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 08/24/2022

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 conducted a follow-up survey onsite on 08/23/22 and desk review 08/24/22 with an exit via telephone on 08/24/22.	{D 000}		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to ensure two medication aides observed 2 of 3 sampled residents (Resident #1 and #2) taking medications administered, related to one resident who held back three doses of a medication used to treat bipolar disorder and then taking all of the medication at once with the intent to commit suicide (#1) and a second resident whose daily medications were left on the resident's bedside table in his room (#2). The findings are: Review of the facility's policy on medication	D 366		

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administration revealed staff will provide documentation on the eMAR after observing the resident taking their medications and before administration to another resident.

1. Review of Resident #1's FL2 dated 01/25/22 revealed diagnoses included bipolar disorder, current episode depressed severe without psychotic features, suicidal ideation, and dependent personality features.

Review of Resident #1's primary care provider's medication orders dated 05/13/22 revealed:
-There was an order for olanzapine (used to treat bipolar disorder) 5mg 1 tablet daily at bedtime.
-There were no other scheduled medications to be administered at bedtime.

Review of Resident #1's July 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for olanzapine 5mg 1 tablet daily scheduled at 8:00pm.
-The olanzapine was documented as administered as ordered from 07/01/22 to 07/31/22 for 25 occurrences out of 31 opportunities.
-On 07/13/22 to 07/17/22, the olanzapine was documented as not administered due to the resident being in the hospital.
-On 07/29/22, the olanzapine was documented as not administered due to the resident being out of the facility.

Review of Resident #1's Resident Register dated 02/02/22 revealed:
-The resident was admitted to the facility on 01/04/22.
-The resident was his own responsible person.

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Review of Resident #1's Care Plan dated 08/09/22 revealed the resident was oriented with adequate memory.

Review of Resident #1's Accident and Incident Report dated 07/14/22 revealed:
-Resident #1 reported to staff while in facility hallway he was depressed.
-Resident #1 reported thoughts of self-harm with no plan.
-Resident #1 requested to go to the emergency room.
-Resident #1 was taken to a local hospital for evaluation and treatment.

Interview with Resident #1 during the initial tour on 08/23/22 at 9:10am revealed:
-He wanted to kill himself "a month or so ago."
-He held back a "couple" doses of his sleeping medicine and then took them all at one time.
-The medication just made him sleep a long time.
-He told a personal care aide (PCA) he wanted to kill himself and the staff sent him to the hospital.

Interview with Resident #1 on 08/23/22 at 10:40am revealed:
-A medication aide (MA) had administered his scheduled bedtime medications, had given him his medication in a cup and did not watch him take the medication.
-He took the medication in the cup to his room.
-He did not take the medication for 3-days and then took it all at once.
-On 07/13/22, he told a PCA he wanted to kill himself and he wanted to go to the hospital.
-The PCA immediately called 911 to take him to the hospital for evaluation.
-He left the facility right before lunch to go to the hospital.
-When he returned to the facility after being

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discharged from the hospital, he told the MA who had administered the medication, he had held 3 doses and took it at one time.

Observation of Resident #1's medications on hand on 08/23/22 at 10:51am revealed:
-There was one bubble pack of olanzapine 5mg tablets with three tablets remaining.
-There was a second bubble pack of olanzapine 5mg tablets with thirty tablets remaining.

Review of Resident #1's discharge instructions dated 07/18/22 revealed:
-The discharge diagnoses included bipolar disorder, current episode depressed, severe, without psychotic features, and anxiety.
-Resident #1 arrived via law enforcement for evaluation of suicidal ideation.
-The resident reported feeling depressed "the past few days."
-The resident thought about ending his life by taking sleeping pills and overdosing.

Interview with an MA on 08/23/22 at 11:45am revealed:
-Resident #1 was sent out to the hospital for evaluation for suicidal ideation on 07/13/22.
-She had documented the wrong date (07/14/22) on Resident #1's Accident and Incident Report.
-It was her initials on Resident #1's eMAR which documented administration of olanzapine 5mg 1 tablet at 8:00pm from 07/04/22 to 07/12/22.
-Resident #1 routinely took his medications without any problems.
-She watched to make sure each resident took their medications.
-She had each resident stand in front of her when she administered medications.
-She watched each resident swallow their medications.

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D 366	Continued From page 4 -Resident #1 told her "a long time ago" he had held multiple doses of a medication and took it all at one time. -The incident had occurred long before she worked as an MA at the facility. Interview with a PCA on 08/23/22 at 11:55am revealed: -Resident #1 came to him on 07/13/22 and told him he wanted to kill himself. -He immediately called 911 and stayed with Resident #1 until EMS arrived. -Resident #1 was taken to the hospital. -Resident #1 was good about taking his medications. -They had not had any trouble or any reason to believe Resident #1 was holding medications, and not taking them. -Resident #1 never reported to him an incident of holding medications and taking multiple doses of a medication at one time with the intent to harm himself. Interview with a second MA on 08/23/22 at 12:50pm revealed Resident #1 never gave her any trouble with taking his medications. Interview with the Administrator on 08/23/22 at 3:24pm revealed: -The MAs were supposed to observe the residents taking their medications prior to documenting the administration. -Resident #1 had not ever told her he had held back three doses of his bedtime medication and then took all three tablets of the medication at one time. -A couple of days prior to Resident #1 going to the hospital with the intent of harming himself on 07/13/21, he told her he was "feeling down." -She offered to arrange a mental health	D 366		

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appointment, but he did not want that.
-Resident #1 already had a mental health appointment coming up.
-Resident #1 had access to his mental health professionals to speak with him Monday through Friday 8:00am to 6:00pm.
-Resident #1 could have asked for an appointment and the facility would arrange to find someone to speak with Resident #1 as quickly as possible.
-Resident #1 arranged his own transportation to and from his mental health appointments.
-On 07/13/22, she ran into Resident #1 walking down the hill towards the office and she stopped and spoke with him.
-Resident #1 told her he was feeling down and wanted to kill himself.
-Resident #1 did not have a plan when she spoke with him.
-They immediately sent Resident #1 out to the hospital for evaluation and treatment.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/24/22 at 11:27am revealed:
-Resident #1 taking a one-time 15mg dose of olanzapine did not pose a significant risk of side effects.
-A dose of 15mg of olanzapine was not significantly higher than the 5mg dose Resident #1 was ordered to take.

Telephone interview with the Resident Care Coordinator (RCC) on 08/24/22 at 11:27am revealed:
-Resident #1 told staff he wanted to hurt himself, but he did not have a plan.
-Resident #1 wanted to go to the hospital.
-The staff immediately sent Resident #1 out to the hospital.

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-Resident #1 had not exhibited any types of behaviors prior to 07/13/22.
-He was a model resident.
-Resident #1 never reported to her he had held back medication and then had taken the medication at one time.
-She had no knowledge of Resident #1 having any prior history of holding medications.
-Staff did not report any knowledge of Resident #1 not taking his medications.
-The facility policy was for the MAs to watch residents take their medications and drink water after the medications.
-The facility did have a cheeking protocol.
-The protocol involved requiring residents to drink a whole cup of water after taking medications, wait 10 minutes, and then have the resident open their mouths to let staff see inside to ensure the medications were swallowed.

2. Review of Resident #2's current FL2 dated 01/07/22 revealed diagnoses included major depressive disorder, anxiety, hypertension, and gastroesophageal reflux disease.

Review of Resident #2's current Resident Register dated 08/04/21 revealed:
-An admission date of 08/09/19.
-He had a designated responsible person.

Review of Resident #2's physician's orders dated 01/07/22 revealed:
-There was a medication order for amlodipine (used to treat high blood pressure) 10mg take 1 tablet daily.
-There was a medication order for acetaminophen (used to treat minor aches and pain) 325mg take 2 tablets daily.
-There was a medication order for sertraline (used to treat depression) 100mg take 2 tablets

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daily.
-There was a medication order for sucralfate (used to treat ulcers) 1 gram take 1 tablet twice daily.
-There was no order Resident #2 could self-administer medications.

Review of Resident #2's physician's orders dated 06/20/22 revealed:
-There was a medication order for metoprolol (used to treat chest pain and high blood pressure) 100mg take 1 tablet twice daily.
-There was a medication order for pantoprazole (used to treat ulcers and gastroesophageal reflux disease) 20mg take 1 tablet daily.
-There was a medication order for lisinopril (used to treat high blood pressure) 2.5mg take 1 tablet daily.
-There was no order Resident #2 could self-administer medications.

Observation upon initial tour of the facility on 08/23/22 at 8:55am revealed:
-The door to Resident #2's bedroom was open.
-Resident #2 was lying on his bed with his eyes closed.
-There was a medication cup containing 9 pills setting on the bedside table in Resident #2's room.

Interview with Resident #2 on 08/23/22 at 8:55am revealed:
-The medication aide (MA) brought him the medication cup with the pills earlier that morning and left the medications for him to self-administer.
-He forgot to take the medications and left them setting on the bedside table.
-Staff left his medications in his room for him to self-administer "all the time".

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D 366	Continued From page 8 Review of Resident #2's August 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 10mg take 1 tablet daily with documentation as administered on 08/23/22 at 8:00am. -There was an entry for acetaminophen 325mg take 2 tablets every morning with documentation as administered on 08/23/22 at 8:00am. -There was an entry for lisinopril 2.5mg take 1 tablet daily with documentation as administered on 08/23/22 at 8:00am. -There was an entry for metoprolol 100mg take 1 tablet daily with documentation as administered on 08/23/22 at 8:00am. -There was an entry for pantoprazole 20mg take 1 tablet daily with documentation as administered on 08/23/22 at 8:00am. -There was an entry for sertraline 100mg take 2 tablets daily with documentation as administered on 08/23/22 at 8:00am. -There was an entry for sucralfate 1 gram take 1 tablet twice daily with documentation as administered on 08/23/22 at 8:00am. Interview with the MA on 08/23/22 at 11:00am revealed: -She handed Resident #2 his scheduled morning medications around 8:30am on 08/23/22 and did not watch Resident #2 take the medications. -Resident #2 must have taken his medications back to his room and left the medications setting on the bedside table. -Sometimes residents would take their medications back to their rooms and self-administer the medications. -She knew she was supposed to watch residents swallow their medications when she administered medications to the residents.	D 366		

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D 366	Continued From page 9 -She thought Resident #2 had taken his scheduled morning medications. Interview with the Administrator on 08/23/22 at 3:20pm revealed: -She did not know why there was a medication cup containing 9 pills in Resident #2's room at 8:55am on 08/23/22. -MAs were not supposed to leave medications in resident rooms unless a resident had a physician's order to self-administer medications. -Resident #2 did not have a physician's order to self-administer medications. -The facility's policy for medication administration included to scan the medication bubble pack card, check the card with the eMAR 3 times to make sure the medications were to be administered, and administer the medications to the residents while observing the residents swallowed the medications. -She expected the MA to follow the facility's policies and procedures for medication administration. _____ The facility failed to ensure medications were administered as ordered by not observing two residents take their medications which resulted in one resident who held back three doses of a medication used to treat bipolar disorder and took all three doses at once with the intent to commit suicide (#1) and another resident's nine morning medications were not administered and left in a medication cup in his room (#2) which was easily accessible to other residents. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/24/22 for this violation.	D 366		

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D 366	Continued From page 10 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 8, 2022.	D 366		
{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 observation, interviews, and record reviews, the facility failed to ensure two medication aides observed 2 of 3 sampled residents (Resident #1 and #2) taking medications administered, related to one resident who held back three doses of a medication used to treat bipolar disorder and then taking all of the medication at once with the intent to commit suicide (#1) and a second resident whose daily medications were left on the resident's bedside table in his room (#2). [Refer to Tag 366 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)]	{D912}		