Rec'd via email 9/30/23

PRINTED: 09/18/2023
FORM APPROVED

Division of Health Service Regulation

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 ______	R 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 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 and follow up survey on 08/29/23 to 08/31/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 3 medication aides (Staff A) who administered medications completed the 5, 10 or 15 hour medication aide training within 60 days from date of hire. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 06/12/23 as a MA. -There was documentation Staff A passed the MA written exam on 10/31/17.	D 125	ED will manage all staff files. Upon hire, all medication aides will complete the 5 + 10 hour courses before permitted to work on med cart as med aide. All staff files will be in ED office + will be audited monthly.	9/30/23

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lacey Russell	Administrator	9/28/23

STATE FORM 6899 LF3511

Reviewed + acknowledged Renate Pacheco 10/3/23

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D 125	Continued From page 1	D 125		

-There was documentation Staff A completed a medication clinical skills checklist dated 08/08/23.
-There was no documentation of a 5, 10 or 15 hour MA training.

Review of a resident's electronic Medication Administration Record (eMAR) for August 2023 revealed Staff A documented she administered medications to the resident on 08/29/23 at 8:00am.

Interview with the Clinical Administrator on 08/30/23 at 2:57pm revealed:
-Staff A administered medications to residents in the facility.
-She knew Staff A completed the 15 hour MA training but did not know where the documentation was.
-Staff A started the 15 hour training after she was hired but did not complete it.
-She did not know why Staff A did not complete the training.
-The Administrator was responsible for ensuring staff received the required training.

Interview with the Administrator on 08/30/23 at 2:48pm revealed:
-She was not aware Staff A did not have the 15 hour MA training.
-The Clinical Administrator was responsible for ensuring required training is completed and the documentation is in the personnel record.
-She was responsible for auditing personnel records and had done so twice since April 2023.

Attempted telephone interview with Staff A on 08/31/23 at 8:10am was unsuccessful.

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D 273	Continued From page 2	D 273		
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 observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 3 sampled residents related to orders for physical therapy (PT) (Resident #3), orders for lab work and a follow-up appointment at a pain center (Resident #2) and orders for an ophthalmology appointment (Resident #1). The findings are: 1. Review of Resident #3's current FL2 dated 10/18/22 revealed: -Diagnoses included chronic lung disease, muscle weakness and fatigue. -Resident #3 was independent with ambulation and required limited assistance with bathing. Observation of Resident #3 on 08/29/23 at 8:32am during initial tour revealed Resident #3 was wearing a right arm/shoulder sling. Review of Resident #3's physician orders revealed: -An order dated 05/01/23 for PT evaluation and treatment of resting tremor. -An order dated 07/24/23 for PT evaluation and treat for ataxic gait (poor muscle control resulting	D 273	All PCP/MD visit notes are reviewed by RCC immediately upon receipt and all referrals will be sent same day and followed upon by RCC within 24-48 hours. RCC will report any referrals, labs orders to ED after they are scheduled + transport service has	9/30/23

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D 273	Continued From page 3 in difficulty walking), resting tremor and age-related physical debility. Interview with Resident #3 on 08/30/23 at 2:57pm revealed: -She had not received PT within the past year. -She had passed out and fell in the bathroom on 07/18/23 and fractured her right shoulder. -She knew her nurse practitioner (NP) had ordered PT after her fall on 07/18/23. -She did not understand why her PT had not started yet. Interview with the Clinical Administrator (CA) on 08/30/23 at 1:24pm revealed: -She was not aware of the PT order dated 05/01/23 for Resident #3. -She was aware of the PT order dated 07/24/23 for Resident #3 because it was written by the NP a few days after Resident #3's fall when she fractured her right shoulder. -There had been an issue trying to fax the order to the PT provider because the facility was not set up to fax long distance. -There was a lot going on in the facility and she had some issues getting everything to the PT provider. -Resident #3 did not receive PT after the 05/01/23 NP order. -Resident #3 did not receive PT after 07/24/23 NP order. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -She was unaware the NP had ordered PT for Resident #3 on 05/01/23 or 07/24/23. -Resident #3 should have had an evaluation for therapy after the original order on 05/01/23 was written. -The CA should have followed up with the PT	D 273	been established. all appts will be added to resident's Emar Calendar as well as maintained in a Calendar in ED's office to ensure proper organization of appts. lab providers will be asked to document all draws in a binder located in front office. Binder will be establish for all PT/OT providers to document visits →	

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D 273	Continued From page 4 provider and the NP to start services for Resident #3 before now. Telephone interview with the NP on 08/31/23 at 9:00am revealed: -There was a possibility if Resident #3 had PT when he first ordered it on 05/01/23, she may not have had the fall on 07/18/23 which resulted in a right humerus fracture. -He had written an order on 07/24/23 for Resident #3 to have a PT evaluation and treatment. -He was very frustrated with not being able to get therapy services for his residents at the facility timely. -He took the initiative this week and met with the PT provider on 08/28/23 to assist in arranging services for all residents that needed therapy at the facility. 2. Review of Resident #2's current FL-2 dated 05/22/23 revealed diagnoses included chronic lung disease, high blood pressure and angina (chest pain). Interview with Resident #2 on 08/29/23 at 8:44am during initial tour revealed she was resting in bed because she stated her back was hurting. A. Review of Resident #2's physician orders dated 07/24/23 revealed an order for a follow-up appointment at a local pain center for spondylosis of the lumbar region (low back pain due to deterioration of the spinal column). Interview with the CA on 08/30/23 at 11:05am and 1:24pm revealed: -Resident #2 had chronic back pain. -When an order was written, the NP gave it to her. -She made a copy for herself, then gave the	D 273	and keep @ front office so that RCC/ED can ensure visits are being made as ordered.	

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orders to the Business Office Manager (BOM) to call and schedule the appointment and arrange for transportation for the resident.
-After reviewing her notes, the last appointment Resident #2 had with the pain clinic was on 04/07/23.
-She was unsure why the appointment to the pain clinic was not scheduled.

Interview with the Administrator on 08/30/23 at 3:25pm revealed:
-She was not aware Resident #2 had a follow-up appointment for pain management.
-The CA was responsible for following up with the BOM to ensure appointments were being scheduled.

Telephone interview with the NP on 08/31/23 at 9:00am revealed:
-He was not aware Resident #2 had not had her follow-up appointment for pain management.
-Resident #2 was supposed to have an x-ray of her spine during the appointment at the pain clinic.

B. Review of Resident #2's physician orders dated 05/29/23 revealed:
-An order for a CBC (complete blood count) to determine the health of blood cells.
-An order for TSH (thyroid stimulating hormone) to determine thyroid function.
-An order for Free T4 (free thyroid) used along with TSH to determine thyroid function.
-An order for Hgb A1c (hemoglobin) blood test to determine glucose levels.
-An order for Lipid Panel used to monitor fat molecules circulating in the blood.
-An order for Vitamin D used for vitamin deficiency and prevention of osteoporosis (bone loss).

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D 273	Continued From page 6 -An order for B-12 used for vitamin deficiency and increases red blood cell production. -An order for Folic Acid used for vitamin deficiency and assists in red blood cell production. Review of Resident #2's medical record revealed no labs that included CBC, TSH, Free T4, Hgb A1c, Lipid Panel, Vitamin D, B-12 and Folic Acid were completed after 05/29/23. Interview with the CA on 08/30/23 at 1:24pm revealed: -The NP got the lab report directly from the lab company. -She was sure the order written on 05/29/23 for Resident #2's labs was completed. Interview with the NP on 08/31/23 at 9:00am revealed: -There had been some difficulty receiving lab work from the previous company the facility used for laboratory services. -He took the initiative to find a different company and the facility changed to a new lab company a few weeks ago. -He never received a report that the labs he ordered for Resident #2 on 05/29/23 were completed. -Receiving lab work had been an ongoing issue that should improve with the new lab company. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -The lab work for Resident #2 should have been completed as soon as possible after it was ordered by the NP. -She was not aware the lab work for Resident #2 did not occur. -The CA was responsible for following up to	D 273		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 95 RICHMOND HILL ROAD, ASHEVILLE, NC 28806

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ensure orders for lab work were carried out.

3. Review of Resident #1's current FL2 dated 08/16/23 revealed a diagnosis of Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose)).

Review of a physician's order for Resident #1 dated 04/10/23 revealed Ophthalmology consult for examination of eyes and vision.

Review of Resident #1's record revealed:
-There was a summary of an Ophthalmology eye exam dated 04/20/22.
-There was no other documentation of an Ophthalmology eye exam.

Interview with a medication aide (MA) on 08/30/23 at 8:15am revealed:
-She could not recall if Resident #1 had been to the eye doctor.
-She gave all paperwork to the Clinical Administrator after a resident came back to the facility from a medical appointment.
-It was the Clinical Administrator or Administrator's responsibility to schedule medical appointments.

Telephone interview with a second MA on 08/30/23 at 8:45am revealed:
-She gave all paperwork to management when a resident returned from a medical appointment.
-She did not know if Resident #1 had been to the eye doctor.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/30/23 at 9:05am revealed:
-He was not aware Resident #1 had not been to the Ophthalmologist as he ordered on 04/10/23.

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-Resident #1 was a diabetic and needed to have an eye exam every year because he was at risk of diabetic retinopathy (damage to the blood vessels at the back of the eye caused by poorly controlled blood glucose).

Interview with the Administrator on 08/30/23 at 9:14am revealed:
-It was the Clinical Administrator's responsibility to schedule referrals by telephoning or faxing the referral to the medical office and writing down the appointment time.
-Chart audits were completed weekly.
-She never saw the order for the Ophthalmology consult and did not know why it was not done.

Interview with Resident #1 on 08/29/23 at 10:05am revealed he had not been to the eye doctor or opthalmologist in 2023.

Attempted telephone interview with the Ophthalmology office on 08/30/23 at 8:32am was unsuccessful.

____

The facility failed to ensure a resident had health care referral and follow up for a Resident (#3) with two orders for physical therapy that were not processed and a fall which resulted in a right humerus fracture. This failure placed residents at substantial risk for serious physicial harm and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/30/23 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2023.

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D 276	Continued From page 9	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement a physician's order for 1 of 3 sampled residents (Resident #1) related to the application and removal of compression hose. The findings are: Review of Resident #1's current FL2 dated 08/16/23 revealed diagnoses included Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose) and congestive heart failure (CHF). Review of a physician's order for Resident #1 dated 06/10/23 revealed compression hose apply every morning and remove at bedtime. Review of Resident #1's electronic treatment administration record (TAR) for July 2023 revealed: -There was an entry for compression hose apply daily at 8:00am and remove at 8:00pm. -There was documentation the compression hose were applied 07/01/23 - 07/31/23 at 8:00am. -There was documentation the compression hose	D 276		

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were removed 07/01/23 -07/13/23, 07/15/23 - 07/23/23, and 07/25/23 - 07/31/23 at 8:00pm.

Review of Resident #1's electronic treatment administration record (TAR) for August 2023 revealed:
-There was an entry for compression hose apply daily at 8:00am and remove at 8:00pm.
-There was documentation the compression hose were applied 08/01/23 - 08/20/23 and 08/22/23 - 08/31/23 at 8:00am.
-There was documentation the compression hose were removed 08/01/23 - 08/16/23 and 08/18/23 - 08/30/23 at 8:00pm.

Observation of Resident #1 on 08/29/23 at 8:54am and 08/30/23 at 10:55am revealed Resident #1 had white tube socks pulled half way up his calves.

Interview with a medication aide (MA) on 08/30/23 at 10:12am revealed:
-She applied diabetic socks on Resident #1 because he did not have any compression hose to apply.
-He had a pair of compression hose previously but they were ripped and dirty.
-She thought the Clinical Administrator was aware that Resident #1 did not have compression hose to apply so she did not order any from the facility's contracted pharmacy.

Telephone interview with a second MA on 08/30/23 at 1:43pm revealed:
-She worked 8:00pm to 8:00am at the facility.
-She documented she removed Resident #1's compression hose but she did not remove them.
-Resident #1 removed the compression hose himself and she just "clicked it" (documented on the TAR).

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D 276	Continued From page 11 Telephone interview with a third MA on 08/31/23 at 9:40am revealed she did not apply or remove Resident #1's compression hose because he said he could do it himself. Telephone interview with a representative from the facility's contracted pharmacy on 08/31/23 at 8:07am revealed: -The pharmacy received an electronic physician's order for compression hose for Resident #1 on 06/10/23. -The pharmacy dispensed one pair of compression hose on 06/10/23. -The pharmacy did not receive any requests for additional compression hose until 08/30/23. Interview with Resident #1 on 08/30/23 at 10:55am revealed: -He knew that it was greater than one month since he had any compression hose to wear. -He was supposed to wear the compression hose because he had swelling in his legs. -There had been one pair of compression hose that was ripped and dirty. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/31/23 at 9:05am revealed: -He did not know Resident #1 was not wearing compression hose. -He ordered the compression hose for Resident #1 to decrease lower extremity edema. -Resident #1 was taking a blood pressure medication that caused the edema and the compression hose would reduce that. -Resident #1 had a few visits in the past to the emergency department (ED) due to the swelling. Interview with the Clinical Administrator on	D 276		

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D 276	Continued From page 12 08/30/23 at 11:10am reveled: -She attempted to order another pair of compression hose for Resident #1 from the facility's contracted pharmacy but could not recall the date. -The pharmacy could not deliver another pair of compression hose due to Resident #1's insurance coverage. -She informed the NP about the issue. -The MAs should not have documented they applied and removed the compression hose. Interview with the Administrator on 08/31/23 at 8:12am revealed: -She thought there had been an insurance issue with Resident #1's compression hose. -The facility purchased 2 pairs of compression hose in April 2023. -She was not informed by staff that Resident #1 did not have anymore compression hose. -The Clinical Administrator was responsible for contacting the pharmacy for another pair of compression hose. -Staff should not have documented they applied the compression hose when they applied diabetic socks as they were not the same.	D 276	All MAs will be inserviced on proper documentation EMAR. 24 hour shift reports will be implemented as a communication tool to ensure all issues/ needed will be communicated. to RCC/ED who will review daily. Any supplies such as compression stockings needed will be documented on reports. Daily staff stand up meetings will be held b/w staff + RCC so communication can be relayed.	9/30/23
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306		

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D 306	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal, in addition to other beverages. The findings are: Observation of the lunch meal service on 08/29/23 between 12:00pm and 12:20pm revealed: -There were 9 residents present at the lunch meal. -Beverages served included, milk, tea, Kool-Aid and coffee. -No residents were served water. -No residents were asked if they wanted water. Interviews with 4 residents on 08/29/23 between 1:04pm and 1:24pm revealed: -One resident would have drunk water at the lunch meal if it had been offered to her. -A second resident would like to have water at each meal, but not out of the kitchen spigot. -He would prefer bottled water. -A third resident was not offered water at the lunch meal, but would have drunk water if he had been offered it. Interview with a personal care aide (PCA) on 08/29/23 at 1:16pm revealed: -She set up the plates, cups and silverware on the tables for the noon meal on 08/29/23. -She was trained to follow the menu and the lunch menu beverage for 08/29/23 was listed as milk. -She also offered tea and Kool-Aid to the residents, along with coffee to one resident who only drank coffee with all his meals. -She did not offer water to the residents for the	D 306	All staff will be inserviced on serving water during each meal while also serving additional drinks. RCC or Ed will monitor @ least one meal each day to ensure staff is serving water.	9/30/23

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D 306	Continued From page 14 lunch meal on 08/29/23. -She was not aware she was supposed to offer the residents water at every meal. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -All residents should be served water at each meal. -She was not aware residents were not being offered water at each meal.	D 306	Activity calendars will be approved by ED. Med techs will be tasks with ensuring all activities are taking place daily. ED will hire a PCA to assist with activities to ensure all tasks are met.	9/30/23
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 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 or her 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, interviews and record reviews, the facility failed to develop a program of activities to promote residents' active involvement. The findings are: Interviews with 3 residents during the initial tour on 08/29/23 from 8:40am - 9:30am revealed: -There were very few activities offered. -The activities posted on the activity calendar did not occur.	D 315		

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D 315	Continued From page 15 -One resident would like staff to conduct the activities that were on the calendar. -The only activity that occurred was bingo. -A second resident would lay in her bed a lot because she had nothing to do. -Bingo was the only activity for the residents. -Management just hired an activity director a few weeks ago, but she has to do activities for all 4 houses. Review of the August 2023 activity calendar revealed a fruit snack social on 08/30/23 from 10:00am - 11:00am. Observation of the facility on 08/30/23 from 10:00am - 11:00am revealed the fruit snack social did not occur. Interview with the medication aide (MA) on 08/30/23 at 3:10pm revealed: -She did not conduct the fruit snack social on 08/30/23 because most of the residents were out of the facility at appointments. -It was difficult to conduct activities when she was the only staff in the facility. Interview with the Clinical Administrator on 08/30/23 at 2:57pm revealed: -The facility no longer had an Activity Director. -The staff did not follow the activity calendar because the residents did not want to participate in the activity posted on the calendar "like baking cookies". Interview with the Administrator on 08/30/23 at 2:48pm revealed: -The facility did not have an Activity Director. -The facility had a "barbecue" recently for an activity. -The personal care aides (PCA) were to conduct	D 315		

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D 315	Continued From page 16 daily activities with residents. -She was aware staff were not consistently conducting activities.	D 315	Cart audits will be completed for each resident weekly by MAs weekly + reviewed by RCC/ED to ensure adacegate supply of medications on hand (including insulin) RCC n ED will check narcotic counts each week to ensure no new scripts are needed to ensure there are no delays in reordering medications. RCC will pull blood sugar/insulin log report daily to ensure all BS vitals are documented and within	9/30/23
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: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 2 of 3 sampled residents (#1 and #2) related to missed scheduled and sliding scale insulin (#1) and missed doses of a narcotic pain medication and a mood stabilizer (#2). The findings are: Review of the facility's Medication Administration Policy and Procedure revealed: -There was no date on the policy and procedure. -Medication should be ordered when the availability is at a 7 day count. -Failure to order medications in a timely manner could result in medications not being available. -Medication should be ordered so that at no time are residents without medications.	D 358		

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D 358	Continued From page 17 1. Review of Resident #2's current FL2 dated 05/22/23 revealed: -Diagnoses included chronic lung disease and angina (chest pain). -There was an order for hydrocodone (medication used to relieve moderate to severe pain) 10/325mg three times daily. -There was an order for clonazepam (medication used to treat anxiety) 1mg three times daily. Interview with Resident #2 on 08/29/23 during initial tour at 8:44am revealed: -She was lying in bed because she was having back pain. -The facility had been running out of some of her medication recently. -She knew her hydrocodone and her clonazepam had not been available for several days. A. Review of Resident #2's electronic medication administration record (eMAR) for 07/01/23 - 07/31/23 revealed: -There was an entry for hydrocodone 10/325mg three times daily at 8:00am, 2:00pm, and 8:00pm. -There was no documentation the hydrocodone was administered from 07/03/23 at 8:00pm through 07/07/23 at 8:00am, resulting in 11 missed doses of hydrocodone. Review of Resident #2's eMAR for 08/01/23 - 08/29/23 revealed: -There was an entry for hydrocodone 10/325mg three times daily at 8:00am, 2:00pm, and 8:00pm. -There was no documentation the hydrocodone had been administered from 08/05/23 at 2:00pm through 08/07/23 at 8:00pm, resulting in 8 missed doses of hydrocodone. Telephone interview with a representative from	D 358	normal ranges and to also ensure the proper amounts of Insulin has been administered. Any ~~[illegible]~~ issues will be reported to PCP immediately.	

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D 358	Continued From page 18 the facility's contracted pharmacy on 08/29/23 at 11:25am revealed: -Resident #2 could only get a 7-day supply of hydrocodone at a time due to insurance restrictions for this narcotic. -The pharmacy records indicated there was a lapse in the request for hydrocodone 07/01/23 and 08/05/23. -Because of the lapse requesting the hydrocodone, it was not sent to the facility timely. -The hydrocodone was one of the medications that had to go through their pharmacy and could not be requested from the facility's back up pharmacy. Interview with Resident #2 on 08/29/23 at 1:55pm revealed: -She had chronic pain all over her body daily. -She was prescribed hydrocodone for pain management three times a day. -The facility has been out of her hydrocodone several times. -Her pain was much worse without her hydrocodone. Observation of Resident #2's medication available for administration on 08/29/23 at 2:11pm revealed there was hydrocodone 10/325mg available for administration. Interview with a medication aide (MA) on 08/29/23 at 2:03pm revealed: -Resident #2 was not administered her hydrocodone for several days. -All controlled medications had to be ordered. -She called the pharmacy each time she worked and left a message trying to reorder the hydrocodone. -Resident #2 was very upset about not having her medication and was in a lot of pain.	D 358		

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D 358	Continued From page 19 Interview with the Clinical Administrator (CA) on 08/29/23 at 2:28pm revealed: -There had been a problem getting the scripts for controlled substances for Resident #2. -Resident #2 had been without her hydrocodone for "a few days" in July and August 2023. -On each occasion Resident #2 was found to be without her medication, she personally called the pharmacy and was told by a pharmacy representative the medication would be sent to the facility the same day she called the pharmacy. -The CA did not know why the hydrocodone took so long to show up, even though she kept calling the pharmacy to ask where the hydrocodone was. -On each occasion for Resident #2 being out of her hydrocodone, CA had to contact the nurse practitioner (NP) to get a hard script for the pharmacy. -There was no clinical or administrative staff that compared the eMARs to the doctor's orders each month to see if there were any issues. Interview with a second MA on 08/30/23 at 10:36am revealed: -Resident #2 was out of hydrocodone several times in the past few weeks. -She had called the pharmacy on multiple occasions and could not get a response. -After not being able to speak to anyone at the pharmacy, she told the CA that she was trying to get the hydrocodone from the pharmacy. -The CA told her if she was leaving a message at the pharmacy to reorder the hydrocodone that was all she needed to do. -Resident #5 was having increased pain when she did not have her hydrocodone. Interview with the Administrator on 08/30/23 at 3:25pm revealed:	D 358		

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D 358	Continued From page 20 -The facility should never run out of any resident medication. -Medication should be ordered from the pharmacy when there are five to seven days of medication left. -The pharmacy may have needed a hard script for the hydrocodone. -She was not aware Resident #2 had ran out of her hydrocodone. -If she had been made aware of this, she would have requested the hydrocodone from the back-up pharmacy. Telephone interview with the nurse practitioner (NP) on 08/31/23 at 9:00am revealed: -He had been made aware by facility staff that Resident #2 had been without her hydrocodone for several days. -He was sure Resident #2 had an increase in pain after missing so many doses in July and August 2023. -Facility staff should be giving medications as ordered and the residents should not be going without medications. B. Review of Resident #2's eMAR for 08/01/23 - 08/29/23 revealed: -There was an entry for clonazepam 1mg three times daily at 8:00am, 2:00pm, and 8:00pm. -There was no documentation the clonazepam was administered from 08/11/23 at 8:00pm through 08/14/23 at 8pm, resulting in 10 missed doses of clonazepam. Telephone interview with a representative from the facility's contracted pharmacy on 08/29/23 at 11:25am revealed: -Resident #2 had a delay in receiving her clonazepam on 08/11/23 because there was not a request from the facility to refill the clonazepam.	D 358		

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D 358	Continued From page 21 -The clonazepam could have been ordered through the back-up pharmacy. -On 08/11/23 a control template (form used by the facility to ensure medications were requested timely from the nurse practitioner)was sent to the facility nurse practioner requesting a new script for the clonazepam, but the script was not received for several days. Interview with Resident #2 on 08/29/23 at 1:55pm revealed: -She was also out of her clonazepam for a few days in August 2023. -She felt more "irritated" without her clonazepam and felt "more shaky" inside her body than usual. -The facility staff told her there was a problem getting her medication from the pharmacy. Interview with a medication aide (MA) on 08/29/23 at 2:03pm revealed: -All controlled medications had to be ordered. -She called the pharmacy each time she worked and left a message trying to reorder the clonazepam. -Resident #2 was very upset about not having her medication. Observation of Resident #2's medication available for administration on 08/29/23 at 2:11pm revealed there was clonazepam 1mg available for administration. Interview with the Clinical Administrator (CA) on 08/29/23 at 2:28pm revealed: -There had been a problem getting the scripts for controlled substances for Resident #2. -Resident #2 had been without her clonazepam for "a few days" in August 2023. -On each occasion Resident #2 was found to be without her medication, she personally called the	D 358		

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pharmacy and was told by a pharmacy representative the medication would be sent to the facility the same day she called the pharmacy.
-The CA did not know why the clonazepam took so long to show up, even though she kept calling the pharmacy to ask where the clonazepam was.
-On each occasion for Resident #2 being out of her clonazepam, CA had to contact the nurse practitioner (NP) to get a hard script for the pharmacy.
-There was no clinical or administrative staff that compared the eMARs to the doctor's orders each month to see if there were any issues.

Interview with a second MA on 08/30/23 at 10:36am revealed:
-Resident #2 was out of clonazepam several times in the past few weeks.
-She had called the pharmacy on multiple occasions and could not get a response.
-After not being able to speak to anyone at the pharmacy, she told the CA that she was trying to get clonazepam from the pharmacy.
-The CA told her if she was leaving a message at the pharmacy to reorder the clonazepam that was all she needed to do.

Interview with the Administrator on 08/30/23 at 3:25pm revealed:
-The facility should never run out of any resident medication.
-Medication should be ordered from the pharmacy when there are five to seven days of medication left.
-The pharmacy may have needed a hard script for the clonazepam.
-She was not aware Resident #2 had ran out of her clonazepam.
-If she had been made aware of this, she would have requested the clonazepam from the back-up

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D 358	Continued From page 23 pharmacy. Telephone interview with the nurse practitioner (NP) on 08/31/23 at 9:00am revealed: -He had been made aware by facility staff that Resident #2 had been without her clonazepam for several days. -Resident #2 was probably having mild symptoms of withdrawal when she went without her clonazepam in August 2023. -Facility staff should be giving medications as ordered and the residents should not be going without medications. 2. Review of Resident #1's current FL2 dated 08/16/23 revealed a diagnosis of Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose)). Review of physician's orders for Resident #1 dated 08/16/23 revealed: -There was an order to check finger stick blood sugar (FSBS) before each meal and inject Humalog insulin (medication used to treat high blood glucose) 100unit/ml inject per sliding scale; FSBS: 151-200 = 2 units, 201-250=4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 11 units, and over 400 = 13 units. -There was an order for Humalog insulin 100unit/ml inject 25 units three times a day with meals. Review of Resident #1's electronic Medication Administration Record (eMAR) for 08/01/23 - 08/30/23 revealed: -There was an entry for Humalog 100unit/ml inject 25 units three times a day with administration times of 6:30am, 11:30am, and 4:30pm. -There was no documentation the Humalog insulin was administered on 08/29/23 at 6:30am	D 358		

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or 11:30am.
-There was an entry for Humalog 100unit/ml SSI for FSBS: 151-200 = 2 units, 201-250=4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 11 units, and over 400 = 13 units with administration times of 6:30am, 11:30am, and 4:30pm.
-There was no documentation the Humalog insulin was administered on 08/29/23 at 6:30am or 11:30am.

Interview with Resident #1 on 08/29/23 at 8:54am revealed:
-He had eaten breakfast earlier on 08/29/23 and did not receive his insulin injection because staff told him the facility was out of the insulin.
-There were times when he did not get the insulin injection but he could not recall the dates.

Interview with the medication aide (MA) on 08/29/23 at 9:10am revealed:
-He obtained Resident #1's FSBS at 6:30am and it was 272 but he could not give the 6 units of Humalog SSI and the 25 units that was scheduled because the Humalog insulin pen was empty and there was not any more in the facility.
-The last time the Humalog insulin was ordered was 08/17/23.
-The MAs were to request refills of medications via the eMAR before a medication ran out.
-He did not know why the insulin had not been refilled before it was out.

Observation of Resident #1's medications available for administration on 08/29/23 at 9:15am revealed there was not any Humalog insulin in the medication cart or in the medication refrigerator.

Telephone interview with a representative from

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	HAL011373	A. BUILDING: ______ B. WING ______	R 08/31/2023

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

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the facility's contracted pharmacy on 08/29/23 at 11:30am revealed:
- On 03/13/23 and 08/16/23 the pharmacy received a faxed physician's order for Resident #1 for Humalog 100unit/ml inject 25 units three times daily with meals.
- On 03/13/23 and 08/16/23 the pharmacy received a faxed physician's order for Resident #1 for Humalog 100unit/ml SSI before meals, for FSBS 151-200 = 2 units, 201-250=4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 11 units, and over 400 = 13 units.
-The Humalog insulin pen for the schedule doses was last refilled, dispensed and delivered to the facility on 08/08/23 and it was a 7 day supply.
-The Humalog insulin pen for the SSI was last refilled, dispensed and delivered on 08/18/23 and it was 6 day supply.
-There were no other refill requests for the insulin.
-It was the facility's responsibility to refill medications via the eMAR or telephone the pharmacy for refills of insulin.
-The insulin should have been refilled before 08/29/23 to ensure Resident #1 did not run out of the insulin.

Telephone interview with a second MA on 08/29/23 at 1:42pm revealed:
-She was the MA on 08/28/23 and administered the Humalog insulin to Resident #1 but she did not know how much insulin was left in the pen.
-She knew she had requested a refill of the Humalog insulin but could not recall when.
-She knew to request a refill via the eMAR or telephone the pharmacy for the medication.

Interview with a third MA on 08/30/23 at 8:15am revealed:
-She was the MA on 08/27/23 and Resident #1 had a Humalog insulin pen that was full.

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-Resident #1 recently had high FSBS which would require more doses.
-She thought she requested a refill on 08/27/23.
-She was too busy to telephone the pharmacy to check on the refill because she had to administer medications at the sister facility.
-Medication cart audits were completed weekly by management.

Telephone interview with the facility's contracted NP on 08/31/23 at 9:04am revealed:
-Resident #1 was prescribed Humalog insulin because of diabetes.
-He was notified by the facility that Resident #1 did not have any Humalog insulin to administer on 08/29/23 at 6:30am and 11:30am because they had not requested a refill of the medication.
-Not receiving the Humalog insulin as ordered put Resident #1 at risk of hyperglycemia (high blood glucose levels) and diabetic ketoacidosis (serious complication of diabetes that can be life threatening requiring hospitalization).

Interview with the Clinical Administrator on 08/29/23 at 1:35pm revealed:
-She was informed on 08/29/23 that Resident #1 was out of the Humalog insulin.
-The MAs were trained to refill medications via the eMAR when medications were low on doses.
-She thought Resident #1 had Humalog insulin in the medication cart on 08/25/23.
-Medication cart audits were completed weekly to ensure all ordered medications were in the cart.
-She did not know why the insulin had not been refilled.

Telephone interview with the Administrator on 08/29/23 at 1:17pm revealed:
-She was informed on 08/29/23 that Resident #1 did not have any insulin.

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D 358	Continued From page 27 -The MAs were trained to refill medications via the eMAR before the last dose. -The Humalog insulin could have been dispensed by a local back up pharmacy after telephoning the facility's contracted pharmacy. -The MAs should have telephoned the facility's contracted pharmacy when the medication doses were low. ______ The facility failed to administer medications as ordered to Resident #2 who missed 19 doses of Hydrocodone which caused an increase in pain and 10 doses of Clonazepam which caused withdrawal symptoms, and two doses of scheduled and SSI putting Resident #1 at risk of diabetic ketoacidosis, a life threatening condition requiring hospitalization. This failure placed Resident #1 and #2 at substantial risk to their health, safety and welfare and constitutes a Type A2 Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/29/23 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2023.	D 358	all med aides will be inserved in ensuring Residents are monitored while taking medications and that no medications will be left with resident unattended	9/30/23
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	D 366		

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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:
Based on observations, record reviews, and interviews, the facility failed to ensure a medication aide (MA) observed 1 of 1 sampled resident (#5) take medications administered resulting in medications left on the resident's bedside table in her room.

The findings are:

Observation of Resident #5's private room on 08/29/23 at 1:10pm revealed there was a plastic medication cup with 4 pills on her bedside table.

Interview with Resident #5 on 08/29/23 at 1:10pm revealed:
-The medications on her bedside table in the medication cup were her Vitamin C, Vitamin D, and Zinc the medication aide (MA) had given her the morning of 08/29/23.
-She also added a Benadryl Allergy tablet that she kept in her room to the medication cup.
-She liked to take her supplements with food, and she didn't eat breakfast.
-She often kept her supplements and took them after lunch.

Review of Resident #5's current FL2 dated 06/05/23 revealed:
-Diagnoses included chronic pain syndrome and high blood pressure.
-Orientation was intermittently disoriented.
-An order for Vitamin C (vitamin supplement) 500mg daily.
-An order for Vitamin D (vitamin supplement) 5,000 units daily.

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D 366	Continued From page 29 -An order for Zinc (vitamin supplement) 220mg daily. -There was not an order for a daily antihistamine. -There was no order for self-administration of any medications. Review of the electronic medication admnistration record (eMAR) for 08/29/23 revealed: -There was documentation Vitamin C 500mg was administered at 8:00am. -There was documentation Vitamin D 5,000 units was administered at 8:00am. -There was documentation Zinc 220mg was administered at 8:00am. Interview with the Clinical Administrator on 08/29/23 at 2:28pm revealed: -MAs should not leave medication at the bedside. -MAs should always observe the resident take all medications. -She verified the three medications Resident #5 self-administered were Vitamin C, Vitamin D, and Zinc. -The fourth medication was not a prescription medication. -The fourth medication was Benadryl Allergy that Resident #5 had "hidden" in her room. Telephone interview with a MA on 08/29/23 at 3:30pm revealed: -He gave Resident #5 her morning medications on 08/29/23. -Resident #5 could not self-administer any of her scheduled daily medications. -He witnessed her take all her morning medications and removed the medication cup from her room on 08/29/23. Interview with the Assistant Administrator on 08/29/23 at 3:35pm revealed:	D 366	unless resident has a self admin. order, which will be reflected on EMAR. any resident with a self admin order will also have a Self admin assessment done by a licensed RN quarterly.	

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D 366	Continued From page 30 -Residents should not have medications at the bedside. -Staff should observe residents taking all their medication before leaving the room. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -Medication should never be left at the bedside. -The MA should always observe a resident take all their medications. -She was not aware the MA was leaving prescribed medication in Resident #5's room without observing her take them. -Resident #5 could not self-administer medications without a physician's order and an assessment to self-administer medications.	D 366		
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 medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 375		

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D 375	Continued From page 31 interviews, the facility failed to ensure 1 of 1 sampled resident (#5) had a physician's order to self-administer an antihistamine (a medication used to treat allergies) and three vitamin supplements. The findings are: Observation of Resident #5's room on 08/29/23 at 1:10pm revealed there was a plastic medication cup with 4 pills in it on her bedside table. Interview with Resident #5 on 08/29/23 at 1:10pm revealed: -The medications on her bedside table in the medication cup were her Vitamin C, Vitamin D, and Zinc the medication aide (MA) had given her the morning of 08/29/23. -She also added a Benadryl Allergy tablet that she kept in her room to the medication cup. -She liked to take her supplements with food, and she didn't eat breakfast. -She often kept her supplements and took them after lunch. Review of Resident #5's current FL2 dated 06/05/23 revealed: -Diagnoses included chronic pain syndrome and high blood pressure. -Orientation was intermittently disoriented. -An order for Vitamin C (vitamin supplement) 500mg daily. -An order for Vitamin D (vitamin supplement) 5,000 units daily. -An order for Zinc (vitamin supplement) 220mg daily. -There was not an order for a daily antihistamine. -There was not an order to self administer any medications.	D 375		

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D 375	Continued From page 32 Review of the electronic medication admnistration record (eMAR) for 08/29/23 revealed: -Documentation Vitamin C 500mg was administered at 8:00am. -Documentation Vitamin D 5,000 units was administered at 8:00am. -Documentation Zinc 220mg was administered at 8:00am. Interview with the Clinical Administrator on 08/29/23 at 2:28pm revealed: -Resident #5 did not have an order to self-administer medications. -MAs should not leave medication at the bedside. -MAs should always observe the resident take all medications. -She verified the three medications Resident #5 self-administered were Vitamin C, Vitamin D, and Zinc. -The fourth medication was not a prescription medication. -The fourth medication was Benadryl Allergy that Resident #5 had hidden in her room. Telephone interview with a MA on 08/29/23 at 3:30pm revealed: -He gave Resident #5 her morning medications on 08/29/23. -Resident #5 could not self-administer any of her scheduled daily medications. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -She was not aware Resident #5 had Benadryl Allergy tablets in her room and were self-administering them. -Resident #5 could not self-administer medications without a physician's order and an assessment to self-administer medications.	D 375		

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D 375	Continued From page 33 Interview with the nurse practitioner (NP) on 08/31/23 at 9:00am revealed: -Resident #5 has a significant history of medication mismanagement. -Facility staff have removed medications from Resident #5's room on multiple occasions. -There was no order for Resident #5 to self-administer Vitamin C, Vitamin D or Zinc or Benadryl Allergy. -There was no order for Resident #5 to keep Benadryl Allergy in her room. -Resident #5 should not be self-administering these medications.	D 375		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident involving 1 of 3 sampled residents (#3) who received injuries requiring emergency medical treatment. The findings are: Review of Resident #3's current FL2 dated 10/18/22 revealed diagnoses included chronic	D 451		

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D 451	Continued From page 34 lung disease, muscle weakness and fatigue. Observation of Resident #3 on 08/29/23 at 8:32am during initial tour revealed Resident #3 was wearing a right arm/shoulder sling. Interview with Resident #3 on 08/29/23 at 8:32am during initial tour revealed: -She fell about 4 or 5 weeks ago in the bathroom. -She fell on her right arm and had shoulder pain, so the personal care aide (PCA) called an ambulance. -She was transported to the hospital and an x-ray indicated she broke her right shoulder. Interview with the Administrator on 08/30/23 at 3:25pm revealed: -An incident/accident report should have been completed by the agency MA on the day Resident #3 fell. -The CA was responsible for making sure the incident/accident reports were completed by the staff involved with the incident and sending the report to DSS if the resident required emergency treatment. Interview with the local DSS Adult Home Specialist on 08/31/23 at 8:35am revealed she had not been notified of Resident #3's fall requiring emergency intervention at the local hospital on 07/18/23. Telephone interview with a MA on 08/31/23 at 9:26am revealed: -She was on duty the night Resident #3 fell and was sent out to the hospital. -She contacted the facility's contracted provider, the Clinical Administrator (CA) and the Administrator.	D 451	Med tech will be inserviced on Incident/Accident reporting. Med techs will be instructed to complete reports for all fall related + non fall related events and to notify both RCC + ED of such incidents immediately. Reports will then be turned into RCC or ED for review and RCC or ED will send "reportable" reports to DSS.	9/30/23

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D 451	Continued From page 35 -She asked the CA and Administrator if she needed to do any paperwork and they both told her no.	D 451		