

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: HAL-011-378	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETED: 10/06/2022
NAME OF PROVIDER Richmond Hill Rest Home #2		STREET ADDRESS, CITY, STATE, ZIP CODE 95 Richmond Hill Road, Asheville, NC 28806	
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)
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(D 000)	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 10/04/22 through 10/06/22 with a telephone exit on 10/06/22.		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F. 0407 Other Staff Qualifications (a) Each staff person at an adult care home shall (5) have no substantiated findings listed on the North Carolina Personnel Registry according to G.S. 131E-256. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 09/05/22. -Staff B worked as a medication aide (MA) and Resident Care Coordinator (RCC). -There was no documentation a HCPR check was completed prior to hire. Review of Staff B's HCPR check completed 10/05/22 revealed there were no substantiated findings. Interview with the Clinical Director on 10/05/22 at 2:17pm revealed: -She could not find a HCPR check completed on Staff B in Staff B's personnel record. -She was responsible to complete the HCPR check on Staff B prior to the hire date.		Admin reviewed all staff files to ensure that each employee had a health care Registry completed and filed in chart. Admin will run health care registry as application is placed prior to interview to ensure registry ran prior to employment. Paperwork will be given to RCC to be placed in staff file and Clinical Admin will audit files within one

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STATE FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

Reviewed and Acknowledged
Date: 11/22/22

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0137	-She completed the HCPR check on Staff B but was unable to find the document. -She or the Administrator were responsible for filing the HCPR checks in staff records. -She had not completed an audit on employee files. -Staff B was still orienting to the RCC position but was responsible for making sure all required documentation was filed in employee records. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -Staff B should have had a HCPR check completed prior to the hire date. -The HCPR check for Staff B should have been in a binder in the office. -She did not know why Staff B's HCPR check was not in the binder. -She or the Clinical Director were responsible for filing HCPR checks in the binder.		Week of employment to ensure all needed paperwork is completed and in file.	
0273	10A NCAC 13F.0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up for 2 of 3 sampled residents (Residents #2 and #3) related to not notifying the prescriber of missed doses of clozapine (#2), failing to send complete blood cell (CBC)		RCC will get all orders from doctors and referrals. RCC will call referral office ^{the same week} to schedule appointment. RCC will then call for transportation if done by Medicaid transport or call family if family transport.	11/16/22

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D 273	laboratory results to the contracted pharmacy for clozapine refill (#2), failing to report fingerstick blood sugars (FSBS) less than 80 (#3) and a resident's refusal to have ordered monthly weights obtained (#3). The findings are: 1. Review of Resident #2's current FL2 dated 05/11/22 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, prolapsed mitral valve, asthma, and gastroesophageal reflux disease. -There was an order for clozapine (used to treat schizoaffective disorder) 100mg one and a half tablets daily. Review of Resident #2's Care Plan dated 05/09/22 revealed the resident was oriented with adequate memory. a. Interview with Resident #2 on 10/04/22 at 8:59am and at 3:15pm revealed: -She recently went without her clozapine. -Staff told her the pharmacy would not deliver the clozapine. -She suffered from withdrawal symptoms of cold sweats and diarrhea after missing the doses of clozapine. Review of Resident #2's July 2022 electronic medication administration records (eMAR) revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 07/01/22 to 07/11/22 and from 07/13/22 to 07/31/22. -On 07/12/22, the clozapine was documented as not	RCC will then post all appointment in calendar in office as well as in Quick Mar system to show up on mod pass. RCC will then let resident know of appointment date and transport Agency. RCC will inform Clinical Admin of all appointments. Clinical Admin will follow up after each appointment weekly to ensure that paperwork gets filed in charts. RCC will follow up after each appointment to ensure that resident went to appointment.	
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D273	administered due to the medication arriving from the pharmacy. -There was a note the clozapine was ordered 07/08/22. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 08/01/22 to 08/06/22 and from 08/14/22 to 08/31/22. -From 08/06/22 12:00pm to 08/14/22 at 12:00pm, Resident #2 was documented out of facility. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 09/01/22 to 09/22/22, 9/24/22 to 09/28/22, and on 09/30/22. -On 09/23/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tomorrow" (09/24/22). -On 09/29/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tonight" (09/29/22). Review of Resident #2's October 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 10/01/22 to 10/03/22.	REC will inform Clinical admin of any and all appointments made for residents that facility has to transport + to ensure staffing coverage for transport. Admin will follow up weekly on referrals and appointments to ensure all appointments were made and were taken to appointments.
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D273	Observation of Resident #2's available medications on 10/04/22 at 1:50pm revealed: -There was one bubble pack of clozapine 100mg tablets available. -Two doses of clozapine 150mg (one and one-half tablets) remained in the bubble pack. -The 6-day supply of the clozapine was dispensed 09/29/22. Telephone interview with the contracted facility pharmacy on 10/04/22 at 1:11pm revealed: -They received a prescription for Resident #2 on 06/08/22 for clozapine 100mg one and a half tablets by mouth daily at bedtime with 7 refills. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 06/08/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 07/14/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 08/08/22. -They dispensed an emergency 6-day supply (9 tablets) of clozapine 100mg tablets for Resident #2 on 09/29/22. -The emergency 6-day supply covered Resident #2 until 10/05/22. -They were waiting on the facility to send Resident #2's CBC (a laboratory test that provides information about the cells in a person's blood including white blood cell counts) results for the month of September to be able to dispense the clozapine refill to supply the medication after 10/05/22. Telephone interview with Resident #2's Mental Health Nurse Practitioner (NP) on 10/04/22 at 3:00pm revealed: -The facility staff did not notify her Resident #2's clozapine was not administered from 09/23/22 to 09/29/22.			
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D273	-Resident #2 took a high dose of clozapine. -Resident #2 could have had a seizure after having missed consecutive doses of clozapine and then staff restarting the clozapine at the same dose. -One missed dose of clozapine would cause withdrawal symptoms and be "uncomfortable" for Resident #2. -She had spoken numerous times with facility staff about the importance of administering clozapine as it was ordered. -She expected the staff to notify her immediately of what to do if they did not have the medication to administer and how to safely restart the medication if two consecutive doses were missed. Interview with a medication aide (MA) on 10/04/22 at 2:05pm revealed: -She administered Resident #2's 8:00pm medications on 09/29/22. -There was no clozapine available for administration on 09/29/22. -She spoke with the facility's contracted pharmacy and they dispensed a 6-day emergency supply of the clozapine on 09/29/22. -She did not notify Resident #2's Mental Health NP about the clozapine being unavailable to administer. Telephone interview with a MA on 10/04/22 at 2:25pm revealed: -She frequently administered Resident #2's 8:00pm medications. -She had not noticed Resident #2 ever being out of the clozapine. -The last time Resident #2's clozapine was delivered the bubble pack only had a few doses. -On 09/30/22, Resident #2 reported having symptoms of diarrhea to her. -She administered an as needed dose of antidiarrheal medication to Resident #2.			
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0273	-She did not report Resident #2's diarrhea to the NP. Interview with the Clinical Director (CD) on 10/05/22 at 9:00am revealed: -It was the facility's policy to administer medications as they were ordered. -It was the facility's policy when a dose of a medication was not administered as ordered, the MA who was unable to administer the medication was supposed to let the CD know why the medication was not administered. -The MAs were supposed to let the CD know a medication was missed as soon as the medication pass for the scheduled time was completed. -The MAs did not tell her Resident #2's clozapine was out. -If she had known the clozapine was not available, she would have called the pharmacy and asked why they had not sent the clozapine and what needed to be done to get the medication for the resident. -It was also her responsibility to reach out to the prescriber to notify them when a medication was not administered. -She did not notify Resident #2's Mental Health NP about the missed doses of clozapine because she was unaware Resident #2 had missed doses of clozapine. -The eMAR system did not alert them of residents with medications not administered due to being out of stock of a medication. -She did not receive any voicemail messages or faxes from the pharmacy about them not being able to refill the clozapine. -She performed a medication cart audit at the first of September 2022. Interview with the same MA on 10/05/22 at 9:30am revealed: -She had been trained to reorder medications that were			
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0273	unavailable for administration. -She documented reordering medications in the eMAR. -The Administrator, CD, and Resident Care Coordinator (RCC) were responsible for following-up on the receipt of medications reordered from the pharmacy. -She also would tell the resident when they were out of a medication and what date it was reordered from the pharmacy. Interview with the Administrator on 10/05/22 at 4:47pm revealed: -She did not know Resident #2 ran out of the clozapine. -She did not notify Resident #2's NP the clozapine had not been available to administer. -The RCC and Head Supervisor-In-Charge (SIC) were responsible for notifying the prescriber when a medication was unavailable and obtain a refill of the medication. -Staff were trained to "demand" an emergency fill of a medication from the pharmacy if a medication was unavailable to administer. -Staff were expected to call the pharmacy to inquire about a refill of clozapine when the resident was down to their last two doses. -MAs were responsible for requesting emergency refills of medications from the pharmacy. -If the MAs did not receive the refill, she expected them to notify the pharmacy, not just keep reordering the medication. -If the pharmacy tells the MAs they cannot refill a medication, the MAs are supposed to reach out to the RCC for assistance. -The MAs can request refill assistance from the RCC by posting a note in the employee chat group. -The MAs did not post a note about Resident #2's clozapine being out.			
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D273	b. Interview with Resident #2 on 10/04/22 at 8:59am revealed: -She recently went without her clozapine. -She required monthly labs while taking the clozapine. -Her last outpatient lab was drawn in September. -October labs should be drawn "next week." According to the National Institute of Health, use of clozapine can have hematologic side effects (disorders involving the blood) such as low numbers of white blood cells (WBC) in the blood leading to increased susceptibility to infection and necessitates monitoring of WBC levels. Review of Resident #2's record revealed there were white blood cell (WBC) counts completed on 07/13/22, 08/17/22, 08/24/22, and 09/21/22. Telephone interview with the contracted facility pharmacy on 10/04/22 at 1:11pm revealed: -They dispensed an emergency 6-day supply of clozapine for Resident #2 09/29/22. -The emergency 6-day supply covered Resident #2 until 10/05/22. -They were waiting on the facility to send Resident #2's CBC (a laboratory test that provides information about the cells in a person's blood including white blood cell counts) results for the month of September to be able to dispense the clozapine refill to supply the medication for Resident #2 after 10/05/22. -They had not received a CBC lab test for Resident #2 since 08/24/22. -They were held accountable and could not dispense the clozapine without having a CBC lab result. -They had left a voicemail for facility staff on 09/18/22 notifying them they were waiting on the CBC lab result before they could refill Resident #2's clozapine.			
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0273	-They did not get a response from the facility from the attempted contact on 09/18/22. -They spoke with facility staff on 09/28/22 when they obtained the emergency authorization for a 6-day emergency supply of the clozapine for Resident #2. -Facility staff told them on 09/28/22 they were awaiting the CBC results obtained on 09/21/22 for Resident #2 from the outpatient lab. Telephone interview with Resident #2's Mental Health NP on 10/04/22 at 3:00pm revealed: -She ordered Resident #2's CBC lab from a new outpatient laboratory in September 2022. -There were some issues that arose after the change over to the new outpatient lab service. -The outpatient lab services communicated the results of Resident #2's CBC drawn 09/21/22 to her office, but they did not send the results to the facility. -Her staff entered Resident #2's CBC results from 09/21/22 into the online clozapine database. -She thought the pharmacy would accept the results entered into the online clozapine database to dispense Resident #2's clozapine. -When she arrived at the facility on 10/04/22 to see Resident #2, she discovered from facility staff the pharmacy still had not refilled Resident #2's clozapine. -She discovered the facility's pharmacy required a copy of the 09/21/22 CBC before they would dispense more clozapine for Resident #2. -She provided facility staff a copy of Resident #2's 09/21/22 CBC results to fax over to the pharmacy. -She would have expected facility staff to notify her when they had not received a copy of the CBC results for 09/21/22 for Resident #2. Interview with a medication aide (MA) on 10/04/22 at 2:05pm revealed: -The outpatient lab did not send Resident #2's 09/21/22			
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D273	CBC results to the facility. -Resident #2's 09/21/22 CBC results were faxed to the pharmacy today (10/04/22). Interview with the CD on 10/05/22 at 9:00am revealed: -The Mental Health NP ordered Resident #2's CBC lab with the outpatient lab, directly. -She asked the outpatient laboratory to let her know when they arrived on campus and which residents' they were collecting labs on. -She had not been made aware the Resident #2 had a CBC lab drawn on 09/21/22. -She was dependent on communication with the outpatient lab service staff to know when labs were drawn. -Typically, she would receive lab results from the outpatient lab via fax the same day the labs were drawn. -She would then fax Resident #2's CBC results to the pharmacy. -She did not receive the results of Resident #2's CBC drawn 09/21/22 from the outpatient lab. -The Mental Health NP provided Resident #2's CBC results drawn 09/21/22 to her when the NP came to see the resident on 10/04/22. -The CBC results for Resident #2's obtained on 09/21/22 were not faxed to the facility pharmacy until 10/04/22. -She and the RCC were responsible for ensuring completed lab results were sent to the pharmacy. 2. Review of Resident #3's current FL2 dated 05/12/22 revealed diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and mental and behavioral disorder. Review of Resident #3's Care Plan dated 06/09/21			
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D273	revealed Resident #3 was sometimes disoriented and forgetful. a. Review of Resident #3's current FL2 dated 05/12/22 revealed there was an order for finger stick blood sugars (FSBS) 4 times per day at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was an order for Novolog (a rapid acting insulin to treat high blood sugar levels) sliding scale give 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-500=10 units, and greater than 500=12 units and contact the primary care provider (PCP). Contact PCP if the FSBS was less than 80 or greater than 500. Review of Resident #3's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS daily at 8:00am, 12:00pm, 5:00pm, and 8:00pm and to notify the PCP if the FSBS was less than 80 or greater than 500. -On 09/02/22 at 8:00am the FSBS was documented as 75. -On 09/03/22 at 12:00pm the FSBS was documented as 28. -On 09/06/22 at 8:00am the FSBS was documented as 23. -On 09/11/22 at 8:00pm the FSBS was documented as 38. -On 09/15/22 at 8:00pm the FSBS was documented as 52. -On 09/18/22 at 8:00am the FSBS was documented as 70. -On 09/26/22 at 8:00am the FSBS was documented as 65. -There was no documentation the PCP was notified of the FSBS's less than 80.			
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0273	Interview with a medication aide (MA) on 10/05/22 at 11:15am revealed: -She thought she was in a hurry and accidentally typed 28 instead of 128 for Resident #3's FSBS on 09/03/22 at 12:00pm. -She would normally enter a comment on the eMARs if a resident's FSBS was low. -Resident #3 had an order to notify the PCP of FSBS less than 80. -She did not notify Resident #3's PCP of the FSBS reading of 28 she documented on 09/03/22 at 12:00pm. Interview with Resident #3 on 10/05/22 at 11:41am revealed: -Sometimes his FSBS would run low and it made him feel "tingly and shaky". -He did not know if the facility staff ever called his PCP about his FSBS's being low. -He would just eat and drink something and it would usually make the tingling and shakiness go away. Interview with the Clinical Director (CD) on 10/05/22 at 11:55am revealed: -It was the facility's policy for the MAs to follow physician's orders. -The MA was supposed to document notifications to the PCP in the comment section on the eMAR. -She did not know why the MA's did not notify the PCP or document in the comment section on the eMAR for Resident #3's FSBS when it was less than 80. -After the MA notified Resident #3's PCP of any FSBS's less than 80, the MA was responsible to notify her. -None of the MA's notified her in September 2022 of			
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D273	any FSBS less than 80 for Resident #3. Telephone interview with a second MA on 10/05/22 at 2:46pm revealed: -When Resident #3's FSBS was less than 80 she had the resident eat and drink and then rechecked a FSBS in 30 minutes. -She did not contact Resident #3's PCP to notify of low FSBS less than 80. -She was newly hired as a MA and another MA who trained her said to give food and drink to Resident #3 when the FSBS was low. -She did not remember "seeing" a physician's order on Resident #3's eMAR to contact the PCP for FSBS less than 80. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -All physician's orders were entered on the eMAR including orders with call instructions. -The MA's were responsible to follow physician's orders and notify the PCP when Resident #3's FSBS was less than 80. -The MA's were responsible to document a note in the comment section on the eMAR when the PCP was notified. Attempted telephone interview with Resident #3's PCP on 10/05/22 at 3:45pm was unsuccessful. b. Review of Resident #3's current FL2 dated 05/12/22 revealed there was an order for monthly weights. Review of Resident #3's July 2022 electronic medication			
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0273	administration record (eMAR) revealed: -There was an entry to check monthly weights. -On 07/04/22, the weight was documented as not checked with the reason as "resident refused." -There was no documentation any other attempts were made to check a monthly weight. Review of Resident #3's August 2022 eMAR revealed: -There was an entry to check monthly weights. -On 08/01/22, the weight was documented as not checked with the reason as "resident refused." -There was no documentation any other attempts were made to check a monthly weight. Review of Resident #3's September 2022 eMAR revealed: -There was an entry to check monthly weights. -There was no documentation a weight was checked in September 2022. Interview with a medication aide (MA) on 10/05/22 at 11:15am revealed: -Resident #3 refused to let her check a weight on 07/04/22. -She did not try to check another weight that month after Resident #3 refused. -Sometimes Resident #3 refused medications and other orders such as checking weights. -She did not notify the Clinical Director or PCP of the refusal. Interview with the Clinical Director (CD) on 10/05/22 at 9:00am revealed: -She did not know monthly weights were ordered for Resident #3 or why the monthly weights were ordered.			
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D273	-It was the facility's policy to follow all physician's orders. -The MA's were responsible to notify her of resident refusals. -The MA's did not notify her of Resident #3 refusing to have a weight checked in July 2022 or August 2022. -She did not know why there was no documentation of a weight for Resident #3 in September 2022. -She received a daily summary sheet with an alert from the facility's contracted pharmacy regarding orders not completed. -She did not realize the alert on the daily summary sheet did not include orders not completed due to refusals made by residents. -She was responsible to contact the PCP to clarify if the order needed to be changed for resident refusals or to see if the order could be discontinued if not needed. -She did not contact Resident #3's PCP for the monthly refusals of weight in July 2022 or August 2022 and the weight not checked in September. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -It was the facility's policy to follow all physician's orders for residents. -Monthly weights for Resident #3 should have been checked. -Resident refusals for orders should be reported to the CD or herself. -The CD was responsible for contacting the PCP to clarify orders or to get discontinue orders for resident refusals. -She did not know why the monthly weights for Resident #3 were not completed.			
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D273	The facility failed to notify the primary care provider for 2 of 3 sampled residents (#2 and #3) including a resident who missed doses of clozapine causing withdrawal symptoms of night sweats and diarrhea (#2) and failed to send complete blood cell lab results to the pharmacy delaying a refill of the clozapine (#2), and not notifying the primary care provider of critically low blood sugars as ordered (#3) or monthly weights as ordered (#3). 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 10/05/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2022.			
D358	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. FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION Based on these findings, the Previously Unabated Type A2 Violation has not been abated.		RCC and Clinical Admin will complete weekly cart audits to ensure meds are available. Admin and Clinical Admin Set up email report that is sent daily to report	

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D358	Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (Residents #1 and #2) related to a medication used to treat schizoaffective disorder (#2), medications used to treat high blood pressure, schizoaffective disorder, low testosterone levels, and excessive ear wax (#1). The findings are: Review of the facility's medication administration policy revealed: -Medications will always be ordered when the availability is at a full seven-day count. -Failure to order medications in a timely manner can result in medications not being available, there is no reason for this to occur. -If a medication is not available, due to the pharmacy not having said medication in stock, the pharmacy will obtain the medication from one of their backup pharmacies. -If for some reason this does not happen, in the eMAR system click on the medication that is not available, at the next screen click on "Arriving from" [pharmacy name]. -Note this on the Report of Consultation and notify the prescribing physician. -Complete a Drug Error report and copy all listed via facsimile, including the pharmacy, within one hour of the occurrence. 1. Review of Resident #2's current FL2 dated 05/11/22 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, prolapsed mitral valve, asthma, and gastroesophageal reflux disease. -There was an order for clozapine (used to treat	any late or missed meds. Admin and Clinical Admin review report daily and follow up on all meds posted missed or late. Clinical Admin set up additional alerts to be sent after each med pass cut off time to ensure all meds were given on time and are available.	10/16/22
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D358	schizoaffective disorder) 100mg one and a half tablets daily. Review of Resident #2's Care Plan dated 05/09/22 revealed the resident was oriented with adequate memory. Interview with Resident #2 on 10/04/22 at 8:59am and at 3:15pm revealed: -She recently went without her clozapine. -Staff told her the pharmacy would not deliver the clozapine. -She suffered with withdrawal symptoms of cold sweats and diarrhea after missing the doses of clozapine. Review of Resident #2's July 2022 electronic medication administration records (eMAR) revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 07/01/22 to 07/11/22 and from 07/13/22 to 07/31/22. -On 07/12/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was ordered 07/08/22. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 08/01/22 to 08/06/22 and from 08/14/22 to 08/31/22. -From 08/06/22 12:00pm to 08/14/22 at 12:00pm, Resident #2 was documented out of facility.			
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0358	Review of Resident #2's September 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 09/01/22 to 09/22/22, 9/24/22 to 09/28/22, and on 09/30/22. -On 09/23/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tomorrow" (09/24/22). -On 09/29/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tonight" (09/29/22). Review of Resident #2's October 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 10/01/22 to 10/03/22. Observation of Resident #2's available medications on 10/04/22 at 1:50pm revealed: -There was one bubble pack of clozapine 100mg tablets available. -Two doses of clozapine 150mg (one and one-half tablets) remained in the bubble pack. -The 6-day supply of the clozapine was dispensed 09/29/22. Telephone interview with the contracted facility pharmacy on 10/04/22 at 1:11pm revealed: -They received a prescription for Resident #2 on 06/08/22 for clozapine 100mg one and a half tablets by mouth daily at bedtime with 7 refills.			
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0358	-They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 06/08/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 07/14/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 08/08/22. -They dispensed an emergency 6-day supply (9 tablets) of clozapine 100mg tablets for Resident #2 on 09/29/22. -The emergency 6-day supply covered Resident #2 until 10/05/22. -They were waiting on the facility to send Resident #2's CBC (a laboratory test that provides information about the cells in a person's blood including white blood cell counts) results for the month of September to be able to dispense the clozapine refill to supply the medication after 10/05/22. Review of Resident #2's pharmacy dispense history of clozapine and September 2022 eMAR revealed: -On 08/08/22, the pharmacy dispensed a 28 day-supply of clozapine to supply required doses until 09/08/22. -On 09/29/22, the pharmacy dispensed a 6 day-supply of clozapine to supply required doses until 10/05/22. -There were no additional dispenses of clozapine from the pharmacy for Resident #2 during September 2022. -On 09/23/22, the clozapine was documented as not administered due to the medication being unavailable. -On 09/29/22, the clozapine was documented as not administered due to the medication being unavailable. -There was no clozapine available to administer to Resident #2 for 7 consecutive days from 09/23/22 to 09/29/22. Telephone interview with Resident #2's Mental Health Nurse Practitioner (NP) on 10/04/22 at 3:00pm revealed: -Resident #2 took a high dose of clozapine.			
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D358	-Resident #2 could have a seizure after having missed consecutive doses of clozapine and then staff restarting the clozapine at the same dose. -One missed dose of clozapine would cause withdrawal symptoms and be "uncomfortable" for Resident #2. -She had spoken numerous times with facility staff about the importance of administering clozapine as it was ordered. -She expected the staff to notify her immediately of what to do if they did not have the medication to administer and how to safely restart the medication if two consecutive doses were missed. Interview with a medication aide (MA) on 10/04/22 at 2:05pm revealed: -She administered Resident #2's 8:00pm medications on 09/29/22. -There was no clozapine available for administration on 09/29/22. -She spoke with the facility's contracted pharmacy and they dispensed a 6-day emergency supply of the clozapine on 09/29/22. Telephone interview with a MA on 10/04/22 at 2:25pm revealed: -She frequently administered Resident #2's 8:00pm medications. -She had not noticed Resident #2 ever being out of the clozapine. -The last time Resident #2's clozapine was delivered the bubble pack only had a few doses. Interview with the Clinical Director (CD) on 10/05/22 at 9:00am revealed: -It was the facility's policy to administer medications as they were ordered. -It was the facility's policy when a dose of a medication was not administered as ordered, the MA who was			
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D358	unable to administer the medication was supposed to let the CD know why the medication was not administered. -The MAs were supposed to let the CD know a medication was missed as soon as the medication pass for the scheduled time was completed. -The MAs did not tell her Resident #2's clozapine was out. -If she had known the clozapine was not available, she would have called the pharmacy and asked why they had not sent the clozapine and what needed to be done to get the medication for the resident. -It was also her responsibility to reach out to the prescriber to notify them when a medication was not administered. -The eMAR system did not alert them of residents with medications not administered due to being out of stock of a medication. -She did not receive any voicemail messages or faxes from the pharmacy about them not being able to refill the clozapine. -She had performed a medication cart audit at the first of September 2022. Interview with the same MA on 10/05/22 at 9:30am revealed: -She had been trained to reorder medications that were unavailable for administration. -She documented reordering medications in the eMAR. -The Administrator, CD, and Resident Care Coordinator (RCC) were responsible for following-up on the receipt of medications reordered from the pharmacy. -She also would tell the resident when they were out of a medication and what date it was reordered from the pharmacy. Interview with the Administrator on 10/05/22 at 4:47pm revealed:			
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D358	-It was the facility's policy to administer medications as ordered. -She did not know Resident #2 ran out of the clozapine. -The RCC and Head Supervisor-In-Charge (SIC) were responsible for notifying the prescriber when a medication was unavailable and obtain a refill of the medication. -Staff were trained to demand an emergency fill of a medication from the pharmacy if a medication was unavailable to administer. -Staff were expected to call the pharmacy to inquire about a refill of clozapine when the resident was down to their last two doses. -The MAs were responsible for requesting emergency refills of medications from the pharmacy. -If the MAs did not receive the refill, she expected them to notify the pharmacy, not just keep reordering the medication. -If the pharmacy told the MAs they could not refill a medication, the MAs were supposed to reach out to the RCC for assistance. -The MAs could request refill assistance from the RCC by posting a note in the employee chat group. -The MAs did not post a note in the employee chat group about Resident #2's clozapine being out. 2. Review of Resident #1's current FL2 dated 01/07/22 revealed diagnoses included hypertension, schizoaffective disorder, major depressive disorder, and Parkinson's disease. Review of Resident #1's Care Plan dated 01/31/22 revealed Resident #1 required moderate assistance from staff with activities of daily living (ADL's). a. Review of Resident #1's physician's orders dated 06/30/22 revealed there was a medication			
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D358	order for amlodipine (used to treat high blood pressure) 10mg take 1 tablet daily. Review of Resident #1's September 2022 eMAR revealed: -There was an entry for amlodipine 10mg take 1 tablet daily. -Amlodipine was documented as not administered 12 instances out of 30 opportunities with a comment the amlodipine was "ordered" from the facility's contracted pharmacy. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 10/04/22 at 3:21pm revealed: -There was a blue line on each bubble pack of medication indicating there was a week's worth of medication left and the MA on duty was supposed to reorder when the medication was getting low. -She did not know why Resident #1 did not receive the scheduled dose of amlodipine on 09/03/22 through 09/08/22, 09/11/22, 09/12/22, 09/15/22, 09/17/22, 09/19/22, and 09/20/22. -A request was made by the facility to the facility's contracted pharmacy on 09/19/22 for a refill of Resident #1's amlodipine. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -Resident #1's amlodipine 10mg was last dispensed on 09/21/22 in the quantity of 30 tablets. -Resident #1's amlodipine 10mg was previously dispensed as an emergency supply on 05/24/22 with 30 tablets, 06/30/22 with 30 tablets, and on 07/24/22 with			
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0358	30 tablets. -An emergency supply of Resident #1's amlodipine was filled without a prescription because the pharmacy did not want Resident #1 to go without the prescribed medication. -A notification was faxed to the facility on 07/24/22 that the pharmacy could not continue to dispense Resident #1's amlodipine as an emergency supply because a new prescription was needed from the primary care provider (PCP). -A notification was also faxed to the facility on 05/24/22, 06/30/22, and 09/12/22 that a new prescription for Resident #1's amlodipine was needed. -The PCP faxed a new prescription for Resident #1's amlodipine on 09/21/22 in the quantity of 30 tablets with 11 refills. -The previous prescriptions for Resident #1's amlodipine was always in the quantity of 30 tablets and had no refills. Refer to the interview with the Clinical Director on 10/05/22 at 9:00am. Refer to the telephone interview with the Administrator on 10/05/22 at 4:47pm. Attempted interview with Resident #1 on 10/04/22 at 3:40pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 10/05/22 at 1:10pm was unsuccessful. b. Review of Resident #1's physician's orders dated 04/18/22 revealed there was a medication order for risperidone (used to treat schizophrenia)			
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D358	0.5mg take 1 tablet daily. Review of Resident #1's September 2022 eMAR revealed: -There was an entry for risperidone 0.5mg take 1 tablet daily. -Risperidone 0.5mg was documented as not administered daily for 15 instances out of 30 opportunities with a comment "ordered" from the facility's contracted pharmacy. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for risperidone 0.5mg take 1 tablet daily. -Risperidone 0.5mg was documented as not administered daily from 10/02/22 through 10/04/22 with a comment "ordered" from the facility's contracted pharmacy. Interview with a medication aide (MA) on 10/04/22 at 1:59pm revealed: -She administered Resident #1's risperidone on 09/23/22 through 09/25/22 and on 09/29/22 because she documented on the eMAR the medication was administered. -She thought Resident #1 had enough risperidone to administer the entire month of September 2022. Interview with the MA/Resident Care Coordinator (RCC) on 10/04/22 at 3:21pm revealed: -There was a blue line on each bubble pack of medication indicating there was a week's worth of medication left and the MA on duty was supposed to reorder when the medication was getting low.			
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0358	-Another MA reordered Resident #1's risperidone from the facility's contracted pharmacy on 10/03/22. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -On 06/30/22, Resident #1's risperidone was dispensed in the quantity of 30 tablets. -On 08/03/22, Resident #1's risperidone was dispensed in the quantity of 30 tablets. -On 09/11/22, an emergency supply of Resident #1's risperidone was dispensed in the quantity of 3 tablets. -Resident #1's risperidone was last dispensed on 09/21/22 as an emergency supply in the quantity of 6 tablets. -The pharmacy faxed a notification on 08/03/22, 09/07/22, and 09/11/22 that a new prescription was needed for Resident #1's risperidone to the primary care provider (PCP) and the facility. -There were 9 tablets dispensed as an emergency supply of Resident #1's risperidone in September 2022. -An emergency supply of Resident #1's risperidone was filled twice without a prescription with a combined quantity of 9 tablets because the pharmacy did not want Resident #1 to go without the prescribed medication. Refer to the interview with the Clinical Director on 10/05/22 at 9:00am. Refer to the telephone interview with the Administrator on 10/05/22 at 4:47pm. Attempted interview with Resident #1 on 10/04/22 at			
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D358	3:40pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 10/05/22 at 1:10pm was unsuccessful. c. Review of Resident #1's physician's orders dated 04/18/22 revealed there was a medication order for testosterone (replacement therapy to treat low hormone levels) 200mg/ml inject 1ml intramuscular every 2 weeks. Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for testosterone inject 1ml intramuscular every 2 weeks. -There was no documentation testosterone was administered from 07/01/22 through 07/31/22. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for testosterone inject 1ml intramuscular every 2 weeks. -There was documentation testosterone was administered on 08/10/22. Review of Resident #1's September 2022 eMAR revealed: -There was an entry for testosterone inject 1ml intramuscular every 2 weeks. -There was no documentation testosterone was administered from 09/01/22 through 09/30/22. -There was a second entry for testosterone inject 1ml intramuscular every 2 weeks. -There was documentation testosterone was not administered on 09/07/22 with a comment "ordered" from the facility's contracted pharmacy.			
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0358	Review of Resident #1's October 2022 eMAR revealed: -There was an entry for testosterone inject 1ml intramuscular every 2 weeks. -There was no documentation testosterone was administered from 10/01/22 through 10/04/22. Observation of Resident #1's medications on hand on 10/04/22 at 3:02pm revealed there were no testosterone injections available for administration. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 10/04/22 at 3:21pm revealed: -Resident #1's testosterone injections were kept in the refrigerator. -There were no testosterone injections available for Resident #1. -The facility's contracted home health registered nurse (RN) administered the testosterone injections to Resident #1. -The MA would get the testosterone injection out of the refrigerator to give to the home health RN to administer when it was due and would request a refill from the pharmacy at that time. Interview with the Clinical Director on 10/05/22 at 9:30am revealed: -The home health RN gave the testosterone injections to Resident #1. -The home health RN did not have access to the eMAR so she or the MA on duty would sign the eMAR for Resident #1's testosterone injections when it was given. -She thought Resident #1's eMARs were not signed because the MA did not want to sign for the injection.			
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D358	Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -Resident #1's testosterone injection was last dispensed on 09/22/22 in the quantity of 1 dose. -On 08/13/22, there were 2 doses of testosterone injections dispensed on 08/13/22 for Resident #1. -On 07/18/22, there were 2 doses of testosterone injections dispensed on 07/18/22 for Resident #1. -Resident #1's testosterone injections were not on a cycle fill and the facility had to send a refill request. -The last request for a medication refill sent to the pharmacy from the facility was on 09/22/22. Telephone interview with the facility's contracted home health RN on 10/05/22 at 10:18am revealed: -Resident #1 had testosterone injections ordered every 2 weeks but recently he had to go 3 weeks before he received the injection because the testosterone was unavailable on 09/22/22. -The MA would give her the testosterone injection to give to Resident #1. -The MA told her there were no testosterone injections available for Resident #1 on 09/22/22. -The MA on duty reported she had to call the PCP to get a new prescription for the testosterone injections in order to get the pharmacy to refill the medication for Resident #1. -She gave the testosterone injections to Resident #1 on 07/28/22, 08/11/22, 08/25/22, 09/09/22, and 09/28/22. Attempted interview with Resident #1 on 10/04/22 at 3:40pm was unsuccessful.			
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0358	Attempted telephone interview with Resident #1's PCP on 10/05/22 at 1:10pm was unsuccessful. Refer to the interview with the Clinical Director on 10/05/22 at 9:00am. Refer to the telephone interview with the Administrator on 10/05/22 at 4:47pm. d. Review of Resident #1's physician's orders dated 04/18/22 revealed there was a medication order for Debrox (to aide in the removal of excessive ear wax) 6.5% ear drops place 5 drops each ear twice daily for 4 days and repeat for the first 4 days of each month. Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Debrox 6.5% place 5 drops in each ear twice daily for 4 days and repeat the first 4 days of each month. -Debrox ear drops were documented as administered from 07/05/22 through 07/08/22 at 8:00am and 8:00pm. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Debrox 6.5% place 5 drops in each ear twice daily for 4 days and repeat the first 4 days of each month. -Debrox ear drops were documented as administered from 08/02/22 through 08/05/22 at 8:00am and 8:00pm. -Debrox ear drops were documented as administered on 08/30/22 at 8:00am and 8:00pm,			
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D358	and 08/31/22 at 8:00pm. -Debrox ear drops were documented as not administered on 08/31/22 at 8:00am with a comment "resident refused." Review of Resident #1's September 2022 eMAR revealed: -There was an entry for Debrox 6.5% place 5 drops in each ear twice daily for 4 days and repeat the first 4 days of each month. -Debrox ear drops were documented as administered from 09/01/22 through 09/02/22 at 8:00am and 8:00pm. -Debrox ear drops were documented as administered from 09/27/22 through 09/30/22 at 8:00am and 8:00pm. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for Debrox 6.5% place 5 drops in each ear twice daily for 4 days and repeat the first 4 days of each month. -There was no documentation Debrox ear drops were administered from 10/01/22 through 10/04/22. Observation of Resident #1's medications on hand on 10/04/22 at 3:02pm revealed there were no Debrox ear drops available for administration. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 10/04/22 at 3:21pm revealed: -Resident #1's Debrox ear drops were missing from the medication cart. -The MA on duty was responsible for requesting refills			
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0358	from the facility's contracted pharmacy when a medication ran out. -She did not see a refill request in the computer system for Resident #1's Debrox ear drops. -She and the Clinical Director were responsible for medication cart audits to make sure all resident's medications were available for administration. -She could not remember when a medication cart audit had last been completed. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -Resident #1's Debrox ear drops were last dispensed on 07/06/22 in the quantity of a 15ml bottle. -Debrox ear drops for Resident #1 were previously dispensed on 09/21/21 and were reordered on 04/18/22. -The facility had not requested a refill for Resident #1's Debrox ear drops since they were last dispensed on 07/06/22. -The 15ml bottle of Debrox ear drops for Resident #1 was for a 3-month supply if administered as ordered. Attempted interview with Resident #1 on 10/04/22 at 3:40pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 10/05/22 at 1:10pm was unsuccessful. Refer to the interview with the Clinical Director on 10/05/22 at 9:00am. Refer to the telephone interview with the				
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D358	Administrator on 10/05/22 at 4:47pm. Interview with the Clinical Director on 10/05/22 at 9:00am revealed: -The facility's policy for medication administration included the MA was supposed administer medications as ordered and to notify her by calling or sending a text message immediately after the medication pass if a resident missed a dose of medication due to the medication being unavailable for administration. -The MA on duty was responsible for requesting a refill on a medication when the medication reached a blue line on the bubble pack indicating there was about a week's worth of medication available for administration. -She was not notified by the MAs of residents missing any medications in September 2022 or October 2022. -She or the RCC was responsible to contact the pharmacy when a medication was requested but had not been refilled. -She tried to complete a medication cart audit every 2 weeks. -She did not always complete a medication cart audit every 2 weeks. -The RCC completed a medication cart audit about a week and a half ago but she could not find the document where the cart audit was completed. -She was responsible to contact the PCP for new prescriptions if one was needed for the pharmacy to refill a resident's medication. -She, the Administrator, and the RCC were responsible for completing random eMAR audits to check if residents were being administered their medications			
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D358	and if any doses were missed. -She tried to complete 3 eMAR audits every weekend but did not always complete the eMAR audits. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -It was the facility's policy to administer medications as ordered. -She did not know Resident #1's amlodipine, risperidone, testosterone, and Debrox ear drops were missing from the medication cart. -She told the MAs to request emergency refills for medications from the pharmacy when a resident's medication was low on supply or out. -The MA was supposed to then send a message to the Clinical Director so the Clinical Director could make sure a new prescription was received for the resident's medication. -If a MA already requested a resident's medication refill from the pharmacy and the medication was not sent, they were supposed to call the pharmacy to see why it was not sent. -The MA supervisor or the RCC were responsible to notify the PCP why a medication could not be filled by the pharmacy. -There was no process established for if a medication had been requested as an emergency supply from the pharmacy more than once to get a new prescription from the PCP. -The RCC and Clinical Director were responsible for medication cart audits and to get medications discontinued, clarified, or refilled by the pharmacy when medications were missing from the medication cart.			
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STATE FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

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D358	The facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1 and #2) which caused Resident #2 to have withdrawal symptoms experiencing cold sweats and diarrhea and placed at an increased risk of having seizures when restarted on the high dose of antipsychotic medication (Resident #2) and another resident who missed 12 doses of a blood pressure medication which placed the resident at risk of experiencing high blood pressures and 18 doses of an antipsychotic medication which placed the resident at risk of increased mental health behaviors (Resident #1). This failure placed the residents at substantial risk for serious physical harm and neglect and constitutes an Unabated, Unabated Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 10/05/22.			
D366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by:		<i>Admin & Clinical Admin had staff meeting with all med techs regarding the importance of not letting residents walk away with medications and not to sign MAR until staff watched resident take</i>	

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0366	TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to ensure a medication aide observed 1 of 3 sampled residents (Resident #3) take medications administered related to daily medications left on the resident's bedside table in his room. The findings are: Review of the facility's undated policy on medication administration revealed staff will observe the resident swallow the medication and document all medications administered on the eMAR immediately after administration. Review of Resident #3's FL2 dated 05/12/22 revealed: -Diagnoses included diabetes mellitus type 2, intracranial injury with mental and behavioral disorder, hypertension, chronic obstructive pulmonary disease, chronic pain, depression, chronic kidney disease, history of stroke, and hyperlipidemia. -There was no order Resident #3 could self-administer medications. -There was a medication order for aspirin (a blood thinner medication used to prevent blood clots and stroke) 81mg take 1 tablet daily. -There was a medication order for metoprolol (used to treat high blood pressure) 25mg take half a tablet twice daily. -There was a medication order for clopidogrel (a blood thinner medication used to prevent blood clots and stroke) 75mg take 1 tablet daily. -There was a medication order for escitalopram (used to treat depression) 10mg take 1 tablet daily. -There was a medication order for Januvia (used to	medication. Clinical Admin and Admin spoke with staff involved one on one to educate further on not given residents meds and walking away. Clinical Admin & Admin will review camera footage throughout the weeks to watch med pass to ensure meds were not given to residents and left to take unattended. RCC will make daily rounds and look in residents rooms to ensure no meds were	11/16/22
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0366	treat high blood sugar levels) 50mg take 1 tablet daily. -There was a medication order for lactulose (used to treat constipation and lower ammonia levels) give 30ml daily. -There was a medication order for pioglitazone (used to treat high blood sugar levels) 45mg take 1 tablet daily. -There was a medication order for Therems-M (a vitamin supplement used to treat or prevent vitamin deficiency) take 1 tablet daily. -There was a medication order for Topamax (used to treat nerve pain) 25mg take 3 tablets twice daily. -There was a medication order for amlodipine (used to treat high blood pressure) 2.5mg take 1 tablet daily. Review of Resident #3's Care Plan dated 06/23/21 revealed Resident #3 was sometimes disoriented and forgetful. Review of Resident #3's current Resident Register dated 10/24/19 revealed: -An admission date of 10/23/19. -He had a designated responsible person. Observation upon initial tour of the facility on 10/04/22 at 8:57am revealed: -The door to Resident #3's bedroom was open. -Resident #3 was sitting on the side of his bed watching television. -There were 2 medication cups sitting on the bedside table in Resident #3's room with one cup containing 9 visible tablets and the other cup containing a yellow colored liquid. Interview with Resident #3 on 10/04/22 at 8:57am revealed: -A medication aide (MA) brought him the medication cups with the pills and liquid earlier that morning and		left to take. Clinical Admin will continue to monitor and interview residents weekly to ask about meds being administered and left for them to take	
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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)
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D366	left the medications for him to self-administer. -He forgot to take the medications and left them setting on the bedside table. -The yellow liquid in the cup was lactulose. -Staff usually left his medications in his room for him to self-administer because they knew he would take them. Review of Resident #3's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aspirin 81mg take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for metoprolol 25mg take half a tablet twice daily with documentation as administered on 10/04/22. -There was an entry for clopidogrel 75 mg take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for escitalopram 10mg take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for Januvia 50mg take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for lactulose give 30ml daily with documentation as administered on 10/04/22. -There was an entry for pioglitazone 45mg take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for Therems-M take 1 tablet daily with documentation as administered on 10/04/22. -There was an entry for Topamax 25mg take 3 tablets twice daily with documentation as administered on 10/04/22. -There was an entry for amlodipine 2.5mg take 1 tablet daily with documentation as administered on 10/04/22.			
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0366	Interview with a MA on 10/04/22 at 1:59pm revealed: -She administered Resident #3's morning medications and watched him swallow the medications. -She never left medications with residents to self-administer. -She did not know where the medications came from that were in Resident #3's room. -The facility's policy for medication administration included to watch the residents take their medications and then sign the eMAR the medications were administered. Interview with the Clinical Director on 10/04/22 at 3:31pm revealed: -The MAs were trained to administer medications as ordered, watch the resident take the medication, and then document on the eMAR the medication was administered. -She did not know Resident #3 had a medication cup with pills and another with a yellow liquid in his room and swallowed the medications without staff observing the resident. -She thought the medications belonged to Resident #3 and they were Resident #3's morning medications. Interview with the Administrator on 10/05/22 at 4:47pm revealed: -She did not know why there was a medication cup containing 9 visible pills and another medication cup containing a yellow liquid in Resident #3's room at 8:57am on 10/04/22. -MAs were not supposed to leave medications in resident rooms unless a resident had a physician's order to self-administer medications. -Resident #3 did not have a physician's order to self-			
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0366	administer medications. -The facility's policy for medication administration included to scan the medication bubble pack card, check the card with the eMAR 3 times to make sure the medications were to be administered, and administer the medications to the residents while observing the residents swallowed the medications. -She expected the MA to follow the facility's policies and procedures for medication administration. Attempted telephone interview with Resident #3's primary care provider (PCP) on 10/05/22 at 1:10pm was unsuccessful. The facility failed to ensure medications were administered as ordered by not observing a resident take his medications leaving the medications in a cup in his room which was easily accessible to other residents or the resident swallowed a cup of at least 9 unidentified pills and a yellow liquid that may or may not have been Resident #3's medications. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/05/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 20, 2022.			
0367	10 NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:		<i>Clinical Admin will complete will audits of MAR to ensure that there are no missed meds and that MAR has proper documentation.</i>	

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D367	(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, interviews and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were complete and accurate for 2 of 3 sampled residents (Resident #1 and #2) related to medications used to treat high blood pressures and schizoaffective disorder (#1) and another medication used to treat schizoaffective disorder (#2). The findings are: 1. Review of Resident #1's current FL2 dated 01/07/22 revealed diagnoses included hypertension, schizoaffective disorder, and major depressive disorder. a. Review of Resident #1's physician's orders dated 04/18/22 revealed there was a medication order for	Clinical Admin will review daily reports with MAR to ensure they match reasoning for meds signed on MAR. Clinical Admin had meeting with ^{10/4/22} med techs to educate on proper documentation of MAR	11/16/22
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D367	risperidone (used to treat schizophrenia) 0.5mg take 1 tablet daily. Review of Resident #1's September 2022 eMAR revealed: -There was an entry for risperidone 0.5mg take 1 tablet by mouth daily. -Risperidone 0.5mg was documented as not administered daily for 15 instances out of 30 opportunities with a comment "ordered" from the facility's contracted pharmacy. -There was documentation Resident #1's risperidone was administered on 09/05/22, 09/16/22, 09/28/22, and 09/29/22 when there was no risperidone available for administration. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for risperidone 0.5mg take 1 tablet by mouth daily. -Risperidone 0.5mg was documented as not administered daily from 10/02/22 through 10/04/22 with a comment "ordered" from the facility's contracted pharmacy. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -On 06/30/22, Resident #1's risperidone was dispensed in the quantity of 30 tablets. -On 08/03/22, Resident #1's risperidone was dispensed in the quantity of 30 tablets. -On 09/11/22, an emergency supply of Resident #1's risperidone was dispensed in the quantity of 3 tablets. -Resident #1's risperidone was last dispensed on			
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D367	09/21/22 as an emergency supply in the quantity of 6 tablets. -The pharmacy faxed a notification on 08/03/22, 09/07/22, and 09/11/22 that a new prescription was needed for Resident #1's risperidone to the primary care provider (PCP) and the facility. -An emergency supply of Resident #1's risperidone was filled twice with a combined quantity of 9 tablets because the pharmacy did not want Resident #1 to go without the prescribed medication. Telephone interview with a medication aide (MA) on 10/05/22 at 2:46pm revealed: -She thought she administered Resident #1's risperidone on 09/16/22, and 09/28/22. -She may have "accidentally signed" she administered the risperidone to Resident #1 instead of documenting the medication as not administered because it was unavailable. Interview with the Clinical Director on 10/05/22 at 9:00am revealed: -The facility's policy for medication administration included the MA was supposed administer medications as ordered and document the medication as administered on the eMAR. -She, the Administrator, and the RCC were responsible for completing random eMAR audits to check if residents were being administered their medications and if any doses were missed. -She tried to complete 3 eMAR audits every weekend but did not always complete the eMAR audits. Telephone interview with the Administrator on			
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D367	10/05/22 at 4:47pm revealed: -The MAs were trained to document administration of a medication on the eMAR after they watched the resident take the medications. -The MAs should not have documented they administered Resident #1's risperidone if the medication was unavailable to administer. b. Review of Resident #1's physician's orders dated 06/30/22 revealed there was a medication order for amlodipine (used to treat high blood pressure) 10mg take 1 tablet daily. Review of Resident #1's September 2022 electronic Medication Administration Record (MAR) revealed: -There was an entry for amlodipine 10mg take 1 tablet daily. -Amlodipine was documented as not administered 12 instances out of 30 opportunities with a comment the amlodipine was "ordered" from the facility's contracted pharmacy. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/05/22 at 9:41am revealed: -Resident #1's amlodipine 10mg was previously dispensed as an emergency supply on 05/24/22 with 30 tablets, 06/30/22 with 30 tablets, and 07/24/22 with 30 tablets. -Resident #1's amlodipine 10mg was last dispensed on 09/21/22 in the quantity of 30 tablets. -An emergency supply of Resident #1's amlodipine was filled without a prescription because the pharmacy did not want Resident #1 to go without the prescribed medication.			
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D367	-A notification was faxed to the facility on 07/24/22 that the pharmacy could not continue to dispense Resident #1's amlodipine as an emergency supply because a new prescription was needed from the primary care provider (PCP). -A notification was also faxed to the facility on 05/24/22, 06/30/22, and 09/12/22 that a new prescription for Resident #1's amlodipine was needed. -The PCP faxed a new prescription for Resident #1's amlodipine on 09/21/22 in the quantity of 30 tablets with 11 refills. -Resident #1's amlodipine should have lasted until 08/24/22 if the amlodipine was administered as ordered. Telephone interview with a second MA on 10/05/22 at 2:46pm revealed: -She did not know how she administered Resident #1's amlodipine on 09/09/22, 09/10/22, 09/16/22, and 09/18/22 when she documented the amlodipine was not administered and "ordered" from the facility's contracted pharmacy on 09/06/22, 09/07/22, 09/11/22, 09/12/22, 09/15/22, and 09/17/22. -She may have "accidentally signed" she administered the amlodipine to Resident #1 instead of documenting the medication as not administered. Interview with the Clinical Director on 10/05/22 at 9:00am revealed: -The facility's policy for medication administration included the MA was supposed administer medications as ordered and document the medication as administered on the eMAR. -She, the Administrator, and the RCC were responsible			
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D367	for completing random eMAR audits to check if residents were being administered their medications and if any doses were missed. -She tried to complete 3 eMAR audits every weekend but did not always complete the eMAR audits. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -The MAs were trained to document administration of a medication on the eMAR after they watched the resident take the medications. -The MAs should not have documented they administered Resident #1's amlodipine if the medication was unavailable to administer. Attempted interview with Resident #1 on 10/04/22 at 3:40pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 05/11/22 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, prolapsed mitral valve, asthma, and gastroesophageal reflux disease. -There was an order for clozapine (used to treat schizoaffective disorder) 100mg one and a half tablets daily. Interview with Resident #2 on 10/04/22 at 8:59am revealed she recently went without her clozapine. Observation of Resident #2's available medications on 10/04/22 at 1:50pm revealed: -There was one bubble pack of clozapine 100mg tablets available. -Two doses of clozapine 150mg (one and one-half tablets) remained in the bubble pack.			
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D367	-The 6-day supply of the clozapine was dispensed 09/29/22. Telephone interview with the contracted facility pharmacy on 10/04/22 at 1:11pm revealed: -They received a prescription for Resident #2 on 06/08/22 for clozapine 100mg one and a half tablets by mouth daily at bedtime with 7 refills. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 06/08/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 07/14/22. -They dispensed a 28-day supply of clozapine 100mg tablets for Resident #2 on 08/08/22. -They dispensed an emergency 6-day supply (9 tablets) of clozapine 100mg tablets for Resident #2 on 09/29/22. -The emergency 6-day supply covered Resident #2 until 10/05/22. Review of Resident #2's July 2022 electronic medication administration records (eMAR) revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 07/01/22 to 07/11/22 and from 07/13/22 to 07/31/22. -On 07/12/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was ordered 07/08/22. Review of Resident #2's August 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily			
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0367	at 8:00pm from 08/01/22 to 08/06/22 and from 08/14/22 to 08/31/22. -From 08/06/22 12:00pm to 08/14/22 at 12:00pm, Resident #2 was documented out of facility. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 09/01/22 to 09/22/22, 9/24/22 to 09/28/22, and on 09/30/22. -On 09/23/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tomorrow" (09/24/22). -On 09/29/22, the clozapine was documented as not administered due to the medication arriving from the pharmacy with a note the medication was expected to arrive "tonight" (09/29/22). Review of Resident #2's October 2022 eMAR revealed: -There was an entry for clozapine 100mg take one and a half tablets every night at bedtime scheduled at 8:00pm. -The clozapine was documented as administered daily at 8:00pm from 10/01/22 to 10/03/22. Interview with one medication aide (MA) on 10/05/22 at 9:30am revealed: -She was trained to document the administration of a medication after watching the resident take the medication. -She documented medications not administered due to the medication being unavailable on the eMAR by making a note indicating the date the medication was reordered and when the pharmacy expected the			
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D367	medication to arrive at the facility. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -The MAs were trained to document administration of a medication in the eMAR when they saw the resident take the medication. -The MAs should not have documented they administered Resident #2's clozapine if the clozapine had not been available to administer. Review of the facility's medication administration policy revealed: -Pass the resident the medication(s) and watch them take each medication. -Initial the eMAR for every dose given before moving onto the next resident.			
D935	G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures			

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D935	for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications had completed the 5-hour medication administration training course prior to administering medications to residents. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 09/05/22. -Staff B worked as a medication aide (MA) and Resident Care Coordinator (RCC). -There was no documentation Staff B completed the 5-hour medication administration training course. -There was no documentation of the completed facility MA Verification form for Staff B prior to employment as a MA.			
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STATE FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

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NAME OF PROVIDER Richmond Hill Rest Home #2		STREET ADDRESS, CITY, STATE, ZIP CODE 95 Richmond Hill Road, Asheville, NC 28806		
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D935	Review of a resident's September 2022 electronic medication administration record (eMAR) revealed Staff B administered medication on 09/19/22 at 12:00pm. Review of a second resident's September 2022 eMAR revealed Staff B administered 4 medications on 09/19/22 at 2:00pm. Interview with Staff B on 10/05/22 at 12:16pm revealed: -She worked as a MA at one of her previous employers. -She thought she completed the 5-hour MA training after she was hired by the facility. -The facility hired her as the RCC, but she also filled in as a MA when needed. Interview with the Clinical Director (CD) on 10/05/22 at 2:17pm revealed: -Staff B was hired on 09/05/22 as a MA and RCC. -Staff B did not have the 5-hour medication administration training. -Staff B passed the MA test on 12/01/15. -She was responsible for making sure Staff B's personnel record was complete and that all documents were filed in the record. -She thought Staff B completed the 5-hour MA training on 09/12/22 but she could not find the form. -There was not an employment verification form in Staff B's personnel record. Telephone interview with the Administrator on 10/05/22 at 4:47pm revealed: -The Clinical Director or herself were responsible for filing employee documents in the personnel records. -Staff B previously worked as a MA. -She knew the 5-hour MA training was required before			
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PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE

TITLE

DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: HAL-011-378	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETED: 10/06/2022
NAME OF PROVIDER Richmond Hill Rest Home #2		STREET ADDRESS, CITY, STATE, ZIP CODE 95 Richmond Hill Road, Asheville, NC 28806	
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D935	before passing medications. -She thought Staff B had completed the 5-hour MA training but did not know why the document was not in Staff B's personnel record.		
D936	10A NCAC 13F .1010 (d) (e) Pharmaceutical Services 10A NCAC 13F .1010(d) Pharmaceutical Services (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: (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; (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: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician.		Clinical Admin had a meeting with med tech 10/9/22 to educate on printing proper LOTA paperwork and how to complete it when resident leaves facility on leave. RCC will follow up daily to ask staff of any future leaves to reminder staff to print and complete paperwork and where to put paperwork until

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