PRINTED: 11/14/2023
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 11/07/2023

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 and the Buncombe County Department of Social Services conducted a follow up survey and complaint investigation on 11/07/23. The complaint investigation was initiated by the Buncombe County Department of Social Services on 10/12/23.	D 000		12/7/2023
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to a medication to treat high cholesterol and a vitamin supplement. The findings are: Review of Resident #3's current FL2 dated 10/30/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and	D 358	All medication aides will be in serviced on ordering medications: when, who to contact. All MAs will also complete weekly cart audits to ensure that all ordered medications are on hand according to current medication orders. RCC will also pull medication exception report daily and follow up on any medications that were/are not given. ED will pull medication exception report weekly to do a second check on medications that have not been given and to follow up on anything that may need followed up on.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacey Russell TITLE: Administrator (X6) DATE: 12/6/23

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D 358	Continued From page 1 hypertension. 1. Review of a physician's progress note for Resident #3 dated 09/25/23 revealed an order for atorvastatin (medication used to treat high cholesterol) 20mg at bedtime. Review of Resident #3's electronic Medication Administration Record (eMAR) for October 2023 revealed: -There was an entry for atorvastatin 20mg at bedtime with an administration time of 8:00pm. -There was documentation the atorvastatin was administered 10/05/23 - 10/09/23, 10/12/23, and 10/17/23 - 10/31/23 at 8:00pm. -There was documentation the atorvastatin was not administered 10/01/23 - 10/04/23, 10/10 - 10/11/23, and 10/13/23 - 10/16/23 at 8:00pm due to "waiting on refill, arriving from pharmacy, not in from pharmacy". Observation of Resident #3's medications available for administration on 11/07/23 at 10:30am revealed: -There was one bubble pack labeled atorvastatin 20mg at bedtime. -There were 28 tablets dispensed on 10/16/23 and 14 tablets remained in the bubble pack. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/07/23 at 10:20am revealed: -The pharmacy received an electronic physician's order for atorvastatin 20mg at bedtime for Resident #3 on 09/25/23. -The pharmacy dispensed and delivered to the facility 24 tablets of atorvastatin 20mg for Resident #3 on 09/25/23, and dispensed and delivered 28 tablets on 10/16/23. -The facility would have had enough atorvastatin	D 358		

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D 358	Continued From page 2 to administer to Resident #3 at bedtime the month of October 2023. -The pharmacy did not receive any refill requests from the facility for atorvastatin for Resident #3. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/07/23 at 2:13pm revealed Resident #3 was prescribed atorvastatin for high cholesterol and he expected it to be administered as ordered. Refer to the interview with the medication aide (MA) on 11/07/23 at 10:45am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/07/23 at 11:00am. Refer to the interview with the Administrator on 11/07/23 at 11:10am. 2. Review of a physician's progress note for Resident #3 dated 09/25/23 revealed an order for vitamin D3 (supplement that treats vitamin D deficiency) 1000IU daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for October 2023 revealed: -There was an entry for vitamin D3 1000IU daily with an administration time of 8:00am. -There was documentation the vitamin D3 1000IU was administered on 10/01/23, 10/05/23 - 10/07/23, 10/10/23 - 10/15/23, 10/18/23 - 10/31/23 at 8:00am. -There was documentation the vitamin D3 1000IU was not administered on 10/02/23 - 10/04/23, 10/08/23 - 10/09/23 and 10/16/23 - 10/17/23 at 8:00am due to "needs refill, arriving from pharmacy".	D 358		

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D 358	Continued From page 3 Observation of Resident #3's medications available for administration on 11/07/23 at 10:30am revealed: -There was one bubble pack labeled vitamin D3 1000IU one tablet daily. -There were 28 tablets dispensed on 10/16/23 and 18 tablets remained in the bubble pack. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/07/23 at 10:20am revealed: -The pharmacy received an electronic physician's order for vitamin D3 1000IU for Resident #3 on 09/25/23. -The pharmacy dispensed and delivered to the facility 24 tablets of vitamin D3 1000IU on 09/25/23, and dispensed and delivered 28 tablets on 10/16/23. -The facility would have had enough vitamin D3 to administer to Resident #3 daily the month of October 2023. -The pharmacy did not receive any refill requests from the facility for vitamin D3 1000IU for Resident #3. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 11/07/23 at 2:13pm revealed Resident #3 was prescribed vitamin D3 for a vitamin d deficiency and he expected it to be administered as ordered. Refer to the interview with the medication aide (MA) on 11/07/23 at 10:45am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/07/23 at 11:00am. Refer to the interview with the Administrator on 11/07/23 at 11:10am.	D 358		

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D 358	Continued From page 4 Interview with the MA on 11/07/23 at 10:45am revealed: -She was responsible for requesting refill requests when a resident was out of medications. -She thought another staff may have removed the atorvastatin and vitamin D3 when conducting a medication cart audit. -She telephoned the pharmacy to request refills of the medications but could not recall when. -She knew she informed the Resident Care Coordinator (RCC) about the missing medications but could not recall when. -The MAs were responsible for conducting medication cart audits to ensure medications were available for administration. Interview with the RCC on 11/07/23 at 11:00am revealed: -She did not know Resident #3 was out of atorvastatin and vitamin D3. -She expected staff to inform her when medications were not available for administration. -Staff should telephone the pharmacy when a medication is completely out and request a refill via the eMAR when there is a 7 day supply left. -The MAs were responsible for conducting medication cart audits for two random residents dally to ensure all medications were available for administration. Interview with the Administrator on 11/07/23 at 11:10am revealed: -Staff should telephone the pharmacy and notify her, and the RCC, when medications were not available. -She could not recall if she was notified or not about Resident #3's atorvastatin and vitamin D3. -The MAs were responsible for conducting medication cart audits and that process had been initiated 2 -4 weeks ago.	D 358		

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