Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Richmond Hill Assisted Living #5 County: Buncombe
Address: 95 RICHMOND HILL ROAD ASHEVILLE, NC 28806 License Number: HAL011372

II. Date(s) of Visit(s): 01/23/2024 Purpose of Visit(s): Monitoring, Follow Up to CAR

Exit/Report Date: 02/22/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.1004(a) MEDICATION ADMINISTRATION Rule/Statutory Reference: 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. Level of Non-Compliance: A1 Violation Based on interview and review the facility failed to ensure medication was administered as ordered for 1 of 1 resident (Resident #1) sampled related to a blood thinner. The findings are: Review on 1/23/24 of the facility's policy and procedure for medication administration revealed: -To ensure staff who have demonstrated competency according to the state rules prepare and administer medications, prescriptions and non-prescriptions and treatments in accordance with the prescribing practitioner's orders. -The electronic Medication Administration Record (eMAR) will be updated and changed when medication or treatment orders change from the prescribing practitioner.	☒ POC Accepted KW - 3/25/24 *DSS Initials*	

Review of Resident #1's current FL2 dated 10/16/23 revealed a diagnoses of cardiomyopathy. Review of the anti-coagulation clinic's notes dated 12/12/23 for Resident #1 revealed the therapeutic range for International Normalized Ratio (INR; a test used to see how long blood takes to clot) should be between 2.0 and 3.0. Review of Resident #1's physician orders dated 12/27/23 revealed: -A subtherapeutic INR of 4.0. -Hold warfarin 3mg 12/27/23. -Warfarin 3mg, 12/28/23, 12/30/23, 12/31/23 and 1/2/24. -Warfarin 4mg, 12/29/23 and 1/1/24. -Next scheduled INR lab work 1/3/23. Review of Resident #1's December 2023 and January 2024 eMAR from 12/28/23 through 1/4/24 revealed: -There was an entry for warfarin 3mg, 12/28/23, 12/30/23, 12/31/23 and 1/2/24. -There was an entry for warfarin 4mg, 12/29/23 and 1/1/24. -There was documentation warfarin 4mg was administered on 12/30/23, 12/31/23, 1/2/24; 3mg should have been administered. -There was an entry for INR labwork to be completed on 1/3/24. -There was no documentation the INR labwork scheduled 1/3/24 was completed. -There was documentation warfarin 3mg was administered on 1/3/24 and 1/4/24. -There was no documentation of orders for warfarin 1/3/24 and 1/4/24. Review of Resident #1's January 2024 eMAR and physician's orders dated 01/05/24, 01/08/24, 01/09/24 revealed warfarin was administered as ordered. Review of Resident #1's physician's orders dated 1/12/24 revealed a -A subtherapeutic INR of 4.6. -Hold warfarin on 1/12/24. -Warfarin 2mg on 1/13/24. -Warfarin 3mg on 1/14/24. -Next scheduled INR lab work 1/15/24. Review of Resident #1's January 2024 eMAR from 1/12/24 through 1/17/24 revealed: - There was an entry dated 1/12/24 to hold warfarin. -There was documentation warfarin 4mg was administered on 1/12/24. -There was an entry dated 1/13/24 warfarin 2mg and documentation warfarin 4mg was administered. -There was an entry dated 1/14/24 warfarin 3mg and documentation warfarin 4mg was administered. -There was an entry 1/15/24 for INR labwork. -There was no documentation INR lab work scheduled 1/15/24 was completed. -There was documentation warfarin 4mg was administered on	• Warfarin binder has been put in placed and will be used to track all warfarin orders and INR orders. Admin will be in charge of updating binder and notify staff of all order Changes. Admin will also pull warfarin administry each day to ensure proper dose has been adminstered and will notify pcp if any issues occur.	3/10/24

1/15/24 and warfarin 3mg was administered on 1/16/24.
-There was no documentation of orders for warfarin administered on 1/15/24 or 1/16/24.
-Resident #1's warfarin was documented as administered incorrectly for 6 of 6 opportunities from 1/12/24-1/17/24.

Review of Resident #1's physician orders dated 1/17/24 revealed:
-A subtherapeutic INR of 4.6.
-Hold warfarin on 1/17/24.
-Warfarin 3mg on 1/18/24 through 1/21/24.
-Next scheduled INR labwork 1/22/24.

Review of Resident #1's January 2024 eMAR from 1/17/24 through 1/21/24 revealed:
-There was an entry dated 1/17/24 to hold warfarin.
-There was documentation on 1/17/24 warfarin 4mg was administered.

Interview on 1/23/24 at 9:30am with Resident #1 revealed:
-He never knew if he received the correct dosage of medication.
-He received the wrong warfarin dosage in the past and was not sure if the facility had "ever gotten it right".

Interview on 1/23/24 at 10:00am with the Medication Aide revealed:
-The orders change frequently for the warfarin doses and is hard to follow.
-The RCC and Administrator had to approve the orders before they appear on the eMAR.
-If the orders are not approved on the day the dose changes, the MA's could be giving the resident the previous ordered dose.
-The MA is not sure why the wrong dose of warfarin has been administered incorrectly.

Interview on 1/23/24 at 2:00pm with the Resident Care Coordinator (RCC) revealed:
-The orders based on the lab results are faxed to the pharmacy by the home health provider.
-The pharmacy enters the adjusted orders into the electronic eMAR.
-The RCC or the Administrator must approve the adjusted order for it to show up on the eMAR for the Medication Aide (MA) to administer.
-The RCC or Administrator receives the faxed orders from the pharmacy to check for accuracy before approving the entry on the eMAR.
-She has no good answer as to why some of the orders are not in the resident's chart and why the medication is not being administered as ordered.

Interview on 1/23/24 at 2:30pm with the Administrator revealed:
-They are doing medication cart audits.
-She did not know why they had not discovered the medication errors for this resident.
-The cart audits are completed randomly.
-There is no available schedule of the last cart audit and results.

PCP, SoCentnoell, and Admin will work together to ensure all parties are notified of INR results, lab days + order changes in a timely manner.

-The home health provider revealed there have been medication errors with the dosages for Resident #1.
-There is no communication with the MA's to hold the warfarin for the resident on the days he is scheduled for lab work.
-Due to the concerns about the medication errors, the provider is texting the new orders to the Administrator for her to ensure the orders are being approved timely.
-The Administrator will begin notifying the MA's to hold the warfarin until they receive new orders on the days the resident is scheduled or lab work.
-There has not been any additional medication training for the MA's at this time.

Interview on 1/25/24 at 11:00am with the home health provider revealed:
-The home health provider faxes the new orders from the lab results to the pharmacy and the facility.
-There have been concerns for this resident due to the incorrect dosages of warfarin administered by the facility and his subtherapeutic INR.
-The medication cart has multiple bubble packs of warfarin that have been discontinued due to the new orders.
-The multiple bubble packs may be causing confusion for the MA's leading to medication errors.
-She is not aware of any communication with the MA's to hold the orders for warfarin, when there is scheduled lab work, until the results of the INR have been received.
-The provider spoke to the Administrator about the wrong dosages of warfarin administered by the MA's and suggested sending a text with the new orders directly to the Administrator for her to communicate the new orders to the MA's.

Interview on 1/26/24 at 1:00pm with the owner of the facility revealed:
-There should be a better process in place for ensuring orders are entered correctly and in a timely manner.
-The resident receiving the wrong dosage of warfarin placed him at risk of bleeding or at risk for stroke.

Interview on 1/29/24 with the primary care provider revealed:
-Resident #1 must be on a blood thinner for a diagnosis of atrial fibrillation.
-The INR therapeutic range for this resident is between 2 and 3.
-If he is not within this range, he is at risk for excessive bleeding or at risk for the blood clotting that could lead to a stroke.
-The resident will continue to have regular lab work until he is in therapeutic range.
-MA's not administering the correct ordered dosage can cause the resident to be in subtherapeutic range.
-The medical provider sees the resident weekly at the facility.

The facility failed to administer warfarin as ordered (used to keep the

blood thin) resulting in INR results (time it takes for the blood to clot) ranging from 2.5-7.0. The therapeutic range set for Resident #1 by his PCP was between 2 and 3. This failure resulted in serious neglect and constitutes a Type A1 violation. The facility provided a plan of protection in accordance with 10A NCAC 13F .1004(a) on 1/26/24. DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED 03/23/2024		

IV. Delivered Via: Email **DSS Signature:** KRISTY J. WILSON	**Certified Mail #:**	Date: 02/22/2024 Return to DSS By: 03/14/2024

V. CAR Received by:	Administrator/Designee (print name): Lacey Russell	
	Signature: Lacey Russell	Date: 2/23/24
	Title: Administrator.	

VI. Plan of Correction Submitted by:	Administrator (print name): Lacey Russell	
	Signature:	Date: 3/25/24

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By: Kristy Wilson	Date: 3/25/24
Comments: POC was received by email from Administrator on 3/25/24. POC was not signed by Administrator, but email message was received w/ email signature 3/25/24.		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			

** For follow-up to CAR, attach Monitoring Report showing facility in compliance.*