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 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 and the Buncombe County Department of Social Services conducted a follow-up survey and complaint investigation on 09/03/25-09/04/25. The complaint investigations were initiated by the Buncombe County Department of Social Services on 08/12/25 and 08/15/25.	D 000		
D 086	10A NCAC 13F .0306 (a)(12) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (12) have at least one telephone that does not require electricity or cellular service to operate. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to ensure the availability of at least one telephone which did not require electricity or cellular service, resulting in all residents in the facility being unable to make telephone calls. Interview with a resident on 09/03/25 at 9:45am and on 09/04/2025 at 9:30am revealed: -She was unable to contact her guardian due to the facility telephone not working. -She was unable to contact her family or receive telephone calls because the facility telephone was not working. -She preferred to call her family member at least once daily. -She was upset when she could not make	D 086		

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telephone calls.
-The phone in the facility had not been working for a few months.

Interview with the resident's family member on 09/04/2025 at 10:00am revealed:
-She informed the administrator on multiple occasions of the facility telephone not working.
-She thought the telephone was had not worked for the past few months.
-The facility telephone was her only way to contact her family member.
-She was frustrated when the telephone did not work as she never received a call back from the facility staff when she called the office.

Interview with another resident on 09/04/25 at 9:50am revealed:
-She could not make telephone calls at the facility because the telephone was broken.
-She believed the telephone was broken for at least a month.
-The only residents who made calls had their own cellular telephone.

Interview with a third resident on 09/04/25 at 9:55am revealed:
-The telephone had not worked for "well over a month".
-She did not have a cellular telephone.
-She informed the administrator of the telephone being broken a few weeks ago.

Interview with a personal care aide (PCA) on 09/04/25 at 10:15am revealed:
-She knew the telephone was not working.
-She was informed by the residents of the issue with the telephone but could not recall the date.

Interview with the Administrator on 09/04/25 at

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D 086	Continued From page 2 4:30pm revealed: -She was made aware of the telephone not working on 8/12/25 and informed the facility owner of the issue. -The facility owner usually arranged the repairs to the telephone services. -She believed the issue was fixed on 8/13/25, as she had been informed a service technician was sent to the facility to work on the telephone. -She was not aware the telephone was not currently working.	D 086		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to incorrect dosages of a sliding scale insulin (SSI) administered and administering scheduled insulin when there was an order to hold when the fingerstick blood sugar (FSBS) value was less than 200. The findings are:	D 358		

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Review of the facility's undated Medication Administration Policy revealed:
-Medications will be administered in accordance with the prescribing practitioner's orders.
-Documentation will be provided for each dose of medication by the staff that prepares the medications for administration.
-Staff that administer medications and perform treatments to the residents on the facility medication administration record will provide documentation.
-In the event of medication errors and adverse reactions to medications, facility staff will notify a physician or appropriate health professional and their immediate supervisor.
-Staff will document any orders received by the physician or health professional and actions taken by the facility to comply with the order.

Review of Resident #1's current FL2 dated 08/01/25 revealed:
-Diagnoses included diabetes mellitus type 2.
-There was an order for fingerstick blood sugars (FSBS) three times a day before meals and notify the primary care provider (PCP) if the FSBS was less than 70 or greater than 350.

Review of Resident #1's Resident Register revealed an admission date of 07/31/25.

a. Review of Resident #1's physician's orders dated 08/08/25 revealed there was an order for lispro (a rapid acting insulin used to control blood sugar levels) 100u/ml three times daily with meals if the FSBS value was 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, and if the FSBS value was greater than 350, call the PCP.

Review of Resident #1's record revealed there

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was no documentation the facility contacted Resident #1's PCP regarding FSBS values greater than 350 or additional orders for lispro SSI amounts to be administered.

Review of undated facility staff group chat messages at 4:24pm from the Administrator to Resident #1's PCP revealed Resident #1's FSBS was 452 and Resident #1's PCP responded to administer 12u SSI and to recheck the FSBS in 2 hours.

Review of Resident #1's physician's orders revealed there was no order to administer 12u SSI and to recheck a FSBS in 2 hours.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for lispro 100u/ml three times a day at 7:30am, 11:30am, and 4:30pm per sliding scale: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, and call the PCP if the blood sugar was greater than 350.
-There was documentation lispro SSI was administered incorrectly 12 out of 64 opportunities.
-There was documentation FSBS values were documented as greater than 350 on 08/15/25, 08/29/25, and 08/30/25 at 11:30am, 08/09/25 and 08/27/25 at 4:30pm, and 8u SSI were administered with no documentation the PCP was notified, or orders were obtained to administer 8u of SSI.
-There was documentation the FSBS value on 08/10/25 at 4:30pm was 355 and 5u SSI were administered with no documentation the PCP was notified, or orders were obtained to administer the 5u of SSI.
-There was documentation the FSBS value on

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D 358	Continued From page 5 08/29/25 at 4:30pm was 384 and 6u SSI were administered with no documentation the PCP was notified, or orders were obtained to administer the 6u of SSI. -There was documentation the FSBS value on 08/30/25 at 4:30pm was 392 and 0 units SSI were administered with no documentation the PCP was notified. -There was documentation on 08/10/25 at 7:30am the FSBS value was documented as "high" and 5u of SSI were administered with no documentation of any orders obtained to administer the 5u SSI. -There was documentation FSBS values were not checked on 08/20/25 at 7:30am and 11:30am, 08/22/25 at 4:30pm, and 08/28/25 at 11:30am with the documented reason being "resident unavailable" and on 08/26/25 at 4:30pm with the documented reason being "due to condition". Review of Resident #1's September 2025 eMAR revealed: -There was an entry for lispro 100u/ml three times a day at 7:30am, 11:30am, and 4:30pm per sliding scale: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, and call the PCP if the blood sugar was greater than 350. -There was documentation lispro SSI was administered incorrectly 2 out of 8 opportunities from 09/01/25-09/02/25 at 7:30am, 11:30am, and 4:30pm and 09/03/25 at 7:30am and 11:30am. -There was documentation the FSBS value was 370 on 09/02/25 at 11:30am and 8u SSI were administered with no documentation the PCP was notified, or orders were obtained to administer 8u of SSI. Review of Resident #1's Incident and Accident Report dated 08/29/25 at 9:00pm revealed Resident #1 was transported to the local	D 358		

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emergency room (ER) because Resident #1's blood sugar level was "high" and the PCP "said to send her".

Review of Resident #1's local ER discharge instructions dated 08/30/25 at 1:19am revealed:
-The reason for visit was documented as hyperglycemia (elevated blood sugar level).
-Resident #1's serum glucose lab result was 369.
-Resident #1 was instructed to follow-up with her PCP within one day and discharged back to the facility.

Interview with a medication aide (MA) on 09/04/25 at 10:03am revealed:
-She administered SSI to Resident #1 on 08/11/25 at 11:30am for a FSBS value of 281 and documented 8u but thought she made a "typo error" when she documented the dosage.
-On 08/30/25 at 11:30am, Resident #1's FSBS value was 352 and she administered 8u SSI because it was the maximum dosage on the SSI scale.
-She documented zero units were administered to Resident #1 on 08/30/25 at 4:30pm for a FSBS reading value of 392 because the SSI scale said to call Resident #1's PCP.
-She thought she notified one of the Resident Care Coordinators (RCCs) or the Administrator in a group chat message of the FSBS values greater than 350.
-She did not know if the PCP ordered SSI to be administered on 08/30/25 at 4:30pm after she did not administer any SSI to Resident #1 for a FSBS value of 392.

Interview with a second MA on 09/04/25 at 11:50am revealed:
-She was new to the position of working as an MA and Resident #1's eMAR "confused" her.

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D 358	Continued From page 7 -Resident #1 had several different orders for insulin because some insulin was scheduled and Resident #1 also had SSI ordered. -She thought she administered 5u SSI to Resident #1 on 08/10/25 at 4:30pm when the FSBS value was 355 because she administered the scheduled dose of lispro instead of using the sliding scale. -On 08/29/25 at 4:30pm, Resident #1's FSBS value was 384 and she notified a MA supervisor who told her to administer the maximum dosage of SSI per the SSI scale. -She was not supposed to notify Resident #1's PCP of FSBS values greater than 350 because only the supervisors or Administrator were allowed to contact the PCP. -She assumed the MA supervisor contacted the PCP or informed the Administrator and the Administrator notified the PCP to see if other orders were needed for Resident #1. -She did not know why she documented 6u SSI were administered to Resident #1 on 08/29/25 at 4:30pm and thought she may have hit the wrong number when she entered the amount on the eMAR. Interview with a RCC on 09/04/25 at 9:40am revealed: -All the physician's orders for Resident #1 were kept in her record. -When Resident #1's FSBS value was greater than 350, the MAs were supposed to notify her, the other RCC, or the Administrator and they were responsible to notify Resident #1's PCP. -When Resident #1's PCP ordered additional units of SSI, her, the other RCC or Administrator relayed to the MAs what dosage to administer. -The SSI dosages ordered by the group chat messages were not documented on a physician's order sheet and signed by the PCP.	D 358		

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D 358	Continued From page 8 -She was not instructed by the Administrator to perform MAR audits for the residents to make sure medications were being administered as ordered. Refer to the telephone interview with Resident #1's PCP on 09/04/25 at 12:14pm. Refer to the interview with the Administrator on 09/04/25 at 2:52pm. b. Review of Resident #1's physician's order dated 08/01/25 revealed there was an order for lispro (a fast-acting insulin used to control elevated blood sugar levels) 100u/ml inject 5 units (u) three times a day and hold if the blood sugar value was less than 200. Review of Resident #1's physician's order dated 08/15/25 revealed there was an order to increase lispro 100u/ml to 7u three times a day and hold if the blood sugar value was less than 200. Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lispro inject 5 units three times a day before meals and hold for blood sugar values less than 200 with a start date of 07/31/25 and a discontinue date of 08/15/25. -On 08/06/25 at 7:00am, there was documentation 5u were administered with a FSBS value documented as "low". -There was an entry for lispro inject 7u three times a day before meals and hold for blood sugar values less than 200 with a start date of 08/15/25 and no end date provided. -On 08/21/25 at 4:30pm, there was documentation 7u were administered with a FSBS value of 162.	D 358		

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D 358	Continued From page 9 Review of Resident #1's September 2025 eMAR revealed: -There was an entry for lispro inject 7u three times a day before meals and hold for blood sugar values less than 200. -On 09/02/25 at 4:30pm, there was documentation 7u were administered with a FSBS value of 191. -On 09/03/25 at 7:00am, there was documentation 7u were administered with a FSBS value of 191. Interview with a medication aide (MA) on 09/04/25 at 10:03am revealed: -Resident #1's FSBS values usually were elevated and not below 200. -She thought she held Resident #1's scheduled 7u lispro on 08/21/25 at 4:30pm when the FSBS value was 162 and she accidentally signed the eMAR as administered. -She did not document anywhere else when she held Resident #1's scheduled insulin when the FSBS value was less than 200. -She thought the 2 Resident Care Coordinators (RCCs) were responsible for checking the eMARs for accuracy. Interview with a RCC on 09/04/25 at 9:40am revealed: -Resident #1 had orders for scheduled lispro insulin to be administered three times a day and hold if the FSBS value was less than 200. -She was not aware that some MAs administered the scheduled insulin when the FSBS value was less than 200. -She was not instructed by the Administrator to perform MAR audits for the residents to make sure medications were being administered or held as ordered.	D 358		

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D 358	Continued From page 10 Refer to the telephone interview with Resident #1's PCP on 09/04/25 at 12:14pm. Refer to the interview with the Administrator on 09/04/25 at 2:52pm. _____ Interview with Resident #1's PCP on 09/04/25 at 12:14pm revealed: -He recently accepted Resident #1 as a new patient when she was moved from another facility at the beginning of August 2025. -He thought the facility staff notified him each time Resident #1's blood sugar value was greater than 350 but was not certain. -He knew he was notified at least a "couple of times" by a group chat message with the Administrator of Resident #1's blood sugar value being high. -He did not remember if he was notified that Resident #1 was administered 6u SSI on 08/29/25 at 4:30pm instead of the ordered 8u per the SSI scale. -If Resident #1 received too little of a dosage of insulin at 4:30pm on 08/29/25, it could have contributed to Resident #1's elevated blood sugar level. -He was notified by the Administrator around 7:30pm on 08/29/25 that Resident #1's blood sugar level was high after the evening dosages of insulin were administered so he instructed the Administrator to send Resident #1 to the local ER for an evaluation. -He did not know if he was notified by the facility staff each time Resident #1 was administered too little or too much insulin on multiple occasions or when the scheduled insulin should have been held when the blood sugar value was less than 200 and it was administered instead. -If Resident #1 received too little insulin it could	D 358		

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cause elevated blood sugar levels which could result in dehydration, infection, neuropathy, stroke, and/or heart attack.
-If Resident #1 received too much insulin it could cause the blood sugar level to run low which could result in dizziness, lightheadedness, or falls.
-He expected staff to notify the Administrator if Resident #1 received incorrect insulin doses or if the blood sugar values were greater than 350 so the Administrator could notify him.

Interview with the Administrator on 09/04/25 at 2:52pm revealed:
-She was not aware Resident #1 was administered incorrect dosages of insulin when comparing the blood sugar values to the sliding scale or administered scheduled insulin when there was an order to hold if the blood sugar value was less than 200.
-MAs were responsible for notifying her or the RCCs of any medication administration errors or if Resident #1's blood sugar value was greater than 350 so that they could notify Resident #1's PCP.
-The MAs were not allowed to directly notify the PCP.
-She did not know why some of the MAs administered insulin dosages to Resident #1 without orders from the PCP if the blood sugar value did not correspond to insulin dosages on the sliding scale.
-She did not know how the MAs determined what dosage of insulin to administer to Resident #1 when the blood sugar value was greater than 350 and the order said to notify the PCP, but the PCP was not notified.
-There was no one currently completing eMAR audits to check to make sure Resident #1 was receiving the correct amount of insulin.

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D 358	Continued From page 12 -She and a RCC completed the last eMAR audits in July 2025. -She expected the MAs to administer Resident #1's insulin as ordered or notify her or the RCCs if Resident #1's blood sugar value was greater than 350 so that the PCP could be notified and orders obtained. _____ The facility failed to administer Resident #1's insulin as ordered and administered incorrect dosages of a rapid-acting SSI on multiple occasions between 08/09/25 and 09/03/25, administered multiple dosages of SSI for blood sugar levels greater than 350 on multiple occasions without an order, and administered a scheduled insulin on 4 occasions between 08/06/25 and 09/03/25 when the blood sugar value was less than 200 and had orders to be held, increasing Resident #1's risk of high and/or low blood sugar levels, dehydration, infection, neuropathy, stroke, heart attack, dizziness or lightheadedness, falls, or hospitalization. This failure placed Resident #1 at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/25 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 04, 2025.	D 358		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each	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 09/04/2025

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

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D 433	Continued From page 13 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 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.	D 433		

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D 433	Continued From page 14	D 433		

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

The findings are:

1. Review of Resident #1's current FL2 dated 08/01/25 revealed diagnoses included type 2 diabetes mellitus, peripheral neuropathy, gastroesophageal reflux disease, and anxiety disorder.

Refer to the interview with a personal care aide (PCA) on 09/03/25 at 9:13am.

Refer to the interview with a medication aide (MA) on 09/04/25 at 10:03am.

Refer to the interview with the Supervisor on 09/03/25 at 9:36am.

Refer to the interview with the Administrator on 09/04/25 at 2:52pm.

2. Review of Resident #2's current FL2 dated 07/01/25 revealed diagnoses included seizures, convulsions, abdominal pain and intellectual and developmental disability.

Refer to the interview with a personal care aide (PCA) on 09/03/25 at 9:13am.

Refer to the interview with a medication aide (MA) on 09/04/25 at 10:03am.

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D 433	Continued From page 15 Refer to the interview with the Supervisor on 09/03/25 at 9:36am. Refer to the interview with the Administrator on 09/04/25 at 2:52pm. 3. Review of Resident #3's current FL2 dated 05/05/25 revealed diagnoses included schizophrenia, medication non-adherence, type 2 diabetes mellitus, gastroesophageal reflux disease, chronic kidney disease, possible intellectual and developmental disability, and Metabolic Dysfunction-Associated Steatohepatitis (MASH) (a form of liver disease). Refer to the interview with a personal care aide (PCA) on 09/03/25 at 9:13am. Refer to the interview with a medication aide (MA) on 09/04/25 at 10:03am. Refer to the interview with the Supervisor on 09/03/25 at 9:36am. Refer to the interview with the Administrator on 09/04/25 at 2:52pm. 4. Review of Resident #4's FL2 dated 06/24/25 revealed diagnosis included schizoaffective disorder-bipolar type and post traumatic stress disorder. Refer to the interview with a personal care aide (PCA) on 09/03/25 at 9:13am. Refer to the interview with a medication aide (MA) on 09/04/25 at 10:03am. Refer to the interview with the Supervisor on 09/03/25 at 9:36am.	D 433		

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D 433	Continued From page 16 Refer to the interview with the Administrator on 09/04/25 at 2:52pm. Interview with a PCA on 09/03/25 at 9:13am revealed: -The resident records were not kept in the facility. -She was the only staff working in the facility and would have to ask the Supervisor to bring the resident records to her from the business office located in a different building on the property. Interview with a MA on 09/04/25 at 10:03am revealed: -She administered the residents' medications at the facility and at other sister facilities on the property. -The residents' records were not kept in the facility and were located in the business office which was in a different building on the property. -In the event of an emergency, she would contact the Supervisor via telephone or group chat message and have her check the resident record for any information needed from the chart such as code status or contact telephone numbers. Interview with the Supervisor on 09/03/25 at 9:36am revealed: -All resident records were kept in the business office located in another building. -If a MA needed a resident record during the day, she would take the record to the facility. -She was instructed by the Administrator that all resident records were to remain in the business office. Interview with the Administrator on 09/04/25 at 2:52pm revealed: -She was told by the Owner that when the resident records were previously kept in the	D 433		

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D 433	Continued From page 17 facility that parts of the records went missing including FL2's, Do Not Resuscitate orders, Care Plans, and new prescriptions. -She did not allow resident records to be stored in the facility and kept them in the business office. -She was currently in the process of scanning some of the resident records into the computer system because all the records would eventually be electronic. -She started scanning some of the residents' records in June 2025, but encountered some issues and the process was taking longer than expected. -None of the 9 resident records were completely scanned in and available to access by staff electronically. -Staff knew what care assistance each resident needed because there was a work logbook stored in each facility that included what day each resident showered, the schedule of room cleaning, and the laundry schedule. -In the event of an emergency outside of office hours, staff would have to notify her or one of the two Supervisors, and they would notify the primary care provider (PCP) of any issues. -Staff knew who to telephone in case of an emergency because she listed who would be on-call that evening on the daily assignment sheet.	D 433		