Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Richmond Hill Assisted Living #3 County: Buncombe
Address: 95 RICHMOND HILL ROAD ASHEVILLE, NC 28806 License Number: HAL011374

II. Date(s) of Visit(s): 04/01/2025 Purpose of Visit(s): Follow Up to CAR
Exit/Report Date: 05/22/2025

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

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

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

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

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13F.0902(b) HEALTH CARE Rule/Statutory Reference: The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: Unabated Type B Violation FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 3 of 3 sampled residents (Resident #1, Resident #2 and Resident #3) related to referrals for mental health services and substance abuse treatment (Resident #1), follow up appointments with the primary care provider (PCP) (Resident #1, Resident #2 and Resident #3), follow-up appointments with mental health provider (Resident #2) and follow up with neurology (Resident #3) after hospitalizations. 1. Review of Resident #1's current FL2 dated 8/12/24 revealed diagnoses included substance induced mood disorder and major depressive disorder. Review of Resident #1's Resident Register revealed: -Date of admission was 5/9/24. -The resident had a guardian. Review of Resident #1's hospital discharge summary dated	☐ POC Accepted_____ *DSS Initials*	

12/30/2024 revealed:
-The resident was evaluated for influenza-like symptoms and chest pain.
-Discharge diagnosis was acute viral syndrome.
-The physician instructed her to follow up closely with her PCP after discharge.

Review of Resident #1's hospital discharge summary dated 01/29/2025 revealed:
-The resident was evaluated for cough and chest pain symptoms which started a few days ago.
-The discharge diagnosis was cough.
-She was to follow up with her PCP in 5 to 7 days.

Review of Resident #1's hospital discharge summary dated 02/12/2025 revealed:
-She was admitted to the hospital on 02/05/2025 for suicidal ideation in the setting of substance withdrawal and intrusive thoughts about her deceased spouse.
-She reported substance use for 4 days with plan to jump off bridge.
-She was transferred from the hospital to an inpatient psychiatric care facility on 02/06/2025 and discharged on 02/12/2025.
-She was to follow up with her PCP in 3 days and her mental health provider in 5 to 7 days.
-There was a new order to follow up with the local health department scheduled for 02/18/2025 at 10:30am.
-The discharge diagnoses were substance use severe, unspecified depressive disorder substance induced, communicable disease and suicidal ideation- resolved.

Review of Resident #1's record revealed there was no documentation of PCP visits for Resident #1 from 12/30/2024 to 03/11/2025.

Review of Resident #1's PCP visit notes dated 3/12/2025 revealed:
-The resident was abusing substances and was trying to quit.
-The resident was at the hospital on 02/12/2025 for substance use and suicidal ideation.
-The resident was assessed for chest pain and there were no further concerns.
-The resident was treated for a communicable disease.

Interview with Resident #1 on 04/01/2025 at 10:00am revealed:
-She had been in the hospital several times recently because she was depressed and going through substance use withdrawal.
-The last time she used substances was a week ago.
-She had no mental health treatment since being admitted to the facility until a few weeks ago.
-She wanted to move from the facility so she could get more help.
-She wanted to work with an assertive community treatment (ACT) team because that has helped her in the past.
-She wished she would have received mental health treatment because she wanted to feel better.
-She wanted to go to a substance use detoxification program but kept being told there were not any beds.

Interview with the facility's contracted mental health provider on 03/26/2025 at 4:00pm revealed:
-Resident #1's first appointment was on 03/13/2025.
-She would be recommending the resident also receive psychotherapy.
-The facility did not make any referrals for psychiatry or psychotherapy prior to the 03/13/2025 appointment.

Interview with Resident #1's PCP on 04/04/2025 at 11:55am revealed:
-He was always notified of the resident's hospitalizations through a text message from the Administrator.
-He was aware of the resident's substance use and that she had episodes of suicidal ideation.
-When there were PCP follow-ups after discharge recommended the resident would usually be non-compliant or away from the facility.
-If a follow up needed to occur within a certain amount of time it could be difficult to meet recommended time frames because he usually went to the facility once a month.
-Telehealth video conferencing appointments were always an option to see a resident sooner but the Administrator had not requested any telehealth appointment for the resident.

Interview with the Administrator on 04/01/2025 at 3:00pm revealed:
-She had no documentation of efforts to communicate with Resident #1's PCP regarding follow up appointments needed after the resident's hospitalizations.
-She notified the PCP of the resident's hospitalizations by uploading the hospital discharge summaries through a shared computer program.
-The resident was often away from the facility when she was scheduled to see the PCP.
-They would remind the resident of her appointments the day before and the morning of the appointment but they could not stop her from leaving.
-Telehealth video conferencing appointments with the PCP were an option for the resident but she had not utilized this service yet.
-She had made referrals for mental health services but the resident would be away from the facility for these appointments.
-She did not have documentation of referrals made for substance use detoxification programs for the resident.
-She did not have documentation of referrals made for mental health services prior to the resident's appointment with a psychiatrist on 03/13/2025.

2. Review of Resident #2's current FL2 dated 10/23/2024 revealed diagnoses included osteoporosis, high blood pressure, dementia, schizophrenia, borderline intellectual functioning and anxiety.

Review of Resident #2's Resident Register revealed:
-There was no documentation of the date of admission.
-The resident had a guardian.

Review of Resident #2's hospital discharge summary dated 01/09/2025 revealed:
-The resident was evaluated for behavioral health concerns related to being agitated, verbally aggressive and screaming and yelling at staff and other residents.
-He received a psychiatric evaluation.
-He resident was to follow up with his PCP and no time frame was specified.

Review of Resident #2's hospital discharge summary dated 02/10/2025 revealed:
-On 1/24/2025 the resident was admitted to the hospital for verbal aggression, paranoia and intermittently refusing medications.
-He was transferred to inpatient psychiatric treatment and received changes in psychiatric medications to treat psychosis.
-His discharge diagnosis was schizophrenia, unspecified.
-He was to follow up the PCP within 2 days after discharge and with the facility's mental health provider within 2 days after discharge.

Review of Resident #2's record revealed there was no documentation of PCP visits for Resident #2 from 01/09/2025 to 02/26/2025.

Review of Resident #2's PCP visit dated 02/27/25 revealed there was no reference to the resident being hospitalized on 01/09/2025 and from 01/24/2025 until 02/10/25.

Interview with Resident #2's PCP on 04/04/2025 at 12:05pm revealed:
-He was always notified of the resident's hospitalizations through a text message from the Administrator.
-The resident would "usually" be non-compliant or away from the facility when there were PCP follow-ups appointments after discharge.
-If a follow up needs to occur within a certain amount of time it could be difficult to meet recommended time frames because he usually went to the facility once a month.
-Telehealth video conferencing appointments were always an option to see the resident sooner but the Administrator had not requested any telehealth appointments for the resident.

Interview with the Administrator on 04/01/2025 at 3:00pm revealed:
-She could no locate any documentation of efforts to communicate with Resident #2's PCP or mental health provider regarding the discharge recommendation for follow up appointments with providers within 2 days of discharge for the resident's hospitalization from 01/24/2025 until 2/10/2025.
-She notified the PCP of the resident's hospitalizations by uploading the hospital discharge summaries through a shared computer program.
-Telehealth video conferencing appointments with the PCP were an option for the resident but she had not utilized this service yet.

3. Review of Resident #3's current FL2 dated 12/06/2025 revealed diagnoses included intellectual disability and seizure disorder.

Review of Resident #3's Resident Register revealed:
-The resident had an admission date of 12/04/2024.
-The resident had a guardian.

Review of Resident #3's hospital discharge summary and instructions dated 12/26/2024 revealed:
-She presented to the hospital for seizure-like activity.
-The documented diagnosis was seizure like activity.
-The physician advised resident to follow up with the facility PCP and neurology as needed.
-The facility made a handwritten note on the discharge instructions that resident would report if she wanted a neurology appointment.

Review of Resident #3's hospital discharge summary dated 12/31/2024 revealed:
-She presented to the hospital after taking medication and choked, having a seizure after that and throwing up a little blood.
-She was diagnosed with seizure and choking.
-There was no follow up information provided.

Review of Resident #3's hospital discharge summary dated 02/11/2025 revealed:
-On 02/10/2025 the resident received electroencephalogram (EEG) monitoring, which is a medical test that records the electrical brain activity.
-The EEG was scheduled from a previous referral made by the neurologist prior to admission to the facility.
-There was documentation that epilepsy could not be ruled out.
-She was to obtain an ambulatory EEG for further evaluation.
-The resident was to follow up with neurology in 4-6 weeks.

Review of Resident #3's hospital discharge summary dated 3/05/2025 revealed:
-The resident was evaluated because she was concerned she had a seizure.
-The physician recommended the resident follow up with her PCP and no time frame was specified.

Review of Resident #3's hospital discharge summary dated 3/13/2025 revealed:
-The resident was evaluated for lower extremity pain from a fall.
-There was documentation the resident had a knee abrasion, knee contusion, hand contusion, hand abrasion and rib pain.
-The resident was to follow up with her PCP within the next few days for recheck.

Review of Resident #3's hospital discharge summary dated 4/06/2025 revealed:
-The resident presented to the emergency department on 3/31/2025 and was admitted that day for numbness on left side of her body which started 2 to 3 days ago and she stated she was having difficulty talking and swallowing.
-There was documentation of an appointment scheduled with a

neurologist within 4 weeks with a contact number for scheduling.

Review of Resident #3's charting notes revealed there was no information documented related to hospital follow up appointments from 12/30/2024 to 3/31/2025.

Review of Resident #3's PCP visit notes after hospital discharge on 12/30/2024 until 4/03/2025 revealed:
-The resident had a visit with the PCP on 02/26/2025 and there was no reference of any hospital visits or seizures.
-The resident had a visit with the PCP on 3/13/2025 and there was no reference to any hospital visits or possible seizures.

Telephone interview with Resident #3 on 4/02/2025 at 1:00pm revealed:
-She was currently in the hospital because she had numbness on the left side of her body and was having difficulty talking and swallowing
-Before being admitted to the facility she saw a neurologist regularly but had not seen a neurologist since being at the facility.
-She had numerous seizures since being at the facility and she was currently at the hospital for numbness on the left side of her body.

Interview with Resident #3's PCP on 04/04/2025 at 12:10pm revealed:
-He was aware the resident had multiple hospitalizations for seizure activity and she did not have an established neurologist.
-He received text messages from the administrator when the resident was hospitalized.
-If a follow up appointment needed to occur for a resident within a certain amount of time it could be difficult because he usually went to the facility once a month.
-A telehealth appointment video conference appointment was always an option to see the resident sooner but the Administrator had not asked for any telehealth appointments.

Interview with Resident #3's guardian on 4/03/2025 at 9:00am and 5/01/2025 at 10:15am revealed:
-Guardianship of the resident was transferred to him on 02/19/2025.
-He was not notified by the facility of the resident's hospitalizations on 3/05/2025, 3/13/2025 or 3/31/2025.
-The facility did not make him aware of any needed follow up appointments for the resident with the PCP or neurologist after those hospitalizations.
-He had requested that the Administrator send him information on the follow-up appointments needed and he had not received any information.
-The resident had an established neurologist in her previous county of residence but the Administrator said they could not provide transport for those appointments or any outside provider appointments.
-The facility was not working on finding the resident a local neurologist so he was attempting to find one for her.

Interview with the Administrator on 4/01/2025 at 3:00pm revealed: -They were not able to provide transportation for the resident to go to her existing neurologist because the neurologist was located in a neighboring county which was too far for her staff to travel. - She had not attempted to schedule a neurology appointment for the resident because the resident would let her know if she wanted neurologist appointment. -The guardian was working on establishing a local neurologist. -Telehealth video conferencing appointments with the PCP were an option for the resident but she had not utilized this service yet. The facility failed to ensure follow up for Resident #1 with a mental health provider and PCP after hospital discharges on 12/30/2024, 01/29/2025 and 02/12/2025 which resulted in worsening symptoms of depression, suicidal ideation, and ongoing use of substances; for Resident #2 related to appointments with the PCP and mental health provider after hospitalization which contributed to the resident being hospitalized a second time; and for Resident #3 related to appointments with a neurologist and the PCP which contributed to multiple hospitalizations due to seizures. This failure was detrimental to the health, safety and welfare of Resident #1, Resident #2 and Resident #3 and constitutes an Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 4/20/2025 for this violation.		

IV. Delivered Via: Email	**Certified Mail #:**	Date: 05/23/2025
DSS Signature: Kelly L. Schaefer		Return to DSS By: 06/16/2025

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☒ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

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

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