STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011373	A. BUILDING: _____ B. WING _____	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 4	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 conducted an annual survey from 05/27/21 through 06/01/21 with a telephone exit on 06/02/21.	D 000		
D 086	10A NCAC 13F .0306(a)(12) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (12) have at least one telephone that does not depend on electricity or cellular service to operate. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to have an operable telephone that did not depend upon electricity or cellular service. The findings are: Interview with a resident's guardian on 05/27/21 at 10:37am revealed: -The telephone in the facility did not work and had been inoperable for at least 2 weeks. -She had attempted to call the facility several times and the telephone just rang. -The Administrator-in-Charge (AIC) informed her two weeks ago the telephone did not work because there was something wrong with the line. Interview with a resident on 05/27/21 at 2:05 revealed: -The telephone had not been working for 1-2 weeks and had something to do with the internet. -Calls could not be received nor could calls be	D 086		

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D 086	Continued From page 1 dialed out. Interview with a personal care aide (PCA) on 05/27/21 at 2:07pm revealed: -The telephone was not working because there was an issue with the internet. -Eight of the 11 residents had their own personal cell phone. -One resident who did not have a personal cell phone never used the facility telephone. -Another resident who did not have a personal cell phone used a staff's cell phone when she needed to make calls. -The 3rd resident who did not have a personal cell phone used another residents personal cell phone when they needed to make calls. Observation of the facility telephone on 05/27/21 at 2:09pm revealed: -The cordless telephone was located in the dining room on a side-table. -The telephone did not have a dial tone. -When a call was attempted to be made on the telephone a message blinked onto the screen informing the dialer that the line was unavailable. Interview with a 2nd resident on 05/27/21 at 2:10pm revealed: -The facility's telephone had not been working for 3 days but someone was trying to fix it. -There was also a problem a couple months ago with the telephone not working. -She used a staff's cell phone when she wanted to make a call. -Her family was unable to contact her; she had to call them when she could borrow someone's cell phone. Interview with the AIC on 05/27/21 at 2:23pm revealed:	D 086		

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D 086	Continued From page 2 -The facility received a new internet based telephone system 2 months ago. -The telephone company was aware of the problem but said they could not fix it as it was an internet problem. -The telephone stopped working several times since it was installed, most recently 6 days ago. -The residents in the facility that did not have a personal cell phone were supposed to have access to a prepaid cell phone that the Administrator put minutes on. -She did not know why the Administrator had not put minutes on the prepaid cell phone "yet". -Residents knew to go to a sister facility across the street to use the telephone or use someone else's personal cell phone. Interview with another PCA on 05/28/21 at 9:18am revealed: -There was something wrong with the new telephone system that was recently installed. -The Administrator and the phone company were working to fix the issue. -Residents used her personal cell phone. -Families were aware of the telephone issue and were "not too happy about it". -The facility did not have a prepaid cell phone for residents to use that she was aware of. Interview with the Administrator on 05/28/21 at 2:10pm revealed: -The facility had a new internet-based telephone system installed several months ago and the internet signal was not strong enough to operate it. -The local telephone company informed her that their IT department needed to fix the modem. -The facility may need to return to an analog telephone if the new internet-based system did not work consistently.	D 086		

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D 086	Continued From page 3 -Residents knew to use someone's personal cell phone or use the telephone in the main office. -Family members knew to call the office if there was no answer to the telephone in the living room. -She was unaware of a prepaid cell phone that the facility owned that she could purchase minutes for. -She was willing to purchase a cell phone with prepaid minutes for residents to use if that was necessary.	D 086		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure at least one staff was on	D 167		

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D 167	Continued From page 4	D 167		

the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 1 of 1 sampled staff (Staff A).

The findings are:

Review of Staff A's personnel record revealed:
-She was hired as a night shift housekeeper in May 2021.
-There was no documentation of completion of CPR and choking management training or certification.

Interview with the Administrator-in-Charge (AIC) on 05/27/21 at 11:10am and 12:12pm revealed:
-Staff A was new and worked at night as a housekeeper.
-She thought every new employee was trained in CPR when they were hired but she did not know if Staff A was.
-The facility "tried" to have a CPR trained employee in every building.

Interview with the Administrator on 05/27/21 at 11:31am revealed:
-Staff A was a night shift housekeeper and started about 2 weeks ago.
-Staff A worked alone with the residents at night.
-She did not know if Staff A had a current CPR and choking management certification.
-Staff A did not have a complete employee record because she had just started and all the paperwork had not been completed yet for her employment.
-She was responsible for ensuring all employee paperwork was completed.

Telephone interview with Staff A, housekeeper, on 05/27/21 at 12:50pm revealed:

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D 167	Continued From page 5 -She had been hired as a housekeeper "about a week and a half ago". -She was the only staff available to supervise residents in the building during her shift. -She thought she had completed CPR and choking management training but would need to look for her card. _____ The facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management related to Staff A being the only employee supervising residents throughout her shift without CPR certification and choking management training. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/21 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 16, 2021.	D 167		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter.	D 176		

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D 176	Continued From page 6 The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record review and interview the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services and to be free of neglect as related to cardio-pulmonary resuscitation certification and resident rights. The findings are: Interview with the Administrator-in-Charge (AIC) on 05/27/21 at 8:45am revealed there were 11 residents who resided in the home. Interview with the AIC on 05/27/21 between 10:30am and 2:23pm revealed: -She lived across the street from the facility. -The Administrator did not live on site. -The facility was short staffed. -A newly hired staff worked in the facility by herself on third shift and had not been trained "yet".	D 176		

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D 176	Continued From page 7 -The facility did not have a working telephone. Interview with the Administrator on 05/27/21 at 3:05pm revealed: -She lived in a town about an hour away. -She worked Monday through Friday but was available as needed if they were short staffed. -She was responsible for the total operations of the facility. The AIC lived across the street from the facility. -The AIC was the business office manager. Non-compliance was identified in the following rule areas: 1. Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 1 of 1 sampled staff (Staff A). [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)] 2. Based on observation, interview and record review the facility failed to ensure 1 of 1 sampled residents (Resident #2) was free from neglect related to Resident #2 leaving the facility with whereabouts unknown for approximately 16 hours and failing to immediately contact the Resident's guardian, Department of Social Services (DSS) and local law enforcement. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)] The failure of the Administrator to ensure at least one staff was on premise with CPR and to ensure staff were trained on the management of elopement resulted in one resident eloping from	D 176		

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D 176	Continued From page 8 the facility and her whereabouts was unknown for approximately 16 hours. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility failed to provide an acceptable Plan of Protection in accordance with G.S. 131D-34 by 06/01/21. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 01, 2021.	D 176		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure an initial assessment was completed within 72 hours of admission using the Resident Register for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 05/13/21 revealed: -Diagnoses included hydrocephalus due to shunt malfunction, urinary tract infection and depression	D 253		

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D 253	Continued From page 9 with anxiety. -She was semi-ambulatory without the use of an assistive device. -She had episodes of intermittent disorientation. -She had a guardian from the Department of Social Services. -She was admitted to the facility on 05/11/21. Review of Resident #2's resident record revealed: -The record consisted of a file folder containing an FL2 and medications documented on a recent hospital discharge summary. -There was no resident register in the folder. Interview with the Administrator-in-Charge (AIC) on 05/27/21 at 1:39pm revealed: -Resident #2 did not have a resident record "yet" because she moved in 2 weeks ago. -She knew Resident #2 because she lived at the facility in the past. Interview with the Administrator on 05/27/21 at 2:10pm revealed: -She was "new" and did not know where things were in the office. -Resident #2 was a new admission and did not have a resident record. -She did not know where to look for a record. -The AIC did the business office management work. -She was aware that each resident needed a record, including a resident register signed within 72 hours.	D 253		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the	D 315		

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residents' active involvement with each other, their families, and the community.
(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure the development of an activity program which promoted active involvement for 11 residents living at the facility.

The findings are:

Observations during initial tour on 05/27/21 at 8:30am revealed:
-A dry erase calendar board was observed on the wall in the hallway.
-There with 4 activities written on it; 2 with a specific start time and 2 with no information other than the type of activity.
-No month was listed on the calendar.
-The only numbers written in the date boxes for the calendar were 2 -18.

No group activities were observed on 05/27/21 from 8:30am to 5:00pm or on 05/28/21 from 9:00am to 4:30pm.

Interviews with 8 residents on 05/27/21 from 9:02am to 9:49am during the initial tour revealed:
-"We do not have anything to do."
-The staff told us we could go outside and walk, but "I am scared I might fall."
-They did not have any activities.
-"I watch television in my room."

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D 315	Continued From page 11 -The staff used to take them on trips before COVID. -There has not been an activity calendar posted since COVID started. -They had arts and crafts not too long ago and did some painting, but nobody told me about it, so I did not get to do it. -There was not an activity calendar posted. -Activities included cook-outs and shopping. -One resident went shopping one time with a staff person and recently there had been some cook-outs. -The facility provided activities like cook-outs and arts and crafts. -One resident played games on her phone but knew that arts and crafts were available. -Recently there was a dance activity. Interview with the Administrator-in-Charge (AIC) on 05/28/21 at 11:40 revealed: -The May 2021 activity calendar was not filled out but lots of activities happened at the facility, even though they were not listed on the calendar. -Activities consisted of cook-outs with music and food activities. -An activity was done on Mother's Day. -Activities were done individually by residents, as they wanted to do things. -A group of residents were scheduled to attend a local baseball game in a few days. Observation of craft supplies on 05/28/21 at 1:11pm revealed: -Craft supplies were stored on a shelf in the dining room. -Craft supplies consisted of 1 tray of acrylic paints, several pads of art paper, 6 large containers of beads and 1 box that contained rolls of material to string beads.	D 315		

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D 315	Continued From page 12 Second interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm revealed: -They had a Medication Aide (MA) who was responsible for creating and implementing the activity calendar. -She did not know why there was not an activity calendar posted for May 2021. Interview with the Administrator on 05/28/21 at 2:10pm revealed: -One of the MA's was given the responsibility of activities coordinator 2 weeks ago. -No activities were occurring other than cook-outs and shopping and that was discussed with staff. -The activities calendar was not being used recently but the new activities director would be responsible for completing the calendar each month. -Most activities were spontaneous rather than planned. Second interview with the Administrator on 05/28/21 at 2:48pm revealed: -There was an activity white board that should be completed monthly. -There had not been much of an activity plan since COVID. -She spoke with a staff member about making an activity calendar about two weeks ago. -Most activities implemented had been spur of the moment.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 13 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interview and record review the facility failed to ensure 1 of 1 sampled residents (Resident #2) was free from neglect related to Resident #2 leaving the facility with whereabouts unknown for approximately 16 hours and failing to immediately contact the Resident's guardian, Department of Social Services (DSS) and local law enforcement. Review of the facility's Missing Person Checklist revealed: -It defined a missing person as someone who left the facility unexpectedly. -Referred the reader to steps to follow outlined in the policy and procedure manual. -The Administrator, DSS, law enforcement and the missing person's guardian were to be notified. The facility's Elopement/Missing Persons Policy was requested on 05/28/21 but not provided by 06/01/21. Review of Resident #2's current FL2 dated 05/13/21 revealed: -Diagnoses included hydrocephalus due to shunt malfunction, urinary tract infection and depression with anxiety. -She had episodes of intermittent disorientation. -She had a guardian from DSS. -She was admitted to the facility on 05/11/21. Review of Resident #2's resident record revealed there was no resident register or care plan in the file folder. Interviews with the Administrator-in-Charge (AIC)	D 338		

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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 338	Continued From page 14 on 05/27/21 between 8:45am and 11:31am revealed: -Resident #2 was new to the facility, recently had a surgical procedure and sutures were scheduled to be removed on 05/27/21. -Resident #2 refused to sign herself out when she left the facility on 05/26/21 at 11:32pm, refusing to give any information as to her whereabouts. -She found out Resident #2 was missing when she awoke and read a text message from the housekeeper who was working third shift. -She was asleep when the text message was sent and did not hear the text beep. -She was told by the night shift housekeeper Resident #2 went to a friend's house when she reported to work on the morning of 05/27/21. -She did not know how long Resident #2 was expected to be gone. -The housekeeper was supposed to contact the guardian on 05/26/21 after Resident #2 left the facility as well as the administrator and the AIC. -The housekeeper who was working when Resident #2 left was new and did not know how to respond to the incident because she had not been trained. -She was responsible for training the new housekeeper but did not do it. -She contacted Resident #2's guardian at 8:00am to inform her of Resident #2's missing status. -She had not talked with the guardian since she reported Resident #2 missing. -The guardian was "taking care of everything" so she did not contact law enforcement or the local DSS. Review of the facility's sign out register revealed there was no documentation Resident #2 signed out to leave the facility on 05/26/21. Telephone interview with Resident #2's guardian	D 338		

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	HAL011373	A. BUILDING: _____ B. WING _____	06/01/2021

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D 338	Continued From page 15 on 05/27/21 at 10:37am revealed: -She worked for an adjoining county's DSS and was Resident #2's guardian. -Resident #2 lived at the facility previously and just moved back in about 2 weeks ago. -She received a call from the AIC at 8:00am on 05/27/21 informing her that Resident #2 left the facility the previous night. -She did not know what time Resident #2 left but was told by the AIC that she was going to a family member's house. -She made a Silver Alert immediately and then contacted local law enforcement. -Local law enforcement went to the facility to investigate what happened. -She contacted Resident #2's family member but was told she was not there. -She attempted to contact both Resident #2 and her estranged spouse by phone and text but there was no response from either. -The local law enforcement called Resident #2 and she answered the phone, informing him that she was with a family member in a nearby county and provided an address. -Resident #2 called her guardian after speaking with law enforcement, putting a female on the phone who stated she was Resident #2's family member. -The guardian contacted the other family member and was informed that the address provided to the law enforcement was not the family member's address and the person on the phone claiming to be a family member was false information. -She was very concerned about Resident #2's health because she recently had a surgical procedure and was scheduled to have sutures removed 05/27/21, was supposed to be receiving antibiotics to treat an infection and was scheduled to have another surgical procedure on 05/28/21.	D 338		

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D 338	Continued From page 16 Second interview with Resident #2's guardian on 05/27/21 at 11:50am revealed Resident #2 would no longer answer her phone. Interview with the Administrator on 05/27/21 at 11:31am revealed: -She was told at 8:00am on 05/27/21 that Resident #2 left the facility the previous evening and refused to sign herself out. -The housekeeper should have informed Resident #2 that she could not leave in the middle of the night. -Since Resident #2 refused to stay at the facility and refused to sign out giving information about where she was going, the housekeeper should have called the AIC or the Administrator. -The AIC did not train the housekeeper on missing person protocol so she did not know what to do. -The AIC had not trained the housekeeper yet, since she only started about 2 weeks ago. -If the AIC had been called she would have contacted Resident #2's guardian immediately. -Resident #2 lived at the facility previously and had a history of elopement so when she moved into the facility 2 weeks ago she and the AIC spoke with Resident #2 and had her "promise" that she would not do it again. -The incident had been turned over to the guardian so the facility did not need to do anything else. -She did not know how to provide more supervision to or prevent Resident #2 from leaving; "What should I do? Tie her to the bed?". -The facility did not have a care plan for Resident #2 yet because she just moved to the facility 2 weeks ago. Telephone interview with the housekeeper on 05/27/21 at 12:50am revealed:	D 338		

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D 338	Continued From page 17	D 338		

-She started working at the facility 1 1/2 weeks ago as a third shift housekeeper and was never trained.
-Resident #2 was upset the previous evening for an unknown reason and refused to sign out.
-Resident #2 left on foot at 11:32pm.
-She attempted to call and text the AIC who lived down the street from the facility but was unsuccessful in reaching her.
-She did not attempt to contact the Administrator.
-She did not call Resident #2's guardian because she did not have a phone number.

Second interview with the Administrator on 05/27/21 at 3:05pm revealed:
-The facility's policy on resident elopement/missing persons listed who needed to be contacted.
-When she found out earlier in the morning that Resident #2 was missing, she asked the AIC if law enforcement or anyone else needed to be called per the missing person policy.
-The AIC informed her that law enforcement did not need to be contacted because she already called the guardian and she would "tend to it from here".
-She never contacted the guardian because the AIC called her earlier in the morning.
-She was not planning to contact the guardian because the guardian was "taking care of everything".
-She spoke with law enforcement when they came to investigate at the request of the guardian and there was nothing else she needed to do.

Telephone interview with Resident #2's guardian on 05/27/21 at 3:45pm revealed:
-Resident #2 was located by law enforcement, just a bit ago in an adjoining county, when she answered her phone and provided a location.

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D 338	Continued From page 18 -Law enforcement went to the location provided and Resident #2 did not want to leave. -Resident #2 was with people she knew when she was growing up; one of them was a known felon. -Resident #2 was not planning to return to the facility. Interview with a AIC on 05/28/21 at 11:07am and 11:40am revealed: -Per the facility's policy on elopements/missing persons, the first person she was to call was the guardian and then if the guardian wanted her to, she would contact law enforcement. -If the guardian wanted to, they would contact law enforcement. -Per policy she should then notify the local DSS and the Administrator. -She did not she did not think she needed to call the local DSS because the guardian was with an adjoining county's DSS. -If the guardian had been "far away" she would have contacted the local DSS. -The guardian "took over" so she did not contact law enforcement, DSS or anyone else listed on the elopement/missing person policy. -She knew Resident #2 as she had lived at the facility in the past and had an elopement history. -Normally she did call the guardian, DSS and local law enforcement but Resident #2 lived at the facility before and was 'just different; she was known to do this". -If it had been any other resident she would have followed the facility's policy and procedure. _____ The facility failed to immediately contact the guardian, Department of Social Services and the local law enforcement when Resident #2, who had a history of elopement and was documented as intermittently disoriented, left the facility, was missing for approximately 16 hours and her	D 338		

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D 338	Continued From page 19 whereabouts was unknown. This failure resulted in serious neglect and constitutes a Type A1 violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 by 06/01/21. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 01, 2021.	D 338		
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; (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).	D 367		

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D 367	Continued From page 20 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration record (MAR) for 1 of 3 sampled residents (Resident #3) related to documenting the administration of Xigduo (used to treat diabetes), Lovaza (used to lower cholesterol) and Benztropine (used to treat involuntary movements such as tremors and muscle spasms). The findings are: Review of Resident #3's current FL2 dated 06/15/20 revealed diagnoses included diabetes and schizoaffective disorder. a. Review of a physician order for Resident #3 revealed Xigduo XR 10 milligrams - 1,000mg tablet twice daily. Review of Resident #3's April 2021 Medication Administration Record (MAR) revealed: -There was an entry for Xigduo XR 10 mg -1,000 mg tablet take one tablet twice daily with meals at 8:00am and 5:00pm. -Xigduo was not documented as administered for 18 of 60 opportunities from 04/01/21 through 04/30/21. Review of Resident #3's May 2021 MAR revealed: -There was an entry for Xigduo XR 10 mg -1,000 mg tablet take one tablet twice daily with meals at 8:00am and 5:00pm. -Xigduo was not documented as administered for 1 of 52 opportunities from 05/01/21 through 05/27/21 due to "medication requires prior authorization - not received by pharmacy."	D 367		

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D 367	Continued From page 21 Review of medications on hand revealed Xigduo was available for administration. Telephone interview with the contracted Pharmacist on 05/28/21 at 11:38am revealed: -The Xigduo was are on a cycle system. -The facility did not call in scheduled medications. -Medications are automatically refilled monthly until we receive an order from the physician to discontinue the medication. Interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm revealed: -The facility has been short-staffed, and she has been administering medications in multiple buildings. -She has not always signed off on medications immediately after administering them to residents. -She may be forgetting to sign off that she has administered medications throughout the day. Refer to interview with Administrator on 05/28/21 at 2:48pm. b. Review of a physician order for Resident #3 revealed Lovaza 1 gram capsule take 2 capsules twice daily. Review of Resident #3's April 2021 MAR revealed: -There was an entry for Lovaza 1g capsule take two capsules by mouth twice daily at 8:00am and 8:00pm. -Lovaza was not documented as administered for 13 of 60 opportunities from 04/01/21 through 04/30/21. Review of Resident #3's May 2021 MAR revealed:	D 367		

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D 367	Continued From page 22 -There was an entry for Lovaza 1g capsule take two capsules by mouth twice daily at 8:00am and 8:00pm. -Lovaza was not documented as administered for 4 of 52 opportunities from 05/01/21 through 05/27/21. Review of medications on hand revealed Lovaza was not available for administration. Telephone interview with the contracted Pharmacist on 05/28/21 at 11:38am revealed: -The facility did not call in scheduled medications. -Medications are automatically refilled monthly until we receive an order from the physician to discontinue the medication. -The Lovaza was never approved for prior authorization and was never sent to the facility. Interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm revealed: -The facility has been short-staffed, and she has been administering medications in multiple buildings. -The pharmacy was still working on getting a prior approval for the Lovaza. -Resident #3 has never taken the Lovaza because it was never approved through her insurance. -She should have documented correctly on the MAR each time the Lovaza was ordered that it was not available. Refer to interview with Administrator on 05/28/21 at 2:48pm. c. Review of a physician order for Resident #3 revealed Benztropine 1mg tablet take 1 tablet three times daily.	D 367		

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D 367	Continued From page 23 Review of Resident #3's April 2021 MAR revealed: -There was an entry for Benztropine 1 mg tablet take 1 tablet by mouth three times daily. -Benztropine was not documented as administered for 4 of 90 opportunities from 04/01/21 through 04/30/21. Review of Resident #3's May 2021 MAR revealed: -There was an entry for Benztropine 1 mg tablet take 1 tablet by mouth three times daily. -Bentropine was not documented as administered for 10 of 78 opportunities from 05/01/21 through 05/27/21. Review of medications on hand revealed Benztropine was available for administration. Telephone interview with the contracted Pharmacist on 05/28/21 at 11:38am revealed: -The Benztropine was on a cycle system. -The facility did not call in scheduled medications. -Medications are automatically refilled monthly until we receive an order from the physician to discontinue the medication. Interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm revealed: -The facility has been short-staffed, and she has been administering medications in multiple buildings. -She has not always signed off on medications immediately after administering them to residents. -She was responsible to sign off on all 10 of the 2:00pm Benztropine administrations for Resident #3. -Sometimes the computer was down in the afternoon.	D 367		

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D 367	Continued From page 24 -She was sure she had been administering the 2:00pm Benztropine daily to Resident #3. -She may be forgetting to sign off that she has administered medications throughout the day. Refer to interview with Administrator on 05/28/21 at 2:48pm. _____ Interview with the Administrator on 05/28/21 at 2:48pm revealed: -Medications should be documented correctly on the MAR. -She had not been aware there was documentation missing on the MAR's for April and May 2021. -She had assumed that the Medication Aide (MA) or the Resident Care Coordinator (RCC) were checking the MAR's for missing documentation. -There should always be documentation on the MAR for why a medication is not given. -The MA's are responsible to accurately document medications received on the MAR.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the	D 375		

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D 375	Continued From page 25 medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure 1 of 1 resident (Resident #3) had physicians' orders to self-administer an inhaled medication. The findings are: Review of physician's orders dated 11/05/20 revealed an order for ProAir HFA 90 mcg inhale 2 puffs every four hours as needed for shortness of breath or wheezing. Review of Resident #3's current FL2 dated 06/15/20 revealed diagnoses included diabetes, gastric reflux, and headaches. Observation of Resident #3's private room on 5/27/21 at 9:16am revealed an inhaler was on the desk. Review of Resident #3's record revealed no documentation of a self-administration of medication assessment and no physician's order to self-administer medications. Review of the electronic Medication Administration Record (eMAR) for April 2021 revealed: -There was not an entry for administration of ProAir by staff. -No documentation was present the inhaled medication was self-administered. Review of the eMAR for May 2021 revealed:	D 375		

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 375	Continued From page 26 -There was not an entry for administration of ProAir by staff. -No documentation was present the inhaled medication was self-administered. Interview with Resident #3 on 5/27/21 at 9:16am revealed: -She used the medication as an emergency inhaler. -She self-administered her inhaler. -She did not tell staff when she used her inhaler. -She most recently used her inhaler three times on 05/26/21. Observation of medication on hand on 05/27/21 at 4:22pm revealed there was no ProAir on the medication cart available for administration. Interview with Resident #3 on 5/28/21 at 9:52am revealed: -She used the inhaler as her rescue inhaler when she was short of breath. -She was in the hospital for seizures, chest pain and shortness of breath a few weeks ago and after she returned to the facility, had asked the Medication Aide (MA) if she could keep the inhaler in her room. Telephone interview with Resident #3's Guardian on 5/28/21 at 11:23am revealed: -She has been Resident #3's Guardian for over 10 years and spoke with her at least twice weekly. -She was not aware of any physician orders for Resident #3 to self-administer her inhaled medications. Interview with the Administrator in Charge (AIC) on 05/28/21 at 11:45am revealed: -She was not aware there was an inhaler in	D 375		

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D 375	Continued From page 27 Resident #3's room. -She thought a previous MA who no longer worked at the facility must have given Resident #3 the inhaler to keep in her room. -The MA should have called to get a self-administration order from the physician. -The MA should not have given the inhaler to Resident #3 to self-administer and keep in her room. Interview with the Administrator on 05/28/21 at 2:48pm revealed: -Residents were not allowed to have medications in their rooms. -All medications were kept on the medication cart. -The MA should have made sure there was an assessment to self-administer medications and a physician's order to self-administer medication in Resident #3's chart before giving her the inhaler. -She had not been aware Resident #3 was keeping the inhaler in her room and self-administering the medication.	D 375		
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 observations, interviews and record	D 392		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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review the facility failed to ensure a readily retrievable record that accurately reconciled the administration of controlled substances for 2 of 3 residents (Resident #1 and #3).

The findings are:

1. Review of Resident #1's current FL2 dated 05/06/21 revealed diagnoses included arthritis, fibromyalgia, bipolar disorder and intervertebral disc degeneration.

a. Review of the physician's orders for Resident #1 dated 05/19/21 revealed an order for Clonazepam (used to treat anxiety) 0.5 mg tablet take one tablet every morning.

Review of Resident #1's electronic Medication Administration Record (eMAR) for May 2021 revealed:
-Clonazepam 0.5 mg was documented as administered for 9 of 9 opportunities from 05/19/21 - 05/27/21.

Review of Resident #1's controlled substance (CS) log for Clonazepam for May 2021 revealed:
-Clonazepam 0.5mg was not documented as administered from 05/25/21 through 05/27/21 at 8:00am.
-The medication amount remaining as of 5/24/21 at 8:00am was 26 which matched medication available on hand.

b. Review of the physician's orders for Resident #1 dated 05/19/21 revealed an order for Pregabalin (used to treat pain) 75 mg capsule - take 2 capsules by mouth twice daily for pain.

Review of Resident #1's eMAR for May 2021 revealed Pregabalin 75mg - two capsules were

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documented as administered for 17 of 17 opportunities from 05/19/21 - 05/27/21.

Review of Resident #1's CS log for Pregabalin for May 2021 revealed:
-Pregabalin 75 mg (2 capsules) was not documented as administered from 5/24/21 through 05/27/21 at 8:00am.
-The medication amount remaining as of 5/23/21 at 8:00pm was 23 which matched medication available on hand.

c. Review of the physician's orders for Resident #1 dated 05/19/21 revealed an order for Zolpidem (used to treat insomnia) 10 mg tablet - take 1 tablet by mouth at bedtime.

Review of Resident #1's eMAR for May 2021 revealed Zolpidem 10mg was documented as administered for 8 of 8 opportunities from 05/19/21 through 05/26/21.

Review of Resident #1's CS log for Zolpidem for May 2021 revealed:
-Zolpidem was not documented as administered from 05/24/21 through 05/26/21 at 8:00pm.
-The medication amount remaining as of 05/23/21 at 8:00pm was 27 which matched medication available on hand.

Refer to telephone interview with the contracted Pharmacist on 05/28/21 at 11:38am.

Refer to interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm.

Refer to interview with the Administrator on 05/28/21 at 2:48pm.

2. Review of Resident #3's current FL-2 dated

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D 392	Continued From page 30 06/15/20 revealed diagnoses included schizoaffective disorder and seizures. Review of the physician's orders for Resident #3 dated 04/26/21 revealed an order for Lorazepam (treats anxiety) 1mg tablet take 1 tablet every morning. Review of Resident #3's eMAR for May 2021 revealed Lorazepam 1mg was documented as administered for 27 of 27 opportunities from 05/01/21 through 05/27/21. Review of Resident #3's CS log for Lorazepam for May 2021 revealed: -Lorazepam was not documented as administered from 5/25/21 through 05/27/21. -The medication amount remaining as of 05/24/21 was 26 which matched medication available on hand. Refer to telephone interview with the contracted Pharmacist on 05/28/21 at 11:38am. Refer to interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm. Refer to interview with the Administrator on 05/28/21 at 2:48pm. _____ Telephone interview with the contracted pharmacist on 05/28/21 at 11:38am revealed all scheduled controlled substances were on an automatic re-order to the facility as long as there is a valid script from the physician. Interview with the Administrator in Charge (AIC) on 05/28/21 at 1:45pm revealed: -She was administering the medications for	D 392		

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D 392	Continued From page 31 Residents #1 and #3 as ordered but was not signing off on them immediately. -She should have signed off on the CS log after administering the medication. -She was the only MA administering medications so the controlled medications were not being counted daily. Interview with the Administrator on 05/28/21 at 2:48pm revealed: -She was not aware the eMAR and the CS logs did not match for Resident #1. -She was not aware the eMAR and the CS logs did not match for Resident #3. -The MA should scan the medication before it was removed from the bubble pack and then document on the CS log after the medication is administered. -The Resident Care Coordinator (RCC) or Medication Aide (MA) should have been checking to make sure the CS log matched what was available on the bubble pack. -She "assumed" the RCC/MA was doing this.	D 392		
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, record reviews and interviews the facility failed to ensure the residents received care and services that were adequate, appropriate and in compliance with relevant federal and state laws and rules and	D912		

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D912	Continued From page 32 regulations related to staff qualifications. The findings are: Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months for 1 of 1 sampled staff (Staff A). [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	D912		
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 observation, record review and interview the facilty failed to ensure all residents were free from neglect as related to a resident who left the facility and whereabouts was unknown for 16 hours and Management of Facilities with a Capacity or Census of Seven to thirty Residents. The findings are: 1. Based on observation, interview and record review the facility failed to ensure 1 of 1 sampled residents (Resident #2) was free from neglect as related to Resident #2 leaving the facility with whereabouts unknown for approximately 16 hours and failing to immediately contact the	D914		

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D914	Continued From page 33 Resident's guardian, Department of Social Services (DSS) and local law enforcement. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 2. Based on observation, record review and interview the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services and to be free of neglect as related to cardio-pulmonary resuscitation certification and resident rights. [Refer to Tag D176 10A NCAC 13F .0601 Management of Facilities with a Capacity or Census of Seven to thirty Residents (Type A1 Violation)].	D914		