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RICHMOND HILL REST HOME # 2	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 an annual survey on December 5, 2019 with an exit conference via telephone on December 6, 2019.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was competency validated by a Registered Nurse with return demonstration prior to performing Licensed Health Professional Support (LHPS) task of finger stick blood sugars and medication administration through injection. The findings are:	D 161		

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D 161	Continued From page 1 Observation of the physical plant and review of licensing records revealed: -There were 5 individually licensed facilities on the property. -All 5 facilities were under the same ownership and management. Review of Staff B's, Medication Aide (MA) personnel record revealed: -Staff B was hired on 08/26/19. -There was documentation of LHPS validation dated 07/02/19 for finger stick blood sugars and medication administration through injection but did not specify which building at the facility she was validated to work at. Review of a residents November 2019 electronic Medication Administration Record (eMAR) for facility #2 revealed Staff B had checked finger stick blood sugars (FSBS) and administered insulin 9 out of 30 days. Review of a residents December 2019 eMAR for facility #2 revealed Staff B had checked FSBS and administered insulin 8 times out of 5 days. Interview with the Medication Aide (MA) on 12/05/19 at 3:00pm revealed: -Her first day working at that building was 12/01/19. -She was off on 12/02/19 and 12/03/19 and then worked 12/04/19 and today (12/05/19). -She "really had not gotten to know all the residents yet." -She had previously worked in a different building at the facility. -She had not completed a new LHPS validation for finger stick blood sugars (FSBS) and medication administration through injection for the building where she worked.	D 161		

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D 161	Continued From page 2 -She had LHPS validation for FSBS and insulin administration for the previous facility where she worked. Interview with the Administrator on 12/05/19 at 3:35pm revealed: -The LHPS Nurse from the facility's contracted pharmacy taught the LHPS skills and validated the ability of the MA to perform finger stick blood sugars and medication administration through injection. -LHPS validation for the MA's were generalized for the entire facility and were not building specific. -When the facility was "short-staffed" she had the MA's work in other buildings at the facility. -She did not know the MA had to have LHPS validation completed for each facility. Telephone Interview with the LHPS Nurse at the facility's contracted pharmacy on 12/06/19 at 12:01pm revealed: -He provided the LHPS training and validated the skills for the medication aides at the facility. -The LHPS validation will not transfer from one building to another if a facility has more than one building. -After the LHPS validation was completed for the MA, he would put the facility's name on the certificate but not a specific building because he did not know which building the MA was hired to work at.	D 161		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes:	D 286		

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D 286	Continued From page 3 (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide sufficient staff for timely, safe, and sanitary food service as evidenced by a male resident observed in the kitchen using ungloved hands to plate food and delivered the plates to the dining room. The findings are: Review of the resident roster on 12/05/19 revealed the facility census was 11 residents. Observation upon entering the facility on 12/05/19 at 9:00am revealed: -There was a medication aide (MA) pushing the medication cart down the hall towards the entrance door to the facility. -There was a male in the kitchen preparing breakfast. -He used his bare hands to pick up cooked waffles lying on a large baking pan and cooked bacon from a second pan and set the food onto plates. -The male carried the plates into the dining room, set them on the table and returned to the kitchen to plate more food. Interview with the male who was plating the breakfast meal on 12/05/19 at 9:15am revealed: -He resided at the facility. -He was bored, the MA was late serving breakfast, and he wanted to help serve the food. -The MA cooked the food. -He plated the food and delivered the plates to the dining room tables.	D 286		

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D 286	Continued From page 4 Interview with the MA on 12/05/19 at 2:40pm revealed: -She was working by herself and was "running behind". -The male in the kitchen serving breakfast was a resident who resided at the facility. -The male resident did not help "that often" in the kitchen. -She prepared and cooked the food. -The male resident plated the food and served it in the dining room. -The male resident said he was bored and volunteered to help. Interview with the Administrator on 12/05/19 at 3:35pm revealed: -The MA informed her the male resident helped serve breakfast on 12/05/19. -She was short a night shift MA in facility #2 the 8:00pm to 8:00am shift. -The night shift MA would cook breakfast and serve it to the residents at 8:00am, while the day shift MA began medication administration. -The MA was not aware residents were only allowed in the kitchen while supervised by staff. -The facility's policies and procedure regarding residents in the kitchen was always for residents to be supervised by staff while in the kitchen, and were required to wash their hands, use gloves and a hair net while working in the kitchen. -She expected all staff to follow the policies and procedures of the facility.	D 286		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the	D 315		

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

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to assure the development of an activity program which promoted active involvement of the eleven living at the facility.

The findings are:

Observation of the physical plant and review of the licensing records revealed:
-There were 5 individually licensed facilities on the property.
-All 5 facilities were under the same ownership and management.

Review of the activity calendar posted on each resident door on 12/05/19 revealed:
-The month on the calendar was December 2019.
-There were 14 hours of scheduled activities Monday through Friday.
-Examples of posted activities included, arts and crafts, coffee social, board games, church service, walking in the neighborhood with identified staff and bingo.
-Most of the activities were listed as being held in "#1" which was the facility next door to this facility (#2).
-The activity posted for 12/05/19 was church from 6pm-8pm.

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D 315	Continued From page 6 Observation on 12/05/19 revealed there were games and crafts in the living room area for use by the residents. Review of the December 2019 calendar revealed: -The activity scheduled for 12/5/19 was church service scheduled to begin at 6:00pm. -Most daily activities were listed as 2- and 3-hour events. -There were no activities scheduled for weekends. -Listed on the calendar for Saturday and Sunday as "Check calendar of events in the [named local newspaper], [facility name] will NOT provide transportation." Resident interviews on 12/05/19 revealed: -"I am not aware of any activities being offered, but if they are I would like to participate." -Church was offered, but they were not interested, had not seen any board games offered and no one had asked them what they would like to do, but if asked would enjoy card games. "I get bored with nothing to do." -"No one has asked about activities" and "I have not seen anything offered, but might do them if asked." -"Sometimes offered but not really interested." -"Activities are OK, I get tired of just doing crafts and do not want to walk." -"No, I don't think they offer activities" and "I do not do the shopping day." -"I guess they offer the activities, not really sure, but it's OK." -"Activities are offered in different homes, so depending on where they are offered and if they tell me I might go." -Two residents reported they were fine without activities.	D 315		

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-One resident stated they really enjoyed activities, "especially the computer classes" that were offered "once or twice a month."
-Two resident reported activities never lasted 2 hours, "maybe 30 minutes to an hour."

Interview with the Medication Aide/Supervisor-in-Charge (MA/SIC) on 12/05/19 at 3:00pm revealed:
-Her first day at this building was 12/01/19.
-She was off on 12/02/19 and 12/03/19 and then worked 12/04/19 and today (12/05/19).
-She "really had not gotten to know all the residents yet."
-She thought activities were offered in different homes and if she was aware of activities, she would try to remind residents of which home the activity was being offered.
-When asked about the coffee/donut social scheduled from 1:00pm until 4:00pm, she stated in my previous facility, it really depended on what the resident wanted to do as to how long activity lasted.
-When asked if she had a specific role related to assuring activities were offered, the MA/SIC responded, "not really, I just make sure they are aware when the activity was offered and what facility they will be offering the activity in."

Interview with the Administrator on 12/05/19 at 3:30pm revealed:
-There were two staff who were certified as activity directors.
-One staff MA/SIC in facility #1 was primarily responsible for coordinating to assure a monthly calendar was posted and that the activities were offered.
-The activities are rotated between the facilities (currently 5 facilities).
-Staff in each facility are responsible for assuring

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D 315	Continued From page 8 residents are aware of the activity and where the activity was being offered. -The facility did not offer activities on the weekend and posted on the calendar for them to check local newspaper for options, but transportation was not provided. Observation during the survey on 12/05/19 from 9:00 am until 3:30pm revealed: -One resident went to a day program. -Three residents were observed staying in their room most of the day, other than at mealtimes. -Six residents were seated on the front porch area smoking throughout the day. -The television was turned on in the living room however there were no residents watching television. Telephone interview with the MA/SIC, facility #1 on 12/05/19 at 4:30pm was unsuccessful.	D 315		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer	D 358		

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medications as ordered by a physician for 1 of 3 sampled residents (Resident #1) related to administering the incorrect dose of fast acting insulin, administering an inhaler for lung disease, and administering a cream and powder without a medication order.

The findings are:

Review of Resident #1's current FL2 dated 09/05/19 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia, respiratory failure, and diabetes.
-There was a physician's order for Novolog (used to treat diabetes) Flexpen (a device used to administer insulin) inject sliding scale insulin as directed - if fingerstick blood sugar (FSBS) 0-150 - inject no units; FSBS 151-200 inject 2 units; FSBS 201-250 inject 4 units; FSBS 251-300 inject 6 units; 301-350 inject 8 units; 351-400 inject 11 units; 400 + inject 13 units.
-There was a physician's order for Proair inhale 2 puffs by mouth four times daily as needed for shortness of breath (used to treat COPD).

a. Review of Resident #1's physician's order dated 09/23/19 revealed a physician's order for Novolog Flexpen Use as directed per sliding scale with meals - if fingerstick blood sugar (FSBS) 0-150 - inject no units; FSBS 151-200 inject 4 units; FSBS 201-250 inject 6 units; FSBS 251-300 inject 8 units; 301-350 inject 10 units; 351-400 inject 12 units; 401 + inject 15 units.

Observation of the medication pass on 12/05/19 at 11:41am revealed:
-The medication aide (MA) checked Resident #1's FSBS in his bedroom.
-Resident #1's FSBS was 243.

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D 358	Continued From page 10 -The MA administered Novolog Flexpen 8 units to Resident #1. Review of Resident #1's December 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Novolog Flexpen Use as Directed per sliding scale with meals scheduled to administer at 8:00am, 12:00pm, and 5:00pm. -Novolog Flexpen was documented as administered at 8:00am, 12:00pm, and 5:00pm for 6 of 13 opportunities when FSBS was greater than 150. -FSBS ranged from 99 to 230 from 12/01/19 to 12/05/19. -FSBS was documented as 254 on 12/05/19 at 12:00pm with 8 units of Novolog Flexpen administered. Observation of medications on hand for Resident #1 on 12/05/19 at 2:30pm revealed one Novolog Flexpen was available to administer with an open date of 12/05/19. Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed the pharmacy last dispensed 3 pens of Novolog Flexpen to Resident #1 on 11/04/19 with the directions Use as Directed per Sliding Scale. Observation of medication pass on 12/05/19 at 4:50pm revealed: -Resident #1 was sitting on the side of his bed. -The MA checked Resident #1's FSBS and the result was 85. Interview with Resident #1 on 12/05/19 at 9:20am and 5:20pm revealed: -His FSBS was checked three times daily by the	D 358		

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Supervisor/MA.
-His FSBS usually ranged from 150 to 200 but did have at tendency to be "low."
-If his FSBS was less than 70, he would get shaky.
-He was not sure what dose of Novolog he was supposed to be administered.

Interview with a Supervisor/MA (Staff B) on 12/05/19 at 3:20pm revealed:
-She administered medications based on the eMAR.
-She did not know what dose of sliding scale insulin she was supposed to administer to Resident #1.
-She did not see the sliding scale directions on the medication order.
-She entered Resident #1's FSBS into the eMAR and it would "pop-up" how much Novolog to administer.
-She had entered the FSBS as 254 on the eMAR and the eMAR "popped" and gave instructions to administer 8 units of Novolog.
-Resident #1's FSBS was only 243 and she should have administered 6 units of Novolog.
-She had entered the FSBS reading into the eMAR incorrectly causing the wrong amount of insulin to "pop" on the eMAR.
-She did not know she had administered the wrong amount of Novolog insulin to Resident #1.

Interview with the Property Manager/MA on 12/05/19 at 3:40pm revealed:
-The Supervisor/MA should have double checked the FSBS reading before entering it onto the eMAR.
-She was responsible for administering orders based on the eMAR.
-The Supervisor/MA should look at the label on the medication and at the eMAR to verify if the

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dose was correct before administering medications.

Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed:
-She had recently discontinued Resident #1's scheduled Novolog dose because his blood sugar was dropping.
-Resident #1 was at an increased risk for hypoglycemia (low blood sugar) if he received more Novolog than the prescribed dose.
-Hypoglycemia increased the risk of Resident #1 having weakness, dizziness, clamminess, loss of consciousness, and even passing out.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm.

Refer to the interview with the Property Manager/MA on 12/05/19 at 3:40pm.

Refer to the interview with the Administrator on 12/05/19 at 5:45pm.

b. Review of Resident #1's record revealed a physician's order dated 10/10/19 for Proair use as directed twice daily for 1 week.

Review of Resident #1's physician's order dated 10/29/19 revealed there was a physician's order to continue Proair inhale 2 puffs every 6 hours as needed.

Observation during initial tour on 12/05/19 at 9:20am revealed:
-There was a Proair inhaler laying on Resident #1's nightstand without a medication label.
-There were 183 doses remaining in the Proair inhaler.

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D 358	Continued From page 13 Interview with Resident #1 on 12/05/19 revealed: -He administered the Proair himself at least once daily. -He would tell the Supervisor/medication aide (MA) when he used the inhaler. -The Supervisor/MA let him keep the inhaler in his room. Review of Resident #1's hospital discharge summary dated 09/05/19 revealed he was discharged from the hospital with diagnoses that included right lower lobe pneumonia, respiratory failure, and an acute COPD flare. Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Proair use as directed twice daily for 1 week scheduled to administer at 8:00am and 8:00pm. -Proair was documented as administered at 8:00pm on 10/29/19 and twice daily on 10/30/19 and 10/31/19. -There was a computer-generated entry for Proair inhale 2 puffs every 6 hours as needed scheduled to administer as needed. -There was no documentation the as needed order for Proair was administered from 10/01/19 through 10/31/19. Review of Resident #1's November 2019 eMAR revealed: -There was a computer-generated entry for Proair use as directed twice daily for 1 week scheduled to administer at 8:00am and 8:00pm. -Proair was documented as administered twice daily at 8:00am and 8:00pm from 11/01/19 to 11/04/19 and at 8:00am on 11/05/19. -There was a computer-generated entry for Proair	D 358		

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inhale 2 puffs every 6 hours as needed scheduled to administer as needed.
-There was no documentation the as needed order for Proair was administered from 11/01/19 to 11/30/19.

Review of Resident #1's December 2019 eMAR revealed:
-There was a computer-generated entry for Proair inhale 2 puffs every 6 hours as needed scheduled to administer as needed.
-There was no documentation the as needed order for Proair was administered from 12/01/19 to 12/05/19.

Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed:
-The pharmacy last dispensed 1 inhaler with 200 doses of Proair to Resident #1 on 10/29/19 with the directions inhale as directed twice daily for 1 week.
-The pharmacy had an order on file from 10/30/19 for Proair with the directions inhale 2 puffs every 6 hours as needed.
-Prior to 10/29/19, the last time the pharmacy had dispensed Proair to Resident #1 was 02/02/19.

Interview with a Supervisor/MA on 12/05/19 at 12:07pm revealed:
-This was her third day working in the facility.
-She did not know Resident #1 had a Proair inhaler in his room.
-She had not administered Proair to Resident #1.

Interview with a second Supervisor/MA on 12/05/19 at 5:00pm revealed:
-She did not know Resident #1 had Proair in his room.
-She did not remember administering Proair to

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D 358	Continued From page 15 Resident #1. -She denied giving the Proair to Resident #1 to keep in his room. Interview with the Property Manager/MA on 12/05/19 at 3:40pm revealed: -She did not know the Proair inhaler was in Resident #1's room. -She did not know the Supervisor/MA was not administering the Proair to Resident #1. -The Supervisor/MA should be administering the Proair to Resident #1. Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed: -Resident #1's Proair should be administered by the MAs. -It was important for all doses of Proair to be documented on the eMAR for her review. -She assessed how well Resident #1's lung disease was controlled by the number of Proair doses he received. -If Resident #1 used his Proair a lot then she would adjust his medication to help prevent a "flare." -Resident #1 was at an increased risk for a chronic obstructive pulmonary disease (COPD) flare or a hospitalization if she did not adjust his medications as soon as he had increased shortness of breath. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm. Refer to the interview with the Property Manager/MA on 12/05/19 at 3:40pm. Refer to the interview with the Administrator on 12/05/19 at 5:45pm.	D 358		

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D 358	Continued From page 16 c. Review of Resident #1's physician's order dated 10/10/19 revealed a physician's order for Nystatin powder apply to affected area twice daily for 14 days (used to treat topical fungal infections). Observation during initial tour on 12/05/19 at 9:20am revealed: -There were two bottles of Nystatin powder on Resident #1's nightstand beside his bed. -There was a partially used 30-gram bottle and a partially used 60-gram bottle. Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) -There was a computer-generated entry for Nystatin powder apply topically to affected area twice daily for 14 days scheduled to administer at 8:00am and 8:00pm. -Nystatin powder was documented as administered twice daily from 10/11/19 to 10/24/19 at 8:00am to 8:00pm. Review of Resident #1's November and December 2019 eMAR revealed there was no computer-generated entry for Nystatin powder. Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed: -The pharmacy had last dispensed 60 grams of Nystatin powder to Resident #1 on 10/10/19 with the directions apply to the affected area twice daily for 14 days. -Resident #1 had no active medications orders for Nystatin powder. Interview with Resident #1 on 12/05/19 at 5:20pm revealed:	D 358		

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-He used the powder on a rash three times weekly.
-He applied the powder himself but would tell the Supervisor/medication aide (MA) when he applied it.
-The rash was "95% gone."
-The Supervisor/MA told him he could keep the medication in his room.

Interview with a Supervisor/MA on 12/05/19 at 5:13pm revealed:
-She did not know if Resident #1 had a previous order for Nystatin powder or that the order was discontinued..
-The Supervisor/MA was responsible for removing discontinued medications from the medication cart.
-The Supervisor/MA was responsible for filling out the return form for the pharmacy and taking the medication to the facility office to be returned to the pharmacy.

Interview with the Property Manager/MA on 12/05/19 at 2:30pm revealed:
-She did not know Resident #1 was administering Nystatin powder himself.
-She did not know the Nystatin powder had been discontinued.
-The medication had been returned to the medication cart.

Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed:
-Resident #1 did not have a current order for the Nystatin powder.
-Resident #1 was prescribed the Nystatin for a rash in his groin.
-She had not treated Resident #1 for a rash in several months.
-Resident #1 should not be using the Nystatin

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powder because he did not need the powder.

Interview with the Administrator on 12/05/19 at 5:45pm revealed:
-She did not know the Nystatin powder was discontinued for Resident #1.
-She did not remember the discontinuation order for the powder.
-She thought the Nystatin powder was not returned to the pharmacy because he never had a discontinued medication order but only a length of treatment on the original order.
-She did not know why the powder was still available to be administered to Resident #1.
-The powder should have been returned to the pharmacy to be destroyed once the medication was discontinued.

Refer to the interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm.

Refer to the interview with the Property Manager/MA on 12/05/19 at 3:40pm.

Refer to the interview with the Administrator on 12/05/19 at 5:45pm.

d. Review of Resident #1's signed physician order sheet dated 04/18/19 revealed a discontinuation order for clotrimazole/betamethasone (used to treat topically inflammation and fungal infections).

Review of Resident #1's record revealed no medication order for clotrimazole/betamethasone dated after the current FL2.

Observation during initial tour on 12/05/19 at 9:20am revealed a partially used tube of clotrimazole/betamethasone cream on Resident

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D 358	Continued From page 19 #1's nightstand. Review of Resident #1's October, November, and December 2019 electronic Medication Administration Record (eMAR) revealed no computer-generated entry for clotrimazole/betamethasone cream. Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed: -The pharmacy had last dispensed a 15-gram tube of clotrimazole/betamethasone to Resident #1 with the directions apply to the groin as needed for soiling and redness on 07/19/19. -The 15 grams was filled for a 5-day supply. -The cream was not on Resident #1's current FL2 dated 09/05/19. -Resident #1 had no active orders for clotrimazole/betamethasone. Interview with Resident #1 on 12/05/19 at 5:20pm revealed: -He had asked one of the medication aides (MA) to keep the cream in his room. -He applied the cream daily. -He told the MA when he used to cream. -His previous Primary Care Provider (PCP) gave him the cream. Interview with a Supervisor/MA on 12/05/19 at 5:13pm revealed: -She did not know Resident #1 had been administering the clotrimazole/betamethasone cream. -She did not know the medication order for the cream was discontinued. -The Supervisor/MA was responsible for removing discontinued medications from the medication cart.	D 358		

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D 358	Continued From page 20 -The Supervisor/MA was responsible for filling out the return form for the pharmacy and taking the medication to the facility office to be returned to the pharmacy. Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed: -Resident #1 did not have a current order for the clotrimazole/betamethasone. -Resident #1 was prescribed the cream for a rash in his groin. -She had not treated Resident #1 for a rash in several months. -Resident #1 should not be using the clotrimazole/betamethasone cream. -It could make the rash harder to treat if Resident #1 used the cream without needing it. -Resident #1 should not have access to medication that has been discontinued. Interview with the Administrator on 12/05/19 at 5:45pm revealed: -She did not know the clotrimazole/betamethasone cream was discontinued for Resident #1. -She did not remember the discontinuation order for the cream. -She did not know why the cream was still available to be administered to Resident #1. -The cream should have been returned to the pharmacy to be destroyed once the medication was discontinued. Refer to the interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm. Refer to the interview with the Property Manager/MA on 12/05/19 at 3:40pm.	D 358		

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D 358	Continued From page 21 Refer to the interview with the Administrator on 12/05/19 at 5:45pm. _____ Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed: -The facility was responsible for faxing the medication orders to the pharmacy. -The pharmacy entered the orders onto the eMAR for the facility to approve. -The facility must approve the medication order before it would appear on the eMAR for the medication aides (MA) to administer the medication. -The process was the same for discontinued medications. -When a medication was discontinued the facility was responsible for returning the medication to the pharmacy to be destroyed. Interview with the Property Manager/MA on 12/05/19 at 3:40pm revealed: -She or the Administrator was responsible for faxing new medication orders or discontinued orders to the pharmacy. -The pharmacy was responsible for entering the order into the eMAR. -She or the Administrator was responsible for approving the medication order to appear on the eMAR. -The MA was responsible for administering medications based on the orders on the eMAR. -She, the Administrator, or the nurse was responsible for auditing the medication carts every 2 to 3 months to make sure all medications were available to administer or returned to the pharmacy if discontinued. -The Administrator was responsible for randomly selecting eMARs weekly to monitor fingerstick blood sugars, weights, and to make sure	D 358		

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D 358	Continued From page 22 medications are being administered. Interview with the Administrator on 12/05/19 at 5:45pm revealed: -The MAs were responsible for bringing all new medication orders to the facility office to be faxed to the pharmacy. -The medication orders are faxed to the pharmacy and she or the Property Manager was responsible for approving the orders for the eMAR. -She copied all medication orders and kept the copy in the facility office. -The MA on duty was responsible for reviewing each new medication order and filing the order in the resident's chart. -The process for a discontinued medication order was the same. -The MA was responsible for removing discontinued medications from the medication cart and returning it to the facility office to return to the pharmacy. -The discontinued medication order should not be filed until the medication was removed from the medication cart. -She or the Property Manager were responsible for auditing the eMAR to the medication cart every 28 days when the cycled medications were exchanged. _____ The facility failed to administer medications as ordered by a physician for Resident #1 related to administering the incorrect dose of Novolog increasing the risk of hypoglycemia and putting the resident at risk of weakness, dizziness, loss of consciousness, and passing out. The facility did not administer a Proair inhaler to Resident #1 increasing the risk of a chronic obstructive pulmonary disease (COPD) exacerbation or a hospitalization because the provider was not able	D 358		

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D 358	Continued From page 23 to assess Resident #1's control of his lung disease and could not adjust medications to prevent these events from occurring. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D 358		
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, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) had physician's	D 375		

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D 375	Continued From page 24 orders to self-administer an inhaler, a powder, and a cream. The findings are: Review of Resident #1's current FL2 dated 09/05/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), pneumonia, respiratory failure, and diabetes. a. Review of Resident #1's physician's order dated 10/29/19 revealed there was a physician's order to continue Proair inhale 2 puffs every 6 hours as needed. Observation during initial tour on 12/05/19 at 9:20am revealed: -There was a Proair inhaler laying on Resident #1's nightstand without a medication label. -There were 183 doses remaining in the Proair inhaler. Review of Resident #1's November 2019 eMAR revealed: -There was a computer-generated entry for Proair inhale 2 puffs every 6 hours as needed scheduled to administer as needed. -There was no documentation on the eMAR indicating the Proair was self-administered. Review of Resident #1's December 2019 eMAR revealed: -There was a computer-generated entry for Proair inhale 2 puffs every 6 hours as needed scheduled to administer as needed. -There was no documentation on the eMAR indicating the Proair was self-administered. Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm	D 375		

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revealed:
-The pharmacy last dispensed 1 inhaler with 200 doses of Proair to Resident #1 on 10/29/19 with the directions inhale as directed twice daily for 1 week.
-The pharmacy had an order on file from 10/30/19 for Proair with the directions inhale 2 puffs every 6 hours as needed.
-Prior to 10/29/19, the last time the pharmacy had dispensed Proair to Resident #1 was 02/02/19.

Review of Resident #1's record revealed no physician's order to self-administer the Proair inhaler.

Interview with Resident #1 on 12/05/19 revealed:
-He used his Proair inhaler at least once daily.
-The Supervisor/MA let him keep the inhaler in his room.
-He would tell the Supervisor/medication aide (MA) when he used the inhaler.

Interview with a Supervisor/MA on 12/05/19 at 12:07pm revealed:
-This was her third day working in the facility.
-She did not know Resident #1 had a Proair inhaler in his room.
-She did not know if Resident #1 had an order to self-administer Proair.

Interview with a second Supervisor/MA on 12/05/19 at 5:00pm revealed:
-She did not know Resident #1 had Proair in his room.
-She denied giving the Proair to Resident #1 to keep in his room.

Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed:
-Resident #1's Proair should be kept on the

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medication cart.
-Resident #1 should not be self-administering his Proair inhaler.
-It was important for all doses of Proair to be documented on the eMAR for her review.
-Resident #1 was at an increased risk for a chronic obstructive pulmonary disease (COPD) flare or a hospitalization if she did not adjust his medications as soon as he had increased shortness of breath.

Interview with the Administrator on 12/05/19 at 5:45pm revealed:
-She did not know Resident #1 had the Proair in his room.
-She did not know who had given Resident #1 the Proair inhaler.
-She did not know if Resident #1 had a physician's order to self-administer the inhaler.
-The MA should be administering the inhaler if the resident did not have an order to self-administer.

b. Review of Resident #1's physician's order dated 10/10/19 revealed a physician's order for Nystatin powder apply to affected area twice daily for 14 days (used to treat topical fungal infections).

Observation during initial tour on 12/05/19 at 9:20am revealed:
-There were two bottles of Nystatin powder on Resident #1's nightstand beside his bed.
-There was a partially used 30-gram bottle and a partially used 60-gram bottle.

Review of Resident #1's November and December 2019 eMAR revealed:
-There was no computer-generated entry for Nystatin powder.
-There was no documentation on the eMAR

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	HAL011191	A. BUILDING: _____ B. WING _____	12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 375	Continued From page 27	D 375		

indicating the Nystatin powder should be self-administered.

Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed:
-The pharmacy had last dispensed 60 grams of Nystatin powder to Resident #1 on 10/10/19 with the directions apply to the affected area twice daily for 14 days.
-Resident #1 had no active medications orders for Nystatin powder.

Review of Resident #1's record revealed no physician's order to self-administer the Nystatin powder.

Interview with Resident #1 on 12/05/19 at 5:20pm revealed:
-The Supervisor/medication aide (MA) told him he could keep the medication in his room.
-He used the powder daily on a rash three times weekly.
-He applied the powder himself but would tell the Supervisor/MA when he applied it.

Interview with a Supervisor/MA on 12/05/19 at 5:13pm revealed:
-She did not know Resident #1 had Nystatin powder in his room.
-She did not know if Resident #1 had a physician's order to self-administer the Nystatin powder.

Interview with a second Supervisor/MA on 12/05/19 at 5:00pm revealed:
-She did not know Resident #1 had Nystatin powder in his room.
-She denied giving the Nystatin powder to Resident #1 to keep in his room.

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D 375	Continued From page 28 Interview with the Property Manager/MA on 12/05/19 at 2:30pm revealed: -She did not know Resident #1 was administering Nystatin powder himself. -She did not know the Nystatin powder had been discontinued. -She did not know if Resident #1 had an order to self-administer the powder. Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed: -Resident #1 did not have a current order for the Nystatin powder. -Resident #1 should not be self-administering the Nystatin powder. Interview with the Administrator on 12/05/19 at 5:45pm revealed: -She did not know Resident #1 had the Nystatin powder in his room. -She did not know who had given Resident #1 the Nystatin powder. -She did not know if Resident #1 had a physician's order to self-administer the powder. -The MA should be administering the powder if the resident did not have an order to self-administer. -The powder should have been returned to the pharmacy if the physician's order was discontinued. d. Review of Resident #1's signed physician order sheet dated 04/18/19 revealed a discontinuation order for clotrimazole/betamethasone (used to treat topically inflammation and fungal infections). Review of Resident #1's record revealed no medication order for clotrimazole/betamethasone dated after the current FL2.	D 375		

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D 375	Continued From page 29 Observation during initial tour on 12/05/19 at 9:20am revealed a partially used tube of clotrimazole/betamethasone cream on Resident #1's nightstand. Review of Resident #1's October, November, and December 2019 electronic Medication Administration Record (eMAR) revealed: -There was no computer-generated entry for clotrimazole/betamethasone cream. -There was no indication that the clotrimazole/betamethasone cream was self-administered. Interview with a pharmacist from the facility's contracted pharmacy on 12/05/19 at 3:56pm revealed: -The pharmacy had last dispensed a 15-gram tube of clotrimazole/betamethasone to Resident #1 with the directions apply to the groin as needed for soiling and redness on 07/19/19. -The 15 grams was filled for a 5-day supply. -The cream was not on Resident #1's current FL2 dated 09/05/19. -Resident #1 had no active orders for clotrimazole/betamethasone. Review of Resident #1's record revealed no physician's order to self-administer the clotrimazole/betamethasone cream. Interview with Resident #1 on 12/05/19 at 5:20pm revealed: -He had asked one of the medication aides (MA) to keep the cream in his room. -He applied the cream every day. -He told the MA when he used to cream. Interview with a Supervisor/MA on 12/05/19 at	D 375		

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D 375	Continued From page 30 5:13pm revealed: -She did not know Resident #1 had clotrimazole/betamethasone in his room. -She did not know if Resident #1 had an order to self-administer the clotrimazole/betamethasone. -She did not know who gave the cream to Resident #1. Interview with the Property Manager/MA on 12/05/19 at 2:30pm revealed: -She did not know Resident #1 was administering clotrimazole/betamethasone himself. -She did not know the cream had been discontinued or if Resident #1 had a physician's order to self-administer the cream. Interview with Resident #1's Nurse Practitioner (NP) on 12/05/19 at 4:00pm revealed: -Resident #1 did not have a current order for the clotrimazole/betamethasone and should not be self-administering the cream. -Resident #1 was prescribed the cream for a rash in his groin. -Resident #1 should not be using the clotrimazole/betamethasone cream. Interview with the Administrator on 12/05/19 at 5:45pm revealed: -She did not know the clotrimazole/betamethasone cream was in Resident #1's room. -She did not know who gave the resident the cream. -She did not know if Resident #1 had a physician's order to self-administer the cream. -The MA should be administering the cream if the resident did not have an order to self-administer. -The cream should have been returned to the pharmacy if the physician's order was discontinued.	D 375		

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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 residents received care and services that are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 3 sampled residents (Resident #1) related to administering the incorrect dose of fast acting insulin, administering an inhaler for lung disease, and administering a cream and powder without a medication order [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency	D935		

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D935	Continued From page 32 Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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D935	Continued From page 33	D935		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the Medication Clinical Skills validation was completed for 1 of 3 sampled Medication Aides (Staff B) when the Medication Aide transferred from one facility to another.

The findings are:

Observation of the physical plant and review of licensing records revealed:
-There were 5 individually licensed facilities on the property.
-All 5 facilities were under the same ownership and management.

Review of Staff B's, Medication Aide (MA) personnel record revealed:
-Staff B was hired on 08/26/19.
-There was documentation of a completed Medication Clinical Skills validation dated 07/02/19 but did not specify which building at the facility she was validated to work at.

Review of a residents November 2019 electronic Medication Administration Record (eMAR) for facility #2 revealed Staff B had checked finger stick blood sugars (FSBS) and administered insulin 9 out of 30 days.

Review of a residents December 2019 eMAR for facility #2 revealed:

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D935	Continued From page 34 -Staff B had checked FSBS and administered insulin 8 times out of 5 days. -Staff B had administered the incorrect dosage of insulin on 12/05/19 at 11:41am. Interview with the Medication Aide (MA) on 12/05/19 at 3:00pm revealed: -Her first day working at that building was 12/01/19. -She was off on 12/02/19 and 12/03/19 and then worked 12/04/19 and today (12/05/19). -She had typed in the FSBS incorrectly on the insulin calculator in the computer and that was why she had administered the incorrect dosage of insulin. -There was usually a sliding scale insulin guide visible in the comment section of the eMAR but she could not see it to make sure she administered the correct dosage of insulin. -She had previously worked in a different building at the facility. -She had not completed a new Medication Clinical Skills validation for the building where she recently worked. Interview with the Administrator on 12/05/19 at 3:35pm revealed: -The Licensed Health Professional Support (LHPS) Nurse from the facility's contracted pharmacy taught the Medication Clinical Skills and validated the ability of the MA to correctly check FSBS and administer medications to residents. -The Medication Clinical Skills list for the MA's were generalized for the entire facility and were not building specific. -When the facility was "short-staffed" she had the MA's work in other buildings at the facility. -She did not know the MA had to have the Medication Clinical Skills validation completed at	D935		

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D935	Continued From page 35 each facility. -She did not know why the sliding scale insulin guide was not visible in the comment section on the eMAR for the MA to read and know how much insulin to administer a resident. Telephone Interview with the LHPS Nurse at the facility's contracted pharmacy on 12/06/19 at 12:01pm revealed: -He taught the 15-hour Medication Training class to the MA's and watched the MA perform a medication pass to validate their skills. -The 15-hour Medication Training will transfer from one facility to another. -The Medication Clinical Skills must be completed for each building at the facility if the MA's were going to work in more than one building. -After the Medication Clinical Skills were completed for Staff B, he put the facility's name on the certificate but not a specific building because he did not know which building the Staff B was hired to work at.	D935		