page 30 03/15/22, 03/18/22, 03/19/22, 03/20/22, 03/24/22, and 03/26/22. -There was an entry for carvedilol 3.125mg two times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 02/24/22, 03/07/22, 03/10/22, 03/11/22, 03/15/22, 03/16/22, and 03/21/22. -There was an entry for carvedilol 3.125mg two times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/04/22, 02/07/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/15/22, 03/18/22, 03/19/22, 03/20/22, 03/24/22, and 03/26/22. -There was an entry for namenda 10mg two times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 02/24/22, 03/07/22, 03/10/22, 03/11/22, 03/15/22, 03/16/22, and 03/21/22. -There was an entry for namenda 10mg two times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/04/22, 02/07/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/15/22, 03/18/22, 03/19/22, 03/20/22, 03/24/22, and 03/26/22. -There was an entry for oxycodone 5/326mg three times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 02/24/22, 03/07/22, 03/10/22, 03/11/22, 03/15/22, 03/16/22, and 03/21/22. -There was an entry for oxycodone 5/326mg three times a day at 2:00pm and documentation of administration at 2:00pm on 02/03/22, 02/06/22, 02/10/22, 02/12/22, 02/21/22, 02/28/22, 03/01/22, 03/04/22, 03/05/22, 03/07/22, 03/10/22,	D 364		

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D 364	Continued From page 31 03/16/22, 03/17/22, 03/19/22, 03/23/22, 03/28/22, and 03/29/22. -There was an entry for oxycodone 5/326mg three times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/04/22, 02/07/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/15/22, 03/18/22, 03/19/22, 03/20/22, 03/24/22, and 03/26/22. -There was an entry for gabapentin 300mg four times a day at 8:00am and documentation of administration at 8:00am on 02/01/22, 02/06/22, 02/07/22, 02/12/22, 02/13/22, 02/14/22, 02/15/22, 02/16/22, 02/17/22, 02/20/22, 02/24/22, 03/07/22, 03/10/22, 03/11/22, 03/15/22, 03/16/22, and 03/21/22. -There was an entry for gabapentin 300mg four times a day at 12:00pm and documentation of administration at 12:00pm on 02/05/22, 02/11/22, 02/13/22, 02/20/22, 02/22/22, 02/25/22, 02/28/22, 03/03/22, 03/13/22, 03/14/22, 03/20/22, 03/27/22, and 03/28/22. -There was an entry for gabapentin 300mg four times a day at 4:00pm and documentation of administration at 4:00pm on 02/05/22, 02/18/22, 02/19/22, 02/20/22, 02/21/22, 02/23/22, 03/01/22, 03/04/22, 03/05/22, 03/06/22, 03/11/22, 03/20/22, 03/21/22, 03/22/22, and 03/24/22. -There was an entry for gabapentin 300mg four times a day at 8:00pm and documentation of administration at 8:00pm on 02/01/22, 02/04/22, 02/07/22, 02/23/22, 02/27/22, 02/28/22, 03/04/22, 03/15/22, 03/18/22, 03/19/22, 03/20/22, 03/24/22, and 03/26/22. Review of Resident #2's Medication Variance Report for 02/01/22 - 03/30/22 revealed: -Wellbutrin, carvedilol, Namenda, oxycodone, and gabapentin were scheduled to be administered at 8:00am and were documented as administered on 02/01/22 at 9:27am, 02/06/22 at 9:41am,	D 364		

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D 364	Continued From page 32 02/07/22 at 9:18am, 02/12/22 at 9:23am, 02/13/22 at 9:07am, 02/14/22 at 9:26am, 02/15/22 at 9:15am, 02/16/22 at 9:25am, 02/17/22 at 10:29am, 02/20/22 at 9:46am, 02/24/22 at 9:02am, 03/07/22 at 9:29am, 03/10/22 at 9:20am, 03/11/22 at 10:48am, 03/15/22 at 9:29am, 03/16/22 at 9:29am, and 03/21/22 at 9:12am. -The scheduled 8:00am medications were administered late 17 out of 58 days. -Gabapentin was scheduled to be administered at 12:00pm and was documented as administered on 02/05/22 at 1:07pm, 02/11/22 at 10:45am, 02/13/22 at 1:03pm, 02/20/22 at 1:30pm, 02/22/22 at 10:56am, 02/25/22 at 2:07pm, 02/28/22 at 3:14pm, 03/03/22 at 10:57am, 03/13/22 at 1:38pm, 03/14/22 at 1:01pm, 03/20/22 at 2:53pm, 03/27/22 at 10:40am, and 03/28/22 at 10:52am. -The scheduled 12:00pm medication was administered late 8 out of 58 days and early 5 out of 58 days. -Oxycodone was scheduled to be administered at 2:00pm and was documented as administered on 02/03/22 at 12:55pm, 02/06/22 at 4:02pm, 02/10/22 at 12:52pm, 02/12/22 at 12:45pm, 02/21/22 at 12:04pm, 02/28/22 at 3:14pm, 03/01/22 at 12:33pm, 03/04/22 at 12:32pm, 03/05/22 at 12:31pm, 03/07/22 at 3:11pm, 03/10/22 at 12:36pm, 03/16/22 at 3:56pm, 03/17/22 at 12:27, 03/19/22 at 12:41pm, 03/23/22 at 12:43pm, 03/28/22 at 12:57pm and 03/29/22 at 12:59pm. -The scheduled 2:00pm medication was administered late 4 out of 58 days and 13 out of 58 days. -Gabapentin was scheduled to be administered at 4:00pm and was documented as administered on 02/05/22 at 5:31pm, 02/18/22 at 8:48pm, 02/19/22 at 7:50pm, 02/20/22 at 7:08pm,	D 364		

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02/21/22 at 5:37pm, 02/23/22 at 2:37pm, 03/01/22 at 2:50pm, 03/04/22 at 6:34pm, 03/05/22 at 7:10pm, 03/06/22 at 2:49pm, 03/11/22 at 2:59pm, 03/20/22 at 6:50pm, 03/21/22 at 2:33pm, 03/22/22 at 2:31pm and 03/24/22 at 6:22pm.
-The scheduled 4:00pm medication was administered late 9 out of 58 days and 6 out of 58 days.
-Wellbutrin, carvedilol, namenda, oxycodone, and gabapentin were scheduled to be administered at 8:00pm and were documented as administered on 02/01/22 at 10:28pm, 02/04/22 at 9:48pm, 02/07/22 at 6:35pm, 02/23/22 at 9:08pm, 02/27/22 at 6:48pm, 02/28/22 at 6:34pm, 03/04/22 at 6:34pm, 03/15/22 at 6:47pm, 03/18/22 at 6:35pm, 03/19/22 at 6:25pm, 03/20/22 at 6:50pm, 03/24/22 at 6:22pm, and 03/26/22 at 6:04pm.
-The scheduled 8:00pm medications were administered late 4 out of 58 days and 9 out of 58 days.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/30/22 at 3:09pm revealed:
-When namenda 10mg two times a day is given early or late, it has the least risk of concerns, but is best practice to maintain levels in the system.
-When wellbutrin 150mg two times a day was administered within a two to three hours beyond the regular scheduled dose, then there could be a slight risk for a seizure.
-When oxycodone 5/325mg was administered too early for Resident #1, it could cause increased sedation leading to an increased fall risk and administered too far apart could lead to increased pain.
-When gabapentin 300mg four times a day is administered earlier than scheduled, it could lead

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

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D 364	Continued From page 34 to a slight risk of overdose and increased central nervous system depression if given with the oxycodone which could lead to a life-threatening effect. -When carvedilol 3.125mg two times a day is administered, it decreased Resident #1's blood pressure and heart rate, if administered more than a hour later, the desired effect may not happen and if the doses were given too close together, it could cause Resident #1's blood pressure and heart rate to lower too much and cause hypotension or bradycardia which could be life threatening. Refer to telephone interview with the facility's contracted physician on 03/31/22 at 9:20am. Refer to interview with a medication aide (MA) on 03/30/22 at 5:31pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 04/05/22 at 11:30am. Refer to telephone Interview with the Administrator on 04/05/22 at 11:15am. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Medications should be administered as scheduled. -She would expect the facility to not be late administering the medications. -Medications with multiple dose scheduled during the day should not be late because that would cause the doses to be given too close together and the resident would get too much of the medication in their system. Interview with a medication aide (MA) on 03/30/22 at 5:31pm revealed:	D 364		

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D 364	Continued From page 35	D 364		

-On 03/18/22 and 03/19/22, she worked all four facilities on campus, approximately 40 residents total she administered medication to and medications were either too soon or too late, even 2:00pm and 4:00pm medications were given together.
-She was trained by the Nurse, to administer medications within a one hour before or one hour after time frame.
-She called the Administrator on 03/18/22 and asked for help but none came to help until the Administrator came on 03/19/22 in the afternoon.

Telephone interview with the RCC on 04/05/22 at 11:30am revealed:
-Since December 2021, there was not enough MAs to supply each of the four facilities on campus with one MA.
-There were many times that a MA was responsible for two to four buildings at a time.
-When a MA administered medications in more than one facility at a time, medications were administered outside of the policy window of no sooner that one hour before to one hour after the scheduled time.
-She was responsible for running a weekly medication variance report on each of the buildings which would indicate medication administration times outside of the one hour before and one hour after the scheduled time.
-She was not aware of specific medication issues related to outside the one hour before and one hour after the scheduled time for the residents but was aware medications were administered too early and too late.

Telephone Interview with the Administrator on 04/05/22 at 11:15am revealed:
-The policy was for a MA to administer mediations no sooner than one hour before or one hour later

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D 364	Continued From page 36 that the scheduled time. -Since December 2021, there was a MA assigned to more than one facility at a time. -She hired a new MA within the last month, so one MA was assigned to no more than two facilities at a time and a float MA to assist with any MA needed help with medication administration. -She did receive a phone call from a MA on 02/19/22 informing her the MA was administering mediations in all four building by herself. -There was supposed to be another MA to assist with mediation administration on 03/18/22 and 03/19/22 but one MA did not show up for work so when she found out on 03/19/22, she went to help administer medications.	D 364		
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 interviews and record reviews, the facility failed to ensure all residents were free from neglect related to Personal Care and Supervision, and Health Care and Medication Administration. The findings are: 1. Based on record reviews and interviews, the facility failed to respond immediately for 1 of 3 sampled residents (Resident #1) who displayed	D914		

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D914	Continued From page 37 agitated, cursing, yelling, talking to the wall, laughing at inappropriate times, confused, hands shaking uncontrollably, sweating and hallucinating, which required an immediate emergency response. [Refer to Tag D0271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure contact with the Mental Health Provider (MHP) for 1 of 3 sampled residents (Residents #1) related to obtaining required lab work to refill an antipsychotic medication, and refill of an antipsychotic medication resulting in a 7 day hospital stay. [Refer to Tag D0273 10A NCAC 13F .0902(b) Healthcare (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (Residents #1) related to an antipsychotic medication used to treat schizophrenia. [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (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	D935		

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D935	Continued From page 38 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 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 1 of 3 sampled staff (Staff A) who administered medications, was supervised prior to successfully passing the mediation aide exam. The findings are:	D935		

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D935	Continued From page 39 1. Review of Staff A's medication aide (MA), personnel file revealed: -Her date of hire was 01/20/22. -Her position title was MA. -She completed the 15-hour medication aide training on 02/15/22. -She completed her medication clinical skills on 02/15/22. -There was no documentation of successfully passing the medication aide test. Interview with a Staff A on 03/30/22 at 5:31pm revealed: -She was a day shift MA. -She received her 15-hour medication aide training on 02/15/22. -She did not take her medication aide test yet because she was still within 60 days of hire. -She did administer medications in all 4 sister facility's by herself on 03/18/22 and 03/19/22. -On 03/18/22 and 03/19/22, all medications in all 4 sister facility's were administered too early or too late per the facility's policy. -The RCC was on vacation 03/11/22 to 03/21/22. -On 03/18/22 and 03/19/22, she thought she administered every dose of the clozaril to a resident, but she did not use the scanner every time and may have thought she administered the clozaril and didn't but did document afterwards that she did. -On 03/17/22 there was a text sent by another MA on the facility text chat, informing the MAs, another MA gave Resident #1's last clozaril. -There was no other explanation on why she documented she administered clozaril after 03/17/22 when the clozaril was not in the facility. Telephone interview with the Administrator on	D935		

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D935	Continued From page 40 04/05/22 at 10:13am revealed: -Staff A completed the 15-hour medication aide training on 02/15/22. -She was aware a MA was to be supervised with administration of medications until she successfully passing the medication aide test. -The Resident Care Coordinator (RCC) completed the schedule prior to going on vacation on 03/11/22 and informed her, Staff A would be the only MA for all 4 sister facility's and needed another MA to supervise Staff A. -She called another MA before 03/18/22 and set up for the other MA to work and supervise Staff A on 03/18/22 and 03/19/22. -The MA scheduled to supervise Staff A did not show up for work or did not call and she did not find out Staff A was in the building administering mediation by herself until 03/19/22 when Staff A called her and informed her Staff A was by herself. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation). Refer to Tag D0364 10A NCAC 13F .1004(g) Medication Administration	D935		