POC received via email on 09/03/21
Julie Grooms

PRINTED: 08/16/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with an onsite visit on 08/10/21 and desk review survey on 08/11/21 with an exit conference via telephone on 08/11/21.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were available for administration for 2 of 3 sampled residents (Resident #1 and #3) related to a fast-acting rescue inhaler and nebulizer used to treat difficulty with breathing (#1) and a medication used to treat mood disorders (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 06/23/21 revealed diagnoses included schizoaffective bipolar disorder, diabetes type II, chronic obstructive pulmonary disease (COPD), tobacco use, asthma, and Parkinson's disease.	{D 358}	Any missed dose of medication prescribed on MAR will result in provider being notified and charted. RCC and Administrator will monitor. Cart audits will continue Weekly by RCC. Missed med sheet will be kept in office.	8/12/21 – forward

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melanie Scruggs — TITLE: Administrator — (X6) DATE: 9/2/2021

Julie Grooms Reviewed and Acknowledged 09/03/21

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{D 358}	Continued From page 1 a. Review of Resident #1's physician orders dated 06/23/21 revealed an order for ProAir 90mcg inhale 2 puffs by mouth every 6 hours as needed for shortness of breath. Review of Resident #1's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for ProAir 90mcg inhale 2 puffs by mouth every 6 hours as needed for shortness of breath. -There was no documentation ProAir inhaler was administered. Review of Resident #1's August 2021 eMAR revealed: -There was a computer-generated entry for ProAir 90mcg inhale 2 puffs by mouth every 6 hours as needed for shortness of breath. -There was no documentation ProAir inhaler was administered. Observation of the medication on hand on 08/10/21 at 1:34pm revealed there was no ProAir inhaler available for administration. Interview with the medication aide (MA) on 08/10/21 at 1:34pm revealed: -She could not find the ProAir inhaler for Resident #1 on the medication cart. -She had not administered the ProAir inhaler to Resident #1 because he had not had any difficulty breathing and did not need the medication. -The MA's or Resident Care Coordinator (RCC) was responsible for contacting the pharmacy to get medications refilled, dispensed, and delivered to the facility when there was no more medication available for administration. -The night-shift supervisor had just completed a	{D 358}		

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{D 358}	Continued From page 2 medication cart audit to check for medications availability and expiration. Interview with a representative from the facility's contracted pharmacy on 08/10/21 at 3:30pm revealed: -ProAir 90mcg inhaler was dispensed today for Resident #1 after the MA called to request a refill. -ProAir 90mcg inhaler for Resident #1 was last dispensed in 2019. -The ProAir inhaler was a fast-acting rescue inhaler the facility should "always have on hand" for Resident #1 to treat for difficulty breathing due to asthma and COPD. Telephone interview with the third-shift supervisor on 08/11/21 at 11:10am revealed: -She had completed a medication cart audit on 08/09/21. -There was a ProAir inhaler for Resident #1 on the medication cart on 08/09/21 when she completed the cart audit. Interview with the Administrator on 08/10/21 at 4:25pm revealed she did not know Resident #1 did not have a ProAir rescue inhaler available to be administered. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/11/21 at 2:41pm revealed: -She had reordered the ProAir inhaler for Resident #1, but he was being followed by a Pulmonologist for asthma and COPD that managed his respiratory medications. -She visited the facility weekly and Resident #1 had not shown any signs of difficulty breathing or respiratory symptoms in the past couple of months. -Resident #1 needed the ProAir rescue inhaler	{D 358}		

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{D 358}	Continued From page 3 available in the event he experienced any difficulty with breathing. b. Review of Resident #1's physician orders dated 06/23/21 revealed an order for ipratropium-albuterol (iprat-albut) 0.5mg/3ml inhale 1 vial nebulizer by mouth every 6 hours as needed for shortness of breath or wheezing. Review of Resident #1's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for iprat-albut inhale 1 vial nebulizer every 6 hours as needed for shortness of breath or wheezing. -There was no documentation iprat-albut nebulizer was administered. Review of Resident #1's August 2021 eMAR revealed: -There was a computer-generated entry for for iprat-albut inhale 1 vial nebulizer every 6 hours as needed for shortness of breath or wheezing. -There was no documentation iprat-albut nebulizer was administered. Observation of the medication on hand on 08/10/21 at 1:34pm revealed there was no iprat-albut nebulizer vials available for administration. Interview with the medication aide (MA) on 08/10/21 at 1:34pm revealed: -She could not find the iprat-albut nebulizer vials for Resident #1 on the medication cart. -She had not administered iprat-albut to Resident #1 because he had not had any difficulty breathing and did not need the medication. -The MA's or Resident Care Coordinator (RCC) was responsible for contacting the pharmacy to	{D 358}		

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{D 358}	Continued From page 4 get medications refilled, dispensed, and delivered to the facility when there was no more medication available for administration. -The night-shift supervisor had just completed a medication cart audit to check for medications availability and expiration. Interview with a representative from the facility's contracted pharmacy on 08/10/21 at 3:30pm revealed: -Iprat-albut 0.5-3mg/3ml for Resident #1 was reordered on 07/05/21. - Iprat-albut for Resident #1 was last dispensed 02/03/21. -The Iprat-albut nebulizer treatment was not on a cycle fill and the pharmacy would dispense the medication after it was requested by the facility. -The facility had not requested a refill of the Iprat-albut nebulizer vials since February 2021. Telephone interview with the third-shift supervisor on 08/11/21 at 11:10am revealed: -She had completed a medication cart audit on 08/09/21. -Resident #1 had one vial left of iprat-albut available for administration. -She told the MA to request a refill from the pharmacy of the iprat-albut for Resident #1 on 08/09/21 after the medication cart audit was complete. Interview with the Administrator on 08/10/21 at 4:25pm revealed she did not know Resident #1 did not have iprat-albut nebulizer vials available to be administered. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/11/21 at 2:41pm revealed: -She had reordered the iprat-albut nebulizer vials	{D 358}		

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{D 358}	Continued From page 5 for Resident #1 on 06/23/21, but he was being followed by a Pulmonologist for asthma and COPD that managed his respiratory medications. -The iprat-albut medication for Resident #1 was to treat any shortness of breath or wheezing related to his COPD and asthma. -She visited the facility weekly and Resident #1 had not shown any signs of difficulty breathing or respiratory symptoms in the past couple of months. 2. Review of Resident #3's current FL-2 dated 06/23/21 revealed diagnoses included schizoaffective disorder, bipolar, and Chronic Obstructive Pulmonary Disease (COPD). Review of a physician's order dated 07/30/21 revealed a physician's order for Depakote Delayed Release (used to treat mood disorders) 500mg take 2 tablets by mouth (along with 250mg) at bedtime for 2 weeks then discontinue the 250mg and continue 1000mg at bedtime. Review of Resident #3's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Depakote Delayed Release 500mg take 2 tablets at bedtime scheduled to be administered at daily at 8:00pm. -Depakote Delayed Release 500mg was documented as administered at 8:00pm daily at 07/30/21 and 07/31/21. Review of Resident #3's August 2021 eMAR revealed: -There was a computer-generated entry for Depakote Delayed Release 500mg take 2 tablets at bedtime scheduled to be administered at daily at 8:00pm.	{D 358}		

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{D 358}	Continued From page 6 -Depakote Delayed Release 500mg was documented as administered at 8:00pm daily from 08/01/21 to 08/09/21. Observation of medication on hand on 08/10/21 at 1:45pm revealed Depakote Delayed Release 500mg was not available to administer to Resident #3. Telephone interview with pharmacy technician from the facility's contracted on 08/10/21 at 3:25pm revealed: -The pharmacy received a new prescription for Depakote Delayed Release 500mg for Resident #3 on 07/30/21. -Resident #3 was started on Depakote on 03/31/21 and the 1250mg daily loading dose was delivered on 04/01/21. -The pharmacy needed refills for the Depakote to continue sending it to the facility for Resident #3. -The pharmacy delivered 62 tablets of Depakote Delayed Release 500mg to the facility on 07/17/21. -The facility was supposed to start using the medication delivered on 07/17/21 on 07/20/21. -Resident #3 should have enough Depakote at the facility until the next cycle fill was scheduled to start on 08/20/21. -The pharmacy had no record a faxed refill request was received for Depakote by the pharmacy. Interview with a medication aide (MA) on 08/10/21 at 1:47pm revealed: -She did not remember administering the Depakote to Resident #3. -If the eMAR showed she had administered the medication then she was sure she had administered it to Resident #3. -She did not know why the Depakote was not	{D 358}		

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{D 358}	Continued From page 7 available to administer to Resident #3. -She assumed the medication was in the overflow and did not reorder it. -She and the other MAs were responsible for reordering medications if they were not available on the medication cart. Interview with the Third Shift Supervisor on 08/10/21 at 4:25pm revealed she had completed an audit of the medication cart the day before (08/09/21) and all of Resident #3's medications were available on the medication cart. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 08/11/21 at 2:41pm revealed: -Resident #3 was prescribed Depakote to treat his bipolar and schizoaffective disorder. -It was important for Resident #3 to take all his mental health medications because he was at risk for developing behaviors. -Resident #3 had recently showed some behaviors that were unusual for him, such as smoking in his room. -She recently (07/27/21) treated Resident #3 for pneumonia and chronic low sodium. -She was not sure if the behaviors were from missed medications or his other conditions. Interview with the Administrator on 08/10/21 at 4:25pm revealed she did not know Resident #3 did not have Depakote available to be administered.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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D 367	Continued From page 8 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic Treatment Administration Record (eTAR) for 1 of 3 sampled residents related to a resident who refused to wear oxygen and staff documented the oxygen as administered (Resident # 1). The findings are: Review of Resident #1's current FL-2 dated 06/23/21 revealed diagnoses included schizoaffective bipolar disorder, diabetes type II, chronic obstructive pulmonary disease, tobacco use, asthma, and Parkinson's disease. Review of Resident #1's physician's orders dated	D 367	If a medication is refused provider to be notified and charted. RCC to monitor. missed med sheet will be kept in office.	8/12/21

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D 367	Continued From page 9 06/23/21 revealed an order for oxygen (O2) 2 liters (L) via nasal canula (NC) continuously. Observation of Resident #1's room on 08/10/21 at 10:32am revealed: -There was an O2 concentrator machine in his room with NC tubing attached and the machine was turned off. -Resident #1 was sitting in a recliner chair in his room while not wearing the O2 tubing. -Resident #1 appeared to have mild shortness of breath while talking. Interview with Resident #1 on 08/10/21 at 10:32am revealed: -The O2 concentrator machine was in his room because he needed oxygen when he first was discharged from the hospital about 4 months ago. -He does not use oxygen. -He denied being short of breath and always breathed with increased effort "like this because I smoke cigarettes". Review of Resident #1's July 2021 electronic Treatment Administration Record (eTAR) revealed: -There was an entry for oxygen 2L NC continuously. -There was documentation oxygen 2L NC was administered daily from 07/01/21 through 07/18/21 and 07/20/21 through 07/31/21. -There was documentation oxygen 2L NC was not administered on 07/19/21 due to "resident refused". Review of Resident #1's August 2021 electronic Treatment Administration Record (eTAR) revealed: -There was an entry for oxygen 2L NC continuously.	D 367		

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D 367	Continued From page 10 -There was documentation oxygen 2L NC was administered daily from 08/01/21 through 08/10/21. Interview with the medication aide (MA) on 08/10/21 at 1:30pm revealed: -Resident #1 refused to wear oxygen because he "goes out to smoke". -She had documented the oxygen 2L NC continuously for Resident #1 as administered on 08/10/21 because she was "in a hurry" and accidentally signed it as administered -Once she had documented the oxygen for Resident #1 as administered in the computer system it would not let her change it to refused. Second observation of Resident #1 on 08/10/21 at 3:43pm revealed he was not wearing oxygen. Second interview with Resident #1 on 08/10/21 at 3:43pm revealed: -He had not worn his ordered oxygen in at least a week. -He did not feel like he needed to wear oxygen. -He wore oxygen about a week ago because he felt short of breath. Interview with the Administrator on 08/11/21 at 11:22am revealed: -She did not know why the MA's documented the oxygen for Resident #1 as administered when Resident #1 had refused to wear the ordered oxygen. -She did not know if the primary care provider (PCP) had been notified that Resident #1 had been refusing to wear the ordered oxygen. -She expected staff to document the refusal to wear oxygen by Resident #1 instead of documenting as administered and to notify the PCP per the facility's Medication Administration	D 367		

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D 367	Continued From page 11 Policy. Telephone interview with the PCP on 08/11/21 at 2:41pm revealed: -She had ordered oxygen 2L NC to be worn continuously for Resident #1 because he had a chronic inflammatory lung disease that caused obstructed airflow from the lungs. -She knew Resident #1 was non-compliant with wearing the ordered oxygen because she visited the facility weekly and observed him not wearing oxygen. -Resident #1 told her he did not wear the ordered oxygen. -She could not remember if staff had notified her of Resident #1 refusing to wear oxygen. -She did not want to discontinue the ordered oxygen because she wanted it to be available if Resident #1 had difficulty breathing and needed the oxygen. -Resident #1 did not have orders to check oxygen levels scheduled but his O2 saturation levels were "typically in the 90's". -She expected staff to notify her when residents refused medications or treatments.	D 367		

RICHMOND HILL REST HOMES REFUSED/MISSED MEDICATION LOG

RICHMOND HILL REST HOMES # _____	
Staff Name:	
Resident Name / Initials:	
Date:	
Medication Name:	Dosage
Physician Name	

State reasons for missed medications:

COPY ADMINISTRATOR, PHYSICIAN, DSS AND RESIDENT FILE. Include fax transmittal

Signature

Faxed to Administrator on: _____ _____

Received by Administrator on: _____ _____

Faxed to Prescriber on: _____ _____

Faxed to DSS on: _____ _____