LSB rec'd via email 12/18/23

PRINTED: 11/29/2023
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
	HAL011376	A. BUILDING: _____ B. WING _____	R 11/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 11/28/23.	{D 000}		12/21/2023
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#2 and #3) related to a supplement used to treat vitamin B12 deficiency (#2) , and medications used to treat anxiety and high blood pressure (#3). The findings are: 1. Review of Resident #3's current FL2 dated 10/23/23 revealed diagnoses included schizoaffective and bipolar disorder. a. Review of physician's progress notes for Resident #3 dated 10/12/23 and 11/09/23	{D 358}	All orders will be given/sent to RCC who will then be responsible for sending them to the pharmacy. The order will then be placed in an appropriate order processing folders which will remain with RCC until order has been entered into EMAR system and has arrived from pharmacy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Lacey Russell, Administrator TITLE 12/18/23 (X6) DATE

Reviewed and acknowledged 12-21-23 LSB

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{D 358}	Continued From page 1 revealed orders to continue hydroxyzine (medication used to treat anxiety) 50mg scheduled and as needed to treat anxiety. Review of Resident #3's electronic Medication Administration Record (eMAR) for 10/12/23 - 10/31/23 revealed there was not an entry for hydroxyzine 50mg scheduled. Review of Resident #3's eMAR for 11/01/23 - 11/28/23 revealed there was not an entry for hydroxyzine 50mg scheduled. Observation of Resident #3's medications available for administration on 11/28/23 at 1:07pm revealed: -There was one bubble pack labeled hydroxyzine 50mg take 1 tablet every 6 hours as needed for anxiety. -There was not any other hydroxyzine available. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/28/23 at 10:30am revealed: -The pharmacy received an electronic order for hydroxyzine 50mg daily at 4:00pm for Resident #3 on 12/11/22. -The last active order for the hydroxyzine 50mg daily was in July 2023 when the pharmacy requested the facility obtain a refill prescription. -The pharmacy did not receive the new prescription and the scheduled hydroxyzine was removed from the active medications and no longer dispensed. -The pharmacy did not receive the physician's progress notes dated 10/12/23 and 11/09/23 from the facility and if they had received them the hydroxyzine 50mg scheduled would have been entered onto the eMAR and dispensed to the facility.	{D 358}	All orders will be sent to the pharmacy whether it is believed to have already been sent or not by provider.	12/21/23

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{D 358}	Continued From page 2 Telephone interview with the facility's contracted Physician's Assistant (PA) on 11/28/23 at 1:40pm revealed: -Resident #3 was ordered hydroxyzine 50mg daily and every 6 hours as needed for anxiety. -She did not know Resident #3 was not being administered the hydroxyzine 50mg daily. -Resident #3 appeared to be doing well but the facility should be following the physician's orders. Interview with the Resident Care Coordinator (RCC) on 11/28/23 at 11:30am revealed: -The scheduled dose of hydroxyzine 50mg was last administered to Resident #3 on 07/31/23. -She did not know why the previous RCC did not obtain a refill prescription for the hydroxyzine. -She and the Administrator were responsible for contacting the primary care provider (PCP) when a new refill was needed for a medication. -The PCP would fax the progress notes to the pharmacy but there were times when the PCP would send the progress notes to the Administrator via email. -She would review progress notes and check to ensure any medication orders were added to the eMAR by the pharmacy. -She did not review the progress notes dated 10/12/23 and 11/09/23 for Resident #3 and did not know why. Interview with the Administrator on 11/28/23 at 11:22am revealed: -She did not know why the refill request for the hydroxyzine 50mg scheduled was not done in July 2023. -The PCP was responsible for faxing progress notes with medication orders to the pharmacy. -She and the RCC were responsible for reviewing the progress notes and ensuring the pharmacy	{D 358}		

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{D 358}	Continued From page 3 entered any medications onto the eMAR. -She did not know why the progress notes dated 10/12/23 and 11/09/23 were not reviewed. b. Review of Resident #3's physician's orders dated 10/30/23 revealed propranolol (medication used to treat high blood pressure) 60mg daily, hold for heart rate less than 60 and notify the Primary Care Provider (PCP). Review of Resident #3's electronic Medication Administration Record (eMAR) for 11/01/23 - 11/28/23 revealed: -There was an entry for propranolol 60mg daily with an administration time of 8:00am. -There was documentation the propranolol was administered daily at 8:00am from 11/01/23 - 11/28/23. -There was no entry for a heart rate or documentation of Resident #3's heart rate from 11/01/23 - 11/28/23. Observations of Resident #3's medications available for administration on 11/28/23 at 1:06pm revealed there was one bubble pack labeled propranolol 60mg daily, hold for heart rate less than 60 and notify the PCP. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/28/23 at 10:30am revealed the pharmacy entered an administration time for the medication and it was the facility's responsibility to add a place on the eMAR for the heart rate. Interview with the medication aide (MA) on 11/28/23 at 10:55am revealed: -There was not a place on the eMAR for staff to document Resident #3's heart rate before administering the propranolol.	{D 358}	All medication orders that require a vital sign parameter will be verified to ensure there is an appropriate area for vital sign documentation by RCC. RCC will pull vital sign/parameter reports weekly to ensure accuracy and proper documentation.	12/21/23

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{D 358}	Continued From page 4 -She did not check Resident #3's heart rate on 11/28/23 before administering the propranolol. -The instructions for the propranolol were to hold the medication for a heart rate less than 60 and notify the PCP but she did not realize it because there was no place to document a heart rate. -The Resident Care Coordinator (RCC) was responsible for entering a place on the eMAR to document the heart rate. Interview with a second MA on 11/28/23 at 11:35am revealed: -She administered 8:00am medications to Resident #3 when she was working in the facility during the month of November 2023. -She did not obtain a heart rate prior to administering the propranolol to Resident #3 because there was no place on the eMAR to document a heart rate. Interview with the facility's contracted Physician's Assistant (PA) on 11/28/23 at 1:40pm revealed: -Propranolol was a medication that lowers blood pressure and can also lower the heart rate and should not be administered for a heart rate less than 60. -She expected the facility to follow the medication instructions. Interview with the RCC on 11/28/23 at 11:30am revealed: -She and the Administrator were responsible for entering a place for documenting a heart rate on the eMAR. -She did not know why there was not a place for documenting the heart rate on the eMAR because she did not remember reviewing the order for the propranolol. Interview with the Administrator on 11/28/23 at	{D 358}	All medication aides will receive and in-service to remind them to thoroughly read all orders and obtain vital signs if so ordered. They will be instructed to notify RCC or ED if any parts of orders are missing so that they can be corrected immediately.	

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{D 358}	Continued From page 5 11:22am revealed: -She or the RCC were responsible for entering a place for documentation of a heart rate on the eMAR. -She did not know why it was not done. -The MAs should be obtaining a heart rate in order to know whether or not to administer the propranolol. 2. Review of Resident #2's current FL2 dated 10/23/23 revealed diagnoses included pre-diabetes, hypertension and elevated lipids. Review of physician's progress notes for Resident #2 dated 10/23/23 revealed an order to discontinue Vitamin B-12 500 mcg daily. Review of Resident #2's October 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Vitamin B-12 500 mcg daily. -There was documentation the Vitamin B-12 was administered daily at 8:00am from 10/23/23 through 10/31/23. Review of Resident #2's November 2023 eMAR revealed: -There was an entry for Vitamin B-12 500 mcg daily. -There was documentation the Vitamin B-12 was administered daily at 8:00am from 11/01/23 through 11/28/23. Observation of Resident #2's medications available for administration on 11/28/23 at 10:38am revealed: -There was one bubble pack labeled Vitamin B-12 500 mcg take 1 tablet daily. -There was documentation 28 Vitamin B-12	{D 358}		

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{D 358}	Continued From page 6 tablets were dispensed on 11/16/23. -Eleven Vitamin B-12 tablets had been removed from the bubble pack. Interview with the medication aide (MA) on 11/28/23 at 10:38am revealed: -She was not aware Resident #2's Vitamin B-12 was discontinued on 10/23/23. -The Resident Care Coordinator (RCC) and the Administrator were responsible for ensuring medication changes were processed. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/28/23 at 1:06pm revealed the pharmacy did not receive the physician's progress notes dated 10/23/23 from the facility and if they had received it the Vitamin B12 would have been marked as discontinued on the eMAR. Telephone interview with the facility's contracted Physician's Assistant (PA) on 11/28/23 at 1:45pm revealed: -Vitamin B-12 was a medication used to treat a Vitamin B deficiency. -Continuing to take a Vitamin B-12 supplement when the blood levels were elevated was not dangerous but would cause the blood levels to remain elevated. Interview with the RCC on 11/28/23 at 11:28am revealed: -The PCP would fax the progress notes to the pharmacy but there were times when the PCP would send the progress notes to the Administrator via email. -She would review progress notes and check to ensure any medication orders were changed on the eMAR by the pharmacy. -She did not know why she did not review	{D 358}		

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{D 358}	Continued From page 7 Resident #2's progress note dated 10/23/23. Interview with the Administrator on 11/28/23 at 11:06am revealed: -The PCP was responsible for faxing progress notes with medication orders changes to the pharmacy. -She and the RCC were responsible for reviewing the progress notes and ensuring the pharmacy deleted any discontinued medications on the eMAR. -She did not know why the progress note dated 10/23/23 was not reviewed.	{D 358}		