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-C **06/14/2022**

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 a follow-up survey on 06/13/22 to 06/14/22.	{D 000}		
{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: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (Residents #2 and #3) related to medications used to treat schizophrenia and diabetes mellitus type 2 (#3), and bipolar disorder, anxiety, and depression (#2). The findings are: 1. Review of Resident #3's current FL2 dated 05/09/22 revealed diagnoses included paranoid	{D 358}		

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{D 358}	Continued From page 1	{D 358}		

schizophrenia.

a. Review of Resident #3's current FL2 dated 05/09/22 revealed there was an order for paliperidone ER (used to treat schizophrenia) 3mg one tablet daily.

Observation of Resident #3's medications on 06/13/22 at 12:10pm revealed there was no paliperidone available.

Review of Resident #3's May 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for paliperidone ER 3mg one tablet daily scheduled at 8:00am.
-The paliperidone was documented administered as ordered from 05/01/22 to 05/31/22.

Review of Resident #3's June 2022 eMAR revealed:
-There was an entry for paliperidone ER 3mg one tablet daily scheduled at 8:00am.
-The paliperidone was documented as administered as ordered from 06/01/22 to 06/13/22.

Interview with Resident #3 on 06/13/22 at 2:10pm revealed:
-He did not know he was out of paliperidone.
-He last received paliperidone on the morning of 06/13/22.
-As far as he knew, he had received the paliperidone every day.
-He thought the paliperidone was an orange, oblong shaped tablet.

Telephone interview with the facility's contracted pharmacy representative on 06/13/22 at 12:25pm revealed:

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{D 358}	Continued From page 2	{D 358}		

-There were 30 tablets of paliperidone last dispensed on 05/06/22 a 30-day supply.
-The pharmacy received refill requests from the facility on 06/03/22 and 06/12/22.
-The pharmacy needed a prior authorization to refill the medication.
-The pharmacy left voicemail messages on the facility's office voicemail on 06/03/22 and again on 06/12/22 to make the facility staff aware they had been unable to fill Resident #3's paliperidone.

Telephone interview with a medication aide (MA) on 06/13/22 at 2:42pm revealed:
-She administered Resident #3's daytime medications for the last 4 days.
-She last administered paliperidone to Resident #3 on 06/12/22.
-The paliperidone administered on 06/12/22 was the last tablet in the bubble pack.
-She did not administer paliperidone to Resident #3 at 8:00am on 06/13/22.
-She had mistakenly documented administering the paliperidone to Resident #3 on 06/13/22 on the eMAR.

Telephone interview with the certified medical assistant (CMA) who worked with Resident #3's psychiatric provider on 06/13/22 at 3:48pm revealed:
-Their office had not received a refill request or prior authorization request for paliperidone for Resident #3.
-Resident #3 received oral paliperidone to help manage any symptoms the paliperidone injection the resident received every 4 weeks did not cover.
-Resident #3 could experience hallucinations when the paliperidone was not administered as ordered.

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{D 358}	Continued From page 3 Interview with the Administrator on 06/14/22 at 9:00am revealed: -She was not aware Resident #3's paliperidone tablets were not available until 06/13/22. -She did not receive a faxed request for prior authorization from the pharmacy for Resident #3's paliperidone tablets. -She did not receive a voicemail from the pharmacy concerning inability to refill Resident #3's paliperidone tablets. -She was responsible for performing medication cart audits. -She last audited the medication cart at the facility first of May, but she could not recall the exact date. -The medication aides and the resident care coordinator (RCC) had received training on how to reorder medications. -The MAs, the RCC, and the Administrator were all responsible for reordering medications and ensuring medications were available for administration. b. Review of Resident #3's current FL2 dated 05/09/22 revealed there was an order for Janumet (used to treat diabetes mellitus type 2) 50/1000mg one tablet twice a day with meals. Interview with Resident #3 on 06/13/22 at 8:43am revealed: -He was out of his Janumet and did not receive his 8:00am dose on 06/13/22. -He received two doses of Janumet yesterday (06/12/22) at 8:00am and 5:00pm. -He was told by facility staff the Janumet had been reordered and would arrive from the pharmacy on 06/13/22. Observation of Resident #3's medications on 06/13/22 at 12:10pm revealed there was no	{D 358}		

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{D 358}	Continued From page 4 Janumet available. Review of Resident #3's May 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Janumet 50/1000mg one tablet twice daily with meals scheduled at 8:00am and 5:00pm. -The Janumet was documented administered as ordered from 05/01/22 to 05/31/22. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Janumet 50/1000mg one tablet twice daily with meals scheduled at 8:00am and 5:00pm. -The Janumet was documented administered as ordered from 06/01/22 to 06/13/22 at 8:00am. Review of Resident #3's HBA1C (a blood test that measures your average blood sugar levels over the past three months) result dated 06/07/22 revealed: -The HBA1C was 5.6% which was within normal limits (reference range 4.8-5.6). -The estimated average glucose was 114. Interview with the RCC on 06/13/22 at 12:11pm revealed: -The pharmacy had not yet delivered the first delivery of the day. -The Janumet was ordered yesterday (06/12/22). Telephone interview with the facility's contracted pharmacy representative on 06/13/22 at 12:25pm revealed: -There were 60 tablets of Janumet dispensed on 04/11/22 a 30-day supply. -There were 60 tablets of Janumet dispensed on 05/03/22 a 30-day supply.	{D 358}		

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{D 358}	Continued From page 5 -There had been no additional dispenses of the Janumet since 05/03/22. -The pharmacy needed a prior authorization completed by the prescriber prior to filling the Janumet. -The pharmacy faxed the prior authorization paperwork to the prescriber on 06/04/22. -The pharmacy staff had left a voicemail on the facility's voicemail on 06/03/22 and again on 06/13/22 to inform the facility staff they were unable to fill the Janumet without prior authorization. Telephone interview with a medication aide (MA) on 06/13/22 at 2:42pm revealed: -She administered Resident #3's daytime medications for the last 4 days. -She had ordered a refill from the pharmacy of the Janumet 06/12/22. -She did not administer Janumet on 06/13/22 at 8:00am, because there was no medication available. -She had mistakenly documented administering the Janumet on the eMAR. Telephone interview with Resident #3's primary care provider (PCP) on 06/13/22 at 3:09pm revealed: -The Janumet was prescribed to help manage Resident #3's blood sugar. -Resident #3's blood sugar was well controlled. -Resident #3 might experience symptoms of hyperglycemia like excessive thirst and urination when the resident did not receive the Janumet as ordered. Interview with the Administrator on 06/14/22 at 9:00am revealed: -She was not aware Resident #3's Janumet tablets were not available until 06/13/22.	{D 358}		

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

-She did not receive a faxed request for prior authorization from the pharmacy for Resident #3's Janumet tablets.
-She did not receive a voicemail from the pharmacy concerning inability to refill Resident #3's Janumet tablets.
-She was responsible for performing medication cart audits.
-She last audited the medication cart at the facility first of May, but she could not recall the exact date.
-The medication aides and the RCC had received training on how to reorder medications.
-The MAs, the RCC, and the Administrator were all responsible for reordering medications and ensuring medications were available for administration.

2. Review of Resident #2's current FL2 dated 01/25/22 revealed diagnoses included bipolar disorder episode depressed severe, suicidal ideation and dependent personality features.

a. Review of Resident #2's physician order dated 05/13/22 revealed fluoxetine (used to treat bipolar disorder, anxiety and depression) 20mg one capsule every morning.

Interview with Resident #2 on 6/13/22 at 9:00am revealed:
-He received the last dose of one of his medications yesterday (06/12/22).
-He thought the medication he was out of was olanzapine (used to treat bipolar disorder).
-The medication aide (MA) told him she had reordered the medication and it would arrive today (06/13/22).
-He was not experiencing any new symptoms or discomfort.

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{D 358}	Continued From page 7 Observation of Resident #2's medications on hand on 06/13/22 at 12:00pm revealed there was no fluoxetine available. Review of Resident #2's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for fluoxetine 20mg one capsule daily scheduled at 8:00am. -The fluoxetine was documented as administered as ordered 06/01/22 through 06/13/22. Telephone interview with the contracted facility pharmacy representative on 06/13/22 at 12:36pm revealed: -The fluoxetine was last dispensed on 05/12/22 with a 30-day supply ending 06/10/22. -The pharmacy received a refill request for the fluoxetine on 06/13/22. Telephone interview with a medication aide (MA) on 06/13/22 at 2:40pm revealed: -She administered Resident #2's medications on 06/12/22 and 06/13/22. -She administered the last fluoxetine tablet on 06/13/22 at 8:00am. -She ordered a refill of the fluoxetine from the pharmacy on 06/13/22. Telephone interview with Resident #2's mental health provider representative on 06/13/22 at 1:00pm revealed missing more than 2 doses of the fluoxetine could lead to the resident feeling like they were having "an out of body experience", agitation, dizziness and depression. Interview with the Administrator on 06/14/22 at 9:00am revealed: -She did not know Resident #2's fluoxetine capsules were not available on the medication	{D 358}		

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{D 358}	Continued From page 8	{D 358}		

cart on 06/13/22.
-Staff had ordered a refill of the fluoxetine on 06/13/22.
-The MAs, the RCC, and the Administrator were all responsible for reordering medications and ensuring medications were available for administration.

Telephone interview with Resident #2's primary care provider (PCP) on 6/15/22 at 1:50pm revealed:
-The fluoxetine was prescribed to treat bipolar disorder.
-Any missed doses of fluoxetine can cause anxiety, depression and agitation.

b. Review of Resident #2's physician order dated 05/13/22 revealed sertraline (used to treat bipolar disorder, anxiety and depression) 25mg take two tablets (50mg) daily.

Interview with Resident #2 on 6/13/22 at 9:00am revealed:
-He received the last dose of one of his medications yesterday (06/12/22).
-He thought the medication he was out of was olanzapine.
-The medication aide (MA) told him she had reordered the medication and it would arrive today (06/13/22).
-He was not experiencing any new symptoms or discomfort.

Observation of Resident #2's medications on hand on 06/13/22 at 12:00pm revealed:
-There was an unopened bubble pack of sertraline 25mg tablets in the overflow drawer for Resident #2 dispensed 06/03/22.
-There was no sertraline in the area of the medication cart where Resident #2's other

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{D 358}	Continued From page 9	{D 358}		

scheduled medications were stored.

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry for sertraline 25mg two tablets daily scheduled at 8:00am.
-The sertraline was documented as administered as ordered 06/01/22 through 06/13/22.

Telephone interview with the contracted facility pharmacy representative on 06/13/22 at 12:36pm revealed the sertraline was filled for the first time for Resident #2 on 05/12/22 with a 30-day supply.

Telephone interview with a medication aide (MA) on 06/13/22 at 2:40pm revealed:
-She administered Resident #2's medications on 06/12/22 and 06/13/22.
-She thought she remembered there were "a couple more" tablets remaining in the bubble pack, but she was not completely sure.

Interview with the Administrator on 06/14/22 at 9:00am revealed the MAs, the RCC, and the Administrator were all responsible for reordering medications and ensuring medications were available for administration.

Telephone interview with Resident #2's primary care provider (PCP) on 6/15/22 at 1:50pm revealed:
-The sertraline was prescribed to treat bipolar disorder.
-Any missed doses of sertraline can cause anxiety, depression and agitation.

____

The facility failed to ensure medications used to prevent hallucinations and manage blood sugar levels (Resident #3) and medications used to treat anxiety and depression (Resident #2) were

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{D 358}	Continued From page 10 available to administer increasing the risk of hallucinations and poor blood sugar control (#3) and risk of anxiety and depression symptoms (#2). These failures were detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______________________ The facility provided a plan of protection on accordance with G.S. 131D-34 on 06/13/22 for this violation.	{D 358}		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (Residents #2 and #3) related to medications used to treat schizophrenia and diabetes mellitus type 2 (#3), and bipolar disorder, anxiety, and depression (#2).[Refer to tag D0358, 10A NCAC 13F .1004(a) Medication	D912		

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D912	Continued From page 11 Administration (Type B Violation).]	D912		