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
	HAL011190	A. BUILDING: _____ B. WING _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 3	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 on February 13-15, 2018.	D 000	Please see attached	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance to 3 of 3 sampled residents who required extensive assistance with showers (Residents #1 and #2) and who required assistance with nail care (Resident #4). The findings are: 1. Review of Resident #1's current FL2 dated 6/1/17 revealed diagnoses included diabetes, cardiovascular disease, and dementia. Review of Resident #1's Resident Register revealed she was admitted to the facility on 6/16/08. Review of Resident #1's Care Plan dated 5/31/17 revealed she required extensive assistance with bathing and limited assistance with grooming and dressing.	D 269		

POC Reviewed and accepted with addendum-B Boggs 4/2/18

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D 269	Continued From page 1 Review of Resident #1's record revealed refusals of personal care and showers were not documented. Interview with Resident #1 on 2/13/18 at 9:30am revealed: -Staff will not give her a shower. -She did not know when she last had a shower. -She had requested assistance with showers in the past, date not known. -"It does not do any good" to ask staff to help her shower, because they say they are "too busy." Interview with a first shift Medication Aide/Personal Care Aide (MA/PCA), Staff A, on 2/13/18 at 11:50am revealed: -She had been a first shift MA/PCA in this building since the last of November, 2017. -She worked five days per week from 8:00am to 4:00pm. -She had never assisted Resident #1 with a shower because another MA/PCA, Staff B, was responsible. -Resident #1 required extensive assistance with showering and limited assistance with dressing. -Resident #1 had refused showers in the past. -Residents are supposed to have at least 3 showers per week. Interview with another first shift MA/PCA, Staff C, on 2/13/18 at 11:00am revealed: -She worked weekdays from 8:00am to 4:00pm. -She started working in January 2018. -Her job responsibilities included cooking breakfast and lunch with clean up, cleaning rooms, mopping the floors, cleaning the bathrooms, and assisting residents with showers and personal care. -She assisted Resident #1 with a shower three weeks ago but Resident #1 had refused some	D 269		

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showers.
-She did not document Resident #1's refusal of showers, but told Staff A that Resident #1 was refusing showers.
-Staff A was responsible for communicating any resident refusals to management and physicians.

Interview with the second shift MA/PCA, Staff B, on 2/13/18 at 4:00pm revealed:
-She started working in the facility one year ago.
-She worked alone on Saturday and Sunday from 7:00am to 8:30pm and worked week-days from 4:00pm to 8:30pm.
-She had never assisted Resident #1 with a shower, because it was Staff A and Staff B's responsibility.
-Resident #1 was completely dependent on staff to assist her with showers and could not shower independently.

Observations of Resident #1 during the survey revealed she was independent in walking but walked slowly with short steps.

Review of the Personal Care Tasks documentation sheets from November and December 2017 through January, 2018 revealed:
-The task for showers was routinely checked as "yes" as if they had been completed at least 3 times per week.
-Staff did not initial the tasks but just put a check mark after the "yes" for the task.
-Staff B initialed the bottom of the December 2017 tasks daily and the other sheets did not have any initials.
-There was no documentation Resident #1 had refused any showers.

A second interview with Staff B on 2/14/18 at 4:00pm revealed she filled out the personal care

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sheets for November and December 2017 and January 2018, but they were inaccurate.

A second interview with Staff A on 2/14/18 at 3:45pm revealed:
-She did not yet have the personal care tasks sheet filled out with residents names for the month of February 2018 and they were all blank except for Resident #2's sheet.
-They were supposed to start the sheets on the first day of each month and document daily.

Telephone interview with Resident #1's family member on 2/13/18 at 2:11pm revealed:
-Resident #1 would not allow her to visit and Resident #1 had hung up the phone on her at the last attempted telephone call.
-She had not seen Resident #1 since "last summer."

Interview with the Administrator on 2/15/18 at 2:40pm revealed:
-She did not know Resident #1 was not receiving showers 3 times per week.
-Staff submitted documentation through January 2018 that Resident #1 was receiving routine personal care including showers.
-Personal care documentation sheets were supposed to be initiated on the first day of the month.

Refer to interview with the Administrator on 2/15/18 at 2:40pm.

2. Review of Resident #2's current FL2 dated 1/15/18 revealed diagnoses included dementia and cognitive mood disorder.

Review of Resident #2's Resident Register revealed she was admitted to the facility on

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D 269	Continued From page 4 8/26/08. Review of Resident #2's current Care Plan dated 1/15/18 revealed Resident #2 required extensive assistance with bathing, dressing, and grooming. Interview with Resident #2 on 2/14/17 at 11:15am revealed: -The second shift Medication Aide/Personal Care Aide (MA/PCA), Staff B, gave her a bath once per week on the weekends. -She had requested assistance with showers during the week, but staff always said they were "busy" but they "would take care of it." -She did not know the names of staff who she had requested help with a shower. -"I've had on the same shirt and pants for two days." Interview with the first shift MA/PCA, Staff A, on 2/13/18 at 10:57am revealed: -She started working there as first shift MA/PCA at the end of November 2017. -She had assisted Resident #2 with showers but did not know exact dates. -There was a paper on the wall in Resident #2's room with documentation of assistance with personal care tasks. -She just recently made the form for Resident #2, so Resident #2 would know why staff were coming in her room. Review of the form posted on the wall of Resident #2's room on 2/14/18 revealed: -Documentation from 2/4/18 though 2/14/18 with care provided with dates, reasons, staff, and time for medications given, bed changed, hair combed, laundry completed, and assistance with a shower. -On 2/4/18, Staff B documented she assisted	D 269		

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D 269	Continued From page 5 Resident #2 with a shower and laundry. -There was no documentation of any other showers from 2/4/18 through 2/14/18. Interview with the second shift MA/PCA, Staff B, on 3/15/18 at 4:00pm revealed: -She assisted Resident #2 with a shower once per week, which was always on the weekend. -She worked alone on Saturday and Sunday from 7:00am to 8:30pm and worked weekdays from 4:00pm to 8:30pm. -The other 2 MAs/PCAs, Staff A and Staff C were supposed to assist Resident #2 with a shower on Tuesdays and Thursdays. -She had come to work on some days and noticed that Resident #2 was wearing the same clothes as the day before. -Resident #2 required extensive assistance with showering. Attempted telephone interview with Resident #2's responsible person on 2/14/18 at 2:45pm was not successful. Interview with the Administrator on 2/15/18 at 2:40pm revealed: -She did not know Resident #2 was not receiving showers 3 times per week. -She had personal care sheets which staff had been routinely documenting showers and other personal care tasks for the residents. -There was no written guidelines which indicated which staff were responsible for the residents' personal care but all the staff were responsible. -She would assure in the future the staff were fully trained on their individual responsibilities. Refer to interview with the Administrator on 2/15/18 at 2:40pm.	D 269		

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D 269	Continued From page 6 3. Review of Resident #4's current FL2 dated 7/3/17 revealed diagnosis included schizoaffective disorder. Review of Resident #4's Resident Register revealed she was admitted to the facility on 7/8/16. Review of current Care Plan dated 7/2/16 revealed: -Resident #4 required limited assistance with dressing. -There was no documentation of any assessment of her fingernails or toenails. Observation of Resident #4's fingernails and toenails with staff present on 2/14/18 at 12:08pm revealed: -The nail on the second toe on the right foot extended 1/2 inch over the end of the toe and curled tightly under the toe. -The nails on the big, third, fourth, and fifth toe of the right foot extended approximately 1/4 inch beyond the end of the toes. -The toenails on the left foot extended approximately 3/16 inch beyond the end of the toes. -The toenails were thickened and yellow. -The nails of the fingers on her right hand all extended approximately 1/2 inch beyond the ends of the fingers. -The nail of her thumb on her left hand extended approximately 1/3 inch beyond the end of her finger. -The other nails on her left hand extended approximately 1/2 inch beyond the end of her finger. -The fingernails were light yellow colored with brown areas.	D 269		

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D 269	Continued From page 7 Interview with Resident #4 on 2/14/18 at 12:08pm revealed: -She had not asked anyone to cut her fingernails and toenails, but they needed to be cut. -She did not know when her fingernails and toenails had been trimmed. -She did not have any pain in her toes. Interview with the first shift Medication Aide/Personal Care Aide (MA/PCA), Staff A, on 2/14/18 at 3:55pm revealed: -She had been a first shift MA/PCA in this building since the last of November, 2017. -She called the podiatrist "today" to make Resident #4 an appointment, left a message, but they had not returned her call. -Resident #4 was not a diabetic, but she had never trimmed her nails. -Resident #4 had long fingernails "as long as I have known her." -She had never trimmed Resident #4's fingernails and had not observed her toenails. -Resident #4 was independent with showers and dressing, but required prompting for showers. Interview with the other first shift MA/PCA, Staff C, on 2/13/18 at 11:00am revealed: -She worked weekdays from 8:00am to 4:00pm and had just started working there in January 2018. -Her job responsibilities included cooking breakfast and lunch with clean up, cleaning rooms, mopping the floors, cleaning the bathrooms, and assisting residents with showers and personal care. -She had observed Resident #4's long fingernails, but had not observed her toenails. -She was still learning what her job responsibilities were in this facility. -She was not given a list of job responsibilities	D 269		

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D 269	Continued From page 8 which included specific residents' personal care but knew all the staff were responsible. Interview with the Administrator on 2/15/18 at 2:40pm revealed: -She was not aware Resident #4 was not receiving nail care. -The MAs/PCAs job description did not specifically mention nail care for residents, but all three staff had medication management and personal care training which would have included nail care. -The MAs/PCAs were supposed to trim the fingernails and toenails for non-diabetics with the resident's permission. -The Property Manager or Administrator would complete assessments on all residents. Attempted telephone interview with Resident #4's responsible person on 2/14/18 at 3:20pm was not successful. Refer to interview with the Administrator on 2/15/18 at 2:40pm. _____ Interview with the Administrator on 2/15/18 at 2:40pm revealed: -She had personal care sheets which staff had been routinely documenting showers and other personal care tasks for the residents. -Two staff in this facility were fairly new in these MA/PCA positions, but she could have provided more oversight. -The facility policy for resident refusal of personal care was for the staff to go back to the resident at least three times and if they could not get the resident to agree, staff were supposed to get another staff to attempt assistance with personal care.	D 269		

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D 269	Continued From page 9 -If residents continued to refuse care, staff were supposed to notify management and the residents' physicians. -In the future, the Property Manager or Administrator would interview residents on a weekly basis for any concerns about their care. -The Property Manager or Administrator would complete assessments on all residents. -They would require the facility staff to document on the electronic Medication Records the daily personal care that was provided for each resident.	D 269		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up related to podiatry care for 3 of 3 (#1, #2, and #3) diabetic residents and related to a primary care visit for 1 of 3 residents (#1) sampled. The findings are: 1. Review of Resident #1's current FL2 dated 6/1/17 revealed: -Diagnoses included diabetes, cardiovascular disease, atrilfibrilation, pacemaker, chronic	D 273		

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D 273	Continued From page 10 obstructive pulmonary disease, and dementia. -A physician order for Metformin 500 mg daily (a medication to reduce blood sugars). -No physician order for fingerstick blood sugars. -Resident #1 was documented as ambulatory. Review of Resident #1's Resident Register revealed she was admitted to the facility on 6/16/08. Review of Resident #1's Care Plan, dated 5/31/17 revealed: -She required extensive assistance with bathing and limited assistance with grooming and dressing. -There was no assessment of Resident #1's toenails. Observation of Resident #1's fingernails and toenails revealed: -The nail on the big toe of her left foot extended approximately 1/2 inch beyond the end of her toe and curved left, talon-like, over the second toe. -The nail of her second toe on the left foot extended approximately 1/2 inch beyond the end of the toe and curled under tightly into the skin under her toe. -The nails of her third toe, fourth toe, and fifth toe extended approximately 1/3 inch over the end of the toes. -The nail on her big toe of the right foot extended approximately 1/3 inch beyond the end of her toe and curved talon-like, to the right toward the second toe. -The nails on her second toe, third toe, fourth toe, and fifth toe of the right foot extended approximately 1/3 inch beyond the end of her toes. -The toenails were deep yellow colored, thick, and with visible thick yellow crumbly mass	D 273		

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underneath each one.
-The fingernails extended at least 1/4 inch beyond the end of her fingers.

Interview with Resident #1 on 2/13/18 at 4:00pm revealed:
-Her feet and toes hurt and she rated the pain as a number 6 on a scale of 1 to 10 with 10 as the greatest pain.
-Her feet burned and she wore house slippers except when she went out of the facility at physician appointments.
-"I tried to tell them a lot of time" that her toenails needed attention, but staff had done nothing.
-She would not say which staff she had told about her toenails.
-In addition to her nail care concerns, she was still having a problem with constipation but she had not told any staff of that concern.
-She had a family member but would not allow them to come see her.

Review of Resident #1's most recent visit to a podiatrist dated 4/20/17 revealed:
-"Patient presents with thick painful mycotic nails that limit ambulation. She is a diabetic and on Metformin...and with onychomycosis on all toes."
-"Discussed at length a treatment outline and protocol including initiating conservative treatment today, future treatment options and possible surgical intervention should conservative treatment fail to offer relief."
-"Procedure: Manual and electrical grinder debridement of all infected and mycotic nail tissue. Application of topical antifungal agent. This treatment should routinely be provided by a professional given the patient would be at risk for amputation, infection or ulceration without this service. The patient is at risk given their diabetes and poor peripheral vascular status. Manual

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D 273	Continued From page 12 sharp pairing and debridement of all benign hyperkeretotic lesions were performed. The patient's condition is likely to result in significant medical complications in the absence of recommended treatment." -"Return to clinic in 10 weeks." Review of Resident #1's record revealed: -No documentation related to any podiatry appointments that had been scheduled or missed after 4/20/17. -No documentation she ever returned to the podiatrist after 4/20/17. -The last primary care physician dated 6/6/17 was for a "sick" visit related to pain from the hips down and for constipation and a primary care physician was scheduled for 6/14/17. -There was no documentation Resident #1 was seen by the primary care physician on 6/14/17. -There was no Licensed Health Professional Support review for Resident #1 and no task which required a review because Resident #1 did not have a physician order for fingerstick blood sugars. Interview with a first shift Medication Aide/Personal Care Aide (MA/PCA), Staff A, on 2/13/18 at 10:57am revealed: -Resident #1 had an appointment in December 2017 with the podiatrist but she could not find it on the appointment calendar. -She had been a first shift MA/PCA in this building since the last of November, 2017 and another MA/PCA who no longer worked there had been responsible for scheduling all the resident appointments. -She became responsible for scheduling all residents' medical appointments after the other MA/PCA left in November 2017. -She was aware of Resident #1's nails and	D 273		

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thought she had been to the podiatrist recently.
-She did not have any documentation that an upcoming podiatrist visit was scheduled.
-She had not communicated to any upper management about the condition of Resident #1's nails.
-She had never assisted Resident #1 with a shower so would not have observed her toenails.
-She was not aware Resident #1 had missed a primary physician visit on 6/14/17, but the MA/PCA who left would have been responsible.
-Resident #1 did not refuse medical appointments.

Interview with the second shift MA/PCA, Staff B, on 2/13/18 at 4:00pm revealed:
-She had been in that position for at least 1 year but was not aware Resident #1 was in need of nail care.
-She had never assisted Resident #1 with a shower and would not have observed Resident #1's toenails.
-Resident #1 was independent in putting on her socks and shoes.

Interview with the other weekday first shift MA/PCA, Staff C, on 2/13/18 at 11:00am revealed:
-She assisted Resident #1 with a shower about 3 weeks ago, but also noticed her toenails needed attention some time in January.
-She reported to Staff A that Resident #1's toenails needed trimming.
-She worked from 8:00am to 4:00pm and just started working there in January 2018.
-She understood that she and the first and the second shift MAs/PCAs were all responsible for assisting the residents with their showers and other personal care needs.
-Her job responsibilities included cooking

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 3	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 273	Continued From page 14 breakfast and lunch with clean up, cleaning rooms mopping the floors, cleaning the bathrooms, and assisting residents with showers and personal care. -Staff A was responsible for scheduling medical appointments for residents and communicating any resident refusals to management and physicians. -She knew Resident #1 was a diabetic and that she was not allowed to trim her nails. Telephone interview with the receptionist at the podiatrist office on 2/13/18 at 11:17am revealed: -Resident #1 was seen by the podiatrist on 4/20/17. -An appointment was scheduled for 6/29/17 for Resident #1, but she was a "no show." -No other appointments had been scheduled. -Residents were seen by several different podiatrist and none were available for interview. Telephone interview with a nurse at Resident #1's primary care physician office on 2/13/18 at 2:40pm revealed: -Resident #1 was treated on 6/6/17 for a sick visit and referred to and scheduled for a primary care visit on 6/14/17 visit but was a "no show." -They sent the facility a 'no show' letter which indicated the patient had missed at least 2 appointments. -There were no upcoming visits scheduled for Resident #1. -The physician was not available for interview. Telephone interview with Resident #1's family member on 2/13/18 at 2:11pm revealed: -Resident #1 would not allow her to visit and Resident #1 had hung up the phone on her at the last attempted telephone call. -She had not seen Resident #1 since "last	D 273		

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D 273	Continued From page 15	D 273		

summer."
-She did not know if Resident #1 had missed any medical appointments.

Interview with the Administrator on 2/15/18 at 2:40pm revealed:
-She did not know Resident #1 required nail care and did not know that she had missed a podiatrist and physician appointments.
-Resident #1 was now scheduled for a podiatry visit on 2/20/18 and a primary care visit on 2/23/18.

Refer to interview with the Administrator on 2/15/18 at 2:40pm.

2. Review of Resident #2's current FL2 dated 1/15/18 revealed:
-Diagnoses included dementia and cognitive mood disorder, but no diagnosis of diabetes.
-A physician order for Metformin 500 mg twice daily (a medication to lower blood sugar).
-No physician orders for fingerstick blood sugars (FSBSs).

Review of Resident #2's Resident Register revealed she was admitted to the facility on 8/26/08.

Review of Resident #2's current Care Plan dated 1/15/18 revealed:
-Resident #2 required extensive assistance with bathing, dressing, grooming, and limited assistance with toileting and transferring.
-There was no documentation related to Resident #2's fingernails or toenails.
-Documentation of ambulation with cane and wheel chair.

Review of the current Licensed Health

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D 273	Continued From page 16 Professional Review evaluation for Resident #2 dated 12/12/17 revealed: -"Resident refused to be assessed." -"She uses an electric wheelchair and is administered a hand held nebulizer." Observations of Resident #2 during the survey revealed she independently used an electric wheel chair. Observation of Resident #2's fingernails and toenails with staff present on 2/14/18 at 11:25am revealed: -The fingernails extended over the end of her fingers approximately 1/3 inch. -The toenails on the left foot extended approximately 1/3 inch beyond the end of the toes. -The nail of her second toe on the right foot extended approximately 1/3 inch beyond the end of her toe and curved left toward the big toe. -The nails of the third toe, fourth toe, and fifth toe on the right foot extended approximately 1/3 inch beyond the end of her toes. -The nail of the big toe on the right foot extended approximately 1/8 inch beyond the end of the toe. -The toenails were yellow colored and thick with visible thick crumbly mass underneath them. -The finger nails extended at least 1/3 inch beyond the end of her fingers. Interview with Resident #2 on 2/14/18 at 11:15am revealed: -She had some pain in her toes especially when her socks and shoes were put on her. -She had not discussed her toenails with staff. -The second shift MA gave her a bath once per week. -She had not refused any physician or podiatrist appointments but "wanted to go."	D 273		

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D 273	Continued From page 17 Interview with a first shift Medication Aide/Personal Care Aide (MA/PCA), Staff A, on 2/14/18 at 11:25am revealed: -Resident #2 had 3 appointments scheduled for the podiatrist January 6, 17, and 25th, 2018. -The first 2 appointments got canceled because of the bad weather and the appointment on the 25th was canceled because it was scheduled for 3:30pm which was too late for the transportation van to transport her. -On 2/13/18 she called the podiatrist and scheduled an appointment for Resident #2 for 2/15/18 at 10:00am. -She knew Resident #2 had long fingernails because she had scratched herself in the past. Interview with the second shift MA/PCA, Staff B, on 2/13/18 at 4:00pm revealed: -She had been in that position for at least 1 year and assisted Resident #2 with showers. -She was not aware Resident #2 had missed any medical appointments, but that Staff A was responsible for all the residents' medical appointments. Review of the podiatrist visit for Resident #2 on 8/11/17 revealed: -"The patient presents with onychomycosis." -"Findings specific to bilateral toenails: hallux, second toes, fifth toes, yellow, thickened, subungual debris. Findings specific to the right toenail: hallux, incurvated, pincher shaped, painful with palpation. -Follow up "as needed or sooner if symptoms worsen." Telephone interview with the receptionist at the podiatrist office on 2/13/18 at 11:09am revealed: -Resident #2's last office visit was on 8/11/17.	D 273		

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D 273	Continued From page 18 -She had an appointment scheduled for 11/16/17 but was a "no show." -Facility staff made an appointment "today" for her on 2/15/18. -The podiatrists were not available for interview. Telephone interview with the Nurse Practitioner for Resident #2 on 2/14/17 at 2:14pm revealed: -She was new to this position as primary care practitioner in this home and had not seen Resident #2. -She had reviewed Resident #2's record and planned to see her on 2/19/18 for a six months update when she was in the facility. -The previous Nurse Practitioner last saw Resident #2 in July 2017. -The Nurse Practitioner scheduled a visit at least every 6 months with the residents and depended on the facility staff to alert them if a resident required any attention at other times. Interview with the Administrator on 2/15/18 at 2:40pm revealed she did not know Resident #2 missed a podiatrist appointment in November, 2017. Attempted telephone interview with Resident #2's responsible person on 2/14/18 at 3:45pm was not successful. Refer to interview with the Administrator on 2/15/18 at 2:40pm. 3. Review of Resident #3's FL2 dated 6/27/17 revealed: -Diagnoses included diabetes. -Physician orders included routine insulin and sliding scale insulin. Review of Resident #3's Resident Register	D 273		

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D 273	Continued From page 19 revealed she was admitted to the facility on 4/5/05. Review of Resident #3's Licensed Health Professional Support Review, dated 12/12/17 revealed: -Resident #3 would not allow the nurse to observe her toenails. -The nurse assessed Resident #3's FSBSs and insulin medications. Review of the Resident #3's Care Plan dated 3/20/17 revealed: -Resident #3 required extensive assistance with bathing and dressing. -There was no documentation related to Resident #3's nails. Interview with Resident #3 on 2/15/18 at 9:15am revealed: -Her feet were "good." -She refused to allow the surveyor to observe her feet. Telephone interview with the receptionist at the podiatrist office on 2/14/18 at 11:31am revealed: -Resident #3's last visit was on 8/2/17 and she missed an appointment on 11/22/17. -Facility staff called 'today" and made an appointment for 2/26/18. -The podiatrists were not available for interview. Review of Resident #3's podiatrist visit dated 8/2/17 revealed: -Diagnosis: Oncychomycosis, pain in right toes, pain in left toes, diabetes, type 2 with peripheral vascular complications. -"Findings specific to bilateral toenail: plate, hallux, second toes, third toes, fourth toes, yellow, thickened, incurvated, painful with palpation,	D 273		

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D 273	Continued From page 20 hypertrophic, subungual debris, hypertrophic nail bed." -"Follow-up in 3 months." Interview with the first shift Medication Aide/Personal Care Aide (MA/PCA), Staff A, on 2/13/18 at 10:57am revealed: -Resident #3's family member transported her to medical appointments. -The LHPS nurse assessed all the residents when he visited the facility. -She was not aware Resident #3 had missed any medical appointments. -Resident #3 often refused assistance with personal care. Review of Resident #3's record revealed no documentation of any missed medical appointments and no documentation of refusal of personal care in the past 6 months. Interview with Resident #3's responsible person on 2/13/18 at 2:08pm revealed: -She saw Resident #3 about 5 times per week. -She was not aware Resident #3 had missed any medical appointments and was not aware of any upcoming podiatry appointments. Refer to interview with the Administrator on 2/15/18 at 2:40pm. Interview with the Administrator on 2/15/18 at 2:40pm revealed: -Staff A had been promoted to first shift medication aide/personal care aide (MA/PCA) over 2 months ago. -It was the responsibility of Staff A to schedule physician visits. -It was the responsibility for all staff to assess the diabetic and non-diabetic residents for nail care.	D 273		

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D 273	Continued From page 21 -Staff A and Staff C were fairly new in these MA/PCA positions, but she could have provided more oversight. -If residents missed scheduled appointments, staff were supposed to reschedule and notify management. -The Property Manager or Administrator would review medical records on all residents. _____ The failure of the facility to assure referral and follow-up for podiatry care for 3 of 3 diabetic residents (#1, #2, and #3) increased their risk of amputation, infection, or ulceration. The failure of the facility to assure referral and follow-up for 1 resident (#1) for a primary care visit related to an annual physical increased risks related to her diabetes, cardiovascular disease, atrilfibrilation, chronic obstructive pulmonary disease, and dementia. These failures were detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 2/13/18 revealed: -The facility staff will review resident charts to assure compliance with medical follow-ups and appointments. -Paper work from providers will be given to the Administrator or Property Manager daily and will be reviewed daily by the Administrator or Property Manager. -A log of medical appointments will be maintained and documented when completed. -The documentation for medical appointments will be maintained in the Administrator's office. -The medical appointments will also be listed on the electronic Medication Administration Records for each resident.	D 273		

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D 273	Continued From page 22 DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED April 1, 2018.	D 273		
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: Based on observations, interviews, and record reviews, the facility failed to assure all medications were administered as ordered for 1 of 4 residents sampled (#5). The findings are: Review of Resident #5's current FL2 dated 1/8/18 revealed: -Diagnoses included dementia, bipolar disorder, PTSD (Post Traumatic Stress Syndrome), and anxiety disorder. -A physician's order for Klonopin 0.5mg three times per day as needed (a medication used to treat seizures, anxiety, and panic attacks). Review of Resident #5's Resident Register revealed he was admitted to the facility on 1/10/18 and that he did not have a guardian.	D 358		

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D 358	Continued From page 23 Observations of Resident #5's medications on hand available for administration on 2/15/18 at 10:15am revealed no Klonopin 0.5 mg. Review of the Klonopin 0.5 mg controlled drug sheet revealed 60 doses Klonopin 0.5 mg were dispensed on 2/10/18 and administered from 2/10/18 through 8:43am on 2/7/18 with zero balance on 2/7/18. Review of the electronic medication administration record for January and February 2018 revealed documentation of Klonopin 0.5mg administered from 1/10/18 through 2/7/18. Telephone interview with the pharmacy provider on 2/15/18 at 1:15pm revealed: -They dispensed 60 doses Klonopin 0.5 mg on 1/10/18. -They had no record the facility had requested any more Klonopin 0.5 mg since 1/10//18. -They did not need a new prescription to refill the Klonopin 0.5 mg and could send it "today." Interview with Resident #5 on 2/15/18 at 1:45pm revealed: -He had been out of Klonopin for "over a week." -He usually requested the Klonopin 1 or 2 times daily, but sometimes 3 times daily which was the limit. -When he did not take the Klonopin, he felt "like hell," and "yucky, strange, very shaky, sweaty, and anxious to get relief." -The anxiety feeling "creeps up on my like I am going to have a seizure" but he said he did not have seizures. -He had ongoing pain in his foot and shoulder and without the Klonopin the pain was a number 8 or 9 on a scale of 1 to 10 with 10 as the	D 358		

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D 358	Continued From page 24 greatest pain. -He could not remember what the first shift medication aide, Staff A, told him when he asked for Klonopin when it was not available. -The second medication aide, Staff B, told him that she had reported to Staff A that he was out of Klonopin. -He gave Staff A the telephone number of his mental health worker but "she did not call it." The Medication Aide/Personal Care Aide (MA/PCA), Staff A, was not working and not available for interview on 2/15/18. Interview with the second shift MA/PCA, Staff B, on 2/15/17 at 2:15pm revealed: -She knew Resident #5 was out of Klonopin and had reported it twice to Staff A, who was responsible for ordering all the medications. -She knew she could have reported it to the Property Manager or Administrator but kept thinking the medication would come in. Interview with the Administrator on 2/15/17 at 2:40pm revealed: -She did not know Resident #5 had been without Klonopin. -The policy was for the first shift MA/PCA, Staff A, to order medication refills 7 days in advance to assure it was dispensed timely. -If a medication did not come in on time, Staff A was supposed to communicate with her or the Property Manager that it was unavailable. -The Klonopin would be delivered "today" in the afternoon. Attempted telephone interview with the mental health physician on 2/15/17 at 1:55pm was not successful.	D 358		

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D 358	Continued From page 25 Telephone interview with the primary care physician on 2/15/17 at 2:05pm revealed she had not prescribed the Klonopin and could not comment.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up related to podiatry care for 3 of 3 (#1, #2, and #3) diabetic residents and related to a primary care visit for 1 of 3 residents (#1) sampled. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912		

Plan of Care for Corrective Action Report
Date of Monitoring Report – February 15, 2018

10A NCAC 13F .0902(b) Health Care and 10A NCAC 13F .0902 (a)

Administrator and/or property manager will inspect the Personal Care Sheet for each resident weekly. Documentation will be completed on an exception sheet.
Completed by: Administrator or property manager every Monday for the previous week.

Job duties for Med Techs have been updated. Meeting was held for the med techs and understanding signed by all.

Creation of Office Med Follow Up sheet. The administrator and/or property manager will document all appointments. This will allow the office to keep track of all follow-ups that are required. The "TASK" tab in Quick Mar will be utilized for reminders to staff concerning follow-up appointments or referrals.
Completed by: ongoing

The administrator has added a task in the electronic MAR for checking all extremities monthly and weekly for the residents that are diabetic. Staff to notify administrator and/or property manager if referrals are needed.
Completed by: ongoing

Review of Resident charts to ensure medication list is correct, the last physician visit and any follow up task.
Completed by: Administrator, property manager and med techs Feb 28, 2018.

10A NCAC 13F .1004 (a) MEDICATION ADMINISTRATION

Each staff member is required to read and document they understand the facility policy on medication administration and ordering.
Completed by: Meeting scheduled March 26.

G.S. 131D-21(2) DECLARATION OF RESIDENTS RIGHTS

Administrator will have two meetings to review the Resident Rights booklet that everyone received when they were hired.
Completed by: Administrator March 26

Grievance policy updated and delivered to each resident by March 26th by the administrator or property manager.

I. Grievance Procedures:

1. Please discuss any complaints, suggestions or comments with the unit supervisor.
2. A secure drop box will be placed in the facility where only the administrator will have a key for grievances suggestions.
3. If the supervisory staff is unable to assist you, please call the administration and we will direct you to the best possible source for assistance.

1) Adult Home Specialist at DSS (828) 250-5500

2) Land of Sky Regional Ombudsman's (828) 251-6622

3) NCDHSR-Complaint Hotline 1(800) 624-3004

Administration will follow-up with residents on grievance resolutions within 3 business days of the complaint.

MEDICATION ADMINISTRATION

During a resident's stay in the facility the following policy is to be adhered to at all times. ONLY staff who have received and passed the Med Tech Checklist, as determined by the State of N.C., **and** have passed the Med Tech Test administered by the state may give medications in these facilities. It is not enough to have the Med Checklist only in place. Continuing Educations hours (minimum of three (3)) must be received by each staff person administering medications on an annual basis. Additional hours, annually, must be received in the training of Psychotropic medications. **NOTE: Pre-pouring or pre-dispensing of medications is NOT allowed in this facility.**

A. ADMINISTRATION POLICY

1. At each administration remain free of any other duties or interruptions.
2. With the resident in front of you, compare the photograph in the MAR to the photograph in the medication bin to ensure identification.
3. Have at least four (4) ounces of water for the resident. *If the resident is take with food, make sure that the resident has eaten at least 30 minutes before administering the medication. Likewise, if the resident is to take the medication on an empty stomach, make sure that the resident has not eaten for at least two hours before administering the medication or at least 30 minutes before eating. Some directions from the prescribing physician may differ from these; be certain to follow the physician's directions.*
4. Place each medication into a disposable medication cup while wearing disposable gloves.
5. Pass the resident the medication (s) and watch them take each medication; visually check for any "cheeking" of the medications. If "cheeking" is suspected, have the resident open their mouths and lift their tongues to look for any medication. At no time may a resident leave your sight with their medications in hand.
6. Initial the MAR for each and every dose given before moving onto the next resident.
7. After all medications have been given to all residents, insure that the medication cabinet is locked and secure before leaving the area. Medications must remain under a locked status at all times with only qualified staff having access to the key.

B. REFUSAL OF MEDICATIONS

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2. Complete the facility form "Resident Refusal Form" that the resident refused the medication; noting date, time, name and strength of drug. Fax

to prescribing physician and to the office. You must keep the form as well as the confirmation sheet that you notified the prescriber.

3. If the refused medication is life sustaining, or if the resident refuses more than one dose; contact the prescribing physician and make written documentation that this has been done and what directions have been given to you by the physician.

C. MEDICATIONS NOT AVAILABLE

If a medication is not available, due to the pharmacy not having said medication in stock, the pharmacy will, by the terms of the contract, obtain the medication from one of their backup pharmacies. If for some reason this does not happen:

1. In the Quick Mar system click on the medication that is not available, at the next screen click on "Arriving from BRP or Arriving from VA".
2. Note this on the Report of Consultation and notify the prescribing physician.
3. Complete a Drug Error report and copy to all listed via facsimile, including the pharmacy, within one hour of the occurrence.

** Medications will always be ordered when the availability is at a full seven (7) day count. Failure to order medications in a timely manner can result in medications not being available, there is **NO** reason for this to occur.*

D. RESIDENT NOT PRESENT

An occasion may arise when the resident has signed out from the facility, stated to be back for medication administration, and does not do so. Medications may be passed within an one hour time frame of scheduled dosage. If the resident returns outside of this time frame and medication cannot be administered per state regulations, contact prescribing physician for direction and clarification

1. In the Quick Mar system click the medication that the resident has missed, on the next screen click the **Exception** tab and click on **Resident Unavailable**
2. Note the reason why in the note section of the Quick Mar.

E. EMERGENCY OR STAT ORDERS

Emergency, STAT or routine medication orders are to be called into Blue Ridge Pharmacy by the physician, or hard copy of prescription faxed to pharmacy by facility staff, who will fill and deliver the medication as part of the emergency pharmaceutical services within the facility and pharmacy contract. Antibiotics are considered a STAT order by this facility as a delay in administration may endanger the health of the resident. As the facility pharmacy contract provides for all emergency medication services, borrowing of doses from other resident medication supplies is not allowed.

V. PRN'S (PRESCRIBED AS NEEDED)

PRN medications are to be administered only according to the physician's directions. No medication, whether over the counter or prescribed may be given

without clear written directions from the resident's physician. When giving a prn medication

A. In the Quick Mar system click on the medication and administer as usual. Remember you must follow up in one hour on the effectiveness of the PRN. This must be noted in the Quick Mar system (i.e.Headache) and the results from taking the medication (i.e. headache gone after one hour).

B. If a resident requests a PRN on a routine basis, contact the prescribing physician, noting this in the Report of Health Services, and request direction from the physician. If the physician wishes to continue this medication as a PRN and the resident continually requests it on a routine basis being more than a seven (7) day period, the order will have to be changed by the physician or other medication changes made in order to comply with state regulations.

_____ _____

Staff Signature Date

_____ _____

Administrator Signature Date

RHRH - Medication Aide

First of each month call the office to bring down the **PCS Logs** and **MARs** for the previous month.

Monthly Summaries are completed for each resident and turned in to the office with the PCS Logs and MARs. Forms are in the office.

Check Quick Mar to ensure that the correct physician is listed for each resident's medication. Click Resident Orders, click on each medication then click the Everything Tab.

FL 2s updated by June 30th and December 31st of each year or as needed with change of status. Complete online and print.

Physician Orders are completed every quarter – due dates of March 31, June 30, September 30 and December 31. Print from Quick Mar.

Care Plans are updated yearly or in a change of condition such as an emergency room visit or hospitalization.

Resident Register is updated annually.

Activity Plans are completed upon admission and updated every six months. January and June of each year. Activities Evaluation forms are in the office.

Medication Reconciliation – completed upon admission and April, August and December of each year. Forms are located in the office.

Complete **Change In Resident Condition Report** as needed and turn in to the office. Forms are in the office.

Yellow copies of the **Report of Consultation** must be turned in to the office everyday before you leave. Forms are in the office.

Copies of **Discontinued orders or change in orders** must be turned in to the office every day before you leave. Forms are in the office.

Weekly Transportation Schedules must be turned in to the office by Thursday of each week. Faxed copies will not be accepted. Forms are in the office.

All paperwork for Vanessa should be in the office **by 3pm every Thursday**. This includes FL-2, Care Plans, physician order sheet, Report of Consultation, etc.

Please remember that you **CAN NOT** administer medications **UNLESS** you have an order. If you see an order on the Quick Mar that is new you must look to make sure you have an order signed by the prescriber.

Each staff member **MUST review** each order for accuracy. Remember that we can not accept orders that have **variables** such as 1-2 tabs, 4-6 hours, low carb diet, 30 gram of carb diets, etc.

Appointments are scheduled by the med tech. Please follow these guidelines unless physician has scheduled differently:

- PCP visits every 3 months
- OBGYN yearly for PAP Smear and Pelvic Exam
- Mammogram yearly if over the age of 50 or as ordered by physician
- Colonoscopy – base line should be completed for anyone over the age of 50 and then according to physician
- Ophthalmology should be yearly
- Podiatry for diabetics every 3 months
- Other specialty as recommended by referring physician

The Medication Aide and/or CNA must complete Personal Care Services according to the resident care plan. Documentation is completed on the Aide Weekly Task Schedule for each resident **DAILY**. If you are not able to complete the personal care that is schedule you must document on the **PCS Exception Form**.

Each staff member to review the QuickMar course "Reminders". Medical follow up recorded the day resident returns from initial physicians appointment. Reminder for any follow up required. All Staff members are to review the TASK TAB on a daily basis. The administrator and/or property manager will review on a daily basis.

This is a requirement of your position as UM and/or Med Tech.
1st offense = written warning
2cd offense = written warning and suspension for days determined by administrator.
3rd offense = written warning and suspension for days determined by administrator. and up to and/or including termination of employment.

All staff is to complete Progress Notes for each resident on a daily basis. The administrator and/or property manager will review daily.

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1st offense = written warning
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All Facility Policy concerning medications and documentation must be followed. If you do not understand the policy or have questions you are to address those to the administrator or property manager.

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_____ _____
Signature of Staff Date

_____ _____
Signature of Administrator Date

RHRH WEEKLY TRANSPORTATION AND FOLLOW UP SCHEDULE

	TIME AND ADDRESS IN THE DAY COLUMN									
NAME	MONDAY	FOLLOW UP	TUESDAY	FOLLOW UP	WEDNESDAY	FOLLOW UP	THURSDAY	FOLLOW UP	FRIDAY	FOLLOW UP
COMPLETE ON A WEEKLY BASIS AND FAX TO 236-9486 BY THURSDAY AT 3PM										

HOUSE #	NAME	MED AND DIRECTIONS	LAST PHYS VISIT	FOLLOW UP NEEDED	TASK

Plan of Care for Corrective Action Report
Date of Monitoring Report – February 15, 2018

10A NCAC 13F .0902(b) Health Care and 10A NCAC 13F .0902 (a). Completed April 1, 2018

Administrator and/or property manager will inspect the Personal Care Sheet for each resident weekly. Documentation will be completed on an exception sheet. Completed by: Administrator or property manager every Monday for the previous week.
Completed: April 1, 2018 and ongoing until June 1, 2018 to ensure compliance.

Job duties for Med Techs have been updated. Meeting was held for the med techs and understanding signed by all.
Completed: April 2, 2018

Creation of Office Med Follow Up sheet. The administrator and/or property manager will document all appointments. This will allow the office to keep track of all follow-ups that are required. The "TASK" tab in Quick Mar will be utilized for reminders to staff concerning follow-up appointments or referrals.
Completed by: April 1, 2018 and ongoing

The administrator has added a task in the electronic MAR for checking all extremities monthly and weekly for the residents that are diabetic. Staff to notify administrator and/or property manager if referrals are needed.
Completed by: April 1, 2018 and ongoing

Review of Resident charts to ensure medication list is correct, the last physician visit and any follow up task. By administrator, property manager and med techs.
Completed by: April 1, 2018.

10A NCAC 13F .1004 (a) MEDICATION ADMINISTRATION Completed April 1, 2018

Each staff member is required to read and document they understand the facility policy on medication administration and ordering.
Completed by: April 1, 2018

G.S. 131D-21(2) DECLARATION OF RESIDENTS RIGHTS. Completed April 3, 2018

Administrator will have two meetings to review the Resident Rights booklet that everyone received when they were hired.
Completed by: April 3, 2018

Grievance policy updated and delivered to each resident by April 5, 2018 by the administrator or property manager.

I. Grievance Procedures:

1. Please discuss any complaints, suggestions or comments with the unit supervisor.
2. A secure drop box will be placed in the facility where only the administrator will have a key for grievances suggestions.
3. If the supervisory staff is unable to assist you, please call the administration and we will direct you to the best possible source for assistance.

1) Adult Home Specialist at DSS (828) 250-5500

2) Land of Sky Regional Ombudsman's (828) 251-6622

3) NCDHSR-Complaint Hotline 1(800) 624-3004

Administration will follow-up with residents on grievance resolutions within 3 business days of the complaint.

MEDICATION ADMINISTRATION

During a resident's stay in the facility the following policy is to be adhered to at all times. ONLY staff who have received and passed the Med Tech Checklist, as determined by the State of N.C., **and** have passed the Med Tech Test administered by the state may give medications in these facilities. It is not enough to have the Med Checklist only in place. Continuing Educations hours (minimum of three (3)) must be received by each staff person administering medications on an annual basis. Additional hours, annually, must be received in the training of Psychotropic medications. **NOTE: Pre-pouring or pre-dispensing of medications is NOT allowed in this facility.**

A. ADMINISTRATION POLICY

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