Received via email 07/21/22 LSB

PRINTED: 06/27/2022
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 06/15/2022 |

| 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 |
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| (D 000) | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow up survey on 06/15/2022. | (D 000) | | |
| (D 358) | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW UP TO TYPE A2 VIOLATION<br><br>The previous A2 Violation was not abated.<br><br>Based on observations, interviews and record reviews the facility failed to administer medications as ordered to 1 of 3 sampled residents (#3) related to a medication to treat schizophrenia.<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 04/26/22 revelaed:<br>-Diagnoses included schizophrenia and psychotic disorder.<br>-There was an order for Caplyta 42mg daily (used to treat schizophrenia).<br><br>Interview with Resident #3 on 06/15/22 at 8:44am, 11:45am and 2:35pm revealed:<br>-He did not receive his Caplyta for the last few | (D 358) | Admin and RCC completed cart audit for home on 6/15/22 to ensure that all meds ordered for residents were available. RCC contacted PCP and Pharamcy of any issues. RCC and Admin will complete weekly cart audits x 6 weeks then monthly to ensure all meds available to administer. RCC implemented a new refill process and educated staff on 6/16/22. RCC will review all delivery sheets to ensure that meds ordered came in. RCC will run missed med report daily | 6/28/22 |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Nuth — TITLE: Administrator — (X6) DATE: 7/7/22

STATE FORM 6899 PFR012 If continuation sheet 1 of 15

Reviewed & acknowledged 07/22/22 LSB

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| (D 358) | Continued From page 1<br>days because the facility did not have it available to administer.<br>-His Primary Care Provider (PCP) brought samples of the medication to the facility because the medication was so expensive and could not be provided by the facility's contracted pharmacy.<br>-When he went home on 06/09/22 the facility only had 2 capsules available to send with him.<br>-He was planning to be gone 3 days and would need 3 capsules for his leave of absence but only took the 2 available capsules with him.<br>-He did not take the Caplyta on 06/12/22 when he was at home because he had already taken the 2 sent with him and did not have any more Caplyta available.<br>-The medications Aide (MA) did not give Caplyta to him on 06/13/22, 06/14/22 or 06/15/22 because they did not have any more samples.<br>-Caplyta was a very important medication that treated his paranoia so he made sure he took it everyday when he was at home on a leave of absence from the facility.<br>-When he was home he kept track of and administered his own medications.<br><br>Review of Resident #3's April 2022 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for Caplyta 42mg scheduled to be administered daily at 8:00am.<br>-On 04/01/22, 04/02/22, 04/03/22, 04/16/22 and 04/17/22 there was documentation the Caplyta was not administered because Resident #3 was out of the facility.<br><br>Review of Resident #3's May 2022 eMAR revealed:<br>-There was an entry for Caplyta 42mg scheduled to be administered daily at 8:00am.<br>-On 05/06/22, 05/07/22, 05/08/22, 05/14/22, | (D 358) | X 4 weeks then monthly and document any concerns. RCC will follow up on all refill request made during cart audit to ensure that meds are delivered to facility. RCC and Admin educated med techs of expectations of letting RCC know when meds are low or out and have been ordered and not received so RCC and Admin can follow up to get medication for residents. RCC and Admin educated staff on expectation and process of signing out medications to resident when they leave facility on a leave of Absence. Admin | |

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| (D 358) | Continued From page 2<br>05/15/22, 05/20/22, 05/21/22 and 05/22/22 there was documentation the Caplyta was not administered because Resident #3 was out of the facility..<br><br>Review of Resident #3's June 2022 eMAR revealed:<br>-There was an entry for Caplyta 42mg scheduled to be administered daily at 8:00am.<br>-On 06/10/22, 06/11/22 and 06/12/22 there was documentation the Caplyta was not administered because Resident #3 was out of the facility. .<br><br>Observation of Resident #3's medications available on hand at 11:29am revealed Caplyta 42mg was not available to be administered.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/15/22 at 11:29am revealed:<br>-Resident #3's PCP provided samples of Caplyta because the pharmacy needed prior authorization before it could be delivered.<br>-She did not have a record of how many capsules or how many times the PCP delivered samples.<br>-She did not know when the samples ran out.<br><br>Interview with a MA on 06/15/22 at 1:52pm revealed:<br>-Caplyta was not available when she administered Resident #3's medications on 06/14/22 even though the eMAR indicated she administered it.<br>-She made a mistake when she documented administration.<br>-She assumed the MA who worked 06/13/22 had ordered the medication from the pharmacy.<br><br>Interview with the Administrator on 06/15/22 at 1:57pm revealed:<br>-Caplyta samples for Resident #3 were brought to | (D 358) | Contacted Pharamacy asking that all attempted Prior Auth needed to be faxed to ~~the~~ error office in order for facility to follow up on request or to ensure correct pcp info. | |

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| (D 358) | Continued From page 3 | (D 358) | | |

the facility monthly by his PCP.
-Caplyta was supplied as samples because it was so expensive and needed prior authorization to be covered by insurance.
-The pharmacy would start supplying it once prior authorization was obtained.
-A week or 10 days ago Resident #3 had 2 partial boxes in the medication cart.
-When she administered medications to Resident #3 earlier in the day she noticed he was out of Caplyta.
-She contacted the PCP to obtain more samples when she realized he was out.
-It was not previously reported to her that no more samples were available.

Interview with Resident #3's mental health provider on 06/15/22 at 2:14pm revealed:
-He worked with Resident #3's PCP and was at the facility to visit Resident #3.
-Caplyta samples were brought to the facility by himself, Resident #3's PCP or the Registered Nurse (RN) that worked with the PCP.
-He was unaware that the facility was out of samples.
-He brought several boxes of samples to the facility in May 2022 but was not informed that more samples were needed at this time.

Telephone interview with an RN from Resident #3's PCP's office on 06/15/22 at 2:30pm and 2:40pm revealed:
-She had just been contacted today (06/15/22) by Resident #3's mental health provider and informed that Resident #3 was out of Caplyta.
-She did not understand why the facility ran out because the facility's contracted pharmacy provided it.
-She called the pharmacy and was told they did not supply the Caplyta because they were waiting

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| (D 358) | Continued From page 4 | (D 358) | | |

on prior authorization paperwork to be returned.
-The pharmacy sent the prior authorization form to the incorrect provider.

Telephone interview with Resident #3's PCP on 06/15/22 at 2:48pm and 3:17pm revealed:
-Caplyta was prescribed for bi-polar/schizoaffective disorder and was a very important medication which needed to be administered consistently.
-He recently stopped providing samples because the facility informed him that the pharmacy was obtaining authorization and would start providing the medication.
-No one from the facility had contacted him to request more samples.
-The last time the facility received samples was sometime in May 2022 when the mental health provider delivered 4 boxes containing 10 capsules in each box.
-Resident #3 was currently stable and capable of administering his own medication when he was on a leave of absence from the facility.
-If Resident #3 did not receive his Caplyta consistently he could have a psychotic episode which could result in him hurting himself.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/15/22 at 4:23pm revealed:
-The pharmacy received an order for a 30-day supply of Caplyta 42mg on 03/08/22 and sent 30 capsules to the facility on 03/09/22.
-The pharmacy received an order on 04/25/22 but informed the facility they could not fill it until they received prior authorization, which they were seeking.
-They discovered today (06/15/22), when an RN from Resident #3's PCP's office called about it, that they sent the prior authorization request to

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| (D 358) | Continued From page 5<br>another provider.<br><br>Another interview with the Administrator on 06/15/22 at 4:45pm revealed:<br>-When a medication was not available to administer the MAs had been trained to enter a note in the eMAR system.<br>-She printed a report daily that listed all medications that were not administered the previous day.<br>-Because a note had not been entered in the eMAR system indicating Caplyta was not available, she was unaware until she was administering medications earlier in the day that Resident #3 was out of Caplyta.<br><br>The facility failed to administer medications as ordered to Resident #3 related to Caplyta (a medication used to treat schizophrenia) when the facility ran out of samples resulting in the resident going 4 days without his medication. This failure put Resident #3 at substantial risk for physical harm from a possible psychotic episode and constitutes a Type A2 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/15/22 for this violation. | (D 358) | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication | D 367 | Admin and RCC educated Med Techs on proper documentation of all medications. Med techs instructed that if a medication was not available they were | |

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| D 367 | Continued From page 6<br><br>administered.<br>(4) instructions for administering the medication or treatment.<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(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).<br><br>This Rule is not met as evidenced by<br>Based on observations, interviews and record reviews the facility failed to ensure the electronic Medication Administration Record (eMAR) was accurate for 1 of 3 sampled residents (#3) related to documenting administration of a medication to treat schizophrenia when the medication was not available.<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 04/26/22 revelaed<br>-Diagnoses included schizophrenia and psychotic disorder.<br>-There was an order for Caplyta 42mg daily.<br><br>Interview with Resident #3 on 06/15/22 at 8:44am, 11:45am and 2:35pm revealed:<br>-He did not receive his Caplyta for the last few days because the facility did not have it available to administer.<br>-When he went home on 06/09/22 the facility only had 2 capsules available to send with him. | D 367 | Continued<br>to document on MAR why and contact pharamey and PCP. Staff educated on the importance of letting RCC or Admin Know when documentation was done in error in order to fix Correct documentation. RCC and Admin will complete weekly cart audit X 6 weeks then monthly to ensure meds are available and review missed med report for wholes. RCC and Admin will interview residents weekly X 4 weeks then monthly to ensure they received medication the review MAR to review is interview response match MAR. | 6/28/22 |

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| D 367 | Continued From page 7<br>-He was planning to be gone 3 days and would need 3 capsules for his leave of absence but only took the 2 available capsules with him.<br>-The medications Aide (MA) did not give it to him on 06/13/22, 06/14/22 or 06/15/22 because they did not have any more samples.<br><br>Review of Resident #3's June 2022 eMAR revealed:<br>-There was an entry for Caplyta 42mg daily at 8:00am.<br>-There was documentation Resident #3 was out of the facility and unavailable for 8:00am medications for 3 days on 06/10/22 through 06/12/22.<br>-There was documentation Caplyta 42mg was administered on 06/13/22 and 06/14/22.<br>-There was no note entered in the eMAR system to document why Caplyta was not administered on 06/15/22 at 8:00am.<br><br>Observation of Resident #3's medications available on hand at 11:29am revealed Caplyta 42mg was not available.<br><br>Interview with a MA on 06/15/22 at 1:52pm revealed:<br>-Caplyta was not available to administer when she administered Resident #3's medications on 06/14/22.<br>-She made a mistake when she documented on the eMAR that she administered it.<br><br>Interview with the Administrator on 06/15/22 at 4:45pm revealed:<br>-When a medication was not available to administer the MAs had been trained to write a note in the eMAR system explaining why the medication was not administered.<br>-When a medication was not available to | D 367 | | |

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| D 367 | Continued From page 8<br>administer it should not be documented on the eMAR that it was administered.<br>-The two MAs who erroneously documented administration were trained on proper documentation. | D 367 | | |
| (D914) | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations related to medication administration.<br><br>The findings are:<br><br>Based on observations, interviews and record reviews the facility failed to administer medications as ordered to 1 of 3 sampled residents (#3) related to a medication to treat schizophrenia. [Refer to Tag 358 10A NCAC 13F .1004a, Medication Administration (Type A2 Violation)]. | (D914) | Admin and RCC completed Care audit in home on 6/15/22 to ensure that residents care needs were met by having all ordered medication available to adminster. RCC will run missed med report daily x 4 weeks then weekly to ensure and care needs are met. | 6/28/22 |
| D936 | 10A NCAC 13F .1010 (d) (e) Pharmaceutical Services<br><br>10A NCAC 13F .1010(d) Pharmaceutical Services | D936 | | |

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| D936 | Continued From page 9<br><br>(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:<br>(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;<br>(2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication ' s release from the facility and shall include at least:<br>(A) the name and strength of the medication;<br>(B) the directions for administration as prescribed by the resident's physician,<br>(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;<br>(3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and | D936 | Admin and RCC educated staff on 6/16/22 on the correct way to send residents medication with them when they are leaving facility for leave of absence from facility. RCC and Admin spoke with residents in home on 6/16/22 to inform them that all meds must be sent and paperwork completed and signed when leaving on temporary leave. RCC and Admin also requested through business group chat to post anytime a resident leaves LOA to ensure paperwork is complete. RCC will monitor group chat for messages | 6/16/22 |

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| D936 | Continued From page 10<br>(4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility.<br>(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to ensure medications provided to a resident during a leave of absence were accurately documented and maintained in the resident's record for 1 of 1 sampled residents (#3).<br><br>The findings are:<br><br>Review of Resident #3's current FL2 date 04/26/22 revealed diagnoses included schizophrenia and psychotic disorder.<br><br>Interview with Resident #3 on 06/15/22 at 11:45am revealed he went home on a leave of absence from 06/09/22 through 06/12/22. | D936 | of residents leaving for overnight stays daily x 4 weeks then weekly to ensure that proper paperwork is completed for LOA visits and that residents has enough meds to take home and upon return. | |

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| D936 | Continued From page 11<br><br>Review of Resident #3's April 2022 electronic Medication Administration Record (eMAR) revealed there was a note documenting Resident #3 was out of the facility on 2 different occasions from 04/01/22 through 04/03/22 and 04/16/22 through 04/17/22.<br><br>Review of Resident #3's May 2022 eMAR revealed there was a note documenting Resident #3 was out of the facility on three different occasions from 05/06/22 through 05/08/22, 05/14/22 through 05/15/22/22 and 05/20/22 through 05/22/22.<br><br>Review of Resident #3's June 2022 eMAR revealed there was a note documenting Resident #3 was out of the facility on one occasion from 06/09/22 through 06/12/22.<br><br>Review of Resident #3's Leave of Absence form dated 04/01/22 revealed:<br>-A facility staff signed the document indicating the resident left the facility with 9 different medications on 04/01/22 at 1:30pm.<br>-The 9 medications were documented by name with the number of doses sent with the resident.<br>-Resident #3 signed the document indicating he left the facility on 04/01/22 at 1:30pm but did not sign it upon return to the facility.<br>-The same facility staff member signed the document indicating the resident returned to the facility on 04/03/22 at 8:00pm.<br>-Seven of the 9 medications were documented with the number returned at the end of the leave of absence.<br><br>Review of Resident #3's Leave of Absence form dated 05/13/22 revealed:<br>-A facility staff signed the document indicating the | D936 | | |

| 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 06/15/2022 |

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

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|---|---|---|---|---|
| D936 | Continued From page 12 | D936 | | |

resident left the facility with 8 different medications on 05/13/22 but the time was not documented.
-The 8 medications were documented by name with the number of doses sent with the resident.
-Resident #3 signed the document indicating he left the facility but date and time were not documented.
-The signature line to document return of medications at the end of the Leave of Absence was left blank by both employee and Resident #3.
-There was no documentation indicating the quantity of medications returned at the end of the Leave of Absence.

Further review of Resident #3's record revealed:
-There was no documentation to account for his medications during his leave of absence from 04/16/22 through 04/17/22.
-There was no documentation to account for his medications during his leave of absence from 05/06/22 through 05/08/22.
-There was no documentation to account for his medications during his leave of absence from 05/20/22 through 05/22/22.
-There was no documentation to account for his medications during his leave of absence from 06/09/22 through 06/12/22.

Interview with Resident #3 on 06/15/22 at 2:35pm revealed:
-His medication cards were always sent with him went he went home for a leave of absence from the facility.
-Sometimes he signed a form indicating what medications were sent home with him, but other times he did not.

Interview with the Resident Care Coordinator (RCC) on 06/15/22 at 1:35pm revealed:

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|---|---|---|---|---|
| D936 | Continued From page 13<br>-Resident #3 left the facility a few weekends each month to visit with his family.<br>-The facility had 2 documents to account for medications given to Resident #3 when he left the facility on a leave of absence.<br>-The staff did not always complete the required paperwork so they did not have documentation of medications given to Resident #3 when he left the facility on 04/16/22, 05/06/22, 05/20/22 or 06/09/22.<br>-The MAs were trained to complete the proper documentation each time the resident left.<br><br>Interview with the Administrator on 06/15/22 at 1:57pm and 4:45pm revealed:<br>-Staff were trained to complete a Leave of Absence form when a resident left the facility and took medications with them.<br>-She was aware staff were not always following policy.<br>-In mid-May 2022 she changed the procedure for signing out medications when a resident left the facility and needed to take medications with them.<br>-Prior to mid-May staff were hand writing all the medications on a piece of paper, listing dose and quantity, signing the paper and having the resident sign also.<br>-She changed it so the Resident's electronic Medication Record (eMAR) could be printed as a Leave of Absence record.<br>-The Leave of Absence record documented medication, dose, administration directions, quantity sent and had a place for the staff and the resident to sign and date.<br>-Upon return to the facility the form could then be used to document the quantity of medications returned and another place for staff and resident to sign and date.<br>-She changed it to the new procedure so it was easier for staff to document but the staff were still | D936 | | |

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| D936 | Continued From page 14<br>not following the procedures as they were trained.<br>-The staff needed to follow policy because it was the only way the facility had to account for medications. | D936 | | |