STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011376	A. BUILDING: _____ B. WING _____	R 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 1	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 05/26/21-05/28/21, 06/01/21 with an exit conference via telephone 06/02/21.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 2 of 3 sampled staff (Property Manager/Medication Aide (PM/MA) and the Administrator). The findings are:	D 167		

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D 167	Continued From page 1 1. Review of the PM/MA's personnel record revealed: -She was hired on 09/16/10. -The last documentation of completion of CPR and choking management expired 01/16/19. Interview with the PM/MA on 06/01/21 at 4:30pm revealed: -She did not know her CPR and choking management had expired. -It was the Administrators responsibility to make sure staff had completed CPR and choking management. -She was the only staff member in this facility at times due to staff shortages. Refer to the interview with the Administrator on 06/02/21 at 11:08am. 2. Attempted review of the Administrator's personnel record revealed there was no record provided to review. Interview with the Administrator on 06/02/21 at 11:08am revealed: -She was hired the first week of April 2021. -She did not have CPR training and choking management in the last 24 months. -She was the only staff member in this facility at times due to staff shortages. -She did not know that the PM/MA's CPR training had expired. -She did not know when the last CPR training was offered in the facility. -She was responsible for making sure staff records related to CPR training were up-to-date and complete. -She was responsible for making sure staff had completed all required training.	D 167		

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D 167	Continued From page 2 -She was responsible for the total operations of the facility. Attempted review of records revealed there were none and no way to determine if a resident was a full code. _____ The facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) and choking management related to the PM/MA and the Administrator being the only employees and supervising residents throughout the shift without CPR certification. 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 05/29/21 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2021.	D 167		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall	D 176		

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D 176	Continued From page 3 share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services related to training on cardio-pulmary resuscitation, infection prevention and control, health care, food and nutrition and to be free of neglect as related to management of facilities. The findings are: Interview with a resident on 05/26/21 at 12:51pm revealed: -She had concerns about living in the facility. -"I am afraid to stay here because they don't always have a staff member here for the building and I am afraid." Interview with a second resident on 05/27/21 at 12:25pm revealed: -Staff frequently left the residents alone. -She had difficulty with breathing and had to use	D 176		

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her oxygen but was unsure what would happen to her if she was in distress and staff were not in the facility.

Interview with a third resident on 05/26/21 at 12:34pm revealed:
-"Staff are hard to find."
-Staff visited other facilities to socialize or they had to go administer medications in other facilities because they were short staffed.
-Residents were left alone 2-3 days every week but it was not all day.
-Staff would come back to administer the medications and fix meals but would hurry out the door again.
-She had tried to find staff but sometimes had to go to multiple houses before she could find anyone.

Interview with a fourth resident on 05/26/21 at 1:00pm revealed:
-The MA left residents alone every time she worked.
-The MA comes in late almost every time.
-When the MA worked, she usually received her medication about 9:30am-10:00am when she was supposed to get them at 8:00am.
-The Property Manager (PM)/MA came in on 05/24/21 and gave medications and residents were alone the rest of the time because PM/MA had to give medications in the other facilities and there was no staff to stay at the facility.
-On 05/23/21 her capillary blood sugars (CBGs) could not be done because she could not find the MA.
-She was frequently afraid because they were left alone in the facility.
-She was afraid for the other residents too as one resident had severe breathing issues and she would not know what to do if something

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happened to her.
-She was afraid the other resident would die before she could find a staff member.
-She did not know what to do to help her if staff could not be found.
-She had told the MA and the Administrator about her concerns and nothing had been addressed about her concerns.

Interview with a MA on 05/27/21 at 3:50pm revealed:
-She had discussed her concerns regarding dietary issues for the residents with the Administrator and the Owner.
-She had told the Administrator of her concerns regarding staff leaving residents alone and how "distressed" the residents were each time she came back on her shift.
-She had told the Administrator for several days she did not have access to the resident records but it wasn't until Surveyors came in that the records were unlocked.
-The Administrator seemed "unconcerned" about issues and concerns she had shared.

Telephone interview with the Administrator on 06/02/21 at 11:08am revealed:
-She started working as the Administrator during the first week of April 2021 but could not recall the specific date.
-The overall operation of the facility was her responsibility.
-She was at the facility Monday through Friday and could be reach by phone on the weekends if needed.
-Staff training was also her responsibility.
-There were other staff who were responsible for staff schedules, paperwork, audits, following up on physicians orders and other duties but it was her responsibility to ensure their assigned duties

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D 176	Continued From page 6 were done. -She was the Administrator and it was her responsibility ensure staff did what they were supposed to do. -She was not aware residents were being left alone, residents were fearful of being alone and not receiving medications and meals in a timely manner, medications were not available for administrtiont, new physician orders were not being followed up on or implemented, record and medication audits were not being completed, visitors needing to be screened for signs and symptoms, one resident had not been vaccinated or offered the vaccination for COVID-19 and records not being readily available and accessible. -She was aware staff had been outside in the parking lot smoking instead of being in this facility, leaving residents alone. -She was unaware of staff leaving their facilities for extended periods of time until it was brought to her attention by surveyors. -Staff were expected to get coverage if they needed to leave their homes. -Three residents had told her prior to 05/26/21 that "no one ever came up there" (to the facility) and she passed it on to the MA but had not investigated the concerns any further. -There was no process for resident concerns or complainants. Noncompliance was documented in the following rule areas. Based on observations and interviews, the facility failed to ensure there were always at least one staff member in the facility ensuring that at no time a resident was left alone without a staff member in the facility. [Refer to Tag D 0177 10A	D 176		

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D 176	Continued From page 7 NCAC 13F .0601(b)(3) Management of Facilities with a capacity or census of seven to thirty Residents (Type A1 Violation).] Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from neglect related to residents being fearful of being left alone in the facility and for ensuring all required duties were carried out. [Refer to Tag D 0914 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).] Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 2 of 3 sampled staff (Property Manager/Medication Aide (PM/MA) and the Administrator). [Refer to Tag D 0167 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation).] Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (Resident #2) regarding an order for a finger stick blood sugar (FSBS), complete blood count (CBC) with differential, complete metabolic panel (CMP), fasting lipid panel, hemoglobin A1C (HbA1C), microalbumin, TSH and Free T4. [Refer to Tag D 0273 10A NCAC 13F .0902(c)(3) Health Care (Type B Violation).] Based on observations, record reviews and interviews the facility failed to provide therapeutic diets for a resident on a no concentrated sweet diet (NCS) (Resident #1) for a resident and a carbohydrate controlled with no fruit juices diet for a resident (Resident #2) as ordered by their primary physicians for 2 of 3 sampled residents.	D 176		

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D 176	Continued From page 8 [Refer to Tag D 0310 10A NCAC 13F .0904 (e)(4) Food and Nutrition (Type B Violation.).] Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 11 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents, staff, and visitors and wearing required personal protective equipment (PPE). [Refer to Tag D 0612 10A NCAC 13F .1801 (a)(b) Infection Prevention and Control Program (Type B Violation).] Based on observations, record review and interviews the facility failed to develop a care plan for 1 of 3 sampled residents, (Resident #2) [Refer to Tag D 0259 10A NCAC 13F .0802(a) Resident Care Plans]. Based on observations, record reviews and interviews the facility failed to provide substitutions of equal nutritional value 11 of 11 residents [Refer to Tag D 0292 10A NCAC 13F .0904(c)(3) Nutrition and Food Service]. Based on observation, interviews and record review the facility failed to maintain resident records in an orderly manner and readily available for review [Refer to Tag D 0433 10A NCAC 13F .1201 Resident Records]. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner during the morning medication pass for 1 of 2 residents (Resident #1), including a	D 176		

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D 176	Continued From page 9 medication used to treat bipolar disorder (Resident #1) and for 2 of 3 sampled residents (Residents #2 and #3), including a medication to treat high blood sugars (Resident #2), and medications used to treat shortness of breath and allergies (Resident #3) [Refer to Tag D 0358 10A NCAC 13F .1004(a) Medication Administration]. Based on record reviews and interviews the facility failed to follow up on a pharmacy recommendation for a decrease in medication used to treat osteoarthritis for 1 of 3 sampled residents (Resident #3) Pharmaceutical Care]. _____ The Administrator failed to ensure the management and total operations of the facility were maintained related to residents being left alone and fearful of being left alone and not knowing what to do in case of an emergency, not receiving their medications and meals in a timely manner. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/29/21. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED July 02, 2021.	D 176		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities With A Capacity Or 10A NCAC 13F .0601 Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (b) At all times there shall be one administrator or administrator-in-charge who is directly	D 177		

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responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions in Paragraph (c) of this Rule, one of the following arrangements shall be used to manage a facility with a capacity or census of 7 to 30 residents:
(1) The administrator is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times;
(2) An administrator-in-charge is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; or
(3) When there is a cluster of licensed homes, each with a capacity of 7 to 12 residents, located adjacently on the same site, there shall be at least one staff member, either live-in or on a shift basis in each of these homes. In addition, there shall be at least one administrator or administrator-in-charge who is within 500 feet of each home with a means of two-way telecommunication with each home at all times and directly responsible for assuring that all required duties are carried out in each home.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations and interviews, the facility failed to ensure there were always at least one staff member in the facility ensuring that at no time a resident was left alone in the facility.

The findings are:

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D 177	Continued From page 11 Interview with a Medication Aide (MA) on 05/26/21 at 9:22am revealed there were 11 residents currently residing in the home. Observation on 05/28/21 at 8:10am of the parking lot revealed: -The Administrator and staff from the sister facilities were outside in the parking lot between this facility and a sister facility talking and smoking. -The main office was approximately 169 feet away from the facility. -The Administrator entered the facility at 8:12am and no other staff were observed in this facility. -There were 3 residents on the front porch of the facility. -There was one resident who was leaving to go to an appointment. -There were 2 residents in the living room watching television. -There was a resident lying on her bed with oxygen concentrator set on 7 liters. Interview with the Administrator on 05/28/21 at 8:10 am revealed: -She was covering the facility until staff could arrive from a personal appointment. -She was unsure as to what time the scheduled staff would arrive at work. -Staff were scheduled to work from 8:00am to 8:00pm. Interview with the Administrator on 05/28/21 at 8:32am revealed: -She was leaving the facility to go to the main office. -Another staff was at a sister facility if the residents needed anything. -The night shift staff made breakfast for the	D 177		

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residents which was the usual routine before night shift staff left.
-There was one resident who had not eaten but had to wait so long to eat after the resident took her medicine.

Observation on 05/28/21 at 9:20am of the facility revealed:
-There were no staff in the facility.
-There were 2 residents on the front porch.
-There was a resident in the kitchen cleaning up the kitchen, loading dishes in the dishwasher and starting it.
-There were 5 other residents in the living room watching television.
-One resident was lying in bed with her oxygen concentrator set on 6 liters of oxygen.
-There were 2 other residents in there rooms.

Interview with a resident sitting in the living room on 05/28/21 at 9:20am revealed:
-She was waiting on the Administrator to fix her breakfast but the Administrator had left the facility and not returned.
-She had to wait for 30 minutes after taking her medications to eat and that was at 8:30am this morning.

Observations on 05/28/21 between 10:10am-10:32am revealed:
-The Administrator was covering for the day shift MA staff in the facility.
-The Administrator left the facility and went to the main office.
-There was no other staff in the building.
-During this time there were several residents smoking on the porch, a few in the living room and some were in their rooms.
-The Administrator returned to the building at 10:32am.

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D 177	Continued From page 13 -A resident reminded the Administrator another resident was still waiting on her breakfast from this morning after having to wait because of her medicine. -At 10:35am the Administrator fixed the resident a bowl of cereal who had been waiting. Observation in the facility on 05/28/21 between 1:05pm-1:20pm revealed: -There was no staff working in the facility. -A female resident was in the kitchen washing dishes. -A second female resident was sitting on the couch in the living room. Interview with one resident on 05/28/21 at 1:10pm revealed: -She did not feel safe living at the facility. -The facility did not have enough staff. -The facility did not have a staff member working at the facility that day. -The Administrator went to the facility to serve the breakfast and lunch meals to the residents "but then leaves" the facility. -The MA from a sister facility administered the residents their scheduled medications that morning and then left to return to the sister facility. -This usually happened 2-3 days a week. Observations on 05/28/21 between 2:44pm-3:00pm of the facility revealed: -The MA staff left facility and went to a sister facility. -There was no other staff present in this facility. -The MA returned at 3:00pm. Observation on 05/28/21 at 2:39pm revealed: -One resident was lying in bed, resting with her oxygen on at 7 liters.	D 177		

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(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 177	Continued From page 14 -The residents skin was very pale in color. Observation on 06/01/21 at 2:52pm revealed: -A resident lying in bed with her oxygen on at 6 liters. -There was no staff in the building at this time. Interview with a resident on 05/26/21 at 10:10am revealed: -Staff frequently left the residents alone in the facility. -Staff had to leave their facility at times to give medication in sister facility. -Resident medications and meals were given late 2-3 days a week. -Her medication was due at 8:00am and it would be given "frequently" after 10:00am as there was no one to give her meds when they were due. -She had shared her concerns with a MA who offered support but no response to her concerns. Interview with a second resident on 05/26/21 at 11:28am revealed: -The facility was frequently short staffed. -Staff frequently left the facility for "long periods of time" each week. -She was concerned if she had an emergency and the staff were not in the facility what would happen to her. Interview with a third resident on 05/26/21 at 12:51pm revealed: -She had concerns about living in the facility. -"I am afraid to stay here because they don't always have a staff member here for the building and I am afraid." Interview with a fourth resident on 05/27/21 at 12:05pm revealed: -Staff left the residents alone at least 2-3 days a	D 177		

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D 177	Continued From page 15	D 177		

week except for meals and when they came in to give medication.
-The last time was on 05/24/21.
-As soon as staff finished giving the medication or fixing the meal they would leave, and a female resident would clean up the kitchen.
-The inconsistency of staff and being left alone is what "scares me" about living at the facility.
-She told the MA and the Administrator about her concerns but there was no response because they were short staffed.

Interview with a fifth resident on 05/27/21 at 12:25pm revealed:
-Staff "frequently" left the residents alone.
-She had difficulty with breathing and had to use her oxygen but was unsure what would happen to her if she was in distress and staff were not in the facility.

Interview with a sixth resident on 05/26/21 at 12:34pm revealed:
-"Staff are hard to find."
-Staff went to visit sister facilities to socialize or they had to go give medications in other facilities because they were short staffed.
-Residents were left alone 2-3 days every week but it was not all day.
-Staff would come back to administer the medications and fix meals but would hurry out the door again.
-She tried to find staff but sometimes went to multiple facilities before she could find anyone.

Interview with a seventh resident on 05/26/21 at 1:00pm revealed:
-The MA left residents alone every time the MA worked.
-The MA came in late almost every time.
-When the MA worked, she usually received her

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D 177	Continued From page 16	D 177		

medication about 9:30am-10:00am when she was supposed to get them at 8:00am.
-The Property Manager (PM/MA) came in on 05/24/21 and administered medications and residents were alone the rest of the time because the PM/MA had to administer medications in the other facilities and there was no staff to stay at the facility.
-On 05/23/21, her capillary blood sugars (CBGs) could not be obtained because she could not find the MA.
-She was frequently afraid because they were left alone in the facility.
-She was afraid for the other residents too as one resident had severe breathing issues and she would not know what to do if something happened to her.
-She was afraid the other resident would die before she could find a staff member.
-She did not know what to do to help her if staff could not be found.
-She told the MA and the Administrator about her concerns and nothing had been addressed about her concerns.

Interview with the Administrator on 05/28/21 at 9:40am revealed:
-She was responsible for scheduling qualified staff for each facility with a least a MA.
-She had had numerous challenges with staffing of the past month.
-She had scheduled a MA to administer medications at the facility and at a sister facility or sister facilities.
-She was supposed to have a MA in the facility and 3-5 personal care aides (PCA).
-There was a staff member that did not call or show up for her shift on 05/24/21, 8:00am to 8:00pm.
-On 05/24/21, she staffed the facility with the

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D 177	Continued From page 17 PM/MA. -She told the residents in the facility to be on the front porch of facility on 05/24/21 for an impromptu cookout for lunch and dinner because they were short of staff. -She checked on the facility as much as she could on 05/24/21 but she was involved in something else. -It was "all they could do" that day. -There was a MA who was late for her shift on 05/28/21 at the facility, 8:00am to 8:00pm. -On 05/28/21, she staffed the facility with herself and had asked a MA from a sister facility to administer the morning medications. -She was aware staff used their personal phones to text each other and herself if they needed something. -Residents who required assistance could come to the main office (approximately 169 feet away from the facility) or to one of the sister facilities (the closest being approximately 50 feet) to find staff to assist them. -Residents could call 911 on the facility phone if staff could not be located. Interview with the PM/MA on 06/02/21 at 4:30pm revealed: -No residents ever told her they were concerned or fearful of being alone, or they received their meals or medications late. -The facility was in "dire need" of staff. -She had mainly been working as a MA as there was not enough staff for all five buildings. -The expectation was for staff to be in their assigned facility and take care of the residents. -Residents had to have their medications and meals on time. -She recalled one incident where a resident was afraid at night and called her family but she could not remember when.	D 177		

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D 177	Continued From page 18 -She slept on the couch at the facility that night but did not recall the date. Telephone interview with the Administrator on 06/02/21 at 11:08am revealed: -She was aware staff had been outside in the parking lot smoking instead of being in this facility, leaving residents alone. -She was unaware of staff leaving their facilities for extended periods of time until it was brought to her attention by surveyors. -Staff were expected to get coverage if they needed to leave their homes. -Three residents had told her prior to 05/26/21 that "no one ever came up there" (to the facility) and she passed it on to the MA but had not investigated the concerns any further. -There was no process for resident concerns or complaints. _____ The Administrator failed to ensure there were always one staff in the home and ensuring that at no time a resident was left alone without a staff in the facility resulting in residents being fearful of being alone, fearful of what to do in the case of an emergency and not receiving their medications and meals in a timely manner which resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/28/21. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED July 02, 2021.	D 177		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan	D 259		

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D 259	Continued From page 19 (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to develop a care plan for 1 of 3 sampled residents, (Resident #2). The findings are: Review of Resident #2's current FL2 dated 03/17/20 revealed diagnoses included depression, arthritis, osteopenia, coronary artery disorder, gout, vertigo, schizophrenia, personality disorder, and obesity. Review of Resident #2's Post Discharge Plan and Summary sheet from a local rehabilitation facility dated 04/05/21 revealed: -She had a diagnoses of type 2 diabetes mellitus, acquired absence of kidney, chronic obstructive pulmonary disease (COPD), hypertension, and morbid obesity due to excess calories. -She was admitted to the rehabilitation center, from the local hospital, on 03/20/21 and was discharged to the facility on 04/05/21. -There was no updated FL2 sent from the rehab facility. Review of Resident #2's endocrinologist's telehealth visit note dated 05/07/21 revealed: -She was recently admitted to the hospital in March 2021 for a partial nephrectomy (removal of part of kidney).	D 259		

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D 259	Continued From page 20 -The resident was to stop drinking juices and lemonade, limit carbohydrates to 45 gm per meal and 15gm snacks. Review of Resident #2's endocrinologist's Facility Orders dated 05/11/21 and 05/17/21 revealed: -An order dated 05/11/21 to check FSBS twice daily. Once before breakfast and once before bedtime. -An order dated 05/17/21 to check the FSBS twice daily. Once before breakfast and once before bedtime. -An order dated 05/17/21 for no fruit juice (orange, apple, grape or lemonade). Review of a care plan for Resident #2 dated 03/26/21 revealed:-The care plan was created before she was discharged from the rehab center to the facility (therefore not valid). -All areas related to the activities of daily living were documented as zero (which was independent in areas of eating, toileting ,ambulation, bathing, dressing, grooming/personal hygiene and transfers). -The "attached" physician orders were incorrect. -There was no documentation of new diabetes diagnosis. -There was no documentation of injectable diabetic medications or finger stick blood sugars (FSBS). -There was no documentation of difficulty with ambulation and therapy orders. -There was no documentation of dietary issues and parameters from endocrinologist's visit. -There was no physician signature. -The care plan was not updated to include the recent hospitalization and rehab stays. Interview with Medication Aide (MA) on 06/01/21 at 3:57am revealed:	D 259		

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D 259	Continued From page 21 -She was responsible for completing resident care plans. -She had completed the care plan for Resident #2 on 03/26/21. -Resident #2 was at a rehab facility on 03/26/21 and not in the facility. -She had filled out the care plan in preparation for Resident #2's return to the facility. Interview with the Property Manager/Medication Aide (PM/MA) on 06/01/21 at 4:30pm revealed: -The MA's were responsible for completing and updating resident careplans. -She had not been able to perform her duties as PM/MA for the last 5 months due to staff shortage. -Her duties as PM/MA included supervision of the medication aides. Interview with the Administrator on 06/02/21 at 11:08am revealed: -The MA's are responsible to do the care plans. -She did not know Resident #2 did not have a current care plan. -Care plans should be completed when the residents were in the facility. -It had been an "ongoing thing" to ensure documents were in the residents' records.	D 259		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 22 Rule.	D 276		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (Resident #2) regarding an order for a finger stick blood sugar (FSBS), complete blood count (CBC) with differential, complete metabolic panel (CMP), fasting lipid panel, hemoglobin A1C (HbA1C), microalbumin, TSH and Free T4.

The findings are:

Review of Resident #2's current FL2 dated 03/17/20 revealed:
-Diagnoses included depression, arthritis, osteopenia, coronary artery disorder, gout, vertigo, schizophrenia, personality disorder, and obesity.
-There was an order to check blood glucose levels daily at 8:00am.

Review of Resident #2's Post Discharge Plan and Summary sheet from a local rehabilitation facility dated 04/05/21 revealed:
-She had a diagnoses of type 2 diabetes mellitus, acquired absence of kidney, chronic obstructive pulmonary disease (COPD), hypertension, and morbid obesity due to excess calories.

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D 276	Continued From page 23 -She was admitted to the rehabilitation center, from the local hospital, on 03/20/21 and was discharged on 04/05/21. Review of a Telephone Note (documented phone call from resident to physician office) from Resident #2's endocrinologist dated 05/04/21 revealed: -She spoke to the physicians office about not receiving any of her medications. -They would set-up telehealth visit. Review of an endocrinologist's telehealth visit note for Resident #2 dated 05/07/21 revealed: -Patient was recently admitted to the hospital in March 2021 for a partial nephrectomy. -Her last HbA1C (a lab test used to measure the amount of blood sugar attached to the hemoglobin over a period of 3 months) was 7.0% in January 2020. 1. Review of Resident #2's record revealed there was no order to check FSBS upon return from the rehab facility on 04/05/21. Review of an endocrinologist's telehealth visit note for Resident #2 dated 05/07/21 revealed: -They did not receive a blood sugar log to review for the telehealth visit. -The facility was not checking her blood sugars. -The resident checked her own blood sugar the morning of 05/07/21 and it was 224. -The facility had been checking her FSBS prior to her hospitalization on 03/15/21. -They gave a verbal order on 05/07/21 to check FSBS before breakfast and at bedtime (twice daily), and the order was faxed to the facility. -The fasting glucose goal was 80-130, glucose goal 2 hours after meals was <180.	D 276		

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Review of Resident #2's endocrinologist's Facility Orders dated 05/11/21 and 05/17/21 revealed:
-An order dated 05/11/21 to check FSBS twice daily. Once before breakfast and once before bedtime.
-An order dated 05/17/21 to check the FSBS twice daily. Once before breakfast and once before bedtime.

Review of Resident #2's endocrinologist's office visit note dated 05/21/21 revealed:
-The facility had not provided any FSBS results since the previous visit on 05/07/21 for review.
-The facility had not been checking her FSBS.
-Her HbA1C results went up from 7.0% in January 2020 to 8.8% this visit.
-The plan for the resident included to check FSBS before breakfast and at bedtime.

The American Diabetes Association recommends keeping HbA1C levels below 7% and elevated results are an independent risk factor for coronary heart disease and stroke.

Review of Resident #2's May 2021 eMAR revealed there was no entry to check FSBS.

Interview with Resident #2 on 05/26/21 at 10:25am revealed:
-She was admitted to the hospital from 03/15/21 to 03/20/21.
-She was then sent to rehab for 16 days.
-She returned to the facility around April 5, 2021.
-The facility was not checking her FSBS as ordered.
-They were supposed to be checking FSBS twice daily currently.
-One medication aide (MA) did not check FSBS, and the other MAs did, but not consistently.
-The Property Manager/Medication Aide (PM/MA)

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did not check FSBS, she was only responsible to oversee the MAs.

Interview with the MA on 05/27/21 at 3:55pm revealed:
-She was responsible to check blood sugars for Resident #2.
-The facility had orders to check FSBS once daily for Resident #2, and then it changed to twice daily, but it did not show up on the eMAR and she could not locate the actual orders.
-She documented Resident #2's FSBS in the Charting Notes on the computer.

Review of Resident #2's facility Charting Notes revealed:
-There were no documented FSBS between 04/05/21 and 05/08/21.
-FSBS were documented for the following dates:
05/09/21 at 8:05am was 256
05/22/21 at 8:40am was 169
05/23/21 at 8:09am was 140
05/26/21 at 9:21am was 171
05/26/21 at 7:13pm was 211
05/27/21 at 7:12am was 154
05/27/21 at 7:25pm was 242
05/31/21 at 8:11am was 135
05/21/21 at 8:00pm was 207

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/28/21 at 11:52am revealed:
-There were no current orders from the 05/27/21 physicians order sheet on the eMAR to check FSBS.
-The pharmacy readmitted Resident #2 in their system on 04/20/21 and there were no orders for FSBS

Interview with Resident #2's endocrinologist

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D 276	Continued From page 26	D 276		

medical assistant on 05/28/21 at 1:05pm revealed:
-On 5/7/21 they had a telehealth visit and gave a verbal order to the facility staff to check FSBS twice daily.
-They faxed a hard copy order to the facility on 05/11/21 to check FSBS twice daily.
-They faxed the 05/11/21 order to the facility's pharmacy for the FSBS.
-After continued calls from Resident #2, their office faxed a third order to the facility on 05/17/21 for FSBS to be obtained twice daily.

Interview with the MA on 06/01/21 at 3:00pm and 3:57pm revealed:
-The facility had received discharge orders from rehab for Resident #2.
-The discharge orders were faxed to the pharmacy upon her return to the facility (around 04/05/21).
-She could not find the discharge FL2 from the rehab facility.
-She knew the orders were faxed to the pharmacy because the eMARS had changed.
-The order for FSBS was not on the eMARs when Resident #2 returned from rehab.
-The PM was responsible to enter the FSBS in the eMAR, so the MA could perform the task.
-"I told her several times to add them to the eMAR".
-All orders go to the central fax machine in the main office.
-Sometimes the orders do not make it to the facility from the main office.

Interview with the PM/MA on 06/01/21 at 4:30pm revealed:
-She was responsible to enter all tasks and treatments into the eMAR.
-She would have entered the FSBS on the eMAR

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RICHMOND HILL REST HOME # 1	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 276	Continued From page 27 if she had an order for it. Telephone interview with the Administrator on 06/02/21 at 11:10am revealed she was not aware of the verbal order on 05/07/21 to obtain FSBS for Resident #2. Refer to telephone interview with the Administrator on 06/02/21 at 11:10am. 2. Review of Resident #2's endocrinologist's telehealth visit note dated 05/07/21 revealed: -Her last HbA1C was 7.0% in January 2020. -There was an order dated 05/07/21 which included a complete blood count (CBC) with differential, comprehensive metabolic panel (CMP), fasting lipid panel, fasting glucose, hemoglobin A1C (HbA1C), microalbumin, thyroid stimulating hormone (TSH), and free thyroxine (free T4). -The lab order was faxed to the facility for them to obtain. Interview with Resident #2's endocrinologist medical assistant on 05/28/21 at 1:05pm revealed: -They faxed a lab order to the facility on 05/07/21 for CBC with differential, CMP, fasting lipid panel, fasting glucose, HgbA1C, microalbumin, TSH and Free T4, which were never set-up by the facility. -On 05/21/21 the endocrinologist's office obtained the labs in their office because the facility had failed to obtain them. Review of Resident #2's record revealed the physician's order dated 05/07/21 for CBC with differential, CMP, fasting lipid panel, fasting glucose, HbA1C, microalbumin, fasting glucose, TSH and Free T4 were not in the record.	D 276		

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D 276	Continued From page 28 Review of Resident #2's endocrinologist's visit note dated 05/21/21 revealed her HbA1C had increased to 8.8% this visit (elevated results are an independent risk factor for coronary heart disease and stroke). Interview with the medication aide (MA) on 06/01/21 at 3:57pm revealed: -The facility had not received an order dated 05/07/21 for labs. -The facility had a central fax machine in the main office, but not in this facility. -Orders that were faxed to the office did not always make it to the facility. Interview with the Property Manager/Medication Aide (PM/MA) on 06/01/21 at 4:30pm revealed: -"Information from the telehealth visits are sent to us if we ask for them." -They did not always receive telehealth visit note information from the provider. -The MAs are responsible to set-up lab appointments and follow-up on all orders. -She had not been able to perform her duties as PM/MA for the last 5 months due to staff shortage. -Her duties as PM/MA included oversight of processing new orders and training and supervision of the medication aides. Telephone interview with the Administrator on 06/02/21 at 11:10am revealed she was not aware of the verbal order on 05/07/21 to obtain labs for Resident #2. Refer to telephone interview with the Administrator on 06/02/21 at 11:10am. _____ Telephone interview with the Administrator on	D 276		

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D 276	Continued From page 29 06/02/21 at 11:10am revealed: -The PM/MA was responsible to send orders from the main office to each MA for processing. -She expected all orders to be implemented by the MAs or the PM. _____ The facility failed to ensure physician orders were implemented for Resident #2 with orders to check finger stick blood sugar (FSBS) and obtain labs for CBC with differential, CMP, fasting lipid panel, fasting glucose, HbA1C, microalbumin, TSH, Free T4, putting her at risk for hyperglycemia, hypoglycemia, coronary artery disease, and stroke. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2021.	D 276		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.	D 292		

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D 292	Continued From page 30 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide substitutions of equal nutritional value 11 of 11 residents. The findings are: Interview with a Medication Aide (MA) on 05/26/21 at 9:22am revealed there were 11 residents currently residing in the home. Review of the menu for 05/26/21 revealed residents with a regular diet for the noon meal were to receive Country pork loin with gravy, scalloped corn, Brussels sprouts, wheat dinner roll or bread, margarine, fruit gelatin with whipped topping, milk and a beverage of choice. Observation of the noon meal being prepared on 05/26/21 at 12:18pm and 12:25pm revealed: -Macaroni noodles were boiled, drained and place on a cookie sheet. -A can of tomato sauce was opened, poured directly onto the macaroni noodles, and approximately a handful of cheddar cheese was placed upon top of the tomato sauce and macaroni noodles. -The cookie sheet was placed in the oven to melt the cheese approximately 4-5 minutes, and a spatula was used to place the macaroni into bowls. -There was a small peach fruit cup and a name brand lemonade or the beverage of their choice also served. -This was served to 7 residents. -One resident received 2 hot dogs, no buns, with ketchup, no bread, fruit cup and a glass of milk. -One resident received 2 hot dog on a slice of white bread for each hot dog, a small cup of	D 292		

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mayonnaise, a blueberry muffin, and a fruit cup.
-One resident did not eat lunch.

Review of the menu for 05/27/21 revealed residents with a regular diet for the noon meal were to receive oven fried chicken, mash potato casserole, spinach, cornbread, margarine, peach cobbler, milk and the beverage of their choice.

Observation on 05/27/21 at 11:40am of the noon meal revealed egg salad, mashed potatoes, cornbread, asparagus, butter, a brand-named instant lemonade and the beverage of their choice.

Interview with the Administrator and the Owner on 05/26/21 at 11:15am revealed:
-All residents were on a regular diet.
-Staff were expected to follow the menus.
-It was the MA's responsibility for ensuring the residents were receiving nutritionally adequate and palatable meals.
-There was food available in the facility as well as the food in the basement of the office that staff had access to to ensure the menus were being followed.
-Staff just had to come get it or let someone in the office know what they needed.

Interview with the MA on 05/26/21 at 11:42am revealed:
-She did not go by the menu as she fixed what she had on hand.
-She did not have a substition list to go by for the resident meals.
-She did not have the foods available to prepare the menu as it was listed.
-All the residents were on a regular diet.
-She had explained to the Administrator this morning that she was not going by the menu and

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D 292	Continued From page 32 why. -She reported the Administrator had no answer for her concerns about the meals. Interviews with 5 of 11 residents on 05/26/21 at 12:30pm -12:50pm revealed: -"It was good." -The meal was "ok" but she was still hungry and had asked for a second helping. -It was not what she would have fixed at home but she was not home. -She knew she was not supposed to eat all that pasta and bread so she asked for something else. -She had wanted a hot dog but was told she could not because she had the pasta, so she was given a blueberry muffin instead by the MA.	D 292		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to provide theraputic diets for a resident on a no concentrated sweet diet (NCS) (Resident #1) for a resident and a	D 310		

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carbohydrate controlled with no fruit juices diet for a resident (Resident #2) as ordered by their primary physicians for 2 of 3 sampled residents.

The findings are:

1. Review of Resident #2's current FL2 dated 03/17/20 revealed diagnoses included depression, arthritis, osteopenia, coronary artery disorder, gout, vertigo, schizophrenia, personality disorder, and obesity.

Review of a rehabilitation facility's Post Discharge Plan and Summary sheet for Resident #2 dated 04/05/21 revealed a diagnosis of type 2 diabetes mellitus.

Review of Resident #2's endocrinologist's telehealth visit note dated 05/07/21 revealed:
-Patient was recently admitted to the hospital in March 2021 for a partial nephrectomy (removal of one or both kidneys).
-Her last A1C was 7.0% in January 2020 (a normal hgbA1C is below 5.7% and is measured by the average blood sugar level over the last three months).
-The resident had an order to stop drinking juices and lemonade, limit carbohydrates to 45 gm per meal and 15gm snacks.

Review of Resident #2's endocrinologist's Facility Orders dated 05/11/21 and 05/17/21 revealed an order dated 05/17/21 for no fruit juice (orange, apple, grape or lemonade).

Review of Resident #2's office visit note dated 05/21/21 revealed:
-She tried to drink sugar free beverages, but the facility only had regular beverages.
-HGBA1C was up to 8.8% this visit (which was

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even higher than in January 202).
-The plan for the resident included check glucose before breakfast and at bedtime, continue to limit carbohydrates' for meals and snacks, switch to diet soda, have fruit with meals and not as a snack.

Review of the "Resident Diet Sheet" on the refrigerator in the kitchen on 05/26/21 at 9:39am revealed.
-Each residents first and last name was on the list on the left side of the paper.
-The residents diet order was beside the residents name on the right side of the paper.
-Resident #2 had regular beside her name.

Review of the therapeutic menu for residents with a NCS diet revealed there was no therapeutic menu available to review.

Observation of the kitchen pantry on 05/26/21 at 9:38am revealed there were no sugar-free food items or drinks for residents.

Observation of the office downstairs pantry on 05/26/21 at 11:05 revealed there were no sugar-free food items or drinks for residents.

Observation of the noon meal for Resident #2 on 05/26/21 at 12:18pm and 12:25pm revealed:
-She received two bowls of macaroni with tomato sauce and cheddar cheese, a peaches fruit cup and approximately a 16 oz. cup of a named brand lemonade.

Observation of the kitchen pantry on 05/26/21 at 9:38am revealed there were no sugar-free food items or drinks for residents.

Observation of the named brand lemonade

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nutritional information for a 12-fluid ounce glass on 05/27/21 at 11:47am revealed:
-The first two ingredients were sugar and fructose (a type of sugar found especially in honey and fruit).
-There were 24 grams of sugar and 24 grams of added sugars and it would be 47% of the daily value.
-There were 26 grams of carbohydrates.

Observation of the noon meal for Resident #2 on 05/27/21 at 11:40am revealed egg salad, mashed potatoes, cornbread, asparagus, butter, and approximately a 16 oz. cup of named brand lemonade.

Interview with the Medication Aide (MA) on 05/27/21 at 11:26am revealed:
-She was not aware of any resident or Resident #2 having a carbohydrate controlled diet with no lemonade or fruit drinks diet.
-She had been employed with the since August of 2020 and had not been provided with any therapeutic menus.
-The facility had no sugar free items to eat or drink she could serve the residents.

Interview with Resident #2 on 05/28/21 at 10:43am revealed:
-She was aware of the orders the endocrinologists had made.
-She had no choice but to eat and drink what the facility offered and had told the MA and her physician of her concerns.
-She knew she wasn't eating and drink like her physician wanted but didn't know what else to do.

Interview with the endocrinologist's medical assistant for Resident #2 on 05/28/21 at 1:05pm revealed:

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D 310	Continued From page 36 -They had instructed staff on 05/07/21 and again on 05/11/21 to not give her regular beverages with sugar, to stop giving juices and lemonade, and to limit carbohydrates to 45 gm per meal and 15gm snacks. -Increased sugar levels are linked to an increased risk for heart attack and stroke. -It was not good that Resident #2 was eating uncontrolled carbohydrates and drinking regular lemonade. -Resident #2's diet had been ordered in an attempt to lower her hgbA1C (which was now up to 8.8%). Refer to interview with the Administrator and Owner on 05/26/21 at 11:15am. 2. Review of Resident #1's current FL2 dated 01/25/21 revealed: -Diagnoses included type II diabetes mellitus, depression, bipolar disorder, GERD, chronic constipation, epilepsy, peripheral neuropathy, borderline personality disorder, and post-traumatic stress disorder. -There was an order for a no concentrated sweets (NCS) diet. Review of Resident #1's record revealed hgbA1C was 7.5% on 05/14/21(a normal hgbA1C is below 5.7% and is measured by the average blood sugar level over the last three months). Review of the "Resident Diet Sheet" that was on the refrigerator in the kitchen on 05/26/21 at 9:39am. -Each residents first and last name was on the list on the left side of the paper. -The residents diet order was beside the resident's name on the right side of the paper. -Resident #1 had regular beside her name.	D 310		

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D 310	Continued From page 37 Review of the therapeutic menu for residents with an NCS diet revealed there was no therapeutic menu available to review. Observation of the kitchen pantry on 05/26/21 at 9:38am revealed there were no sugar-free food items or sugar-free drinks available to serve the residents. Observation of the office downstairs pantry on 05/26/21 at 11:05 revealed there were no sugar-free food items or sugar-free drinks available to serve the residents. Observation of the noon meal for Resident #1 on 05/26/21 at 12:18pm revealed she received 2 hot dogs with ketchup, no bread, a fruit cup and a glass of milk. Observation of the noon meal for Resident #1 on 05/27/21 at 11:40am revealed egg salad, mashed potatoes, cornbread, asparagus, butter, and milk. Interview with the Medication Aide (MA) on 05/27/21 at 11:26am revealed: -She was not aware of any resident having a NCS diet. -She was not aware of any dietary orders for NCS. -She had been employed since August 2020 and had not been provided any therapeutic menus. -She was not aware Resident #1 was on a NCS diet. -The facility had no sugar free items to eat nor any sugar free items to drink to serve the residents. Interview with Resident #1 on 05/27/21 at 1:00pm revealed:	D 310		

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D 310	Continued From page 38 -She was aware of her dietary needs and that she was on a NCS diet. -She had purchased her own food and snacks related to her diet order. -The facility did not provide sugar free foods or drinks. -The facility did not provide NCS diets for diabetic residents. Attempted interview with Resident #1's primary care physician on 05/28/21 at 12:06pm was unsuccessful. Refer to interview with the Administrator and Owner on 05/26/21 at 11:15am. _____ Interview with the Administrator and Owner on 05/26/21 at 11:15am revealed: -They did not have any residents who required a NCS diet. -The did not have any therapeutic diet menu's available as the facility only had regular diet menus. -They were both unaware there were two residents in the facility with NCS diet orders. -The MA and the Property Manager were responsible for reviewing physician orders and ensuring orders were correct and being followed. _____ The facility failed to provide therapeutic diets consisting of a resident with a carbohydrate controlled and no juice or lemonade diet (Resident #2) and a resident with a NCS diet (Resident #1) as ordered by their physicians for 2 of 3 sampled residents resulting in the increase in both residents hgbA1C. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D 310		

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D 310	Continued From page 39 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/23/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 17, 2021.	D 310		
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 administer medications as ordered by a licensed prescribing practitioner during the morning medication pass for 1 of 2 residents (Resident #1), including a medication used to treat bipolar disorder (Resident #1) and for 2 of 3 sampled residents (Residents #2 and #3), including a medication to treat high blood sugars (Resident #2), and medications used to treat shortness of breath and allergies (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 01/25/21 revealed: -Diagnoses included depression, bipolar disorder,	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 1	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 358	Continued From page 40	D 358		

and post-traumatic stress disorder.
-There was an order for Depakote ER 500mg (to treat bipolar disorder), take one tablet daily.

Review of Resident #1's record revealed a physician's order dated 02/04/21 for Depakote ER 500mg every morning with 3 refills.

Observation of the morning medication pass on 05/26/21 at 9:40am revealed Depakote 500mg was not administered to Resident #1.

Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed:
-There was a computer-generated entry for Depakote ER 500mg, take one tablet daily for mood.
-Depakote ER 500mg was documented as administered at 8:00am on 05/26/21.

Observation of Resident #1's medications available for administration on 05/26/21 at 10:52am revealed there was no Depakote ER 500mg available for administration on the medication cart.

Interview with the medication aide (MA) on 05/26/21 at 10:52 am revealed:
-She did not administer Depakote ER 500mg to Resident #1 because it was not available on the medication cart.
-She accidentally marked the medication as administered.
-She was unsure of when the medication ran out.
-She last worked on 05/23/21 and the medication was documented as administered.

Interview with Resident #1 on 05/26/21 at 12:22am and 12:41pm revealed she did not

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D 358	Continued From page 41 receive the Depakote ER during the medication pass this morning. Attempted telephone interview with Resident #1's primary care provider PCP on 05/28/21 at 12:06pm was unsuccessful. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/02/21 at 9:56am revealed: -The pharmacy was responsible for dispensing Resident #1's Depakote ER 500mg. -The pharmacy had dispensed a 31-day supply of Depakote ER 500mg, take one tablet daily to Resident #1 on 04/20/21 and 05/26/21. -He was unsure why the medication was not sent prior to 05/26/21 because the facility was on cycle fill, and the start date of scheduled medications is the 20th of each month. -Medications on cycle fill are sent a few days prior to the 20th of each month. -It was possible that she had missed a few doses prior to 05/26/21. Telephone interview with the Administrator on 06/02/21 at 11:10am revealed she was not aware that Resident #1 ran out of Depakote ER 500mg. Refer to interview with the Property Manager/Medication Aide (PM/MA) on 06/01/21 at 4:30pm. Refer to telephone interview with the Administrator on 06/02/21 at 11:10am. 2. Review of Resident #2's current FL2 dated 03/17/20 revealed diagnoses included depression, arthritis, osteopenia, coronary artery disorder, gout, vertigo, schizophrenia, personality disorder, and obesity.	D 358		

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D 358	Continued From page 42 Review of Resident #2's post discharge plan and summary sheet from a local rehabilitation facility dated 04/05/21 revealed: -She had a diagnoses of type 2 diabetes mellitus, acquired absence of kidney, chronic obstructive pulmonary disease (COPD), hypertension, and morbid obesity due to excess calories. -She was admitted to the rehabilitation center, from the local hospital, on 03/20/21 and was discharged on 04/05/21. Review of Resident #2's record revealed: -There was an order dated 04/01/21 from the rehabilitation facility for Ozempic 2mg/1.5ml, inject 0.25ml (0.5mg) dose inject SQ one time a day every (used to treat diabetes mellitus type II). -Review of the rehabilitation Order Summary Report dated 04/05/21 revealed a discharge medication list which included to continue Ozempic 2mg/1.5ml (0.25mg or 0.5mg/dose) every Friday, with a start date of 03/26/21. -There was a signed physician's orders sheet dated 05/27/21 with an order for Ozempic 2mg/1.5ml, inject 0.25ml (0.5mg) dose inject SQ weekly starting 05/25/21, with an origination date of 05/11/21. Review of Resident #2's endocrinologist's telehealth visit note dated 05/07/21 revealed: -Patient was recently admitted to the hospital in March 2021 for a partial nephrectomy. -They did not receive a blood sugar log to review for the telehealth visit. -The endocrinologist's office was "alarmed that there were no diabetic medications on her MAR." -Her last hemoglobin A1C (HbA1C) was 7.0% in January 2020 (a lab test used to measure the amount of blood sugar attached to the hemoglobin over a period of 3 months).	D 358		

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D 358	Continued From page 43 -The resident reported she was no longer taking Ozempic. -She reported being without the Ozempic "for months." -The endocrinologist sent an order to the pharmacy on 05/07/21 for Ozempic 0.25mg SQ injection once weekly for 2 weeks and then increase to 0.5mg once a week thereafter. -The Ozempic order was faxed to the facility's pharmacy provider on 05/07/21. Review of Resident #2's endocrinologist's office visit note dated 05/21/21 revealed: -They had faxed a new order for Ozempic injection once weekly on 05/07/21. -She had her first Ozempic injection on 05/18/21. -Her HbA1C was up to 8.8% this visit. The American Diabetes Association recommends keeping HbA1C levels below 7% and elevated results are an independent risk factor for coronary heart disease and stroke. Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed there was no entry (for the order written on 04/01/21) for Ozempic 2mg/1.5ml, inject 0.25ml (0.5mg) dose inject SQ one time a day every Friday. Review of Resident #2's May 2021 eMAR revealed: -There was a computer-generated entry for Ozempic 0.25-0.5mg dose, inject 0.25mg sub-q once weekly for 14 days, beginning on 05/11/21 and ending on 05/25/21. -The Ozempic 0.25mg was documented as administered on 05/18/21 and 05/25/21. -There was no Ozempic documented as administered before 05/18/21.	D 358		

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-There was a computer-generated entry for Ozempic 0.25-0.5mg dose, inject 0.5mg sub-q once weekly, dated 05/25/21.

Interview with Resident #2 on 05/26/21 at 10:25am revealed:
-She was admitted to the hospital from 03/15/21 to 03/20/21.
-She was then sent to a rehabilitation facility for 16 days.
-She returned to the assisted living facility on 04/05/21.
-Her medications had not been correct until the past 2 weeks.
-Medication changes that were made at rehab had just been corrected by the physician assistant (PA) at the endocrinologist's office.
-She had not been given her Ozempic injection as ordered.
-She had been without the Ozempic injection for 6 weeks.

Interview with Resident #2's endocrinologist's medical assistant on 05/28/21 at 1:05pm revealed:
-On 05/04/21 Resident #2 had called and reported that she was not getting her diabetic medications.
-On 05/07/21 they had a telehealth visit and gave a verbal order to the facility to restart Ozempic 0.25mg SQ weekly.
-They faxed the Ozempic order to the facility's pharmacy on 05/07/21.

Observation of Resident #2's medications on hand on 06/01/21 at 2:00pm revealed:
-A box of two Ozempic 1mg/dose pens, inject 0.75ml (1mg) subcutaneously (SQ) every week.
-The pharmacy label was dated with a fill date of 02/11/21.

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D 358	Continued From page 45 -The box was marked as opened on 05/20/21. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/28/21 at 11:52am revealed: -Ozempic had been prescribed for Resident #2 since March 2021. -The current order was for Ozempic 0.5mg inject SQ weekly. -There was an order dated 05/11/21 for 0.25mg SQ weekly for 14 days. -There was an order dated 05/25/21 for 0.5mg SQ weekly. -Ozempic was discontinued in March 2021 and was not started back until the 05/11/21 order was received. Interview with the MA on 05/27/21 at 3:55pm revealed: -She gave the first Ozempic 0.25mg injection to Resident #2 on 05/18/21. -She was responsible to give medications in the facility. Interview with the MA on 06/01/21 at 3:00pm and 3:57pm revealed: -The facility received the discharge orders from rehab for Resident #2. -They were faxed to the pharmacy upon her return to the facility (around 04/05/21). -She could not find the discharge FL2 from the rehab facility. -She knew the orders were faxed to the pharmacy because the eMARS had changed. -All orders go to the fax machine in the main office. -Sometimes the orders do not make it to the facility from the office. -She performed cart audits, but mostly only on controlled medications.	D 358		

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D 358	Continued From page 46 Telephone interview with the Administrator on 06/02/21 at 11:10am revealed: -She was made aware last week that Resident #2's medications were "not right" after her return from the rehabilitation facility. -She had no documentation related to incorrect medications and she told the MA about the situation. Refer to interview with the Property Manager/Medication Aide (PM/MA) on 06/01/21 at 4:30pm. Refer to telephone interview with the Administrator on 06/02/21 at 11:10am. 3. Review of Resident #3's current FL2 dated 03/17/20 revealed: -Diagnoses included schizophrenia, anxiety, type 2 diabetes non-insulin type. -Medication included fluticasone 50 mcg (used to relieve the symptoms of allergies) one spray to each nostril daily, Ventolin HFA 8 grams (used to treat wheezing and shortness of breath) 2 puffs three times daily as needed. Review of the electronic medication administration record (eMAR) for April 2021 for Resident #3 revealed: -There was an entry for fluticasone 50 mcg one spray to each nostril daily. -There was an entry for Ventolin HFA 8 grams 2 puffs three times daily as needed. -There was no documentation of administration for the fluticasone 50 mcg or the Ventolin HFA 8 grams Review of the electronic medication administration record (eMAR) for May 2021 for	D 358		

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D 358	Continued From page 47 Resident #3 revealed: -There was an entry for fluticasone 50 mcg one spray to each nostril daily. -There was an entry for Ventolin HFA 8 grams 2 puffs three times daily as needed. -There was no documentation of administration for the fluticasone 50 mcg or the Ventolin HFA 8 grams Review of the medication available for administration for Resident #3 on 05/27/21 at 1:10pm revealed: -There was no fluticasone 50 mcg available for administration. -There was no Ventolin HFA 8 grams available for administration. Interview with the Medication Aide (MA) on 05/27/21 at 1:10pm revealed: -She did not know why the medication was not on the medication cart but would check with the pharmacy. -The Property Manager(PM)/MA was responsible for adding some things to the eMAR as she was the administrator for the eMAR system at the facility. -The PM/MA would have been responsible to ensure the medications had been ordered. Interview with Resident #3 on 05/27/21 at 1:18pm revealed: -She had difficulty with allergies but did not have any medication for it. -She had breathing issues at times but was not currently having any issues. -She thought the physician had prescribed something for her but could not remember for sure. -Telephone interview with the pharmacist at the	D 358		

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D 358	Continued From page 48 facility contracted pharmacy on 05/27/21 at 4:54pm regarding Resident #3 revealed: -There was an original order for fluticasone 50 mcg one spray to each nostril daily on 07/15/20. -The prescription for fluticasone 50 mcg was never requested to be filled by the facility. -There was an original order for Ventolin HFA 8 grams 2 puffs three times daily as needed. -There was a new prescription written by the physician for Resident #3 on on 11/02/21 for Ventolin HFA 8 grams 2 puffs three times daily as needed but the facility had never requested the order be filled. -Both of the medications were placed on the eMAR by the pharmacy as they had received the physicians order for the medications. -The pharmacy was not responsible for automatically filling these prescriptions. -The facility was responsible for requesting both of these medications to be filled and/or refilled. Telephone interview Resident #3 nurse practioner on 05/28/21 at 12:18pm revealed: -She ordered the fluticasone 50 mcg for the residents allergies. -She ordered the Ventolin HFA 8 grams for Resident #3's wheezing and difficulty breathing. -She "needed the inhaler" for sudden episodes, if she did not have the Ventolin HFA 8 grams available she could not get any relief from her wheezing or shortness of breath. Refer to interview with the PM/MA on 06/01/21 at 4:30pm. Refer to telephone interview with the Administrator on 06/02/21 at 11:10am. _____ Interview with the PM/MA on 06/01/21 at 4:30pm revealed:	D 358		

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D 358	Continued From page 49 -The cycle date for the new month was to begin on the 20th of each month. -A thirty-or thirty-one-day supply of the medications was filled in blister packs to be administered at the beginning of the new cycle. -All oral medications except controls are on cycle fill with the pharmacy. -Inhalers and as needed (PRN) medications, eye drops, ear drops, and creams have to be ordered manually. -It was her responsibility to order the medications needing to be ordered manually. -If medications were missing from the cycle fill delivery, the MA would contact the pharmacy. -The MA was responsible for completed cart audits which included controlled medications on the cart, and comparing the eMARs, with the orders and medications on hand. -Cart audits were to be completed once monthly. -There was no documentation of cart audits being completed. -New orders received by the facility went to the fax in the main office. -The PM was responsible to fax new orders to the pharmacy and then make a copy for the appropriate facility. -The facility had a box for new or changed orders and were to be picked up by the MAs. -She would notify each MA of new orders in the office via phone call or text message. -The MA were responsible to follow-up on all new orders and ensure the facility received all the medications from the pharmacy. -The facility MA should have followed up with the pharmacy if the medications were not on the medication cart. Telephone interview with the Administrator on 06/02/21 at 11:10am revealed: -She started working in the facility in April 2021.	D 358		

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D 358	Continued From page 50 -The MA was responsible to notify the pharmacy regarding medications that were unavailable for residents. -The MA were responsible for making sure medications were available for administration. -New orders for medications, labs and treatments arrived in the office and the Property Manager was responsible for all orders being distributed to the MAs. -One MA was supposed to do record audits and was trained to do so. -She expected the chart audits to be done weekly. -She did not know the process for chart audits. -She expected all orders to be implemented by the MA's.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to follow up on a pharmacy recommendation for a decrease in medication used to treat osteoarthritis for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated	D 406		

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D 406	Continued From page 51 03/17/20 revealed: -Diagnoses included schizophrenia, anxiety, type 2 diabetes non-insulin type, status post (s/p) tubalization. -Medication included meloxicam 15 mg one tablet daily (used to treat osteoarthritis). Review of the physicians consultation visit for Resident #3 dated 01/18/21 revealed new diagnoses of restless leg syndrome and arthritis. Review of the phamacy recommendations for Resident #3 dated on 03/04/21 revealed a recommendation for a decrease in the meloxicam to 7.5mg (which was the recommended dose). Interview with the Medication aide (MA) on 05/27/21 at 3:50pm revealed: -She was not aware of any pharmacy recommendations for Resident #3. -She had never been involved with the pharmacy recommendations and was not sure who completed those. -The Property Manager (PM)/MA was responsible for anything to do with the residents and the pharmacy. Telephone interview with Resident #3's nurse practioner for on 05/28/21 at 12:02pm revealed: -The facility had not notified her regarding pharmacy recommendations in the meloxicam 15mg made on 03/04/21. -Resident #3 had a followup appointment on 04/26/21 and could have been evaluated for the reduction during that visit. -Too much meloxicam could cause an stomach upset, nausea and even increased anxiety. Interview with the PM/MA on 06/01/21 at 4:30pm revealed:	D 406		

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D 406	Continued From page 52 -MA's were responsible for following up on all pharmacy recommendations. -The office receives a copy of recommendations for each resident and those are copied in the front office. -They are then placed in box of the appropriate facility for each resident. -The MA's are responsible to follow up after that with the physician. -She was not able to assist in her usual responsibilities, which included training the MA's related to Pharmacy recommendations, as she has been working as a MA. -If she was not working as a MA she felt she would have been able to train the MA's in what their job responsibilities were. -She had not been able to train the MA's as she had been working as one herself due to staff shortages. Telephone interview with the Administrator on 06/02/12 at 11:08am revealed: -She was not aware pharmacy recommendations were not being followed up on with the physicians. -The MA in the facility was responsible for all of the facilities pharmacy recommendations. -It was "ultimately" the Administrators responsibility to ensure follow through.	D 406		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services:	D 433		

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D 433	Continued From page 53 (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observation, interviews and record review the facility failed to maintain resident records in an orderly manner and readily	D 433		

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D 433	Continued From page 54 available for review. The findings are: Observation during initial tour of the facility on 05/26/21 at 9:37am revealed a closet on the back hallway of the facility was closed with a latch and a "master lock" on the doors. Observation of the resident record closet on 05/26/21 at 10:42am revealed: -The doors were closed and there was a "master lock" on the door. -The Property Manager (PM) and the Medication Aide (MA) were attempting to open the doors by using a screwdriver and hammer to take the hinges of the doors. -They were unable to open the doors and could not open the record closet. Interview with the PM and the MA on 05/26/21 at 10:42am revealed: -The Medication Aide (MA) did not know where the key was as she had been unable to get in the cabinet since 05/25/21. -She had mentioned it to the Administrator that she could not find the key and did no have access to the residents records. Interview with the Owner on 05/26/27 at 12:58pm revealed he had removed the lock from the record closet and the resident records were now available for review. Observation of the resident record closet on 06/01/21 at 1:20pm revealed the closet was closed with a "master lock" on the door. Interview with the MA on 06/01/21 at 1:20pm revealed:	D 433		

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D 433	Continued From page 55 -The MA did not know where the key was as she was unable to get in the cabinet from 05/31/21 at 8:00am when she returned to work. -She texted the Administrator again this morning as she could not find the key and did not have access to the residents records again. Interview with the Owner on 06/01/27 at 2:05pm revealed: -He removed the lock from the record closet and the resident records were now available for review. -He was unaware of any issues with not having the key to the record closet prior to recent events. -He did not understand what was happening with the keys to the locks. -Staff were responsible for the keys and "should have the key". 1. Review of Resident #1's record on 05/26/21 at 10:20am revealed: -There was no care plan in the resident's record. -There was no quarterly medication review in the resident's record. -There was no Licensed Health Professional Support assessment in the residents record. 2. Review of Resident #2's record on 05/26/21 revealed: -There was no current FL2 with the last FL2 dated 03/17/20. -There was no care plan in the record when resident was readmitted from the rehabilitation center. -The quarterly assessment of the LHPS tasks were not current with a date of -There was no documentation of a 2nd step TB test. . -There were no current quarterly medication reviews by the facility's contracted pharmacy.	D 433		

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D 433	Continued From page 56 -There were no current physician's orders in the record. -The most recent physician ordered labs dated 05/07/21 were not in the record. 3. Review of Resident #3's record on 05/26/21 revealed: -There was no current FL2 with the last FL2 dated 03/17/20. -There were no current quarterly medication reviews by the facility's contracted pharmacy. -There were no current physician's orders in the record. -There was no LHPS quarterly assessment in the record. On 05/27/21 at 10:30am initial request for the following information revealed: -Daily request for Residents #1, #2 and #3 charting notes were not provided during the survey . -Daily request for written guidance from the local health department regarding screening and infection control initially were not provided during the survey. -Daily request for the LHPS, 05/07/21 labs and care plan for Resident #2 was not provided during the survey. _____ Interview with the Owner on 06/01/21 at 1:46pm revealed: -There was no excuse for it taking days to get resident information from the staff. -Staff told him they completed the resident paperwork but now they could not find it. -He said "if you didn't write it down you did not do it." Interview with the Administrator on 06/01/21 at 1:50pm revealed:	D 433		

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D 433	Continued From page 57 -She did not know why it was taking so long to find information that should be in the resident records. -A lot of paperwork was in the office unorganized and scattered. -She said "You have seen my office, its all over the place." -She had not had time to go through all the paperwork.	D 433		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 11	D 612		

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D 612	Continued From page 58 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents, staff, and visitors and wearing required personal protective equipment (PPE). The findings are: Review of the CDC guideline dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. Review of the NC DHHS guidelines dated 05/05/21 for the prevention and spread of the Coronavirus Disease in LTC facilities revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic include screening everyone entering a healthcare facility for signs and symptom of COVID-19 by temperature checks, screening questions, and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperature was checked. -Proper visitor education on COVID-19 signs and symptoms, infection control precautions, and use of a face covering or mask. Review of the facility's infection control policy dated 03/29/21 revealed: -Visitors must cooperate with the facility's screening process at each visit and attest to not having signs or symptoms or current diagnosis of	D 612		

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D 612	Continued From page 59 COVID-19, if they have had a COVID-19, they must provide documentation that they no longer meet CDC criteria for transmission-based precautions. -Any individuals with symptoms of COVID-19 infection will not be permitted to visit with a resident. -The visitor should call the facility staff prior to entry for the staff to meet the visitor outside the facility for screening. -The screening process includes the visitor questionnaire, temperature, and other screenings as may be recommended by the CDC or the NCDHHS. Observation of a medication aide (MA) on 05/26/21 at 9:30am revealed she allowed the two Surveyors into the facility with no COVID-19 screening or temperature checks. Observation of the Property Manager(PM)/MA on 05/26/21 at 9:50am revealed she had entered the facility and was not wearing a mask, not screened and she walked through the facility talking with staff, residents and Surveyors. Interview with a resident on 05/26/21 at 10:09am revealed: -She was a new resident to the facility. -She had had a negative COVID-19 test before she was admitted. -No one had asked her to get the vaccine, but she was interested. -She did not wear a face mask in the facility when she was around other residents as no one had asked her to. Observation of an unvaccinated resident walking around in the hallway on 05/26/21 at 9:55am revealed she was not wearing a face mask and	D 612		

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D 612	Continued From page 60 sitting beside another resident on the couch. Observation of the Administrator in the dining room on 05/26/21 at 10:50am revealed: -She was not wearing a face mask. -She spoke to the new resident who was not wearing a mask. Interview with the Administrator on 05/26/21 at 10:08am revealed: -One resident residing at the facility had not been vaccinated with the COVID-19 vaccination. -She had been vaccinated. -Some staff had not received the COVID-19 vaccination. -Visitors were not asked screening questions and temperatures were not taken as as the facility was not under COVID protocol anymore. -The facility staff, residents or visitors did not have to wear mask anymore. -The facility had not checked temperatures or asked screening questions for COVID-19 in the last couple of weeks. -She was responsible for the overall operations of the facility. Telephone interview with a Registered Nurse from the local disease control department on 05/27/21 at 10:22am revealed: -All facilities should screen visitors by checking their temperatures and completing a questionnaire upon entry into the facility. -Residents and staff should be wearing a mask if there are any unvaccinated residents or staff in the facility. -The facility should be following the guidelines from the CDC and the NCDHHS. Observation of a medication aide (MA) on 05/28/21 at 12:55pm revealed she entered the	D 612		

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D 612	Continued From page 61 facility and went to the medication cart stationed in the main living room. Interview with the MA on 05/28/21 at 4:00pm revealed: -She was the MA for this facility and had come in late as she was at an appointment. -The facility did not require her to wear a face mask anymore. -She had not been told anything about screening visitors or taking their temperatures. Interview with the nurse consultant (RN) from the facility's contracted pharmacy on 05/26/21 at 9:45am revealed: -He was not screened by staff with COVID-19 screening questions or temperature checked upon entrance to the facility. -He was not wearing a mask. Observation of the Owner on 05/26/21 at am revealed he was in the facility and did not have a mask on . Observation on 05/26/21 at 12:40pm revealed: -A resident's therapist talking with MA in the kitchen where the MA was preparing lunch. -The therapist nor the MA was wearing a mask. Interview with the resident's therapist on 05/26/21 at 12:40pm revealed she had not been screened nor her temperature taken upon entering the facility. Interview with the Owner on 05/27/21 at 8:45am revealed: -He presented a COVID-19 infection control notebook where the facility had been screening visitors in the past. -He reported the facility had few visitors and the	D 612		

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D 612	Continued From page 62 staff for each house was to be screening and using the form available in the facility. -Staff had been told to screen visitors and each facility had a thermometer and log. Observation of the facility hallway on 05/28/21 at 12:05am revealed there were three male visitors working inside the facility on the building alarm system not wearing mask. Interview with the three male visitors on 05/28/21 at 10:06am revealed: -They were contracted by the facility to work on the facility's alarm system. -They were asked COVID-19 screening questions at the main office upon arrival, but a temperature was not checked. -They were not instructed by facility staff to wear a face mask while working inside the facility. The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS) for infection prevention and transmission during the COVID-19 pandemic related to staff not wearing face mask with an unvaccinated resident residing in the facility, staff not screening visitors by checking temperatures or asking COVID-19 screening question, and not instructing visitors to wear face mask inside the facility. The facility's failure to follow the guidance related to infection prevention for COVID-19 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 05/27/21 for this violation.	D 612		

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D 612	Continued From page 63 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2021.	D 612		
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, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to management of facilities, health care, food and nutrition, infection prevention requirements, and staff qualifications. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 2 of 3 sampled staff (Property Manager/Medication Aide (PM/MA) and the Administrator). [Refer to Tag D 0167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation).] 2. Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina	D912		

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D912	Continued From page 64 Department of Health and Human Services (NCDHHS) were implemented when caring for 11 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents, staff, and visitors and wearing required personal protective equipment (PPE). [Refer to Tag 0612 10A NCAC 13F .1801 Infection Prevention and Control (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (Resident #2) regarding an order for a finger stick blood sugar (FSBS), complete blood count (CBC) with differential, complete metabolic panel (CMP), fasting lipid panel, hemoglobin A1C (HgbA1C), microalbumin, TSH and Free T4. [Refer to Tag 0276 10A NCAC 13F.0902 (c)(3) Health Care (Type B Violation).] 4.Based on observations, record reviews and interviews the facility failed to provide theraputic diets for a resident on a no concentrated sweet diet (NCS) (Resident #1) for a resident and a carbohydrate controlled with no fruit juices diet for a resident (Resident #2) as ordered by their primary physicians for 2 of 3 sampled residents. [Refer to Tag 0310 10A NCAC 13F.0904 (e)(4) Food and Nutrition (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 65 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from neglect related to residents being fearful of being left alone in the facility and for ensuring all required duties were carried out. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect and fear as related to management of facilities, health care, medication administration, infection prevention and control program, and staff qualifications. [Tag 0176 10A NCAC 13F .0601(a). Management of Facilities (Type A1 Violation)]. 2. Based on observations and interviews, the facility failed to ensure there was always at least one staff member in the facility ensuring that at no time a resident was left alone without a staff member in the facility. [Refer to Tag 0177 D 10A NCAC 13F .0601(b)(3) Management of Facilities with a capacity or census of seven to thirty Residents (Type A1 Violation).]	D914		