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 # 3	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 a complaint investigation on 04/29/25 through 05/01/25.	D 000		
D 273	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: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up for 1 of 3 sampled residents (Resident #1) who had orders to see a pulmonologist and an ophthalmologist.. The findings are: Review of Resident #1's current FL2 dated 11/18/24 revealed diagnoses included schizoaffective disorder, anemia, thrombocytopenia, diabetes type 2, and hypothyroidism. Review of Resident #1's Resident Register revealed an admission date of 08/22/23. Review of Resident's #1's Care Plan dated 10/23/24 revealed: -Resident #1 required supervised assistance eating, toileting, ambulating, and grooming. -Resident #1 required limited assistance with bathing and dressing. -Resident #1 was independent with transfers. a. Review of Resident #1's primary care	D 273		

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provider's (PCP) order dated 02/27/25 revealed a referral to see a Pulmonologist for dyspnea and interstitial lung disease (a group of disorders that cause a progressive scaring of lung tissue).

Interview with Resident #1 on 04/29/25 at 9:49am and on 04/30/25 at 8:15am revealed:
-She had breathing difficulties at times and used a nebulizer.
-Her PCP told her "last month" she needed to see a pulmonologist, but she was unsure why she had not been seen.
-She thought she had a visit in February 2025 but could not remember.
-She had a follow-up visit on 03/21/25 that she missed due to not having transportation.
-She told a staff member about missing the appointment, but no one had assisted her to schedule another appointment.

Telephone interview with Resident #1's PCP on 05/01/25 at 9:30am revealed:
-She wrote an order to refer Resident #1 to pulmonary for a routine check
-She needed to establish baseline care with the pulmonologist, and they needed to follow her for interstitial lung disease.
-He expected the facility to ensure Resident #1 was transported to her appointments.

Telephone interview with a representative from the pulmonology office on 04/30/25 at 3:40pm revealed:
-Resident #1 was an established patient at their office and did not need a referral.
-She was last seen on 02/06/25 and had another appointment scheduled on 03/21/25.
-She was a "no-show" for the 03/21/25 appointment and the facility never called to reschedule the appointment.

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-The facility needed to reschedule the appointment for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 05/01/25 at 10:37am revealed:
-She did not know why Resident #1 missed her pulmonary appointment on 03/21/25.
-She did not know why an appointment had not been rescheduled for Resident #1.
-It was the her responsibility to make sure appointments were made and residents made it to their appointments.

Interview with the Administrator on 05/01/25 at 9:00am revealed:
-She did not know Resident #1 had missed a pulmonary appointment.
-The RCC who worked here at that time would have been responsible for making sure she was transported to her appointments.
-She had not been checking behind the former RCC to make sure tasks were completed.

Attempted telephone interview with the Pulmonologist on 05/01/25 at 10:01am was unsuccessful.

b. Review of Resident #1's primary care provider's (PCP) order dated 10/16/24 revealed an order to see an ophthalmologist for an annual eye examination.

Interview with Resident #1 on 04/30/25 at 8:15am revealed:
-She had not been to an ophthalmologist in "about 2 years."
-She was having trouble seeing out of her left eye.
-She felt like she needed glasses.

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D 273	Continued From page 3 Telephone interview with Resident #1's PCP on 05/01/25 at 9:30am revealed: -He made a referral to an ophthalmologist on 10/16/24 for Resident #1 so she could have a routine eye exam. -Resident #1 had diabetes and he felt she should be seen yearly. -He expected the facility to follow through with referrals. Interview with the Administrator on 05/01/25 at 9:00am revealed: -She did not think the former RCC every scheduled the appointment for Resident #1. -She had been told by the RCC that everyone had appointments, but she had not been checking behind her. -It was the responsibility of the RCC to make sure referral and follow-up was completed. -It was her responsibility to check behind the RCC to make sure tasks were completed.	D 273		
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 interviews and record reviews, the	D 315		

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facility failed to provide the residents' active involvement with each other, their families, and the community.

The findings are:

Observation on 04/29/25 at 9:15am of the April 2025 activities calendar posted on the wall revealed:
-On 04/28/25 and 04/29/25 the activity calendar revealed a shopping trip to a local shopping center with no beginning or completion time.
-On 04/30/25 the activity calendar revealed an "April Birthday Bash" with no beginning or completion time.

Interview with a resident on 04/29/25 at 9:17am revealed there were no activities for them to do.

Interview with a second resident on 04/29/25 at 9:24am revealed:
-The facility did not offer any activities for her to do.
-She was "bored" and wanted activities offered.
-She watched television and slept because it made her depressed not having anything to do.

Interview with a third resident on 04/29/25 at 9:38am revealed:
-They did not do many activities at all.
-They used to have Bingo, but it had been a year or longer since they had Bingo.

Interview with a fourth resident on 04/29/25 at 9:49am revealed:
-It had been about a year since they did Bingo and coloring.
-They have not offered activities in about a year and there was nothing to do.

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D 315	Continued From page 5 Interview with a fifth resident on 04/29/25 at 3:21pm revealed: -He moved into the facility about a month ago. -There were no activities offered at the facility. -He watched television or would go and "bug" the staff to have something to keep him occupied. -He wanted activities offered so that he could be social and befriend the other residents. Interview with a personal care aide (PCA) on 05/01/25 at 8:27am revealed: -She tried to do activities about once a week, but many of the residents refused to join in. -She had attempted coloring, board games, and making slime. -A church van came on Sundays and picked some of the residents up, but none from the house she was working in would ever go. Interview with the Administrator on 04/29/25 at 10:00am revealed: -The facility had been without an activities director (AD) since January 2025. -She was trying to find another AD. -She completed the schedule monthly. -The PCAs were responsible for providing activities with the residents. -She thought the PCAs were engaging residents regularly in activities. -She expected the PCAs to engage the residents in activities and follow the schedule posted.	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 B VIOLATION

Based on observations and interviews, the facility failed to ensure residents were treated with dignity and respect as evidenced by not providing paper towels, toilet tissue, hand soap in 5 of 5 common bathrooms for residents and keeping the bathrooms clean.

The findings are:

Review of the facility's current census on 04/29/25 revealed there were 9 residents residing in the facility.

Observation of the common shower room #2 on 04/29/25 at 9:13am revealed:
-The toilet had dried urine and feces on the toilet lid, rim of the bowl, and inside the commode.
-There was a dried, brown substance smeared on the entrance wall to the shower.
-The shower walls and floor were dirty with a black colored grime.
-The shower curtain had dark brown colored staining around the bottom.
-There was no toilet paper, hand soap, or paper towels available.

Observation of the common bathroom #5 on 04/29/25 at 9:16am revealed:
-There was no toilet paper, hand soap, or paper towels available.
-The toilet had dried feces on the toilet lid, rim of the bowl, and inside the commode.

Observation of the mens common bathroom #1 on 04/29/25 at 9:19am revealed there was no

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hand soap, paper towels, or toilet paper available.

Observation of the common shower room #3 on 04/29/25 at 9:21am revealed:
-The toilet was not flushed and had urine in it.
-The floor of the bathroom and around the toilet was dirty.
-There was an empty toilet paper roll setting on the back of the commode lid.
-There was no hand soap in the canister on the wall or paper towels available.
-There were 2 partial bars of used soap bars lying inside the sink.

Observation of the womens common bathroom #4 on 04/29/25 at 9:23am revealed:
-There was a strong smell of urine in the bathroom.
-There was no hand soap or paper towels available.
-There was a partial roll of toilet paper setting on the sink.

Observation in the kitchen on 04/29/25 at 10:28am revealed there were two packs of toilet paper containing 12 rolls each and one partial bulk package of paper towels stored on top of the refrigerator.

Interview with a resident on 04/29/25 at 9:17am and on 04/30/25 at 10:04am revealed:
-The toilet seats in the bathrooms were always dirty.
-She never thought the bathrooms were cleaned well.
-The bathrooms were out of toilet paper and paper towels "all the time".
-They had not had hand soap in the bathrooms for months.
-She would have to find hand sanitizer to use

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after she used the bathroom due to never having soap.

Interview with a personal care aide (PCA) on 04/29/25 at 10:28am revealed:
-The PCAs were responsible for cleaning the bathrooms, common areas, and restocking supplies including hand soap, paper towels, and toilet paper each shift.
-She had not checked the common bathrooms or cleaned them yet.
-She did not know why the night shift PCA did not restock the common bathrooms with the basic necessities including toilet paper, paper towels, and hand soap.
-She mopped and scrubbed the showers and toilets when she had time but could not remember when she had done it last.

Interview with a second resident on 04/29/25 at 3:16pm revealed:
-The bathrooms never had hand soap to wash her hands and "rarely" had paper towels or toilet paper.
-She made herself a tote bag and bought her own bathroom supplies including hand sanitizer, bar soap, and toilet paper to carry with her when she had to use to bathroom.
-It upset her that she had to buy her own toilet paper and soap to use in the bathroom.
-She dried her hands on her clothing that she wore.

Interview with a third resident on 04/29/25 at 3:21pm revealed:
-He was not able to wash his hands after using the bathroom with soap and just used water to rinse them off because the bathrooms never had any soap.
-Sometimes there was paper towels or toilet

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paper in the bathrooms.

Interview with a fourth resident on 04/30/25 at 10:11am revealed:
-They were out of toilet paper and paper towels "everyday".
-They never had hand soap.
-He had to use his own sanitizer after using the bathroom since they did not have soap available.
-The toilets were often dirty.

Interview with a fifth resident on 04/30/25 at 2:04pm revealed they have not had soap in the bathroom for a long time.

Interview with a sixth resident on 05/01/25 at 2:57pm revealed:
-She had to use her own toilet paper she got from a family member.
-About 9 months ago, she was stuck in the bathroom with no toilet paper, and she had to pull her pants up without wiping because she had no way to wipe herself.
-Often there was no paper towels, so she had to "air dry" her hands.
-They never had soap, so she used her own supplies.
-It made her feel depressed when she did not have necessary supplies.

Interview with a seventh resident on 05/01/25 at 3:03pm revealed:
-He would check other bathrooms when toilet paper was not in the bathroom he was using.
-He had to "air dry" his hands because there would not be any paper towels.
-He had his own soap he used since the bathroom soap dispensers were often empty.
-The issue that frustrated him the most was bathroom cleanliness.

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-He had to find another bathroom if the bathroom he was in was too dirty.
-The bathrooms were dirty often.

Interview with an eighth resident on 05/01/25 at 3:15pm revealed:
-The bathrooms had been out of handsoap, toilet paper, and paper towels for a "long time".
-He did not wash his hands in the bathroom after using the restroom since there was never any soap or paper towels.
-He would use his own personal hand sanitizer after using the restroom when he returned to his room.
-He wanted the bathrooms to be stocked with hand soap, paper towels, and toilet paper.
-He used the restroom once and had a bowel movement but did not have any toilet paper or paper towels to clean himself.
- He pulled up his underwear and pants and walked around to the other bathrooms until he found some paper towels and used a paper towel to clean himself.
-He had to go back to his room and change his underwear because he got stool on them from not being able to wipe.

Interview with a second PCA on 04/30/25 at 8:10am revealed:
-"Sometimes" they ran low on toilet paper, but they never ran out completely.
-The soap had been empty for a long time, but he was unsure how long.
-Sometimes they would have a bottle of hand soap, but he was unsure how long the bottles had been empty.
-He tried to keep things stocked, but he was not always there.
-He also cleaned the bathrooms when he was working on shift.

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D 338	Continued From page 11 Interview with a third PCA on 05/01/25 at 8:27am revealed: -She was aware they ran out of toilet paper and paper towels, but she did not think they ran out but once or twice a month. -She would tell the Administrator if they started to run low on products. -The PCAs were responsible for cleaning the bathrooms. -They would clean toilets, sinks, showers, mop floors, stock bathrooms, and take trash out. -She did not think cleaning always got done every shift. -If the shifts did not clean before her shift, she would see dirty toilet seats and toilets not flushed. -Hand soap had been missing in the bathrooms for a long time, and she did not know when the last time she had seen hand soap in the bathrooms. -She was not sure why the bathrooms did not get cleaned regularly and stocked like they should. Interview with the Administrator on 04/30/25 at 10:40am revealed: -She kept a stock of toilet paper and paper towels in the business office. -She had ordered pumps for the soap, but she was not sure what happened to the pumps. -She was not aware of toilet tissue, paper towels, and soap not being available in the bathrooms. -She expected staff to let her know when they would run low so she could reorder supplies. The facility failed to ensure residents were treated with dignity and respect by not stocking resident bathrooms with toilet paper, hand soap, and paper towels resulting in residents having to return to their rooms to clean themselves and change their underwear, having to wash their	D 338		

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D 338	Continued From page 12 hands using only water and drying their hands on the clothes they were wearing. This failure was detrimental to the health 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 05/12/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2025.	D 338		
D 367	10A 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: (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).	D 367		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to accurately document the administration of medications on the electronic medication administration records (eMARs) for 2 of 4 sampled residents (Resident #2 and #4) related to a medication used to treat anxiety and panic attacks (#2) and movement disorders, schizophrenia, bipolar disorder, constipation, nerve pain, excessive secretions, sleep disorder, mental conditions, depression, and high blood pressures (#4).

The findings are:

Review of the facility's undated policy for Medication Administration revealed:
-Documentation will be provided for each dose of medication by the staff that prepares the medications for administration.
-Staff that administer medications and performs treatments to the residents will provide documentation on the eMAR.
-Staff will provide documentation on the eMARs after observing the residents take medications and before administration to another resident.
-The eMAR will include the resident's name, medication or treatment, strength and dose or quantity, date and time of administration, name or initials of person administering the medication or treatment, as-needed administration and results, omissions and refusals and reason why omitted.

1. Review of Resident #2's current FL2 dated 10/23/24 revealed:
-Diagnoses included anxiety, major depressive disorder, and panic disorder.
-Resident #2's orientation was documented as

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RICHMOND HILL ASSISTED LIVING # 3	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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intermittently confused.
-There was an order for clonazepam (used to treat anxiety and panic attacks) 1mg take 1 tablet daily as-needed for panic attacks and do not give 2 hours before or after scheduled dose.

Review of Resident #2's physician's order dated 02/27/25 revealed clonazepam 1mg take 1 tablet daily as-needed for panic attacks and do not give 2 hours before or after scheduled dose.

Interview with Resident #2 on 04/29/25 at 9:24am revealed:
-She had anxiety and panic attacks, and it caused her to get nervous and made her body shake.
-Her provider ordered her clonazepam daily for when she had a panic attack.
-Most of the time she had panic attacks in the evenings and that was when she needed the clonazepam.

Review of Resident #2's February 2025 eMAR compared to Resident #2's controlled substance count sheet (CSCS) for clonazepam take 1mg daily as needed revealed:
-There was an entry on the eMAR for clonazepam 1mg take 1 tablet daily as needed for panic attacks and do not administer within 2 hours before or after the scheduled clonazepam.
-On the CSCS on 02/01/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 02/02/25 at 11:45 (no am/pm), clonazepam was documented as administered and was not documented on the eMAR.
-On the eMAR on 02/06/25 at 10:56pm, clonazepam was documented as administered and was not documented on the CSCS.
-On the eMAR on 02/07/25 at 11:03pm, clonazepam was documented as administered

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and was not documented on the CSCS.
-On the CSCS on 02/08/25 at 12:00am and 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 02/09/25 at 5:00pm and 1:00 (no am/pm), clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 02/18/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 02/20/25 at 6:30 (no am/pm), clonazepam was documented as administered and was not documented on the eMAR.
-On the eMAR on 02/21/25 at 6:22am, clonazepam was documented as administered and was not documented on the CSCS.
-On the CSCS on 02/26/25 at 11:00pm, clonazepam was documented as administered and was documented as administered on the eMAR by another medication aide (MA) at 12:42pm.

Review of Resident #2's March 2025 eMAR compared to Resident #2's CSCS for clonazepam 1mg daily as-needed revealed:
-There was an entry on the eMAR for clonazepam 1mg take 1 tablet daily as needed for panic attacks and do not administer within 2 hours before or after the scheduled clonazepam.
-On the CSCS on 03/01/25 and 03/02/25 at 4:00am, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS from 03/03/25-03/15/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCSon 03/17/25 and 03/18/25 at

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11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS from 03/21/25-03/23/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 03/26/25 and 03/27/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.

Review of Resident #2's 04/01/25-04/23/25 eMAR compared to Resident #2's CSCS for clonazepam 1mg daily as-needed revealed:
-There was an entry on the eMAR for clonazepam 1mg take 1 tablet daily as-needed for panic attacks and do not administer within 2 hours before or after the scheduled clonazepam.
-On the CSCS on 04/01/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS from 04/04/25-04/06/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 04/07/25 at 12:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 04/10/25 and 04/11/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS on 04/14/25 and 04/15/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.
-On the CSCS from 04/18/25-04/20/25 at 11:00pm, clonazepam was documented as administered and was not documented on the

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eMAR.
-On the CSCS on 04/23/25 at 11:00pm, clonazepam was documented as administered and was not documented on the eMAR.

Interview with a medication aide (MA) on 04/30/25 at 11:28am revealed:
-She always signed Resident #2's CSCS when she administered clonazepam to Resident #2.
-Sometimes the computer would not allow for a signature on the eMAR for the administered clonazepam because the facility did not have "good" internet service.

Telephone interview with a second MA on 04/30/25 at 2:44pm revealed:
-She did not know Resident #2's clonazepam was not documented as administered on the eMAR when she administered clonazepam to Resident #2 on 02/26/25 at 12:30pm.
-She always signed residents' eMARs when she administered medications.
-Occasionally the facility's internet access "would not work" and she could not document medications administered but she always tried to go back and make sure she documented them after service returned.

Interview with the Administrator on 04/30/25 at 4:23pm revealed:
-She was not aware so many doses of Resident #2's as-needed clonazepam were not documented as administered on Resident #2's eMARs when the clonazepam was signed out on the CSCS.
-MAs were required to document the administration of medications both on the eMARs and CSCS for residents.
-The former Resident Care Coordinator (RCC) had been responsible for eMAR audits to make

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sure medications were documented accurately.
-She expected staff to document the administration of medications accurately.
2. Review of Resident #4's current FL2 dated 10/23/24 revealed:
-Diagnosis included schizophrenia and substance use disorder.
-An order for benztropine (used to treat movement disorders) 0.5mg twice daily.
-An order for buspirone (used to treat schizophrenia) 10mg, 2 tablets, three times daily.
-An order for clozapine (used to treat schizophrenia) 100mg daily at bedtime.
-An order for divalproex (extended release used to treat bipolar disorder) 500mg twice daily.
-An order for DOK (docusate sodium used as a stool softener) 100mg at bedtime.
-An order for gabapentin (used to treat nerve pain) 600mg four times daily.
-An order for glycopyrrolare (used to treat peptic ulcers) 1mg twice daily.
-An order for haloperidol (used to treat mental, emotional and nervous conditions) 10mg twice daily.
-An order for melatonin (used to treat sleeplessness) 3mg daily at bedtime.
-An order for mirtazapine (used to treat depression and insomnia) 7.5mg daily at bedtime.
-An order for propranolol (used to treat blood pressure) 20mg three times daily.
-An order for trazodone (used to treat depression) 150mg daily at bedtime.

Review of Resident #4's record revealed:
-He was transported and admitted to the hospital on 03/27/25 at 5:37pm for intentional overdose of buspirone.
-He returned to the facility on 03/28/25.

Review of Resident #4's March 2025 electronic

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Medication administration record (eMAR) revealed:
-There was documentation on 03/27/25 his 8:00pm doses of benztropine, buspirone, clozapine, divalproex ER, DOK, gabapentin, glycopyrrolare, haloperidol, melatonin, mirtazapine, propranolol and trazodone were administered.
-There was documentation in the caregiver key that one medication aide (MA) had 2 different sign in initials.

Telephone interview with a medication aide (MA) on 05/01/25 at 2:57pm revealed:
-She worked on 03/27/25 from 8:00am to 8:00pm but she did not administer 8:00pm medications that day.
-The eMAR documentation access showed she had 2 different sign-in credentials but one of them "never worked".
-She "almost always" used the Resident Care Coordinators (RCC's) log-in credentials and that was what she used when she documented morning and afternoon medication administration on 03/27/25.
-The initials that were used to document the 8:00pm medications administered on 03/27/25 never worked for her and she thought another MA was using that sign-in.
-Resident #4 was not at the facility at 8:00pm on 03/27/25 since he was at the hospital and did not return until 03/28/25 so he would not have received any medications at that time.

Interview with the Administrator on 05/01/25 at 3:30pm revealed:
-The MAs that work 8:00am to 8:00pm were responsible for administering the 8:00pm medications.
-The MA was correct in saying there was trouble

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D 367	Continued From page 20 with sign-ins initially but she thought it was all worked out. -The MA did use the RCC's credentials occasionally when there were computer troubles. -MAs are not supposed to use another MA's sign-in credentials. -Since Resident #4 was not in the building at 8:00pm on 03/27/25 it was a mistake that his medications were documented as administered.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled substance for 1 of 3 sampled residents (Resident #2) who received a medication to treat panic attacks. The findings are: Review of Resident #2's current FL2 dated 10/23/24 revealed: -Diagnoses included anxiety, major depressive disorder, and panic disorder. -Resident #2's orientation was documented as intermittently confused. -There was an order for clonazepam (used to	D 392		

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treat panic attacks) 1mg take 1 tablet daily as needed for panic attacks and do not give 2 hours before or after scheduled dose.

Review of Resident #2's physician's order dated 02/27/25 revealed clonazepam 1mg take 1 tablet daily as needed for panic attacks and do not give 2 hours before or after scheduled dose.

Interview with Resident #2 on 04/29/25 at 9:24am revealed:
-She had anxiety and panic attacks, and it caused her to get nervous and made her body shake.
-Her provider ordered her clonazepam daily for when she had a panic attack.
-Most of the time she had panic attacks in the evenings and that was when she needed the clonazepam.
-There was one specific medication aide (MA) that every time she asked for her clonazepam in the evening the MA told her she was out of the medication, and she would have to wait for the pharmacy to send more of it.
-The other MAs gave her the clonazepam at night when she needed it.
-She told other MAs but nothing was ever done about it "they just think I'm crazy".
-It upset her when she had panic attacks at night and was not administered her clonazepam because it caused her to get nervous, shake, and she could not sleep.

Review of Resident #2's 02/08/25-02/28/25 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg take 1 tablet daily as needed for panic attacks and do not administer within 2 hours before or after the scheduled clonazepam.
-On 02/09/25 at 10:00pm and 11:05pm,

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D 392	Continued From page 22 clonazepam was documented as administered by two different MAs (a day shift MA from a sister facility and night shift MA) with no documentation why clonazepam was administered twice. -On 02/10/25 at 11:33pm, clonazepam was documented as administered. -On 02/11/25 at 11:36pm, clonazepam was documented as administered. -On 02/12/25 at 10:26pm, clonazepam was documented as administered. -On 02/13/25 at 10:41pm, clonazepam was documented as administered. -On 02/14/25 at 11:08pm, clonazepam was documented as administered. -On 02/15/25 at 11:33pm, clonazepam was documented as administered. -On 02/16/25 at 11:08pm, clonazepam was documented as administered. -On 02/19/25 at 11:06pm, clonazepam was documented as administered. -On 02/21/25 at 6:22am, clonazepam was documented as administered. -On 02/23/25 at 11:49pm, clonazepam was documented as administered. -On 02/24/25 at 11:56pm, clonazepam was documented as administered. -On 02/25/25 at 11:33pm, clonazepam was documented as administered. -On 02/26/25 at 12:42pm, clonazepam was documented as administered. -On 02/27/25 at 11:53pm, clonazepam was documented as administered. Review of Resident #2's controlled substance count sheet (CSCS) for clonazepam dated 02/08/25-03/07/25 revealed: -The sticker on the CSCS provided by the facility's contracted pharmacy revealed clonazepam 1mg take 1 tablet every day as needed for panic attacks with a dispense date of	D 392		

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D 392	Continued From page 23 02/06/25 in the quantity of 30 tablets. -There were 2 doses documented as administered on 02/08/25 at 12:00am with 29 tablets remaining and 11:00pm with 28 tablets remaining. -There were 4 doses documented as administered on 02/09/25 at 5:00pm with 27 tablets remaining, 10:00 (no am/pm) with 26 tablets remaining, 1:00 (no am/pm) with 25 tablets remaining, and 12:00am with 24 tablets remaining. -There was 1 dose documented as administered on 02/10/25 at 12:00am with 23 tablets remaining. -There was 1 dose documented as administered on 02/11/25 at 11:00pm with 22 tablets remaining. -There was 1 dose documented as administered on 02/12/25 at 10:26pm with 21 tablets remaining. -There was 1 dose documented as administered on 02/13/25 at 10:43 (no am/pm) with 20 tablets remaining. -There was 1 dose documented as administered on 02/14/25 at 11:00pm with 19 tablets remaining. -There was 1 dose documented as administered on 02/15/25 at 11:00pm with 18 tablets remaining. -There was 1 dose documented as administered on 02/16/25 at 11:00pm with 17 tablets remaining. -There was 1 dose documented as administered on 02/18/25 at 11:00pm with 16 tablets remaining. -There was 1 dose documented as administered on 02/19/25 at 11:00pm with 15 tablets remaining. -There was 1 dose documented as administered on 02/20/25 at 6:30 (no am/pm) with 14 tablets remaining.	D 392		

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D 392	Continued From page 24 -There was 1 dose documented as administered on 02/23/25 at 11:00pm with 13 tablets remaining. -There was 1 dose documented as administered on 02/24/25 at 11:00pm with 12 tablets remaining. -There was 1 dose documented as administered on 02/25/25 at 11:00pm with 11 tablets remaining. -There was one line documented as 02/26/25 with no legible time scribbled through with pen indicating an error and clonazepam was not administered but had 9 tablets remaining written to the side of the scribbled through line. -There were 2 doses documented as administered on 02/26/25 at 12:30 (no am/pm) with 10 tablets remaining and 11:00pm with the amount remaining marked out and 8 tablets remaining written next to the line. -There was 1 dose documented as administered on 02/27/25 at 11:00pm with the amount remaining marked out and 7 tablets remaining written next to the line. -There was 1 dose documented as administered on 03/01/25 at 4:00am with the amount remaining marked out and 6 tablets remaining written next to the line. -There was 1 dose documented as administered on 03/02/25 at 4:00am with the amount remaining marked out and 5 tablets remaining written next to the line. -There was 1 dose documented as administered on 03/03/25 at 11:00pm with the amount remaining marked out and 4 tablets remaining written next to the line. -There was 1 dose documented as administered on 03/04/25 at 11:00pm with the amount remaining marked out and 3 tablets remaining written next to the line. -There was 1 dose documented as administered on 03/05/25 at 11:00pm with 2 tablets remaining.	D 392		

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D 392	Continued From page 25 -There was 1 dose documented as administered on 03/06/25 at 11:00pm with 1 tablet remaining. -There was 1 dose documented as administered on 03/07/25 at 11:00pm with 0 tablets remaining. -There were 2 tablets of clonazepam unaccounted for that were signed out on the CSCS on 02/09/25 at "10" and "1" with no signature to indicate who removed the clonazepam. -There was 1 tablet of clonazepam unaccounted for since there was no clonazepam removed on 02/26/25 with no legible time documented and remaining amount was marked out and 9 tablets remained was written next to the entry. -There were 16 total doses of clonazepam documented as administered on the 02/08/25-02/28/25 eMAR compared to 23 doses documented on the CSCS. Telephone interviews with a former medication aide (MA) on 4/17/25 at 3:00pm and 04/30/25 at 2:20pm revealed: -Resident #2's clonazepam was ordered once per day as-needed. -On 02/09/25, the day shift MA (8:00am-8:00pm) administered Resident #2 clonazepam at 5:00pm. -On 02/09/25, she worked the 8:00pm-8:00am shift. -Later in the evening, a day shift MA that worked at a sister facility entered the building and asked for the medication cart keys and said she "forgot to fill some things out". -Later that evening on 02/09/25, she administered Resident #2's as-needed clonazepam at 11:05pm. -On Resident #2's CSCS she observed "someone" signed out clonazepam for "10" and "1" on 02/09/25. -There was no documentation of am or pm and the signature line was left blank.	D 392		

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D 392	Continued From page 26 -The two entries for "10" and "1" on the CSCS with no signature were not on the sheet at the beginning of her shift when she counted the controlled substances with the day shift MA. Telephone interview with a day shift MA on 04/30/25 at 2:44pm revealed: -She worked as the day shift MA on 02/09/25 from 8:00am-8:00pm. -She counted the controlled substances and compared them to the CSCS at the end of her shift with the night shift MA. -There were no discrepancies discovered during the count of controlled substances at the end of her shift on 02/09/25. -When she reported for work on 02/10/25, the night shift MA told her what happened and showed her a picture that she took of Resident #2's clonazepam CSCS that showed where two doses were signed out but there was no signature. -The two doses of clonazepam were not documented as administered on Resident #2's electronic medication administration record (eMAR). -She reported the incident to the Administrator and showed the Administrator the picture and the CSCS. Review of a text message of a picture of Resident #2's CSCS for clonazepam revealed: -The control sheet was for Resident #2's clonazepam 1mg take 1 tablet every day as needed for panic attacks. -There was documentation on 02/09/25 at 5:00pm that 1 tablet was administered with 27 tablets remaining and was signed by a day shift MA. -There was documentation on 02/09/25 at 10:00 (no am/pm) 1 tablet was administered with 26	D 392		

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tablets remaining and there was no signature.
-There was documentation on 02/09/25 at 1:00 (no am/pm) 1 tablet was administered with 25 tablets remaining and there was no signature.
-There was documentation on 02/09/25 at 12:00am that 1 tablet was administered with 24 tablets remaining and was signed by a night shift MA assigned to administer medications.

Review of a timesheet for the day shift MA who did not originally sign her name next to the removal of clonazepam on 02/09/25 at 10:00 (no am/pm) or 02/09/25 at 1:00 (no am/pm) but documented the removal of clonazepam after the 5:00pm dose on 02/09/25 revealed:
-She clocked in at 7:15am and clocked out at 8:09pm on 02/09/25.
-There were no other time punches on 02/09/25 indicating any hours were worked after 8:09pm on 02/09/25.

Interview with the Administrator on 04/30/25 at 4:23pm and 05/01/25 at 10:02am revealed:
-All medications documented as administered on the controlled substance sheets were supposed to be documented on a resident's eMAR also.
-She did not know why there were only 16 doses of clonazepam documented on Resident #2's eMAR from 02/08/25-02/28/25 when there were 23 doses documented as administered on the CSCS for the same time.
-Sometimes the wifi would quit working and would not save documentation on the eMAR.
-A day shift MA working on 02/10/25 showed her Resident #2's CSCS where someone signed out 2 doses of clonazepam on 02/09/25 and did not sign the CSCS with their name.
-She sent out a mass text message to the facility staff and a day shift MA from a sister facility replied that she administered the 2 doses on

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D 392	Continued From page 28 02/09/25 at 10:00 (no am/pm) and 02/09/25 at 1:00 (no am/pm) (signed out after the 5:00pm dose was administered on 02/09/25) so she had the day shift MA sign her name on the CSCS. -She did not pay attention to the order on the CSCS or question why the clonazepam was documented as administered on the control sheet four times in one day on 02/09/25 when it was only ordered once per day. -The former Resident Care Coordinator (RCC) was responsible for auditing eMARs and the CSCS to make sure all the controlled substances were accurately documented and accounted for. Attempted interview with a day shift MA on 04/30/25 at 3:00pm was unsuccessful. Attempted interview with a night shift MA on 04/30/25 at 3:06pm was unsuccessful.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION	D 399		

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D 399	Continued From page 29 Based on interviews and record reviews, the facility failed to report suspected drug diversion for 1 of 1 sampled resident (Resident #2) to the facility's contracted pharmacy. The findings are: Review of Resident #2's current FL2 dated 10/23/24 revealed: -Diagnoses included anxiety, major depressive disorder, and panic disorder. -Resident #2's orientation was documented as intermittently confused. -There was an order for clonazepam (used to treat panic attacks and anxiety) 1mg take 1 tablet daily as needed for panic attacks and do not give 2 hours before or after scheduled dose. Review of Resident #2's physician's order dated 02/27/25 revealed clonazepam 1mg take 1 tablet daily as-needed for panic attacks and do not give 2 hours before or after scheduled dose. Telephone interviews with a medication aide (MA) on 4/17/25 at 3:00pm and 04/30/25 at 2:20pm revealed: -She stopped working as a MA on 02/10/25 and currently worked as a personal care aide (PCA) due to an incident that occurred involving another MA taking controlled substances from the medication cart during one of her shifts. -On 02/09/25, the day shift MA (8:00am-8:00pm) administered Resident #2's as needed dose of clonazepam at 5:00pm. -Resident #2's clonazepam was ordered once per day as-needed. -On 02/09/25, she worked the 8:00pm-8:00am shift. -Later in the evening, a day shift MA that worked	D 399		

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at a sister facility entered the building and asked for the medication cart keys and said she "forgot to fill some things out".
-She gave the day shift MA the medication cart keys because she was a new MA and thought it was okay.
-She was standing in the next room and heard the sound of two pills being popped out of a bubble pack.
-She overheard the day shift MA talking to herself and say that her family member was not going to be in pain.
-She did not feel comfortable confronting the MA.
-Later that evening on 02/09/25, she administered Resident #2's as-needed clonazepam at 11:05pm.
-On Resident #2's controlled substance count sheet (CSCS) she observed "someone" signed out clonazepam for "10" and "1" on 02/09/25.
-There was no documentation of am or pm and the signature line was left blank.
-She took a picture of Resident #2's CSCS for clonazepam on 02/10/25 at 12:09am.
-On 02/10/25, she reported the incident to the on-coming day shift MA and the Administrator.
-The Administrator told her this would need to be reported and she would handle it.
-The two entries for "10" and "1" on the CSCS with no signature were not on the sheet at the beginning of her shift when she counted the controlled substances with the day shift MA.

Telephone interview with a day shift MA on 04/30/25 at 2:44pm revealed:
-She worked as the day shift MA on 02/09/25 from 8:00am-8:00pm.
-She counted the controlled substances and compared them to the control sheets at the end of her shift with the night shift MA.
-There were no discrepancies discovered during

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the count of controlled substances at the end of her shift on 02/09/25.
-When she reported for work on 02/10/25, the night shift MA told her what happened and showed her a picture that she took of Resident #2's clonazepam CSCS that showed where two doses were signed out but there was no signature.
-The two doses of clonazepam were not documented as administered on Resident #2's electronic medication administration record (eMAR).
-She reported the incident to the Administrator and showed the Administrator the picture and the CSCS.
-The day shift MA who worked at a sister facility should not have been at the facility that night after her shift ended but she sometimes stayed after because her family member worked as a MA at another sister facility on the same property from 8:00pm-8:00am.
-She was concerned because the MAs that were related to each other often signed out controlled substances on the CSCS but did not document the medication as administered on the eMARs.

Review of Resident #2's CSCS for clonazepam revealed:
-There was a pharmacy-generated label at the top of the CSCS for clonazepam 1mg take 1 tablet every day as needed for panic attacks.
-There was documentation on 02/09/25 at 5:00pm that 1 tablet was administered with 27 tablets remaining and was signed by a day shift MA.
-There was documentation on 02/09/25 at 10:00 (no am/pm) 1 tablet was administered with 26 tablets remaining and there was no signature.
-There was documentation on 02/09/25 at 1:00 (no am/pm) 1 tablet was administered with 25

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tablets remaining and there was no signature.
-There was documentation on 02/09/25 at 12:00am (should have been documented as 02/10/25 at 12:00am) 1 tablet was administered with 24 tablets remaining and was signed by the night shift MA assigned to administer the medications.

Review of a timesheet for the day shift MA who was reported to have returned to the facility on 02/09/25 after her shift ended at 8:00pm revealed:
-She clocked in at 7:15am and clocked out at 8:09pm on 02/09/25.
-There were no other time punches on 02/09/25 indicating any hours were worked after 8:09pm on 02/09/25.

Interviews with the Administrator on 04/30/25 at 4:23pm and 05/01/25 at 10:02am revealed:
-The facility did not have a policy regarding controlled substances or drug diversion.
-All medications documented as administered on the controlled substance sheets were supposed to be documented on a resident's eMAR also.
-She did not know why there were two doses of Resident #2's clonazepam signed out on 02/09/25 at "10" and "1" but were not documented on the eMAR.
-A day shift MA who worked on 02/10/25 showed her Resident #2's CSCS that documented two doses of clonazepam were removed from the bubble pack but whomever removed the two doses did not sign their name.
-She sent out a group text message to the facility staff and a day shift MA from a sister facility replied that she administered the 2 doses on 02/09/25 at 10:00 (no am/pm) and 02/09/25 at 1:00 (no am/pm) (signed out after the 5:00pm dose was administered on 02/09/25) so she had

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the day shift MA sign her name on the CSCS.
-She did not pay attention to the order on the control sheet or question why the clonazepam was documented as administered on the control sheet four times in one day when it was only ordered once per day.
-The day shift MA who forgot to sign the control sheet with her name clocked out at 8:09pm on 02/09/25 and should not have been administering any medications at 10:00pm or 1:00am on 02/10/25.
-She asked the night shift MA why she gave the day shift MA the keys to the medication cart and the night shift MA told her the day shift MA reported she forgot to do something.
-The MAs were not supposed to give the medication cart keys to anyone except the on-coming shift after the controlled substances were accounted for.
-The night shift MA told her she heard the day shift MA who borrowed the medication cart keys say that her family member was not going to be in pain, and she heard 2 pops from a medication bubble pack.
-She reviewed the video surveillance footage where the medication cart was kept and observed the day shift MA from a sister facility removed medications from the cart the evening of 02/09/25 but did not know if she took the medications to a resident's room.
-She observed the MA leave the room on the video surveillance footage but could not see if the MA went to a resident's room or towards the exit door.
-She did not report the drug diversion to the HCPR on 02/10/25 because she just thought the day shift MA forgot to sign the control sheet.
-She did not ask the day shift MA why she documented she administered medications after her shift ended at 8:09pm on 02/09/25.

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D 399	Continued From page 34 -She did not report the drug diversion to the local law enforcement, Health Care Personnel Registry (HCPR), or pharmacy because she did not know she was supposed to. Attempted interview with a day shift MA on 04/30/25 at 3:00pm was unsuccessful. Attempted interview with a night shift MA on 04/30/25 at 3:06pm was unsuccessful. _____ The facility failed to report suspected drug diversion to the contracted facility pharmacy after the Administrator was informed of an incident in which a day shift MA re-entered the facility after completing her shift and clocking out, requested the medication cart keys from the night shift MA, and was observed on video surveillance by the Administrator to remove medications from the medication cart, resulting in 2 doses of Resident #2's clonazepam being removed from the bubble package, signed out on the CSCS but not documented as administered on the eMAR. This failure was detrimental to the health and welfare of Resident #2 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/30/25 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2025.	D 399		
D 411	10A NCAC 13F .1010 (d) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (d) The facility shall assure the provision of	D 411		

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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 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:
(A) the name and strength of the medication;
(B) the directions for administration as prescribed by the resident's physician; and
(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
(3) the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and
(4) labeling of each of the resident's individual medication containers for the leave of absence

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D 411	Continued From page 36 shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility. This Rule is not met as evidenced by: TYPE`A2 VIOLATION Based on interviews and record reviews the facility failed to ensure medications provided to a resident during a leave of absence were accurately documented and maintained in the resident's record for 1 of 1 sampled residents (#4). The findings are: Review of the facility's medication policy related to resident absences revealed: -If a resident is to be absent from the facility for more than one administrative dosage of medication, medications are to be listed on the medication release form, a count must be done by the staff, listed on the sign out log and both staff and resident or responsible party are to sign the sign out log with medications.	D 411		

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-Medications are given as packaged by the pharmacy in original containers.
-If the resident will be leaving the facility for overnight, all medications including as needed medications are to be included on the sign out log.
-Upon return to the facility, the sign out log is to be filled out by staff indicating the name and quantity of medications returned to the facility; staff and resident/responsible party are to sign the log.

Review of Resident #4's current FL2 dated 10/23/24 revealed:
-Diagnosis included schizophrenia, and substance use disorder.
-An order for buspirone (used to treat schizophrenia) 10mg, 2 tablets, three times daily.
-An order for lorazepam (used to treat anxiety) 1mg every six hours as needed.

Review of Resident #4's care plan dated 10/16/24 revealed the resident left every weekend for a family visit.

Interview with Resident #4 on 05/01/25 at 9:25am revealed:
-He left to facility every weekend to visit family.
-Someone from the facility gave his medications to his family member.
-His family member administered his medications while he was away from the facility.
-He was transported to the hospital about a month ago, but he could not remember the reason.

Review of Resident #4's March 2025 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #4 was on a

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 3	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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leave of absence (LOA) from the facility on 03/01/25-03/06/25, 03/18/25-03/20/25, 03/26/25, 03/27/25, 04/01/25-04/04/25, 04/08/25-04/1025, 04/15/25-04/18/25, 04/20/25, 04/21/25 and 04/28/25-04/30/25.
-There was documentation Resident #4 was in the hospital on 03/28/25.

Review of Resident #4's April 2025 eMAR revealed there was documentation Resident #4 was on a LOA from the tablets facility on 04/01/25-04/04/25, 04/08/25-04/10/25, 04/15/25-04/18/25, 04/20/25, 04/21/25 and 04/28/25-04/30/25.

Review of Resident #4's control substance count sheet (CSCS) for lorazepam 1mg. revealed:
-There was documentation 29 tablets were sent with Resident #4 on 03/26/25 for a home visit.
-There was no documentation the tablets were returned on 03/27/25.
-There was documentation 1 tablet was administered on 03/30/25 leaving a total of 28 tablets.

Telephone interview with 2 of Resident #4's family members on 04/02/25 at 4:15pm revealed:
-The same family member usually picked up Resident #4 from the facility on weekend LOAs but a different family member returned him to the facility on 03/27/25.
-The family member that returned Resident #4 to the facility on 3/27/25 put all of Resident #4's belongings, including his medication, in his bedroom and then left.
-She did not see any staff in the facility when she returned Resident #4 and forgot that she was supposed to return the medications to staff.
-Resident #4 was hospitalized on 03/27/25 for "taking too many pills" after returning to the

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facility.

Review of Resident #4's hospital discharge summary dated 03/28/25 revealed:
-He was brought to the emergency department (ED) via emergency medical services (EMS) on 03/27/25 at 5:37pm.
-He was treated for intentional overdose of buspirone, and suicidal ideation.
-It was reported that Resident #4 ingested 6-8 tablets of 10mg buspirone.
-He was documented as drowsy and making delusional statements.
-He was discharged back to the facility on 03/28/25.

Interview with a Medication Aide (MA) on 05/01/25 at 12:01pm revealed:
-When a resident went on a LOA the MAs were supposed to complete a LOA form and have the family sign it.
-The form was sent with the family, but "half the time the family did not return it".
-Staff were recently instructed by the new RCC to keep the form rather than send it with the family.
-She and another MA were sitting on the front porch of the facility on 03/27/25 when a resident came and told them Resident #4 was seen in his room "popping pills" out of the package and swallowing them.
-The MA that was on the porch with her called EMS and then called the Administrator to inform her.

Telephone interview with another MA on 05/01/25 at 2:57pm revealed:
-She was the MA assigned to Resident #4's building when he returned from a LOA on 03/27/25 but she was not in the building at the time because she had been called to administer

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medications at a sister facility.
-She did not know why the family member put the medication in the Resident's room and did not turn them into the personal care aide (PCA) that was working .
-She was not at the facility when EMS was called because she had to run an errand, and another MA came to relieve her until she could return.
-The LOA medication form was not consistently completed by staff and the Administer was aware of that problem.

Interview with the Administrator on 05/01/25 at 9:50am and 10:56am revealed:
-She was not informed Resident #4 was transported to the hospital on 03/27/25.
-She did not know anything about an incident requiring hospitalization on 03/27/25.
-The facility used a LOA form that MAs were supposed to complete that documented what medications went with a resident and what medications were returned when the resident came back to the facility after a LOA.
-MAs told her the LOA forms were being sent with family, the forms were not being returned, forms were being thrown away and that the previous Resident Care Coordinator (RCC) was not consistently having them complete a LOA medication disposition form.
-The new RCC reminded all MAs on 04/15/25 that LOA forms needed to be completed because they were not being done consistently.
-Except for the 04/28/25-04/30/25 LOA the facility could not locate any record of medications sent home or returned to the facility with Resident #4.

Interview with the RCC on 05/01/25 at 9:52am revealed:
-She could not locate any paperwork completed when Resident #4 left the facility on a LOA.

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D 411	Continued From page 41 -When a resident left on a LOA the entire medication card was sent with the family. -The LOA documentation was not always completed properly. Telephone interview with Resident #4's Primary Care Provider (PCP) on 05/01/25 at 11:34am revealed: -He was Resident #4's PCP but Resident #4 also had a mental health provider who ordered all his psychotropic medications and managed all his psychological needs. -He knew Resident #4 had schizophrenia but would have to defer any other questions related to psychology to that provider. Attempted telephone interview with Resident #4's family member who returned him to the facility on 03/27/25 on 05/01/25 at 10:26am was unsuccessful. Attempted telephone interview with Resident #4's mental health provider on 05/01/25 at 3:47pm was unsuccessful. _____ The facility failed to ensure Resident #4's medications, including buspirone and lorazepam (a controlled substance), were accounted for upon his return from a LOA, resulting in the resident having in his possession 29 lorazepam tablets and multiple buspirone giving the resident the opportunity to ingest 60-80mg buspirone leading to an admission to the hospital for intentional overdose and suicidal ideation. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/01/25 for this violation.	D 411		

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D 411	Continued From page 42 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 31, 2025.	D 411		
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 4 of 4 sampled residents (Resident's #1, #2, #3, and #4).

The findings are:

1. Review of Resident #1's current FL2 dated 11/18/24 revealed diagnoses included schizoaffective, bipolar, anemia, thrombocytopenia, diabetes type 2, and hypothyroidism.

The Resident Register revealed an admission date of 08/22/23.

Refer to the interview with the medication aide (MA) on 05/01/25 at 12:01pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/25 at 3:11pm.

Refer to the interview with the Administrator on 05/01/25 at 4:00pm.

2. Review of Resident #2's current FL2 dated 10/23/24 revealed diagnoses included allergic

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rhinitis, anxiety, chronic obstructive pulmonary disease, fibromyalgia, major depressive disorder, and panic disorder.

The Resident Register revealed an admission date of 04/01/24.

Refer to the interview with the MA on 05/01/25 at 12:01pm.

Refer to the interview with the RCC on 05/01/25 at 3:11pm.

Refer to the interview with the Administrator on 05/01/25 at 4:00pm.

3. Review of Resident #3's current FL2 dated 12/06/24 revealed diagnoses included intellectual and developmental disabilities, and seizures.

The Resident Register revealed an admission date of 12/04/24.

Refer to the interview with the MA on 05/01/25 at 12:01pm.

Refer to the interview with the RCC on 05/01/25 at 3:11pm.

Refer to the interview with the Administrator on 05/01/25 at 4:00pm.

4. Review of Resident #4's current FL2 dated 10/23/24 revealed diagnoses included schizophrenia and substance use.

The Resident Register revealed an admission date of 04/04/24.

Refer to the interview with the MA on 05/01/25 at

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D 433	Continued From page 45 12:01pm. Refer to the interview with the RCC on 05/01/25 at 3:11pm. Refer to the interview with the Administrator on 05/01/25 at 4:00pm. _____ Interview with a medication aide (MA) on 05/01/25 at 12:01pm revealed: -All records were kept in the business office for the individual houses as long as she had worked there, which was about a year. -On the weekends and night shifts, it would be hard to get access to the records because not everyone had a key to the office. -If staff needed something and could not get into the office, the staff would call the Administrator, and she would send them paperwork if needed by fax. -She was not sure how "Do Not Resuscitate" (DNR) paperwork got handled. Interview with the Resident Care Coordinator (RCC) on 05/01/25 at 3:11pm revealed: -Records had been kept in the business office since she began working there for around a year and a half. -All supervisors had keys to get into the office to obtain records if needed. Interview with the Administrator on 05/01/25 at 4:00pm revealed: -The records had always been in the business office since she began working there in September 2023, and not in each individual building. -Face sheets, DNR, and medication sheets used to be kept in a notebook in each individual buildings but forms would be misplaced.	D 433		

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D 433	Continued From page 46 -Supervisors had access to the business office or staff would call her and she would fax needed paperwork. -She was unaware the state policy required the resident record be kept in the Adult Care Home (ACH).	D 433		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to send an accident/incident report to the local Department of Social Services (DSS) within 48 hours for 1 of 1 sampled resident (#4) who required hospitalization due to an intentional overdose and suicidal ideation. The findings are: Review of the facility's undated Accident and Incident Policy revealed: -Any resident injury which requires more than first aide will be reported to the local DSS. -The report will be sent via mail, fax or email. -The Administrator is responsible for ensuring the	D 451		

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report is sent within 48 hours of the initial discovery or knowledge by staff of the incident or accident.
-The Administrator will be notified by the supervisor of any accident or incident within 24 hours of the accident/incident.

Review of Resident #4's current FL2 dated 10/23/24 revealed diagnosis included schizophrenia, substance use disorder.

Review of Resident #4's hospital discharge summary dated 04/28/25 revealed:
-He was brought to the emergency department (ED) via emergency medical services (EMS) on 03/27/25 at 5:37pm.
-He was treated for intentional overdose of buspirone, and suicidal ideation.
-It was reported that Resident #4 ingested 6-8 tablets of 10mg buspirone.
-He was documented as drowsy and making delusional statements.
-He was discharged back to the facility on 03/28/25.

Telephone interview with the Adult Home Specialist (AHS) from the local DSS on 05/01/25 at 4:37pm revealed:
-She did not receive notification of Resident #4's March 2025 hospitalization.
-She "rarely" received Accident/Incident reports from the facility.

Interview with the Administrator on 05/01/25 at 5:01pm revealed:
-She did not send an Accident /Incident report to DSS because she did not think she needed to.
-She sent reports to DSS for things like falls, fights and elopements but not for medical incidents.

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