STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHMOND HILL ASSISTED LIVING # 1	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on 05/06/25 - 05/07/25. The complaint investigation was initiated by the Buncombe County Department of Social Services on 04/09/25.	D 000		
D 124	10A NCAC 13F .0402 Qualifications Of Manager 10A NCAC 13F .0402 Qualifications Of Manager The facility shall designate a manager when the administrator is absent from the facility. The manager, is responsible for carrying out the day-to-day operations of an adult care home in the absence of the administrator. The administrator remains ultimately responsible for the adult care home, and the manager shall serve under the direction and supervision of the administrator. The manager shall meet the following requirements: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program, or if hired before September 1, 2024, have passed the alternative examination established by the Department; (3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional such as a mental health professional, nurse practitioner, physician assistant, or registered nurse, a nursing home administrator certified pursuant to G.S. 90-276(4), or an assisted living administrator certified pursuant to G.S. 90-288.14; and (4) earn 12 hours a year of continuing education credits in the management of adult care homes or care of the elderly and individuals with physical, intellectual, or developmental	D 124		

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D 124	Continued From page 1 disabilities, cognitive impairment, and mental illness. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the managers (Staff A and B) who were responsible for carrying out the day-to-day operations of the facility in the absence of the Administrator earned 12 hours of continuing education credits related to management or care of the residents. The findings are: 1. Review of Staff A's personnel record revealed: -There was no documentation of a hire date or job title. -There was no documentation of 12 hours of continuing education related to management of the residents. Interview with Staff A on 05/07/25 at 11:00am revealed: -She started working as a medication aide (MA) at the facility October 2023. -She and anther staff member were responsible for managing the facility when the Administrator was not at the facility. -She ensured the facility had enough staff and that staff performed their job duties. -She had been in the position for 3 weeks. -She worked as a Resident Care Coordinator (RCC) at another facility in the past for 4 years. -She did not know she was required to obtain 12 hours of continuing education per year. Refer to the interview with the Administrator on 05/07/25 at 10:15am.	D 124		

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D 124	Continued From page 2 2. Review of Staff B's personnel record revealed: -There was no documentation of a hire date or job title. -There was no documentation of 12 hours of continuing education related to management of the residents. Interview with Staff B on 05/07/25 at 11:05am revealed: -She started working as a medication aide (MA) at the facility October 2023. -She and another staff member were responsible for managing the facility when the Administrator was not at the facility. -She ensured the facility had enough staff and that staff performed their job duties. -She had been in the position for 3 weeks. -She worked as a RCC at another facility in the past for 4 years. -She did not know she was required to obtain 12 hours of continuing education per year. Refer to the interview with the Administrator on 05/07/25 at 10:15am. _____ Interview with the Administrator on 05/07/25 at 10:15am revealed: -She was not in the facility on 05/05/25 and 05/06/25 and Staff A and Staff B were managing the facility in her absence. -She knew they were qualified to manage the facility as both Staff A and Staff had been RCCs at other facilities in the past. -She was not aware that Staff A and Staff B were required to have 12 hours of continuing education in order to manage the facility.	D 124		

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D 270	Continued From page 3	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#3) who ambulated with a wheelchair and had urinary incontinence. The findings are: Observation during the initial facility tour on 05/06/25 between 9:06am and 9:41am revealed resident #1's door was locked from the inside and was unable to be opened. Interview with a medication aide (MA) on 05/06/25 at 9:55am revealed staff had to "bust the door open" of several resident rooms because there were no keys to get into the resident rooms when they were locked from the inside. Review of Resident #1's resident register revealed an admission date of 08/07/24. Review of Resident #1's current FL2 dated 05/05/25 revealed:	D 270		

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-Diagnoses included Guillian-Barre Syndrome (a rare disorder where the immune system attacks the nerves causing muscle weakness and/or paralysis).
-Resident #1 was semi-ambulatory with use of a wheelchair.
-Resident #1 had bladder incontinence and bowel incontinence at times.
-There was no information regarding Resident #1's orientation.

Review of Resident #1's current care plan dated 05/05/25 revealed:
-She required extensive assistance with grooming, bathing, and dressing.
-There was no information listed for the assistance she required with toileting.

Review of Resident #1's mental health provider notes dated 02/17/25 revealed:
-Diagnoses included schizophrenia (a serious mental illness characterized by hallucinations, delusions, disorganized thinking, and disorganized speech) and severe tobacco use disorder.
-Thought processes were documented as impaired abstract reasoning with delusions with some evidence of ongoing, generalized paranoia.
-There was documentation Resident #1 had chronic limitations regarding insight and judgement.

Interview with a personal care aide (PCA) on 05/06/25 at 10:24am revealed:
-Resident #1 was very independent and able to bathe and dress herself.
-Resident #1 was able to transfer from her bed to the wheelchair.
-On 05/03/25 Resident #1 did not come out of her room from 8:00am to between 7:00pm and

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7:30pm that evening.
-She had knocked on Resident #1's door several times with no response throughout the day since 8:00am.
-The door was locked from the inside and she was unable to enter Resident #1's room because she did not have a key.
-Resident #1 did not come out of her room for the lunch or dinner meal.
-She reported this to the MA who told her to "pop the lock" to open the door because there were no keys to unlock the door.
-She and another PCA used a credit card slipped in between the door knob and the door frame to open Resident #1's door.
-When she managed to open the door, the room was very smokey.
-She and another PCA initially thought something was on fire in the room because there was "so much smoke" that "poured out into the hallway."
-Resident #1 was observed lying in her bed with multiple cigarette butts on the bed and on the floor.
-There were also several urine puddles on the floor.

Interview with a second PCA on 05/06/25 at 1:48pm revealed:
-She came over from a sister facility several times throughout the day on 05/03/25.
-She knocked on the door for Resident #1 several times but never got an answer and the door was locked so she did not go inside.
-She did not tell anyone she had not seen or spoken to Resident #1.

Interview with a third PCA on 05/06/25 at 1:57pm revealed:
-Resident #1 was incontinent of urine.
-She refused to wear adult briefs most of the

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time, so her bed linens and clothes were frequently soiled with urine.
-She was working in a sister facility when the second PCA told her that Resident #1 had not been out of her room the entire day on 05/03/25.
-She went to Resident #1's room and the door was locked, but she could smell smoke she thought was coming from Resident #1's room.
-She and another PCA managed to open the door with a credit card.
-It was very smokey in the room and there were cigarette butts all over the bed and the floor.
-She sent a text to the Administrator informed her about Resident #1 smoking in her bedroom with the door locked and did not answer when staff knocked on her door.
-The Administrator directed her to remove all smoking material from Resident #1's room.
-Resident #1 had been observed smoking in her bedroom or the bathroom several times.

Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed:
-Resident #1 refused "all care and all medications."
-Resident #1 had cigarette butts in her room on the bed and on the floor "constantly."
-When Resident #1 had her door locked and was asked if she wanted her medication Resident #1 "will either say no or will not respond at all."

Telephone interview with Resident #1's guardian on 05/06/25 at 4:38pm revealed:
-He visited Resident #1 once a month and talks with her on the phone one to two times a week.
-She was not always verbal with him when he made his monthly visits.
-She would just look at him but not say anything.
-She was supposed to have 24/7 supervision at the facility.

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-He had not been made aware that she was not seen for almost 12 hours on 05/03/25 and that her door had to be broken into, when it was discovered she was smoking in her room and there were multiple urine puddles on the floor.
- He was concerned about her lack of supervision, but due to her mental health issues, if she was discharged from the facility, she would probably become homeless.

Interview with a second MA on 05/07/25 at 8:36am revealed:
-Resident #1 refused medications and personal care "most" of the time.
-Around the first week of April 2025, she smelled cigarette smoke coming from Resident #1's room.
-Whenever Resident #1's door was locked, and she would not answer, so the MA got a "butter knife" to open the door.
-When she entered Resident #1's room, there were multiple cigarette butts all over the floor.
-When she leaned over to pick the cigarette butts off the floor Resident #1 kicked her in the face.
-She informed the Administrator who directed her to remove Resident #1's cigarettes and lighter from the room for the day.

Interview with the Administrator on 05/07/25 at 10:00am revealed:
-She was unaware Resident #1 had not been seen or spoken to for almost 12 hours on 05/03/25.
-The staff should be checking on the residents every two hours and providing personal care when needed.
-Resident #1 was usually incontinent of urine.
-She had spoken with Resident #1 on at least two occasions regarding not smoking in her room and had verbally warned her she may be discharged if

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D 270	Continued From page 8 she continued to smoke inside the facility. Telephone interview with Resident #1's mental health provider Registered Nurse (RN) on 05/07/25 at 1:59pm revealed: -She saw Resident #1 weekly to provide mental health support and services. -She was unaware Resident #1 had been smoking in her bedroom and the bathroom. -At times, she had to talk with Resident #1 through the locked door of her bedroom. -Staff should be monitoring Resident #1 at least every two hours if not more frequently due to her urinary incontinence, dependence on a wheelchair, and her mental health issues. -Resident #1 had poor safety awareness and poor understanding of the self-care (assistance with urinary incontinence) that she needed. _____ The facility failed to provide supervision for Resident #1, who had a history of smoking inside the facility, locking herself in her bedroom for several hours at a time while smoking, and urinating on the floor in her bedroom. This failure placed Resident #1 at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/06/25. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 06, 2025.	D 270		
D 290	10A NCAC 13F .0904(c)(1) Nutrition And Food Service	D 290		

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D 290	Continued From page 9 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prepare menus at least one week in advance with the serving quantities specified and in accordance with the daily food requirements. The findings are: Observation of the menu list in the kitchen on 05/06/25 at 10:00am revealed: -The menu was dated for the week of 04/07/25 to 05/03/25. -There was no current weekly menu posted or available to review. Interview with a personal care aide (PCA) on 05/06/25 at 10:00am revealed: -There was not a current menu posted in the facility. -She had been without a menu to follow on several occasions.	D 290		

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-She decided what to cook when she did not have a menu to follow based on what food was available in the facility.
-On 05/06/25 she was planning to make hamburger patties with brown gravy and rice, macaroni and cheese, and she might include a vegetable for the lunch meal.

Observation of the lunch meal on 05/06/25 at 12:20pm revealed:
-Residents were served a hamburger patty with brown gravy, approximately ¾ cup of rice with brown gravy, and ½ cup of broccoli.
-All residents had water and were offered an additional beverage of their choice.

Second interview with a PCA on 05/06/25 at 12:39pm and 1:48pm revealed:
-None of the utensils used to scoop out food for the lunch meal had measurements.
-She had worked in food service before so she though she had a "good idea about guessing" the amount served.
-All residents received a hamburger patty, but she had not looked at the box to note how many ounces it was.
-All residents also received about 1.5 ounces of rice, 1.5 ounces of broccoli, and the hamburger and rice covered in brown gravy.
-She had no dietary menu or serving quantities to follow.
-She had no dietary training in the facility.

Interview with a second PCA on 05/07/25 at 8:16am revealed:
-When she came into work on 05/07/25, she realized there was not a current menu available.
-When she did not have a menu to follow, she just let the residents know what food was available, then let them decide what they wanted

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D 290	Continued From page 11 to eat. Interview with the Administrator o 05/07/25 at 10:00am revealed: -There was not a current weekly menu posted in the facility. -Every meal for the next few days would be "resident choice", so they could use up some of the current food supply. -She did not want to waste the food they already had so there was not a current menu the staff was following.	D 290		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current list of residents that required a physician ordered therapeutic diet for 1 of 2 sampled residents (#2) related to a no concentrated sweets (NCS) diet. The findings are:	D 309		

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Review of Resident #2's current FL2 dated 05/05/25 revealed Resident #2 was prescribed a NCS diet.

Review of the therapeutic diet list posted in the kitchen on 05/06/25 at 10:04am revealed:
-The list was dated 03/21/25.
-Resident #2 was listed as a regular diet.

Interview with a personal care aide (PCA) on 05/06/25 at 10:00am revealed:
-Resident #2 was not on a therapeutic diet.
-Resident #2 followed a regular diet with no restrictions.
-She was unaware of any therapeutic diet menus in the facility.

Observation of Resident #2's lunch meal on 05/06/25 at 12:20pm revealed:
-There was a hamburger patty with brown gravy, rice with brown gravy, and broccoli on her plate.
-There was water and unsweetened tea for her to drink.

Interview with a second PCA on 05/06/25 at 1:48pm revealed Resident #2 was on a regular diet.

Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed:
-All residents in the facility were on a regular diet.
-None of the residents had a therapeutic diet.

Interview with the Administrator on 05/07/25 at 10:00am revealed:
-All the residents in the facility were on a regular diet.
-The Resident Care Coordinator (RCC) was responsible for updating the therapeutic diet list month.

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D 309	Continued From page 13 -The RCC was also responsible for updating the therapeutic diet list as new admissions came to the facility and significant changes occurred. -She currently had no RCC in the facility. -She and 2 supervisors were responsible for updating the therapeutic diet list. -She was not aware Resident #2 was on a therapeutic diet. -The only special diets they offered at the facility were mechanical soft and pureed.	D 309		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an activities program that promoted the active involvement of the residents. The findings are: Interviews with 6 residents during the initial tour on 05/06/25 from 9:00am - 10:00am revealed: -The facility offered no activities and the resident was bored. -Activities were offered "once in a while". -There were no activities and the resident just	D 315		

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slept.
-One resident would play games on her phone or tablet because there was nothing else to do.
-The only activity actually done on the activity calendar was the shopping trips.
-They used to do arts and crafts together but they do not do this anymore.
-She looked at the calendar in the hallway to see what activities are scheduled, but they rarely occurred.
-She got anxious very easily and thought if she had something to do she would not be as bored or anxious.

Observation of the right hall on 05/06/25 at 9:43am revealed:
-There was an activity calendar for April 2025 posted on a bulletin board on the wall.
-There was not an activity calendar for May 2025.

Observation of the facility on 05/06/25 and 05/07/25 revealed there were not any activities conducted by staff.

Interview with the personal care aide (PCA) on 05/06/25 at 12:13pm revealed:
-She knew the facility had an Activity Director (AD) in the past.
-She worked in the facility for the past 10 months and never saw activities conducted.
-She wondered what the residents were supposed to do all day other than "sit around".
-She thought she might be responsible for conducting the activities with the residents but she did not know what to do and did not receive any training.

Interview with a Supervisor on 05/06/25 at 12:20pm revealed:
-The PCAs were responsible for conducting daily

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D 315	Continued From page 15 activities with the residents. -The AD recently left their employment. -The Administrator was responsible for completing the monthly activity calendar but she must have forgotten it. Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed: -There was an activity calendar on the wall but staff did not follow it. -There was not currently an AD and she had received no guidance on how to carry out the activities listed on the calendar. -She would occasionally try to engage the residents, but they were not interested in playing cards or bingo. -The only activity the residents seemed to want to do was to go to a local retail store and shop. Interview with the Administrator on 05/07/25 at 10:00am revealed: -She had not yet finished the activity calendar for May 2025. -The AD had left in January 2025. -The PCAs were responsible to carry out the activities with the residents. -She was not aware the PCAs were not engaging in activities with the residents. -Many residents would not participate in activities. -She has been trying to find an AD for several months.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on interviews and record reviews, the facility failed to ensure residents were treated with dignity and respect for 1 of 3 sampled residents (#3) who locked herself in her bedroom and the bathroom for hours, had her smoking privileges revoked, and had been sleeping on a urine saturated mattress and moldy box springs.

The findings are:

Review of Resident #1's current FL2 dated 05/05/25 revealed:
-Diagnoses included Guillian-Barre Syndrome (a rare disorder where the immune system attacks the nerves causing muscle weakness and/or paralysis).
-Resident #1 was semi-ambulatory with use of a wheelchair.
-Resident #1 was incontinent of bladder.
-There was no information regarding Resident #1's orientation.

Review of Resident #1's mental health provider notes dated 02/17/25 revealed:
-Diagnoses included schizophrenia (a serious mental illness characterized by hallucinations, delusions, disorganized thinking, and disorganized speech) and severe tobacco use disorder.
-Thought processes were documented as impaired abstract reasoning with delusions with some evidence of ongoing, generalized paranoia.
-There was documentation Resident #1 had chronic limitations regarding insight and judgement.

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D 338	Continued From page 17 1. Observation during initial tour on 05/06/25 between 9:06am and 9:41am revealed Resident #1's room was locked from the inside and could not be open without a key. Interview with a medication aide (MA) on 05/06/25 at 9:55am revealed staff had to "bust the door open" to enter several resident rooms, including Resident #1, because there were no keys to unlock the doors of the resident rooms when they were locked from the inside. Interview with a personal care aide (PCA) on 05/06/25 at 10:24am revealed: -Most recently on 05/03/25, Resident #1 did not come out of her room from 8:00am to between 7:00pm and 7:30pm that evening. -She had knocked on Resident #1's door several times with no response throughout the day since 8:00am. -The door was locked from the inside, and she could not enter Resident #1's room without a key. -Resident #1 did not come out for the lunch or dinner meal. -She reported this to the MA who told her to "pop the lock" to open the door. -She and another PCA used a credit card to slide between the doorknob and the door frame to open Resident #1's door between 7:00pm and 7:30pm on 05/03/25. Interview with a second PCA on 05/06/25 at 1:48pm revealed: -She came over from a sister facility several times throughout the day on 05/03/25. -She knocked on the door of Resident #1 several times but never got an answer and the door was locked so she could not go inside. -She did not tell anyone she did not see or speak	D 338		

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D 338	Continued From page 18 with Resident #1 on 05/03/25. Interview with a third PCA on 05/06/25 at 1:57pm revealed: -She was working in a sister facility when the second PCA told her that Resident #1 had not been out of her room the entire day on 05/03/25. -She went to Resident #1's room and the door was locked. -She and another PCA managed to open the door with a credit card. -It was very smokey in the room and there were cigarette butts all over the bed and over the floor. Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed: -Resident #1 refused "all care and all medications." -When Resident #1 had her door locked and was asked if she wanted her medication Resident #1 "will either say no or will not respond at all." Telephone interview with Resident #1's guardian on 05/06/25 at 4:38pm revealed: -He was not aware staff were having to break into Resident #1's room because they did not have a key to unlock it. -He was not aware this most recently occurred on 05/03/25 and that she had been in her room for at least 11 hours. Interview with a second MA on 05/07/25 at 8:36am revealed: -Around the first week of April 2025, Resident #1's door was locked, and she would not answer when staff knocked on the door. -She was unable to get the resident to unlock the door or respond verbally. -She used a "butter knife" to open the door.	D 338		

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Interview with the Administrator on 05/07/25 at 10:00am revealed:
-She was unaware Resident #1 was not seen or spoken to by staff for almost 12 hours on 05/03/25.
-The staff should be checking on the residents every two hours.

Telephone interview with Resident #1's mental health provider Registered Nurse (RN) on 05/07/25 at 1:59pm revealed:
-She saw Resident #1 weekly to provide mental health support and services.
-Sometimes for her weekly visit with Resident #1, she had to talk with Resident #1 through the locked door to her bedroom.
-The facility had made them aware Resident #1 was refusing all her medications.
-Staff should be monitoring Resident #1 at least every two hours.

Based on attempted interviews at 05/06/25 at 10:36am and 05/07/25 at 12:45pm it was determined Resident #1 was not interviewable.

2. Interview with a personal care aide (PCA) on 05/06/25 at 10:24am revealed:
-She had to force Resident #1's door open on 05/03/25 between 7:00pm and 7:30pm because Resident #1 had locked it from the inside and was not answering when the door was knocked on.
-Once she forced the door open, there was so much smoke in the room she initially thought something was on fire in the room.
-She observed multiple cigarette butts on Resident #1's bedspread and on the floor.
-She had multiple empty cigarette boxes all over her room.
-Resident #1 had been warned multiple times by the Administrator not to smoke in her bedroom.

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-Resident #1 was no longer allowed to smoke at all since this occurred.

Interview with a second PCA on 05/06/25 at 1:57pm revealed:
-She was working in a sister facility when another PCA told her that Resident #1 had not been out of her room at all on 05/03/25.
-She went to Resident #1's room and the door was locked, but she could smell cigarette smoke at the door.
-She and another PCA managed to open Resident #1's locked door with a credit card.
-It was very smokey in the room and there were cigarette butts all over the bed and over the floor.
-Resident #1 was lying in her bed under her blanket.
-She sent a text message to the Administrator regarding the incident.
-The Administrator told her to remove all the cigarettes and lighters from the room because Resident #1 had lost the privilege to smoke.
-She removed all the cigarettes she could find and gave them to the medication aide (MA) on duty.
-She was unable to locate Resident #1's lighter.

Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed:
-Resident #1 had a history of smoking in her bedroom and in one of the bathrooms with the doors locked.
-She constantly had cigarette butts all over her bed and on the floor in her bedroom.
-Resident #1 had her smoking privileges revoked over the previous weekend by the Administrator because she was smoking in her bedroom.

Telephone interview with Resident #1's guardian on 05/06/25 at 4:38pm revealed:

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-He knew Resident #1 smoked.
-He was not informed by facility staff that Resident #1 had been smoking in her room on 05/03/25.
-He was not informed by facility staff that Resident #1 had her smoking privileges revoked with no offer to give her supervised smoking times or had a Nicotine withdrawal plan in place.

Interview with a third PCA on 05/07/25 at 8:16am revealed Resident #1 was no longer allowed to smoke and had her cigarettes taken away within the last week.

Interview with a second MA on 05/07/25 at 8:36am revealed:
-Just a few weeks ago she was walking down the hallway by Resident #1's room and smelled smoke.
-She knocked on the door, but no one answered.
-She got a butter knife and broke the door open.
-When she entered the room, Resident #1 dropped the cigarette from her hand to the floor.
-Resident #1 frequently smoked in her bedroom.
-She explained to Resident #1 that she had to smoke outside and was not allowed to smoke inside the facility.
-She informed the Administrator who directed her to remove Resident #1's cigarettes and lighter just for the day, which she did.

Interview with the Administrator on 05/07/25 at 10:00am revealed:
-She received a text from a staff member at the facility regarding Resident #1 smoking in her room.
-Staff informed her that there were cigarette butts all over Resident #1's bed and all over the floor.
-She thought Resident #1 was unsafe with her smoking, so she informed the staff to remove all

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cigarettes and lighters from the room and to revoke Resident #1's privileges to smoke.
-Resident #1 was not offered any products to assist with smoking cessation such as Nicotine gum or a Nicotine patch.
-Resident #1 was not offered the option of supervised smoking with staff.
-Resident #1 had been discovered smoking in her room twice before and had been warned she may lose her privileges to reside there if she continued to smoke inside the facility.

Interview with Resident #1's mental health provider Registered Nurse (RN) on 05/07/25 at 1:59pm revealed:
-She had not been made aware that Resident #1 was smoking inside the facility.
-The only discussion Resident #1 had with her regarding smoking was about 3 or 4 weeks ago when Resident #1 informed her that she was going to quit smoking and start vaping.
-Many people with mental health issues use smoking as a coping mechanism.
-If her cigarettes were removed, there needed to be a plan in place to ease withdrawal symptoms.
-Staff could have reached out to the physician and requested an order for gum, lozenges, or patches to ease the Nicotine withdrawal.
-Resident #1 had high blood pressure and Nicotine withdrawal could have placed her in a hypertensive crisis since Resident #1 had been refusing to take her blood pressure medication.

Based on attempted interviews at 05/06/25 at 10:36am and 05/07/25 at 12:45pm it was determined Resident #1 was not interviewable.

3. Review of Resident #1's current plan of care dated 05/05/25 revealed:
-Resident #1 required extensive assistance with

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bathing, dressing, grooming, and hygiene.
-There was no documentation regarding the level of assistance Resident #1 required with toileting.

Interview with a personal care aide (PCA) on 05/06/25 at 10:24am revealed:
-Resident #1 was incontinent of urine.
-Resident #1 was very independent and refused most personal care assistance that was offered to her.
-On 05/03/25, Resident #1 had locked herself in her bedroom for several hours.
-She and another PCA had to break into the room and there were urine puddles all over the floor.

Observation of Resident #1 sitting outside on 05/06/25 at 12:18pm revealed:
-She was sitting in her wheelchair, staring forward, did not make eye contact, and would not speak when spoken to.
-There were no visible signs of incontinence but there was a strong urine odor present.

Interview with a second PCA on 05/06/25 at 1:57pm revealed:
-Resident #1 was incontinent of urine but refused to wear adult briefs.
-Resident #1 urinated in her bed almost daily.
-Resident #1's linens had to be changed almost daily because they were usually saturated with urine.
-Resident #1 was very independent and usually refused personal care assistance.

Interview with a medication aide (MA) on 05/06/25 at 2:27pm revealed:
-Resident #1 refused all personal care.
-Resident #1 was incontinent of urine and often had a urine odor on her body and in her room.

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D 338	Continued From page 24 Observation of Resident #1's room on 05/07/25 at 9:37am revealed: -The MA was changing the linens on Resident #1's bed. -There was a large yellow wet area on the mattress that had discolored 1/3 of the top of the mattress. -There was a sunken area in the mattress where the large, yellow wet area was visible. -The MA lifted the mattress off Resident #1's bed and there was a large black circle covering at least ¼ of the top of the box springs that was visibly damp. Interview with the Administrator on 05/07/25 at 10:00am revealed: -The facility owner purchased a new mattress for Resident #1 about 3 months ago. -There was no new box spring purchased, only the new mattress. -She thought Resident #1 had a mattress protector on her bed. -She was unaware the mattress was saturated with urine and the box springs were saturated with urine and moldy. -Staff should have informed her that Resident #1 no longer had a mattress protector on her bed. Interview with the Maintenance Director on 05/07/25 at 11:35am revealed: -A PCA notified him on 05/03/25 that Resident #1 had a "dip" in her mattress and it was wet with urine. -He brought a new mattress to the PCA. -The PCA removed the old mattress and put the new mattress on. -He did not enter Resident #1's room to assist in removing the old mattress or putting on the new mattress. -He did not observe the box spring mattress.	D 338		

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D 338	Continued From page 25 Interview with a PCA on 05/07/25 at 12:01pm revealed: -She noticed that Resident #1 had a big "dip" in her mattress and thought it would be more comfortable if she had a different mattress. -The mattress was wet with urine, but not saturated. -She removed the soiled mattress and placed it in the hallway. -The Maintenance Director assisted her to put the new mattress on top of the box spring mattress. -She did not look at the box spring mattress when she removed the old mattress or put the new mattress on, so she did not know if it was soiled. Interview with Resident #1's mental health provider Registered Nurse (RN) on 05/07/25 at 1:59pm revealed: -Resident #1 was incontinent of urine and primarily wheelchair bound. -She visited Resident #1 weekly, and she often smelled of urine. -Staff should be checking on Resident #1 every two hours and assisting her with incontinence care. -If she was not receiving incontinence care assistance, she was at high risk for dermatitis, a urinary tract infection or a pressure ulcer. Based on attempted interviews at 05/06/25 at 10:36am and 05/07/25 at 12:45pm it was determined Resident #1 was not interviewable. The facility failed to ensure residents were treated with dignity and respect for Resident #1, who had a history of locking herself in her room and had a history of smoking inside the facility placing herself and other residents at risk, staff breaking into her room because they had no key to enter,	D 338		

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(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 338	Continued From page 26 and sleeping on a urine saturated mattress and moldy box springs. This failure placed Resident #1 at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/06/25. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 06, 2025.	D 338		
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: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #4) related to medications that treat involuntary body movements (#1) and stomach acid (#4). The findings are: Review of the facility's undated Medication Administration Policy and Procedure revealed:	D 358		

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-Medications were to be administered as ordered by the prescribing primary care provider (PCP).
-Medications were to be ordered so that at no time a resident was without medication.
-Every resident would have a minimum of a 7 day supply of medications at all times.
-Failure to order medications in a timely manner may result in medications not being available, and there would be no reason for that to occur.

1. Review of Resident #1's current FL2 dated 05/05/25 revealed a diagnosis of Guillian-Barre Syndrome (a rare disorder in which the immune system attacks the nerves causing muscle weakness and/or paralysis).

Review of Resident #1's mental health provider (MHP) notes dated 02/17/25 revealed diagnoses included schizophrenia (a serious mental illness characterized by hallucinations, delusions, disorganized thinking, and disorganized speech) and severe tobacco use disorder.

Review of Resident #1's MHP notes from 01/06/25 revealed Austedo XR (used to treat involuntary movement disorders) 12 mg every night was being initiated as a new order.

Review of the electronic medication administration records (eMAR) from March, April and May 2025 revealed Austedo was not listed on the eMAR.

Review of medications available for administration on 05/07/25 at 11:40am revealed there was no Austedo available for administration.

Interview with a representative from the facility's contracted pharmacy on 05/06/25 at 3:27pm revealed:

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-They usually received new orders from the facility by fax.
-They had never received an order to start Austedo for Resident #1.

Interview with Resident #1's guardian on 05/06/25 at 4:38pm revealed he had not been made aware that Resident #1's Austedo had never been started.

Telephone interview with a MHP from Resident #1's MHP's office on 05/07/25 at 9:07am revealed:
-The MHP had ordered Resident #1 to start Austedo XR 12 mg nightly on 01/06/25.
-The MHP had prescribed Resident #1 Austedo for tardive dyskinesia (a disorder involving uncontrolled movements).
-The order was still active, and her mental health team was not aware she had not been started on the Austedo yet.

Interview with the Administrator on 05/07/25 at 10:00am revealed:
-The Resident Care Coordinator (RCC) was supposed to review the psychiatrist notes for new orders.
-She assumed the former RCC was taking care of reviewing the psychiatrist notes and ensuring new medication orders were started for the residents.
-She currently had no RCC, so she and two of her supervisors were responsible for reviewing new medication orders to verify they were sent to the pharmacy and started timely for the residents.

Attempted telephone interview with Resident #1's MHP on 05/07/25 at 12:53pm was unsuccessful.

2. Review of Resident #4's current FL2 dated

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05/05/25 revealed diagnoses included asthma and schizoaffective disorder.

Review of Resident #4's physician's orders dated 02/27/25 revealed pantoprazole 40mg at bedtime for gastroesophageal reflux disease (GERD).

Review of Resident #4's April 2025 electronic medication administration record (eMAR) revealed there was an entry for pantoprazole 40mg daily at 8:00pm and documentation it was not administered 04/07/25 - 04/18/25 due to waiting on a refill of the medication.

Observation of Resident #4's medications available for administration on 05/07/25 at 9:09am revealed:
-There was one bubble pack labeled pantoprazole 40mg daily at bedtime.
-Thirty tablets were dispensed on 04/24/25 and 17 remained.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/07/25 at 9:15am revealed:
-The facility requested refills for pantoprazole 40mg on 04/07/25, 04/09/25, and 04/12/25 via the eMAR and each time the pharmacy responded via fax that a new signed physician's order was required for the refill.
-The pharmacy received the new physician's order on 04/24/25 and dispensed 30 tablets of pantoprazole the same day.
-The facility should request refills and obtain new physician's orders before the medication runs out.

Interview with the medication aide (MA) on 05/07/25 at 2:00pm revealed:
-She would telephone the pharmacy if a resident was out of medications and then she would notify

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D 358	Continued From page 30 the Supervisor. -Medications should be reordered when there was a 7 day supply left. -She did not remember what happened with the pantoprazole. Interview with the Supervisor on 05/07/25 at 11:10am revealed: -The MA should have requested a refill of the medication via the eMAR and informed the previous Resident Care Coordinator (RCC) that there was not any pantoprazole available. -The previous RCC was responsible for contacting the PCP for medication orders. Telephone interview with Resident #4's primary care provider (PCP) on 05/07/25 at 1:20pm revealed: -Resident #4 was prescribed pantoprazole for GERD and she may have an increase in stomach acid without it. -Staff should administer the medication as ordered. Interview with the Administrator on 05/07/25 at 10:50am revealed: -She did not know that Resident #4 missed doses of pantoprazole. -The previous RCC was responsible for contacting the PCP for new orders. -She or the previous RCC would have seen the faxed communication from the pharmacy on the fax machine and responded to it but she did not remember seeing it.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 31 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 5 sampled residents (#2) related to medications that treat pain and anxiety. The findings are: Review of Resident #2's current FL2 dated 05/05/25 revealed diagnoses included peripheral neuropathy and post traumatic stress disorder (PTSD). 1. Review of Resident #2's physician's orders	D 367		

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dated 02/27/25 revealed hydrocodone/acetaminophen (treats pain) 10/325mg 1 tablet every 8 hours as needed.

Review of a controlled substance count sheet (CSCS) for Resident #2 revealed:
-There were 30 tablets of hydrocodone/acetaminophen 10/325mg dispensed on 01/29/25.
-Printed on the label was take 1 tablet every 8 hours as needed.
-On 03/01/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/02/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/03/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/04/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-0n 03/07/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/08/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/12/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/13/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.

Review of a second CSCS for Resident #2 revealed:
-There were 30 tablets of hydrocodone/acetaminophen 10/325mg dispensed on 02/20/25.
-Printed on the label was take 1 tablet every 8 hours as needed.
-On 03/17/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/18/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/20/25 at 11:00pm 1 tablet was

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documented as removed from the bubble pack.
-On 03/21/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/22/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/23/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/25/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/26/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 03/27/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/01/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/04/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/06/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/09/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/10/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/11/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.

Review of a third CSCS for Resident #2 revealed:
-There were 30 tablets of hydrocodone/acetaminophen 10/325mg dispensed on 04/02/25.
-Printed on the label was take 1 tablet every 8 hours as needed.
-On 04/16/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/19/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/23/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.
-On 04/24/25 at 11:00pm 1 tablet was documented as removed from the bubble pack.

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D 367	Continued From page 34 -On 04/25/25 at 6:00pm 1 tablet was documented as removed from the bubble pack. -On 04/29/25 at 11:00pm 1 tablet was documented as removed from the bubble pack. -On 05/03/25 at 11:00pm 1 tablet was documented as removed from the bubble pack. -On 05/04/25 at 11:00pm 1 tablet was documented as removed from the bubble pack. Review of Resident #2's March 2025 eMAR revealed: -There was an entry for hydrocodone/acetaminophen 10/325mg take 1 tablet every 8 hours as needed. -There was no documentation the medication was administered on 03/01/25 - 03/04/25, 03/07/25 - 03/08/25, 03/12/25 - 03/13/25, 03/17/25 - 03/18/25, 03/20/25 - 03/23/25, and 03/25/25 - 03/27/25. Review of Resident #2's April 2025 eMAR revealed: -There was an entry for hydrocodone/acetaminophen 10/325mg take 1 tablet every 8 hours as needed. -There was no documentation the medication was administered on 04/01/25, 04/04/25, 04/06/25, 04/09/25 - 04/11/25, 04/16/25, 04/19/25, 04/23/25 - 04/26/25, and 04/29/25. Review of Resident #2's eMAR for 05/01/25 - 05/06/25 revealed: -There was an entry for hydrocodone/acetaminophen 10/325mg take 1 tablet every 8 hours as needed. -There was no documentation the medication was administered on 05/03/25 - 05/04/25. Refer to the interview with a medication aide (MA) on 05/07/25 at 2:00pm.	D 367		

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D 367	Continued From page 35 Refer to the interview with the Administrator on 05/07/25 at 10:50am. 2. Review of Resident #2's physician's orders dated 02/27/25 revealed clonazepam (treats anxiety) 0.5mg three times daily as needed. Review of a controlled substance count sheet (CSCS) for Resident #2 revealed: -There were 30 tablets of clonazepam 0.5mg dispensed on 07/10/24. -Printed on the label was take 1 tablet three times daily as needed. -On 03/07/25 at 6:00pm 1 tablet was documented as removed from the bubble pack. -On 03/08/25 at 2:00pm 1 tablet was documented as removed from the bubble pack. -On 03/21/25 at 2:00pm 1 tablet was documented as removed from the bubble pack. -On 03/29/25 at 8:00pm 1 tablet was documented as removed from the bubble pack. -On 04/09/25 at 9:00pm 1 tablet was documented as removed from the bubble pack. -On 04/10/25 at 8:00pm 1 tablet was documented as removed from the bubble pack. -On 04/11/25 at 5:00pm 1 tablet was documented as removed from the bubble pack. -On 04/16/25 at 11:30am 1 tablet was documented as removed from the bubble pack. -On 05/05/25 at 6:00pm 1 tablet was documented as removed from the bubble pack. Review of Resident #2's March 2025 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet three times daily as needed. -There was no documentation the medication was administered on 03/07/25 at 6:00pm, 03/08/25 at 2:00pm, 03/21/25 at 2:00pm and	D 367		

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D 367	Continued From page 36 03/29/25 at 8:00pm. Review of Resident #2's April 2025 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet three times daily as needed. -There was no documentation the medication was administered on 04/09/25 at 9:00pm, 04/10/25 at 8:00pm, 04/11/25 at 5:00pm, and 04/16/25 at 11:30am. Review of Resident #2's eMAR for 05/01/25 - 05/06/25 revealed: -There was an entry for clonazepam 0.5mg 1 tablet three times daily as needed. -There was no documentation the medication was administered on 05/05/25 at 6:00pm. Refer to the interview with a MA on 05/07/25 at 2:00pm. Refer to the interview with the Administrator on 05/07/25 at 10:50am. _____ Interview with a MA on 05/07/25 at 2:00pm revealed: -Sometimes the eMAR system would not allow the user to document an as needed medication. -She never thought about documenting on a paper medication administration record (MAR) when there were problems documenting on the eMAR. -She did not know if she informed anyone in management about the issues. Interview with the Administrator on 05/07/25 at 10:50am revealed: -She knew there were issues with the eMAR connecting with the internet at times. -The facility did not use paper MARs during times	D 367		

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D 367	Continued From page 37 of internet issues and she did not know why. -The previous Resident Care Coordinator was responsible for auditing eMARs and no one was doing it now.	D 367		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the	D 433		

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resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.
When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to maintain resident records in the adult care home that were readily available for review for 5 of 5 sampled residents (Resident #1, #2, #3, #4, and #5).

The findings are:

1. Review of Resident #1's current FL2 dated 05/05/25 revealed diagnoses included Guillain-Barré Syndrome (a rare disorder where the immune system attacks the nerves causing muscle weakness and/or paralysis).

Refer to the interview with the medication aide (MA) on 05/07/25 at 8:36am.

Refer to the interview with the Supervisor on 05/07/25 at 10:25am.

Refer to the interview with the Administrator on 05/07/25 at 10:50am.

2. Review of Resident #2's current FL2 date 05/05/25 revealed diagnoses included peripheral neuropathy and post traumatic stress disorder (PTSD).

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	HAL011376	A. BUILDING: _____ B. WING _____	R 05/07/2025

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 433	Continued From page 39 Review of Resident #2's Resident Register revealed an admission date of 03/01/13. Refer to the interview with the MA on 05/07/25 at 8:36am. Refer to the interview with the lead Supervisor on 05/07/25 at 10:25am. Refer to the interview with the Administrator on 05/07/25 at 10:50am. 3. Review of Resident #3's current FL2 dated 05/05/25 revealed diagnoses included borderline personality disorder and schizoaffective disorder. Review of Resident #3's Resident Register revealed an admission date of 10/14/24. Refer to the interview with the MA on 05/07/25 at 8:36am. Refer to the interview with the Supervisor on 05/07/25 at 10:25am. Refer to the interview with the Administrator on 05/07/25 at 10:50am. 4. Review of Resident #4's current FL2 dated 05/05/25 revealed diagnoses included asthma and bipolar disorder. Review of Resident #4's Resident Register revealed an admission date of 01/01/20. Refer to the interview with the MA on 05/07/25 at 8:36am. Refer to the interview with the Supervisor on 05/07/25 at 10:25am.	D 433		

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 05/07/2025

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 433	Continued From page 40 Refer to the interview with the Administrator on 05/07/25 at 10:50am. 5. Review of Resident #5's current FL2 dated 04/10/25 revealed diagnoses included neurocognitive disorder and hypothyroidism. Review of Resident #5's Resident Register revealed an admission date of 01/28/20. Refer to the interview with the MA on 05/07/25 at 8:36am. Refer to the interview with the Supervisor on 05/07/25 at 10:25am. Refer to the interview with the Administrator on 05/07/25 at 10:50am. _____ Interview with the MA on 05/07/25 at 8:36am revealed: -She would have asked the Supervisor to bring the resident record to her from the business office or she would go get the record herself. -She knew the Supervisor had a key to the business office. -In the event of an emergency, she would telephone the Supervisor and have her check the resident record for the code status. Interview with the Supervisor on 05/07/25 at 10:25 revealed: -All resident records were kept in the business office located in another building. -When a medication aide (MA) required a resident record, she would bring it to the facility. -She did not know how the MA would access the record during the night because the office was locked.	D 433		

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 05/07/2025

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 433	Continued From page 41 Interview with the Administrator on 05/07/25 at 10:50am revealed: -Staff knew they only had to inform the Supervisor to have a resident record brought to the facility from the business office. -The Supervisor during the night had a key to the office in order to access the resident records. -She did not know that the resident records were to be kept in the facility.	D 433		