STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011373	A. BUILDING: _____ B. WING _____	R-C 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 03/03/26-03/06/26. The complaint investigation was initiated by the Buncombe County Department of Social Services on 02/18/26.	D 000		
D 077	10A NCAC 13F .0306 (a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a sanitation report in accordance with one of the following: (A) a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times in facilities with 12 beds or less, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which are incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm; and (B) a North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation scores of 85 or above at all times in facilities with 13 beds or more. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions", 15A NCAC 18A .1300, can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 077		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to maintain an approved sanitation classification at all times in facilities with 12 beds or less from the North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), Environmental Health Section related to a disapproved score with 40 demerits on 02/03/26.

The findings are:

Review of the facility's license effective January 1, 2026, the facility had a licensed capacity of 12 residents.

Review of the facility's NCDHHS DPH Environmental Health Section Inspection of Residential Care Facilities report dated 02/03/26 revealed:
-The classification was disapproved with a total of 40 demerits.
-There was a 4-demerit deduction for beds, linen, laundry, furniture related to no bed linen on a mattress on one resident bed.
-There was a 2-demerit deduction for physical facilities walls, ceilings, and attachments clean related to observed food debris at ceiling of kitchen, all and ceiling attachments such as light fixtures, fans, and vent covers shall be kept clean.
-There was a current bed bug issue in the facility with pest control having visited the facility to try to

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resolve issue.
-There was observed deterioration of an outdoor porch floorboard located right outside of side entry door if stepped on it may result in injury.
-The Environment Health Section would complete an unannounced reinspection of the facility within 30 days at the request of the Administrator.

Interview with a resident during the initial tour on 03/03/26 at 9:04am revealed:
-The facility had bed bugs.
-There were bed bugs in the overhead lighting fixture that was hanging down from the ceiling of his room.
-The Maintenance Director had been treating bed bugs in a sister facility and once he had completed that facility he would start treating the bed bugs in this facility.

Observation of the same residents room during the initial tour on 03/03/26 at 9:04am revealed:
-There was a dead bed bug on the mattress at the bottom of the resident's bed.
-The bed did not have a bottom sheet, top sheet, blanket, or bedspread.
-The mattress was heavily soiled with gray residue, brown stains, and three small purple stains identified by the resident as jelly stains.

Interview with a second resident during the initial tour on 03/03/26 at 9:05am revealed:
-She had bed bugs in her room.
-She thought she was bitten on her left arm by a bed bug last night.

Interview with a third resident during the initial tour on 03/03/26 at 9:16am revealed:
-She had bed bugs in her room that crawled on her and bit her.
-She could not sleep at night because of the bed

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D 077	Continued From page 3	D 077		

bugs biting her.
-The Maintenance Director started spraying for bed bugs in a sister facility but not in the facility where she resided.
-The facility staff had not treated the facility for bed bugs.

Observation of a third resident's room during the initial tour on 03/03/26 at 9:16am revealed:
-The resident was lying in bed.
-There was one live bed bug crawling on the wall near the television.
-There were 2 bed bugs seen crawling on the curtains.
-There was one bed bug crawling on her pillow near her head.
-There was one bed bug crawling on her shirt on her abdomen.

Interview with a fourth resident during the initial tour on 03/03/26 at 9:25am revealed:
-There were bed bugs in his room.
-The spots on the wall above and beside his bed were where he would "smush" bed bugs to kill them.
-He was getting bed bug bites on his arms and feet.

Observation in the fourth resident's room on 03/03/26 at 9:33am revealed:
-There were bed bug droppings at the head of the bed on the mattress cover.
-The bottom sheet was heavily stained with large brown stains.
-There were numerous areas of small circular black stains of various sizes on the bottom sheet.
-There were no pillowcases on the pillows on the bed.

Interview with a fifth resident during the initial tour

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on 03/03/26 at 10:00am revealed:
-His arms itched from the bed bug bites.
-The Maintenance Director sprayed the facility for the bed bugs for "awhile now," but it was not working.
-He was "tired" of the bed bugs biting him and wanted the facility to get rid of them.

Observation of the fifth resident during the initial tour on 03/03/26 at 10:00am revealed:
-The resident was sitting on the side of his bed and scratching both of his arms.
-Both arms had scratch marks with dried blood visible.

Observation of the fifth resident's room during the initial tour on 03/03/26 at 10:00am revealed there were no sheets on the bed and the mattress was discolored with brownish/black residue.

Observation in a sixth resident's room on 03/03/26 at 10:26am revealed:
-The bed did not have a bottom sheet, top sheet, blanket, pillow or bedspread.
-The entire mattress was soiled and discolored grey.
-There was as area approximately 2-foot long by 2-foot wide in the center of the mattress with brown stains.

Observation of the wall in the main hallway between rooms #2 and #3 on 03/03/26 at 10:21am revealed there was a bed bug crawling on the wall.

Observation of the door jamb at the entrance of room #2 on 03/03/26 at 10:32am revealed there was a bed bug crawling on the door jam.

Observation of the wall in the hallway outside

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D 077	Continued From page 5 room #7 on 03/03/26 at 10:35am revealed there was a bed bug crawling on the wall. Observation of the storage room on 03/03/26 at 10:37am revealed there were 7 bed bug carcasses lying on the floor in front of the window. Observation of the side entry outdoor porch on 03/03/26 at 12:30pm revealed: -The paint was chipping from the floorboards. -There was deterioration of five floorboards located under a small table on the porch. Telephone interview with the local Environmental Health Inspector on 03/05/26 at 9:21am revealed: -She conducted the Environmental Health Inspection of the facility on 02/03/26. -The facility received a disapproved classification with 40 demerits. -The facility staff had been instructed to notify her when they had corrected the areas identified on the inspection on 02/03/26. -She would return within 7 days of being notified they were ready for a reinspection. -She was still waiting to hear from facility staff they were ready for her to return. Interview with the Maintenance Director on 03/05/26 at 3:54pm revealed: -He was aware the facility received a disapproved sanitation inspection on 02/03/26. -He was responsible for repairing the items identified on the disapproved sanitation inspection. -He had corrected some of the items identified on the disapproved sanitation inspection. -He had not yet corrected all of the items, but would be completing them once he finished bed bug treatment in the facility.	D 077		

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D 077	Continued From page 6 Interview with the Administrator on 03/05/26 at 10:06am revealed: -The Maintenance Director was responsible for making repairs to address deductions made on the disapproved sanitation inspection from 02/03/26. -The Maintenance Director had been working on making the repairs. -She thought they were about ready for a reinspection. [Refer to tag 0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings Type A1 Violation] [Refer to tag 0087 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings Type B Violation] [Refer to tag 0105 10A NCAC 13F .0311(a) Other Requirements Type B Violation] _____ The facility failed to address demerit deductions on the facility's Environmental Health Inspection dated 02/03/26 including a bed bug infestation, an exterior porch with five deteriorating floorboards, three resident mattresses which were dirty, and three resident beds which did not have bed linens which resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 5, 2026.	D 077		

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D 079	Continued From page 7	D 079		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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: TYPE A1 VIOLATION. Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was clean and free from hazards related to bed bug infestation and unsecured oxygen tanks. The findings are: 1. Review of the facility's North Carolina Department of Health and Human Services (NCDHHS) Division of Public Health Environmental Health Section Inspection of Residential Care Facilities report dated 02/03/26 revealed there was a current bed bug issue in the facility with pest control having visited the facility to try to resolve the issue.	D 079		

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D 079	Continued From page 8 Interview with a resident during the initial tour on 03/03/26 at 9:04am revealed: -The facility had bed bugs. -There were bed bugs in the overhead lighting fixture that was hanging down from the ceiling of his room. -He did not think his room had any live bed bugs. -His room was sprayed "a couple months ago." -His mattress had been changed out when the room was sprayed. -There was a bed bug "nest" in his mattress prior to it being changed out and sprayed. -He used to see bed bugs every day. -He would crush the bed bugs. -The bed bugs would bite his arms. -A personal care aide (PCA) had helped him clean his room "last week." -The PCA sprayed his room last week. -He did not know what type of spray the PCA used to spray his room. -He had not seen any bed bugs in his room since then. -He had not seen any bed bugs on him recently. -He was not getting bitten by bed bugs. -The Maintenance Director told him he was going to take his belongings out of his room and heat treat them so they could get rid of the bed bug problem permanently. -The Maintenance Director had been treating bed bugs in a sister facility and once he had completed that facility he would start treating the bed bugs in this facility. Observation of the same resident's room during the initial tour on 03/03/26 at 9:20am revealed there was a dead bed bug on the mattress at the bottom of the resident's bed. Interview with a second resident during the initial tour on 03/03/26 at 9:05am revealed:	D 079		

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-The facility had a problem with bed bugs that got "bad" about a month ago.
-She had bed bugs in her room.
-She thought she was bitten on her left arm by a bed bug last night.
-She used to get bitten all the time, but she was not bitten as much now since her family member bought her a mattress cover for her bed.
-The facility staff started spraying to treat the bed bugs and purchased a heated tent.
-There was a man from a local pest control company that came to the facility to see about treating for bed bugs, but staff told her it was going to cost too much so the facility staff would treat it themselves.
-The facility staff treated the bed bug infestation themselves about a year ago.

Interview with a third resident during the initial tour on 03/03/26 at 9:16am revealed:
-She had bed bugs in her room that crawled on her and bit her.
-She rubbed hand sanitizer over the bites and on the bed bugs and the bed bugs would run away and disappear.
-She could not sleep at night because of the bed bugs biting her.
-She told several staff she was being bitten by bed bugs.
-The Maintenance Director started spraying for bed bugs in a sister facility but not in the facility where she resided.
-The facility staff had not treated the facility for bed bugs.

Observation of the third resident's room during the initial tour on 03/03/26 at 9:16am revealed:
-The resident was lying in bed.
-There was one live bed bug crawling on the wall near the television.

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D 079	Continued From page 10 -There were 2 bed bugs crawling on the curtains. -There was one bed bug crawling on her pillow near her head. -There was one bed bug crawling on her shirt on her abdomen. Interview with a fourth resident during the initial tour on 03/03/26 at 9:25am revealed: -There were bed bugs in his room. -The spots on the wall above and beside his bed were where he would "smush" bed bugs to kill them. -He was getting bed bug bites on his arms and feet. Observation of the fourth resident's room during the initial tour on 03/03/26 at 9:33am revealed: -There were nine thin brown smears on the wall beside the bed. -There were two thin brown smears on the wall at the head of the bed. -There were bed bug droppings at the head of the bed on the mattress cover. Observation of the fourth resident's left forearm and feet on 03/03/26 at 9:35am revealed: -There were two reddened areas on the residents left forearm. -One of the reddened areas had an area of scabbing. -There were areas of redness too numerous to count on the top of the residents right foot. Interview with a fifth resident during the initial tour on 03/03/26 at 9:41am revealed: -He had a lot of bed bugs in his room now. -The bed bugs were biting him all over his body. -He had bites on his hands, backs of his arms and legs, and on his back and feet. -On 02/28/26, a female staff member came into	D 079		

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his room.
-She had him go through his room and they got rid of items he did not need.
-The staff member swept and mopped his room.
-The staff member sprayed his room.
-The staff member did not do anything to his bed.

Interview with a sixth resident during the initial tour on 03/03/26 at 10:00am revealed:
-His arms itched from the bed bug bites.
-The Maintenance Director sprayed the facility for the bed bugs for "awhile now", but it was not working.
-He was "tired" of the bed bugs biting him and wanted the facility to get rid of them.

Observation of the sixth resident during the initial tour on 03/03/26 at 10:00am revealed:
-The resident was sitting on the side of his bed and scratching both of his arms.
-Both arms had scratch marks with dried blood visible.

Interview with a seventh resident during the initial tour on 03/03/26 at 10:01am revealed:
-A local pest control company sprayed her room and the bed bugs started running around.
-The bed bugs were not bad in her room until the pest control company sprayed her room.
-The pest control company found a few bed bugs in her mattress.
-She had bed bug bites on her arms and the bites itched.
-Her physician gave her some cream to put on the bites to help with the itching.

Interview with an eighth resident during the initial tour on 03/03/26 at 10:09am revealed:
-He had a "bunch" of bed bugs in his room.
-He "squished" a bunch of them.

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D 079	Continued From page 12 -The Maintenance Director sprayed in his room a couple of days ago. -The bed bugs kept him awake at night because they bit him. -The facility was not doing anything else to get rid of the bed bugs except spraying. Interview with a ninth resident during the initial tour on 03/03/26 at 10:15am revealed: -He saw bed bugs running along the walls in his room. -He killed bed bugs in his room. -The Maintenance Director was in the process of getting the bed bug issue taken care of. Observation in the ninth resident's room on 03/03/26 at 10:26am revealed there was black debris in the seams of the resident's mattress and bedsprings. Interview with a tenth resident during the initial tour on 03/03/26 at 10:31am revealed: -The Maintenance Director was supposed to come spray the facility for bed bugs. -The Maintenance Director had been "putting it off." -The Maintenance Director had been treating bed bugs in a sister facility for three weeks. -The Maintenance Director was supposed to come to the facility and do a bed bug treatment as soon as he finished treating the sister facility. Interview with an eleventh resident on 03/06/26 at 9:30am revealed: -He was bitten by bed bugs when he sat on the couch in the living room to watch television a couple months ago. -He would no longer sit in the living room to watch television because he did not want to be bitten anymore.	D 079		

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D 079	Continued From page 13 -The bed bug infestation had been a problem for the past year. -They started heat treating the furniture and residents' belongings yesterday (03/05/26) but when they brought back in one resident's box of belongings, he saw bed bugs still crawling around in it after the heat treatment in the tent was completed. -Staff took the box back outside to the tent to treat it again. -The facility treated bed bugs three times in the past year by two different pest control companies. -A person from a new pest control company came out and said he could treat and get rid of the bed bugs. Observation of the wall in the main hallway between rooms #2 and #3 on 03/03/26 at 10:21am revealed there was a bed bug crawling on the wall. Observation of the door jamb at the entrance of room #2 on 03/03/26 at 10:32am revealed there was a bed bug crawling on the door jam. Observation of the wall in the hallway outside room #7 on 03/03/26 at 10:35am revealed there was a bed bug crawling on the wall. Observation of the storage room on 03/03/26 at 10:37am revealed there were 7 bed bug carcasses lying on the floor in front of the window. Observation of a spray container in the kitchen in the floor by the door on 03/03/26 at 10:38am revealed there was a clear liquid in the container identified by the personal care aide (PCA) as rubbing alcohol.	D 079		

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D 079	Continued From page 14 Observation on the front porch of the facility on 03/04/26 at 4:01pm revealed: -There were two PCAs standing on the porch and one PCA asked the other to scratch her back because it itched. -The PCA said she just found a bed bug crawling on her chest and she did not realize how small they were. Interview with a PCA on 03/03/26 at 9:45am and 10:24am revealed: -She previously worked at the facility but quit in December 2025 because she found three bed bugs crawling on her and she was being bitten by bed bugs. -She started working at the facility again in February 2026. -The facility was not treated for bed bugs before she quit in December 2025. -She knew there were still bed bugs in the facility. -She killed two bed bugs in the kitchen this morning. -Management had not instructed her to do anything regarding treating the bed bugs. -She had alcohol in a spray container in the kitchen and sprayed the baseboards in resident rooms when she had time. -A local pest control company came to the facility to give an estimate for treating the bed bug infestation, but she learned from other staff that the Owner did not want to pay the amount it would cost to have the facility professionally treated. -The Maintenance Director purchased bed bug spray from a local store to treat the bed bugs in a sister facility and a heat tent to treat residents' belongings. -Many of the residents complained about being bitten and one resident was getting "ate up" by bed bug bites.	D 079		

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D 079	Continued From page 15 A second interview with the same PCA on 03/03/26 at 2:15pm revealed: -The Maintenance Director sprayed the living room and dining room with spray to kill bed bugs. -The Maintenance Director told her and the residents to stay out of the area for at least 15-30 minutes. -The Maintenance Director had not treated the resident rooms for bed bugs in the facility. Interview with a second PCA on 03/04/26 at 10:00am revealed: -She worked for the facility since July 2025. -The facility had a bed bug infestation since she started working there in July 2025. -The facility had not been treating consistently for the bed bugs. -A couple of pest control companies treated the facility a "long time ago" but there had not been any treatments completed this year. Interview with the Maintenance Director on 03/03/26 at 11:38am revealed: -The facility had a bed bug infestation that started about 9 months ago. -The Owner recently bought a tent to heat treat all the residents' belongings, mattresses, and furniture for bed bugs. -He was heat treating furniture and residents' belongings at a sister facility and had not started treating at this facility yet. -When the environmental inspection was being done at the facility, the inspector saw a container of bed bug spray purchased at a local store and said it would not treat the bed bug infestation. -He bought an all-in-one disinfectant spray and insecticide online that was recommended by the inspector and sprayed the inside the facility on	D 079		

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2/26/26, 02/28/26, and 03/02/26.
-Two different pest control companies treated the facility for bed bugs about 4 months ago and 9 months ago and neither company treated the facility effectively.
-There had not been any treatments completed by a professional pest control company in the past 4 months.
-The residents' furniture and belongings treated in the heat tent would need to be treated at 120 degrees or higher for the first hour until there was no sign of life and if bed bug life remained the belongings would need to be retreated.

Interview with a medication aide (MA) on 03/05/26 at 4:25pm revealed:
-The facility had a bed bug infestation.
-She knew some of the residents were being bitten by bed bugs.
-None of the residents complained of being bitten by bed bugs except one resident who had orders for a cream to treat bed bug bites.

Telephone interview with a third shift MA on 03/06/26 at 9:05am revealed she administered medications to the residents in the facility third shift on 03/05/26 and she saw bed bugs in some of the residents' rooms.

Observation in the hallway between rooms 3 and 4 on 03/06/26 at 9:39am revealed there was a gallon sized over-the-counter spray bottle labeled "bed bug killer with egg kill" setting on the floor.

Interview with a PCA on 03/06/26 at 9:42am revealed:
-He knew the facility had bed bugs for "awhile now".
-He never found any bed bugs crawling on him because he did not ever sit down on the furniture

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in the facility.
-He had not seen a pest control company in the past couple of months.
-There was a gallon jug of bed bug killer in the building, but he did not feel comfortable spraying the chemicals because he had never been trained to use it.
-He did not want to spray the bed bug killer incorrectly and make the residents sick.
-A resident complained to him about 2 months ago they were being bitten by bed bugs and he reported it to the Administrator.

Review of the facility's receipts for local pest control service revealed the facility was treated for bed bugs on 10/14/24, 04/10/25, and 08/27/25.

Telephone interview with the local Environmental Health Inspector on 03/05/26 at 9:21am revealed:
-She conducted the Environmental Health Inspection of the facility on 02/03/26.
-The facility had a current bed bug issue during the inspection on 02/03/26.
-On 02/03/26, the Administrator told her the facility had a contract with a local pest control company for treatment of bed bugs.
-The Administrator told her they were getting new beds, furniture, and clothes for the residents.
-The Administrator told her the local pest control company would be coming in on an ongoing basis to ensure the bed bug treatment was effective.

Review of an email between a Field Inspector from a local pest control company and the Administrator revealed:
-On 02/25/26 at 12:25pm, the Field Inspector sent an email to the Administrator asking for the Administrator to call him with a method of

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payment for the pest control contract as agreed upon.
-On 02/26/26 at 2:58pm, the Administrator replied to the Field Inspector that the treatment plan kept changing and the Administrator made an "executive decision" to postpone the scheduled treatment because the prep work was not completed.
-The Administrator was informed by the Maintenance Director and Owner that some type of heating treatment was going to be completed by the facility staff.

Telephone interview with the Field Inspector from a local pest control company on 03/06/26 at 8:12am revealed:
-They had a contract with the facility to treat the facility for bed bugs in late February 2026.
-They were about to come out to start treatment and the facility called and cancelled the contract.
-The facility planned to self-treat the bed bugs by moving everything out into a tent to heat treat instead of having the pest control company treating the facility.
-Heat treating the contents of the rooms would do nothing for the inside of the rooms of the facility.
-The facility was going to spray a "disinfectant" inside the rooms and behind outlets and it was not going to kill bed bugs.
-The bed bug infestation in the facility was "extreme."
-The bugs were in every room and in every bed.
-Proper heat treating to kill bed bugs required heating the entire building to 140 degrees.

Interview with the Maintenance Director on 03/05/26 at 3:54pm revealed:
-He was working on bed bug treatment in room #8.
-Resident rooms #9, #10, #11, and #12 remained

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to be treated.
-A local pest control company was paid $8,000 over three months and the bed bug infestation got worse.
-He spoke with a supervisor with the local pest control company about the continued infestation after their failure to treat after three months.
-The pest control Supervisor "pulled him aside" and told him to cancel the contract with them and buy a bed bug killing product that was safer for the residents.
-The pest control Supervisor told him the recommended bed bug product was safe to spray on mattresses.
-The product the pest control company used required the residents to stay out of treated areas for at least four hours and had a long list of side effects.
-The disadvantage of using the bed bug product recommended was you had to continue to spray areas down every 48 hours until the signs of bed bugs were clear.
-The next step was to set up glue traps.
-To treat each room they were removing the contents of the room to the heat tent, deep cleaning the room, then spraying it down with the bed bug killing spray including inside the electrical outlets and light switch boxes.
-The product was safe once dry for the residents and was non-flammable when dry.
-He then encased the resident mattress in 6 mm plastic and secured with tape the bed bugs could not get through.
-Then everything went back into the room.
-He looked for signs of bed bugs in the treated rooms every other night and spray the bed bug killing product if signs were present.
-It was easier to see the bed bugs come out at night, so that was when he was going to do his rounds.

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-If the treatment was not successful, they would get a pest control company to come back and treat.

Observation outside the facility in the parking area on 03/06/26 at 9:37am revealed:
-There was an 8 foot long by 4-foot-wide tent set up in the parking lot.
-There were four heating units connected to the four corners of the tent.
-The heating units had a timer which could be set to 1 hour, 4 hours, or 8 hours.

Telephone interview with the Operations Manager of the company who produced the tent and heating units the facility used to treat for bed bugs on 03/06/26 at 12:20pm revealed:
-The tent and heating units were intended to be used to kill bed bugs on items that would fit inside the tent.
-The heating units could produce temperatures inside the tent of 165 degree Fahrenheit (F).
-The heating units were only safe to be used with the tent and were not designed to heat rooms indoors.

Review of the product label of the product the facility used as bed bug treatment revealed:
-The product was a bactericide (a substance that kills bacteria), sanitizer (a substance used to make something clean and hygienic), fungicide (a chemical that destroys fungus), mildewcide (a chemical designed to destroy and prevent the growth of mildew and mold), insecticide (substance used for killing insects), deodorant, germicide (destroys harmful microorganisms), and viricide (a substance that kills viruses).
-Surfaces and objects must be cleaned of gross filth before treatment.
-Spray surfaces and articles until thoroughly

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dampened and allow them to remain wet for at least 10 minutes.
-To kill bedbugs, the infested areas should be sprayed thoroughly and repeatedly, directing the spray into all crevices, cracks, and hiding places, seams, creases, and folds.

Interview with the Administrator on 03/06/26 at 12:23pm revealed:
-Staff found live bed bugs in a resident's belongings after the belongings were heat treated in the tent on 03/05/26.
-The tent was not heating up to the correct temperature to kill the bed bugs yesterday (03/05/26).
-The resident's belongings had to be heat treated a second time on 03/05/26.
-She got a thermometer to use inside the tent to make sure it got hot enough to kill the bed bugs.
-The staff were now making sure the tent heated up to at least 130 degrees and the items were treated for 3 hours.

Observation of the thermometer sitting on top of a dresser inside the heat-treating tent on 03/06/26 at 12:48pm revealed the temperature was 110.3 degrees.

Interview with the Administrator and the Owner on 03/03/26 at 2:30pm revealed:
-Treatment for bed bugs would begin at the facility on 03/04/26.
-They hired three extra staff to help with the bed bug treatment.
-They did not have a contract with a pest control company to treat bed bugs at the facility.
-They were treating the bed bugs with a system the Maintenance Director researched and implemented.
-They removed all furniture and belongings from

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each resident room and placed it in a tent to be treated with 120-degree heat for three hours.
-The rooms were swept, mopped, and sprayed down with a product to kill bed bugs.
-The mattresses were sprayed with a product to kill bed bugs, allowed to dry, and then wrapped with a plastic barrier.

2. Review of the US Occupational Health and Safety Administration's (OSHA) regulations on the storage of compressed gas cylinders dated 05/21/12 revealed:
-Compressed gas cylinders should be secured in an upright position at all times.
-A steadying device should be used to keep cylinders from being knocked over.
-Compressed gas cylinders should not be intentionally dropped, struck, or permitted to strike each other violently.

Observation in the staff room during the initial facility tour on 03/03/26 at 9:55am revealed:
-There were three approximately 3-foot tall, unsecured, empty oxygen tanks sitting upright on the floor on the right side of the room.
-There was a fourth approximately 3-foot tall unsecured, empty oxygen tank sitting on the floor on the left side of the room.

Interview with a personal care aide (PCA) on 03/03/26 at 10:02am revealed:
-She was not aware there were unsecured oxygen tanks in the staff room.
-They did not have a crate in the facility to secure the oxygen tanks.

Interview with another PCA on 03/04/26 at 8:33am revealed:
-She did not know how to store oxygen tanks.
-She had not received any training on oxygen

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tank storage.
-She did not know where to find an unused oxygen stand or crate on property.

Telephone interview with a representative from the durable medical equipment provider on 03/03/26 at 3:09pm revealed:
-The facility was responsible for notifying them when they had empty oxygen tanks that needed to be picked up.
-There was a risk of the oxygen tanks falling over when they were left out of the storage crates.

Interview with the Administrator on 03/04/26 at 10:30am revealed:
-The oxygen tanks that were unsecured in the staff room on 03/03/26 belonged to a resident who had recently moved out.
-She was sure they had contacted the durable medical equipment (DME) provider to pick up the empty tanks.
-She saw the DME provider arrive at the facility.
-She did not know if the DME provider picked up some oxygen tanks but left the ones in the staff room.
-She had requested the DME provider to bring extra oxygen tank crates when they come back out to the facility.

_____

The facility failed to ensure the facility was free of hazards related to an ongoing bed bug infestation. The bed bug infestation was observed in resident rooms, two hallways, and the storage room which included bed bug activity in a resident's room with bed bugs crawling on the resident lying in bed, on her pillow, curtains, and the wall behind the television in the room, in the hallways, and seven bed bug carcasses in the floor of the storage room. Residents were being bitten causing severe itching and loss of sleep.

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D 079	Continued From page 24 This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/26. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 05, 2026.	D 079		
D 087	10A NCAC 13F .0306 (b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) a bed equipped with a box spring and mattress or a bed frame with solid link springs with a foam mattress or a mattress designed to prevent sagging. A hospital bed equipped with all accessories required for use shall be arranged for as needed. A waterbed is allowed if requested by a resident and permitted by the facility. Each bed shall have the following: (A) at least one pillow with clean pillowcase; (B) a clean top and bottom sheet on the bed, with bed changed at least once a week and when soiled; and (C) clean bedspread and other clean coverings as needed. 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:	D 087		

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D 087	Continued From page 25 TYPE A1 VIOLATION Based on observations, interviews, and record review, the facility failed to provide 4 of 11 residents a bed with a clean top and bottom sheet on their bed. The findings are: Interview with a personal care aide (PCA) on 03/03/36 at 8:55am revealed the facility census was 11. Observation in room #10 during the initial tour on 03/03/26 at 9:04am revealed: -The bed did not have a bottom sheet, top sheet, blanket, or bedspread. -The mattress was heavily soiled. Observation in room #9 on 03/03/26 at 9:33am revealed: -The bottom sheet on the bed was heavily stained with large brown stains. -There were numerous areas of small circular black stains of various sizes on the bottom sheet. -There were no pillowcases on the pillows on the bed. Observation in room #4 during the initial tour on 03/03/26 at 10:00am revealed there were no sheets on the bed and the mattress was discolored with brownish/black residue. Observation in room #12 on 03/03/26 at 10:26am revealed: -The bed did not have a bottom sheet, top sheet, blanket, pillow or bedspread. -The entire mattress was soiled and discolored grey. -There was as area approximately 2-foot long by	D 087		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 087	Continued From page 26 2-foot wide in the center of the mattress with brown stains. Interview with a resident during the initial tour on 03/03/26 at 10:00am revealed: -He did not have any sheets on his bed for "awhile now". -He wanted sheets on his bed because his mattress was dirty and had bugs. -He asked staff for sheets and was told they did not have anything to put on his bed. Interview with another resident on 03/03/26 at 10:15am revealed: -He had gone through two mattresses. -He would urinate on himself while sleeping. -The urine would get on his mattress. -He had gone through 5 mattress covers in a week. -The mattress covers the staff had given him were not washable. -The two pillows on his bed had to be washed at a sister facility. -His pillows got lost when they were sent to the sister facility to be washed. -He now had to sleep on his coat as a pillow. Interview with a PCA on 03/03/26 at 10:24am revealed: -She knew some of the residents did not have sheets on their beds. -The residents told her they wanted sheets, but she did not have any extra sheets to put on the beds. -The Administrator told her she ordered more sheets last week and they had not arrived yet. Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed: -The residents sheets, pillows, blankets, and	D 087		

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	HAL011373	A. BUILDING: _____ B. WING _____	R-C 03/06/2026

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D 087	Continued From page 27	D 087		

bedspreads sometimes got lost.
-It was staff's responsibility to do laundry.
-The residents' bed linens did not always get returned to the residents after they were laundered.
-The residents' did not want to lay down on their beds after taking a shower because their beds were dirty.
-The facility washing machine was broken.
-They did not take bedding to a sister facility to wash and dry now because the facility currently had bed bugs.

Interview with one Resident Care Coordinator (RCC) on 03/04/26 at 10:07am revealed the staff had not said anything to her about residents in the facility needing sheets, blankets, bedspreads, and pillows on their beds.

Interview with the Administrator on 03/04/26 at 10:30am revealed:
-She purchased a new bedding set for each resident upon admission.
-The PCAs were responsible for laundering the residents bedding and keeping the beds made.
-If the residents did not have sheets on their beds, all staff had to do was let her know.
-She had plenty of extra sheets in her office.

[Refer to tag 0077 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings Type B Violation]

[Refer to tag 0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishing Type A1 Violation]

[Refer to tag 0105 10A NCAC 13F .0311(a) Other Requirements Type B Violation]

_____

The facility failed to provide four residents with clean bedding or a top and bottom sheet in the

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D 087	Continued From page 28 midst of a bed bug outbreak and during a time when the facility washing machine was not operational requiring residents to lay down in dirty beds after showering. This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 05, 2026.	D 087		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to maintain the facility's washing machine in operating condition. The findings are:	D 105		

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D 105	Continued From page 29 Interview with one resident on 03/03/26 at 9:04am revealed: -The facility washer was not working. -He had not been able to wash his clothes in "weeks." -He had been wearing the same clothes every day. -He knew one resident who would not take a shower because he did not have clean clothes. -It was "pointless" to take a shower if you did not have clean clothes to put back on. Interview with a second resident on 03/03/26 at 9:25am revealed: -The washer did not work and had been broken "a couple days." -The Maintenance Director just repaired the dryer. Interview with a third resident on 03/03/26 at 9:41am revealed: -The facility washer had been broken for about a week. -He did not have any clean clothes. Interview with a fourth resident on 03/03/26 at 10:04am revealed: -The washer and dryer were not working but the Maintenance Director fixed them yesterday (03/02/26). -The washer was broken a "couple days." -She had gotten down to her last clean towel. -She had the staff to wash some towels for her at a sister facility. Interview with a fifth resident on 03/03/26 at 10:15am revealed: -The two missing pillows on his bed had to be washed at a sister facility.	D 105		

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D 105	Continued From page 30 -His pillows got lost when they were sent to the sister facility to be washed. -He now had to sleep on his coat as a pillow. Interview with a sixth resident on 03/03/26 at 10:31am revealed: -It had taken him three weeks to get his laundry done. -The facility washer and dryer were always breaking down. -The dryer took two cycles for a load of clothes to dry. -The Maintenance Director always bought secondhand washers and dryers to use in the facility and used second hand parts for repairs. -The last time the washer was broken he got some of his clothes stolen when they were laundered at a sister facility. -He also received back clothes that did not belong to him. Interview with a seventh resident on 03/04/26 at 8:53am revealed: -The facility washer would wash if set to quick wash. -On normal wash the tub would fill up with water, stop, and not wash the clothes. -Residents were removing the clothes soaking wet and only partially washed. -The residents would put the partially washed soaking wet clothes in the dryer and it would take all day to dry one load of laundry. -The facility had bought three washers and three dryers in six months. -The facility always bought used washers and dryers and repaired them with used parts. Interview with a personal care aide (PCA) on 03/03/26 at 2:15pm revealed: -The facility washer did not work.	D 105		

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-The washer had been broken a "couple weeks."
-The dryer worked but had to be set on permanent press setting to heat.
-The Maintenance Director told her they would be receiving a new washer being delivered to the facility today (03/03/26).

Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed:
-The facility washing machine did not work.
-The washing machine had been broken "awhile."
-The washing machine quit working often.
-It had not worked for a month.
-The washer would not drain the water out of the clothes.
-Many of the residents did not have clean clothes so they felt like they could not take a shower.
-One resident had to find some clean clothes from a sister facility so he could take a shower.
-The resident told her he had not had a shower in four days.

Interview with a MA on 03/04/26 at 2:22pm revealed:
-The facility washing machine was not working.
-The washing machine had been broken a "couple days."
-They were waiting on the Maintenance Director to put a part in to repair the washer.

Interview with a PCA on 03/04/26 at 8:34am revealed she learned from night shift staff a new washer was supposed to be delivered on 03/04/26 but it had not been delivered yet.

Interview with a PCA on 03/04/26 at 9:05am and 9:56am revealed:
-The facility washing machine was "messed up."
-He asked the Maintenance Director for another washing machine because it had not worked

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correctly for "awhile now".
-They supposedly ordered a new washing machine yesterday (03/03/26) but it never came.
-The facility washing machine had been broken for at least two weeks.
-He informed the Maintenance Director the washer was broken at least 2 weeks ago.

Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 10:07am revealed:
-The first time she had heard anything about the washing machine not working in the facility was on 03/03/26.
-The staff should report appliance issues to maintenance or let the Administrator know.

Review of the facility maintenance needs log on 03/05/26 at 10:17am revealed:
-There were two entries on the log related to needs in sister facilities.
-There were no repair requests for the facility.
-There was no request for washer or dryer repair.

Interview with the Maintenance Director on 03/03/26 at 11:38am revealed:
-One of the staff messaged him on 03/02/26 and reported the washer was broken.
-He had the part to fix the washer but he did not have time to fix it yet.
-The resident's laundry or bedding could be taken to a local laundromat if needed.
-One of the residents told him that she needed her clothes washed because they were all dirty.

Interview with the Maintenance Director on 03/04/26 at 11:30am revealed there was a spin issue before with the washer but he fixed the agitation plate a couple of weeks ago.

Interview with the Maintenance Director on

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D 105	Continued From page 33 03/05/26 at 3:54pm revealed: -The residents told him the washing machine had been broken for two weeks. -He was first told the washing machine worked on quick wash, however when he checked the washing machine on 03/01/26 it did not work at all. Interview with the Administrator on 03/04/26 at 10:30am revealed: -The staff notified her that the facility washing machine was not working for the first time on 03/02/26 at 9:19am. -The Maintenance Director ordered a new washing machine, and it should be delivered today (03/04/26). -The facility dryer would not stay working because the residents put clothes in it that were soaking wet. -The staff did not report the dryer being broken. -The staff said they informed the Maintenance Director the washing machine was broken on 02/28/26. -She did walk through the facility a couple days a week. -She did not check to see if the washer and dryer worked during those walk throughs. -Maintenance staff did not check or monitor if the washer and dryer were working in the facility. [Refer to tag 0087 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings Type B Violation] The facility failed to maintain an operational washing machine which caused residents to not be able to wash their clothes for weeks and therefore wear the same dirty clothes daily. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 105		

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D 105	Continued From page 34 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2026.	D 105		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter.	D 176		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews the Administrator failed to ensure the management and total operations of the facility were maintained in compliance with rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services related to health care, medication administration, housekeeping and furnishings including improperly stored oxygen tanks, not effectively treating an ongoing bed bug infestation in a timely manner, providing bed linens including a clean top and bottom sheet, a washing machine in working condition, accounting for residents' personal funds, treating residents with respect and dignity by providing palatable meals of adequate portion size, foods being served over or under cooked, and not offering alternative meals, and maintaining an approved sanitation classification at all times in facilities with 12 beds or less.

The findings are:

Interview with the Administrator on 03/03/26 at 4:30pm revealed:

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D 176	Continued From page 36 -She did not know there were boxes of rotten and moldy fruit setting in the food storage room. -She did not know when the fruit was ordered. -The medication aide (MA) supervisors and the Maintenance Director were responsible for keeping the food storage room and freezers clean since they were the only staff who had access to the storage room. -She did not know how staff were supposed to know when the milk was still good if it was not dated when it was thawed out. -She did not know how staff would know if foods that were removed from the original packaging were still good if the foods were not labeled with a date. -She did not know why the rotten oranges and bananas were not thrown out when the food supply was checked the previous week. Interview with the Administrator on 03/04/26 at 12:20pm revealed: -Substitutions were made when the listed menu items were not available and were based on resident preferences. -She was not aware the most current substitution log in the facility was dated 2024. -She expected the substitution logs to be filled out when substitutions were made and residents to be informed when changes to the meals were necessary. Interview with the Administrator on 03/04/26 at 11:34pm revealed: -The food supplies were moved to a sister facility on the property because staff or residents were stealing the food. -She was not aware that the personal care aide (PCA) did not know extra food such as bread was stored in the storage room. -Only certain staff had keys for the food storage	D 176		

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room and the PCAs were supposed to ask for whatever they needed.
-She was not aware that tropical fruit mix and frozen mixed vegetables were being served often and the residents did not like them.
-She did not know why the food listed on the menu was not available.
-She did not know that some residents complained about not getting enough food, not being able to ask for seconds or alternatives, and that food was being served burnt or undercooked.

Interview with the Administrator on 03/04/26 at 10:30am revealed:
-She did not know why the medications were running out before the each cycle fill date.
-She was still learning how to do medication variance reports within the eMAR.

Interview with the Administrator on 03/06/26 at 3:12pm revealed:
She was not aware a MA did not administer Resident #3's scheduled Novolog insulin without an order from the PCP to hold the insulin.
-She was not aware of any medication errors for Resident #3.
-There were no eMAR audits completed by management to make sure medications were being administered or being withheld per orders on the parameters for the medications.

Interview with the Administrator on 03/05/26 at 10:06am revealed:
-She did not know how the cycle fill medications were getting "off track."
-She did not know if the MAs were dropping medications in the cart.
-When she had cleaned out the medication cart, there were "a good amount" of loose pills in the bottom of the cart.

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D 176	Continued From page 38 Interview with the Administrator on 03/04/26 at 10:30am revealed: -She did not know why the list of residents with credits to pay towards the pharmacy bill she created that was given to the surveyor did not match the list that was given to the pharmacy in August 2025. -She did not have on her list that Resident #3 paid any money towards his pharmacy bill in August 2025. -She was responsible for creating the list of residents and the amount of money to credit each resident when she sent a check to the pharmacy. -She did not give residents' receipts for monies given to her to pay towards pharmacy bills because she did not know that she needed to. -She did not collect any money from the residents in February 2026 to pay towards pharmacy bills because she did not have any checks and had to wait on the Owner to bring her a new checkbook. Interview with the Maintenance Director on 03/05/26 at 3:54pm revealed: -He was aware the facility received a disapproved sanitation inspection on 02/03/26. -He was responsible for repairing the items identified on the disapproved sanitation inspection. -He had corrected some of the items identified on the disapproved sanitation inspection. -He had not yet corrected all of the items, but would be completing them once he finished bed bug treatment in the facility. Interview with the Administrator on 03/05/26 at 10:06am revealed: -The Maintenance Director was responsible for making repairs to address deductions made on the disapproved sanitation inspection from	D 176		

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D 176	Continued From page 39 02/03/26. -The Maintenance Director had been working on making the repairs. -She thought they were about ready for a reinspection. Interview with the Administrator on 03/04/26 at 10:30am revealed: -She was "sure" they had contacted the durable medical equipment (DME) provider to pick up the empty tanks. -She saw the DME provider arrive at the facility. -She did not know if the DME provider picked up some oxygen tanks but left the ones in the staff room. Interview with a PCA on 03/03/26 at 10:24am revealed: -She knew some of the residents did not have sheets on their beds. -The residents told her they wanted sheets, but she did not have any extra sheets to put on the beds. -The Administrator told her she ordered more sheets last week and they had not arrived yet. Interview with the Administrator on 03/04/26 at 10:30am revealed: -She purchased a new bedding set for each resident upon admission. -If the residents did not have sheets on their beds, all staff had to do was let her know. -She had plenty of extra sheets in her office. Interview with a personal care aide (PCA) on 03/03/26 at 2:15pm revealed: -The facility washer did not work. -The washer had been broken a "couple weeks." -The Maintenance Director told her they would be receiving a new washer being delivered to the	D 176		

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RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 176	Continued From page 40 facility today (03/03/26). Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed: -The facility washing machine did not work. -The washing machine had been broken "awhile." -The washing machine quit working often. -It had not worked for a month. -The washer would not drain the water out of the clothes. -Many of the residents did not have clean clothes so they felt like they could not take a shower. -One resident had to find some clean clothes from a sister facility so he could take a shower. -The resident told her he had not had a shower in four days. Interview with a MA on 03/04/26 at 2:22pm revealed: -The facility washing machine was not working. -The washing machine had been broken a "couple days." -They were waiting on the Maintenance Director to put a part in to repair the washer. Interview with a PCA on 03/04/26 at 9:05am and 9:56am revealed: -The facility washing machine was "messed up." -He asked the Maintenance Director for another washing machine because it had not worked correctly for "awhile now". -They "supposedly" ordered a new washing machine yesterday (03/03/26) but it never came. -The facility washing machine had been broken for at least two weeks. -He informed the Maintenance Director the washer was broken at least 2 weeks ago. Interview with the Administrator on 03/04/26 at 10:30am revealed:	D 176		

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-The staff notified her that the facility washing machine was not working for the first time on 03/02/26 at 9:19am.
-The staff said they informed the Maintenance Director the washing machine was broken on 02/28/26.
-She did walk through the facility a couple days a week.
-She did not check to see if the washer and dryer worked during those walk throughs.
-Maintenance staff did not check or monitor if the washer and dryer were working in the facility.

Interview with the Maintenance Director on 03/03/26 at 11:38am and 03/04/26 at 11:30am revealed:
-He was the Maintenance Director for the facility.
-He was responsible for making repairs to the facility and was also treating the facility for a bed bug infestation by spraying a chemical spray and using a heat treatment tent to treat the residents' personal belongings and furniture.
-He was responsible for printing the weekly menus for the facility and ordering the food.
-He was also the Maintenance Director for the other sister facilities on the property and another sister facility about an hour away.

Interview with the Administrator on 03/06/26 at 3:12pm revealed:
-She was responsible for the total operations of the facility.
-She worked at the facility three or four days per week because she was also the Administrator of other sister facilities including a facility about an hour away.
-She sometimes delegated the operations of the facility to the Maintenance Director when she was not at the facility.
-If the Maintenance Director was not at the

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facility, she would let him know what needed to be done when he was at the facility.

Non-compliance was identified in the following rule areas:

1. Based on observations, interviews and record reviews, the facility failed to maintain an approved sanitation classification at all times in facilities with 12 beds or less from the North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), Environmental Health Section related to a disapproved score with 40 demerits on 02/03/26. [Refer to Tag D077 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was clean and free from hazards related to bed bug infestation and unsecured oxygen tanks. [Refer to Tag D079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type A1 Violation)].

3. Based on observations, interviews, and record review, the facility failed to provide 4 of 11 residents a bed with a clean top and bottom sheet on their bed. [Refer to tag D087 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings (Type A1 Violation)].

4. Based on observations, interviews, and record review, the facility failed to maintain the facility's washing machine in operating condition. [Refer to Tag D105 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)].

5. Based on observations, interviews, and record

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reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 2 of 4 sampled residents (Residents #2 and #4) related to toenail care (#4) and failure to notify the mental health provider (MHP) of missed doses of a mood stabilizer, antidepressant, and medications to treat schizophrenia and movement disorder caused by antipsychotic medications (#2). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

6. Based on observation, interviews, and record reviews, the facility failed to treat residents with respect and dignity as evidenced by residents being served meals that were not palatable, over or under cooked, of adequate portion size, or not offered an alternative meal. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (Resident #2 and #3) related to medications used to treat increased heart rate and blood pressure (#2), to control blood sugar levels (#2 and #3), to stabilize mood (#2), to treat schizophrenia (#2), to treat drug-induced movement disorders caused by antipsychotic medications (#2), to treat depression (#2), and to treat shortness of breath (#2). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

8. Based on observations, interviews, and record reviews, the facility failed to ensure an accurate accounting of all funds received, disbursements, and the balance on hand to 2 of 3 sampled residents (Residents #3 and #5). [Refer to Tag

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D 176	Continued From page 44 D420 10A NCAC 13F .1104(b) Accounting for Resident's Personal Funds (Type B Violation)]. _____ The Administrator failed to ensure the management of total operations of the facility were maintained. The facility did not have an approved sanitation classification which included 40 demerits from Environmental Health since February 2026. In addition the facility had an active bed bug infestation for approximately 12 months, did not provide clean sheets to residents and did not maintain an operational washing machine resulting in residents not having clean clothes and therefore not showering. The facility failed to ensure referral and follow-up to meet the routine and acute health care needs of residents including obtaining toenail care for a resident who had significant toenail problems and requested medical assistance. Residents were served meals that were not palatable, over and under cooked, of adequate portion size, and not offered an alternative. The facility also failed to ensure medications were administered as ordered including medications to treat increased heart rate, increased blood pressure, schizophrenia, depression, movement disorders and shortness of breath. These failures resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/10/2026. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 05, 2026.	D 176		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 45 (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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 2 of 4 sampled residents (Residents #2 and #4) related to toenail care (#4) and failure to notify the mental health provider (MHP) of missed doses of a mood stabilizer, antidepressant, and medications to treat schizophrenia and movement disorder caused by antipsychotic medications (#2). The findings are: 1. Review of Resident #4's current FL2 dated 05/19/25 revealed diagnoses included vascular dementia, chronic kidney disease stage 4, gait and mobility abnormalities, and hypertension. Review of Resident #4's Resident Register revealed an admission date of 02/20/23. Review of Resident #4's Care Plan dated 05/19/25 revealed: -Resident #4 was forgetful. -Resident #4 was ambulatory with use of a walker. -Resident #4 required extensive assistance with bathing. -Resident #4 required limited assistance with dressing and grooming/hygiene. Interview with Resident #4 on 03/03/26 at 9:25am	D 273		

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and 12:30pm revealed:
-He needed his toenails cut.
-He asked staff to cut his toenails a "long time ago."
-He had trouble reaching his feet to trim his toenails.
-He told staff his toenails were long and he needed help to cut them.
-The staff said "Ok" and that was the last he heard of getting help with his toenails.
-He had cut some of his toenails himself.
-He was unable to cut some of his toenails with clippers.
-The long toenails on his feet were painful.
-It had been a long time since some of his toenails had been cut.

Observation of Resident #4's feet on 03/03/26 at 9:38am revealed:
-Resident #4's left foot had dry flaky skin at the base of his toes and between his toes.
-There were multiple small areas of brown discolored skin on all five of his toes and on the skin between the toes of his left foot.
-The flesh around the left great toenail was reddened.
-The left great toenail protruded approximately one half an inch beyond the end of the toe, was jagged, thickened, and yellow with black debris visible on the bottom of the toenail.
-The toenail of the second toe on the left foot was thickened and yellow and had grown over the end of the toe approximately one half of an inch into the flesh of the bottom of the second toe.
-The third, fourth, and fifth toes of the left foot were thick, yellow, and rough.
-Resident #4's right foot had dry flaky skin at the base of the toes and between his toes.
-There were areas of brown discolored skin on all his toes and between the toes of his right foot.

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-The right great toenail was thick, yellow, and rough.
-The second toenail on the right foot was thick, yellow, and rough.
-The third toenail on the right foot was thick, yellow, and rough.
-The fourth toenail on the right foot protruded past the end of the flesh of the toe approximately one quarter of an inch.
-The fourth toenail was rough, thick, yellow, with black debris under the nail.
-The fifth toenail was rough, thick, and yellow with black debris under the nail.
-Resident #4's right foot had dry flaky skin at the base of his toes and between his toes.
-There were areas of brown discolored skin on his toes and between the toes of his right foot.

Interview with a personal care aide (PCA) on 03/03/26 at 12:29pm revealed:
-She worked at the facility as a PCA since mid-February 2026.
-She assisted Resident #4 with showers when he felt like taking a shower.
-She assisted Resident #4 with a shower only a "couple times" since she started in mid-February but she had not seen his tomails.
-She had not provided toenail care to Resident #4.
-Resident #4 had not said anything to her about needing to have his toenails cut or his feet hurting.
-She did not cut residents' toenails just his fingernails.
-If a resident needed toenail care, she would post a message in the group chat for the Resident Care Coordinator's (RCC) and Administrator to see.
-She had not posted a message to the group chat concerning Resident #4's toenails because she

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had not seen his toenails.

Interview with a second PCA on 03/04/26 at 8:33am revealed:
-She worked at the facility since July 2025.
-When she assisted residents to shower, she would help them wash their bodies.
-The residents would wash their own feet and "privates."
-She was not trained what to do if a resident had long toenails that needed to be cut.

Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed:
-She did not shower Resident #4.
-She had not seen Resident #4's feet.
-Resident #4 showered himself.

Interview with a RCC on 03/03/26 at 2:44pm revealed:
-Staff had not told her Resident #4 needed foot and toenail care.
-Whoever bathed Resident #4 was responsible for notifying her that he needed care.

Interview with a second RCC on 03/04/26 at 10:07am revealed:
-The staff who helped Resident #4 should have told her, the other RCC, or the Administrator a referral to podiatry was needed.
-The staff did not say anything to her, or the other RCC, or the Administrator about Resident #4's feet.
-From what she understood, Resident #4 often refused staff assistance with showers.
-If Resident #4 needed assistance the staff would help him.

Interview with the Administrator on 03/04/26 at 10:30am revealed:

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-The staff had not reported Resident #4's toenails were long and needed care to her or the RCCs.
-They could have easily gotten a referral from Resident #4's physician for podiatry.
-Resident #4 did not like staff to help him to shower.
-She knew Resident #4 needed extensive assistance with showers.
-Resident #4 would not allow staff to help him.
-Staff were not allowed to cut resident toenails.

2. Review of Resident #2's current FL2 dated 05/19/25 revealed diagnoses included anxiety, schizophrenia, and insomnia.

a. Review of Resident #2's mental health provider (MHP) order dated 11/18/25 revealed divalproex extended release (ER) (used to treat mood disorders) 500mg one tablet at bedtime.

Review of Resident #2's December 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for divalproex ER 500mg one tablet at bedtime scheduled for 8:00pm.
-Divalproex ER 500mg was documented as administered from 12/01/25-12/31/25 for 25 occurrences out of 31 opportunities.
-Divalproex ER 500 was documented as refused on 12/01/25, 12/06/25, 12/21/25, 12/27/25, and 12/29/25.
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's January 2026 eMAR revealed:
-There was an entry for divalproex ER 500mg one tablet at bedtime scheduled for 8:00pm.
-Divalproex ER 500mg was documented as administered from 01/01/26-01/31/26 for 27

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occurrences out of 31 opportunities.
-Divalproex ER 500 was documented as refused on 01/12/26, 01/24/26, and 01/25/26.
-Divalproex ER 500 was documented as not administered due to "resident unavailable" on 01/16/26.
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's February 2026 eMAR revealed:
-There was an entry for divalproex ER 500mg one tablet at bedtime scheduled for 8:00pm.
-Divalproex ER 500mg was documented as administered from 02/01/26-02/28/26 as ordered.

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for divalproex ER 500mg one tablet at bedtime scheduled for 8:00pm.
-Divalproex ER 500mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities.
-Divalproex ER 500mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy."
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's record revealed there was no documentation the MHP was notified of the missed doses of divalproex ER from December 2025-March 2026.

Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of Resident #2's medications missing from the medication cart.

Observation of Resident #2's medications on

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hand on 03/03/26 at 4:05pm revealed there was no divalproex ER 500mg available.

Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of divalproex 500mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.

Interview with a MA on 03/04/26 at 9:00am revealed:
-She never knew Resident #2 to refuse medications in the past.
-The new supply of cycle medications from the pharmacy were not supposed to be started until 03/05/26.
-The cycle fill medications were delivered from the pharmacy monthly.
-She did not know why Resident #4 ran out of divalproex ER 500mg before 03/05/26.
-The new cycle fill supply was available in the Resident Care Coordinators (RCC) office.
-The supply of divalproex ER 500mg should have lasted until 03/05/26.
-If a medication was not available, she would let a RCC know and document the medication was not available in the eMAR.
-Medications ran "short" every month.
-She communicated in the group chat when resident medications were not available.
-The cycle fill medications had to be put into medication carts early because the medication supplies did not last until the cycle replacement date.

Interview with another MA on 03/04/26 at 2:22pm revealed:
-She was the MA who documented five of the refusals of divalproex in the eMAR from 12/01/25-02/28/26.

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RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 52 -Resident #2 often refused to take medications for her. -The policy was to ask the resident three times to take the medication. -If the resident refused the medication three times, they were to ask another MA to try to administer the medication. -She should have asked another MA try to administer Resident #2's medications before giving up. -If the resident continued to refuse they were supposed to chart the refusal in the eMAR. -They were supposed to let the RCCs know when a resident refused medications. -The RCCs were responsible for notifying the physicians when residents refused medications. Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed: -Staff had never communicated to her Resident #2 refused to take her medications. -Divalproex was ordered for Resident #2 as a mood stabilizer for schizoaffective disorder. -Suddenly missing two doses of divalproex ER 500mg in a row for 01/24/26 and 01/25/26 could cause seizures. -The divalproex needed to be given consistently. -The facility staff did not notify her about Resident #2's refusals to take divalproex in January and February 2026. Refer to the interview with a RCC on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with Resident #2 on 03/04/26 at 4:10pm.	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 53 Refer to the interview with a RCC on 03/05/26 at 9:30am. b. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for fluphenazine (used to treat schizophrenia) 2.5mg one tablet at bedtime. Review of Resident #2's December 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for fluphenazine 2.5mg one tablet at bedtime scheduled for 8:00pm. -Fluphenazine 2.5mg was documented as administered from 12/01/25-12/31/25 for 25 occurrences out of 31 opportunities. -Fluphenazine 2.5mg was documented as refused on 12/01/25, 12/06/25, 12/21/25, 12/27/25, and 12/29/25. -There was no documentation Resident #2's MHP was notified. Review of Resident #2's January 2026 eMAR revealed: -There was an entry for fluphenazine 2.5mg one tablet at bedtime scheduled for 8:00pm. -Fluphenazine 2.5mg was documented as administered from 01/01/26-01/31/26 for 27 occurrences out of 31 opportunities. -Fluphenazine 2.5mg was documented as refused on 01/12/26, 01/24/26, and 01/25/26. -Fluphenazine 2.5mg was documented as not administered due to "resident unavailable" on 01/16/26. -There was no documentation Resident #2's MHP was notified. Review of Resident #2's February 2026 eMAR revealed: -There was an entry for fluphenazine 2.5mg one	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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tablet at bedtime scheduled for 8:00pm.
-Fluphenazine 2.5mg was documented as administered from 02/01/26-02/28/26 as ordered.

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for fluphenazine 2.5mg one tablet at bedtime scheduled for 8:00pm.
-Fluphenazine 2.5mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities.
-Fluphenazine 2.5mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy."
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's record revealed there was no documentation the MHP was notified of the missed doses of fluphenazine from December 2025-March 2026.

Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of Resident #2's medications missing from the medication cart.

Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed there was no fluphenazine 2.5mg available.

Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of fluphenazine 2.5mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.

Interview with a MA on 03/04/26 at 9:00am revealed:
-She did not know why Resident #2 ran out of

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fluphenazine 2.5mg before 03/05/26.
-The new cycle fill supply of fluphenazine was available in the Resident Care Coordinators (RCC) office.

Interview with another MA on 03/04/26 at 2:22pm revealed:
-She was the MA who documented some refusals of the fluphenazine 2.5mg in Resident #2's eMAR from 12/01/25-02/28/26.
-Resident #2 often refused to take medications for her.
-The policy was to ask the resident three times to take the medication.
-If the resident refused the medication three times, they were to ask another MA to try to administer the medication.
-She should have asked another MA try to administer Resident #2's medications before giving up.
-If the resident continued to refuse they were supposed to chart the refusal in the eMAR.
-They were supposed to let the RCCs know when a resident refused medications.
-The RCCs were responsible for notifying the physicians when residents refused medications.

Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed:
-Staff had never communicated to her Resident #2 refused to take her medications.
-Fluphenazine 2.5mg was ordered for Resident #2 as an antipsychotic for schizoaffective disorder.
-Suddenly missing two doses of fluphenazine 2.5mg in a row for 01/24/26 and 01/25/26 could cause the resident to decompensate (the loss of the ability to maintain normal, health functioning).
-The fluphenazine needed to be given consistently.

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-The facility staff did not notify her about Resident #2's refusals to take fluphenazine in January and February 2026.

Refer to the interview with a RCC on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with Resident #2 on 03/04/26 at 4:10pm.

Refer to the interview with a RCC on 03/05/26 at 9:30am.

c. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for benztropine (used to treat drug-induced movement disorders caused by antipsychotic medications) 0.5mg one tablet at bedtime.

Review of Resident #2's December 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for benztropine 0.5mg one tablet at bedtime scheduled for 8:00pm.
-Benztropine 0.5mg was documented as administered from 12/01/25-12/31/25 for 26 occurrences out of 31 opportunities.
-Benztropine 0.5mg was documented as refused on 12/01/25, 12/06/25, 12/21/25, 12/27/25, and 12/29/25.
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's January 2026 eMAR revealed:
-There was an entry for benztropine 0.5mg one

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tablet at bedtime scheduled for 8:00pm.
-Benztropine 0.5mg was documented as administered from 01/01/26-01/31/26 for 27 occurrences out of 31 opportunities.
-Benztropine 0.5mg was documented as refused on 01/12/26, 01/24/26, and 01/25/26.
-Benztropine 0.5mg was documented as not administered due to "resident unavailable" on 01/16/26.
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's February 2026 eMAR revealed:
-There was an entry for benztropine 0.5mg one tablet at bedtime scheduled for 8:00pm.
-Benztropine 0.5mg was documented as administered from 02/01/26-02/28/26 as ordered.

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for benztropine 0.5mg one tablet at bedtime scheduled for 8:00pm.
-Benztropine 0.5mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities.
-Benztropine 0.5mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy."
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's record revealed there was no documentation the MHP was notified of the missed doses of benzotropine from December 2025-March 2026.

Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of Resident #4's medications missing from the

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medication cart.

Observation of Resident #4's medications on hand on 03/03/26 at 4:05pm revealed there was no benztropine 0.5mg available.

Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of benztropine 0.5mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.

Interview with a MA on 03/04/26 at 9:00am revealed:
-She did not know why Resident #2 ran out of benztropine 0.5mg before 03/05/26.
-The new cycle fill supply of benztropine was available in the Resident Care Coordinators (RCC) office.

Interview with another MA on 03/04/26 at 2:22pm revealed:
-She was the MA who documented some refusals of the benztropine 0.5mg in Resident #2's eMAR from 12/01/25-02/28/26.
-Resident #2 often refused to take medications for her.
-She should have asked another MA try to administer Resident #2's medications before giving up.
-The policy was to ask the resident three times to take the medication.
-If the resident refused the medication three times, they were to ask another MA to try to administer the medication.
-If the resident continued to refuse they were supposed to chart the refusal in the eMAR.
-They were supposed to let the RCCs know when a resident refused medications.
-The RCCs were responsible for notifying the

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physicians when residents refused medications.

Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed:
-Suddenly missing two doses of benztropine 0.5mg in a row for 01/24/26 and 01/25/26 could cause the resident to experience tremors or medication side effects of the fluphenazine.
-The benztropine needed to be given consistently.
-The facility staff did not notify her about Resident #2's refusals to take benztropine in January and February 2026.

Refer to the interview with a RCC on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with Resident #2 on 03/04/26 at 4:10pm.

Refer to the interview with a RCC on 03/05/26 at 9:30am.

d. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for duloxetine (used to treat depression) 60mg one capsule daily.

Review of Resident #2's December 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for duloxetine 60mg one capsule daily scheduled for 8:00am.
-Duloxetine 60mg was documented as administered from 12/01/25-12/31/25 for 26 occurrences out of 31 opportunities.
-Duloxetine 60mg was documented as refused on 12/01/25, 12/06/25, 12/21/25, 12/27/25, and

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D 273	Continued From page 60 12/29/25. -There was no documentation Resident #2's MHP was notified. Review of Resident #2's January 2026 eMAR revealed: -There was an entry for duloxetine 60mg one capsule daily scheduled for 8:00am. -Duloxetine 60mg was documented as administered from 01/01/26-01/31/26 for 25 occurrences out of 31 opportunities. -Duloxetine 60mg was documented as refused on 01/03/26, 01/12/26, 01/20/26, 01/21/26, 01/22/26, and 01/24/26. -Duloxetine 60mg was documented as not administered due to "resident unavailable" on 01/24/26. -There was no documentation Resident #2's MHP was notified. Review of Resident #2's February 2026 eMAR revealed: -There was an entry for duloxetine 60mg one capsule daily scheduled for 8:00am. -Duloxetine 60mg was documented as administered from 02/01/26-02/28/26 for 23 occurrences out of 28 opportunities. -Duloxetine 60mg was documented as refused on 02/03/26, 02/13/26, 02/18/26, 02/23/26, 02/25/26, and 02/28/26. -There was no documentation Resident #2's MHP was notified. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for duloxetine 60mg one capsule daily scheduled for 8:00am. -Duloxetine 60mg was documented as administered from 03/01/26-03/03/26 for 1 occurrence out of 3 opportunities.	D 273		

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-Duloxetine 60mg was documented as not administered on 03/01/26 at 8:00am due to "drug/item unavailable."
-There was no documentation Resident #2's MHP was notified.

Review of Resident #2's record revealed there was no documentation the MHP was notified of the missed doses of duloxetine from December 2025-March 2026.

Interview with a MA on 03/04/26 at 2:22pm revealed:
-She was the MA who documented some of the refusals of the duloxetine 60mg in Resident #2's eMAR from 12/01/25-02/28/26.
-Resident #2 often refused to take medications for her.
-She should have asked another MA try to administer Resident #2's medications before giving up.
-The policy was to ask the resident three times to take the medication.
-If the resident refused the medication three times, they were to ask another MA to try to administer the medication.
-If the resident continued to refuse they were supposed to chart the refusal in the eMAR.
-They were supposed to let the RCCs know when a resident refused medications.
-The RCCs were responsible for notifying the physicians when residents refused medications.

Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed:
-Sudden stopping of duloxetine could cause Resident #2 to experience some "unpleasant" side effects like brain zaps (sensations felt in the head), pain, body aches, and runny nose.
-The facility staff did not notify her about Resident

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D 273	Continued From page 62 #2's refusals to take duloxetine in December 2025-February 2026. Refer to the interview with a RCC on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with Resident #2 on 03/04/26 at 4:10pm. Refer to the interview with a RCC on 03/05/26 at 9:30am. _____ Interview with a RCC on 03/04/26 at 10:07am revealed: -The cycle fill medications were running out before it was time to replenish with the new cycle medications from the pharmacy every month. -She did not know why the cycle medications were running out early. -She and the other RCC were responsible for notifying prescribers when medications were refused or not administered due to not being unavailable. Interview with the Administrator on 03/04/26 at 10:30am revealed: -Resident #2 had never refused to take medications for her. -She never had staff report Resident #2 refused her medications. -She was aware medications were running out before the next cycle fill was supposed to be restarted. -The cycle fill for this month was delivered 03/02/26. -She did not know why the medications were running out before the each cycle fill date.	D 273		

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D 273	Continued From page 63 -She was still learning how to do medication variance reports within the eMAR. Interview with Resident #2 on 03/04/26 at 4:10pm revealed: -The MAs administered her medications twice a day. -She did not remember ever refusing any medications. -She did remember one night recently the MA only gave her one pill for 8:00pm. -She asked the MA where were her other 8:00pm medications and the MA said they were not there. Interview with a RCC on 03/05/26 at 9:30am revealed: -The last fill date of Resident #2's cycle fill medication was on 02/26/26. -The cycle fill medications filled on 02/26/26 were not delivered until 03/02/26. -She was required to sign an electronic form presented by the pharmacy delivery driver upon receipt of the cycle fill medications. -The cycle fill delivery sheets for the last delivery were all dated 03/02/26. _____ The facility failed to provide foot and toenail care to Resident #4 resulting in pain in his feet, a reddened left great toe with a half inch long, jagged, protruding toenail with black debris under the toenail, and the toenail growing into the flesh of the bottom of his second toe on his left foot. When the resident asked for assistance with nail care, the facility failed to refer the resident to a medical provider or podiatrist. The facility also failed to notify Resident #2's Mental Health Provider of medication refusals which could have resulted in a seizure, decompensation, breakthrough of drug-induced movement disorders, increasing the possibility of unpleasant	D 273		

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D 273	Continued From page 64 side effects such as brain "zaps," pain, body aches, and runny nose. These failures resulted in substantial risk of harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 5, 2026.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure foods stored and served to all residents were protected from contamination related to foods stored in the	D 282		

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	HAL011373	A. BUILDING: _____ B. WING _____	R-C 03/06/2026

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refrigerator not in the original packaging and were not labeled, moldy and rotten perishable fruit, and expired milk.

The findings are:

Observation of the kitchen on 03/03/26 at 9:45am revealed:
-There was a weekly menu posted on the refrigerator with documentation that milk was to be served at every meal.
-There were 11 corn dogs stored in a unlabeled and undated plastic bag in the refrigerator.
-There was a gallon jug of whole milk with approximately half of the milk remaining and an expiration date of 03/01/26.
-There was no date written on the jug of milk to indicate it was frozen and then thawed.
-There was a gallon sized plastic bag that was not labeled or dated with sausage links lying on the bottom shelf in the refrigerator.

Interview with the personal care aide (PCA) on 03/03/26 at 9:45am revealed:
-The night shift staff were responsible for bringing the food for the meals each day to the facility.
-Most of the foods were stored in the facility but some items were stored at a sister facility on the property.
-Night shift staff removed 11 corn dogs from the bulk supply and put them in the unlabeled and undated plastic bag and stored the corndogs in the refrigerator for her to make the lunch meal.
-She did not realize the half a gallon of milk in the refrigerator was expired.
-She had another partial gallon with about ¼ of milk remaining that she could serve for lunch, but it would not be enough for all the residents.

Observation of the food storage room located in a

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D 282	Continued From page 66 sister facility on the property on 03/03/26 at 2:50pm revealed: -There was one large box of moldy green and white covered oranges and bananas that had turned black and were rotten. -There was another large box of oranges where at least 8 oranges had molded with green and white mold present. -There was a box of rolls in an unsealed plastic bag sitting in a plastic crate on the floor. -There was ice build-up in the stand-up freezer, and the bottom shelf was covered with black and brown grime. -The door to the freezer would not close properly and a medication aide (MA) supervisor pushed a box in the floor against the freezer to hold the door closed. Interview with a MA supervisor on 03/03/26 at 2:50pm revealed: -The door to the freezer had to be pushed closed with a box because it would not stay closed on its own. -The MA supervisors and the Maintenance Director were the only staff that had keys to the food storage area. -The MA supervisor that worked the previous weekend (02/28/26 & 03/01/26) was responsible for going through all the food and disposing of any rotten or expired foods. -She was responsible for checking for expired or rotten foods on 03/02/26 but she could not check the food because she came to work late. -The boxes containing the rotten and moldy oranges and black colored bananas were "gross". -Extra milk was stored in the freezer and thawed out when it was needed in the facility. -She thought the half gallon jug of expired milk and the whole gallon of milk with a past expiration date were still good but that the jugs were frozen	D 282		

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and thawed out later.
-The milk jugs that were frozen were not dated with a date that the milk was frozen or a use by date after the milk was thawed.
-She did not know how staff were supposed to know if the milk was still good if it was not dated with the correct date.

Interview with the Maintenance Director on 03/04/26 at 11:30am revealed:
-He was responsible for printing weekly menus, ordering food weekly through the facility's contracted food service provider, unloading food deliveries, storing the food in the storage room and freezers.
-He rotated older food to the front of the freezers when new food deliveries arrived.
-The MA supervisors were responsible for cleaning the overstock storage room.
-He thought the unopened expired milk that a sister facility took to a PCA on 03/03/26 was frozen.
-He did not know who was responsible for making sure foods were labeled and dated when removed from the original packaging.
-The MA supervisors should have thrown out the moldy and rotten oranges and bananas.

Interview with the Administrator on 03/03/26 at 4:30pm revealed:
-She did not know there were boxes of rotten and moldy fruit setting in the food storage room.
-She did not know when the fruit was ordered.
-The MA supervisors and Maintenance Director were responsible for keeping the food storage room and freezers clean since they were the only staff who had access to the storage room.
-Extra milk was frozen to use later.
-She did not know how staff were supposed to know when the milk was still good if it was not

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D 282	Continued From page 68 dated when it was thawed out. -She researched online and saw that milk was still good for 5-7 days after it was thawed. -Night shift staff were responsible for dividing up bulk foods, repacking the items in plastic bags, and taking the food to the facility for the staff on day shift to prepare meals. -She did not know how staff would know if foods that were removed from the original packaging were still good if the foods were not labeled with a date. -The Maintenance Director was responsible for ordering all the food and should dispose of old or rotten food when checking the food supply every week. -She did not know why the rotten oranges and bananas were not thrown out when the food supply was checked the previous week.	D 282		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.	D 292		

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D 292	Continued From page 69 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Observation in the kitchen on 03/03/26 at 09:46am revealed: -The current week's menu dated 02/26/26-03/04/26 was posted in the kitchen and was signed by a dietician on 2/13/26. -On 03/03/26, the lunch menu listed beef and pork kielbasa with onions, peppers and a dinner roll were to be served to residents. -On 03/03/26, the dinner menu listed chicken breast fillets, homemade mashed potatoes, and flame roasted vegetables. -There was documentation that milk was to be offered at every meal. Interview with a personal care aide (PCA) on 03/03/26 at 9:45am revealed: -She was the PCA but also cooked the meals for the residents. -She did not have the food listed on the menu available to fix for lunch and dinner today. -The night shift staff would bring the food to the facility from a storage room at a sister facility where the food was kept. -Today she would be fixing corn dogs, sweet potato fries, and fruit cocktail for lunch. -She would make cheeseburgers, onion rings, and mixed vegetables for dinner. -The food truck delivered on Wednesdays and sometimes she ran out of items like milk or food before the truck delivered again and she had to make substitutions.	D 292		

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D 292	Continued From page 70 Observation of the lunch meal service on 03/03/26 from 11:57am through 12:40pm revealed: -The meal served was a corn dog that had black, burnt stripes going down the top and bottom length of the corn dog, sweet potato fries, tropical fruit mix, and orange Kool-Aid. -Three of the residents were served approximately 6 ounces of milk and one resident was served about 3 ounces of milk. -All the residents were served the same meal. Observation of the substitution log in the kitchen on 03/04/26 at 8:34am revealed: -There was one substitution log sheet provided by a PCA dated 2024. -There was a second substitution log sheet that had March 4th handwritten on it but no year was documented. Interview with a second PCA on 03/04/26 at 8:34am revealed: -There was no substitution log notebook in the kitchen just the two sheets she found on a shelf. -She did not normally work in the facility and usually worked at a sister facility on the property. -She knew substitutions were supposed to be documented. -She did not know why the substitutions on 03/03/26 were not documented on a log. -The staff rarely followed the menu because the foods listed to serve were not available most of the time. Interview with the Maintenance Director on 03/04/26 at 11:30am revealed: -He was responsible for placing weekly food orders through the facility's contracted food service provider and printing the weekly menus.	D 292		

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D 292	Continued From page 71 -Substitution menu items were made if the listed menu items were not available when the PCA pulled the meal items from the storage room. -PCAs who prepared and served resident meals were responsible for completing the substitution log. Interview with the Administrator on 03/04/26 at 12:20pm revealed: -Substitutions were made when the listed menu items were not available and were based on resident preferences. -The Maintenance Director was responsible for ordering the food for the week based on the menu. -She was not aware the most current substitution log in the facility was dated 2024. -She expected the substitution logs to be filled out when substitutions were made and residents to be informed when changes to the meals were necessary.	D 292		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to treat residents with respect and dignity as evidenced by residents being served meals that were not palatable, over or under cooked, of adequate portion size, or not	D 338		

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D 338	Continued From page 72 offered an alternative meal. The findings are: Interview with a resident during the initial tour on 03/03/26 at 9:05am revealed: -The food the facility served was worse than "crap". -The food was served tough and she could not cut it with a knife. -The facility did not serve big enough portions even if she could eat what was served. -She heard other residents complain about still being hungry after meals. Interview with a second resident during the initial tour on 03/03/26 at 9:16am revealed: -The same foods were served all the time including frozen mixed vegetables and a tropical fruit cocktail that none of the residents liked. -Potatoes were served halfway cooked and still partially raw. -Meat the size of a golf ball and not even a ¼ inch thick was served to them and the staff called it a hamburger patty. -The food was not cooked enough and most of the residents could not eat it, including herself. -The facility ran out of milk a couple days a week and she could not get milk to drink on those days. -Sometimes she was still hungry after eating what was served but she could not get more food unless another resident did not eat all of their food and they gave it to her. -There were no seconds served and the facility staff would just say there was no more food when you ask for more. Interview with a third resident on 03/03/26 at 10:09am revealed: -The food was not cooked enough.	D 338		

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-He did not get enough to eat, "I'm starving right now".
-He did not ask for seconds this morning because the food was "terrible".
-The facility served small portions to the residents.

Review of the lunch and dinner menu on 03/03/26 signed by a dietician revealed:
-The lunch meal consisted of beef and pork kielbasa, onions and peppers, and a roll.
-The dinner meal consisted of chicken breast fillets, homemade mashed potatoes, and flame roasted vegetables.

Interview with a personal care aide (PCA) on 03/03/26 at 9:45am revealed:
-She did not have the foods listed on the menu available for lunch and dinner meals.
-The night shift medication aide (MA) supervisor would bring the food to the facility from a storage room at a sister facility where the food was kept.
-Today she would be fixing corn dogs, sweet potato fries, and fruit cocktail for lunch.
-At dinner she would make cheeseburgers, onion rings, and mixed vegetables.
-There were 11 residents residing in the facility and night shift brought her 11 corn dogs in a plastic bag from the storage room to prepare for lunch.
-The food truck delivered on Wednesdays and sometimes she ran out of items like milk or food items before the truck delivered again and the residents had to go without.
-She has sent out messages before, and the Administrator would respond "you have what you have".

Second interview with a PCA on 03/03/26 at 10:39am and 11:57am revealed:

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D 338	Continued From page 74 -She did not have enough milk to serve the residents. -She asked if another sister facility on the property had any milk and someone brought her a gallon of milk, but she had to pour it out because it expired on 02/15/26. -The stove did not work properly and often burned the food. -Sometimes she could not bake the food for the recommended amount of time because it would burn the food. -She had to serve the burnt corn dogs to the residents because she did not have anything else to fix since night shift only brought her 11 corn dogs. -Normally she could offer to make the residents a sandwich as an alternative but there was no bread in the facility except for a pack of hamburger buns but those were for dinner. Observation of the lunch meal service on 03/03/26 from 11:57am through 12:40pm revealed: -The meal served was a corn dog that had blackened burn stripes going down the top and bottom length of the corn dog, sweet potato fries, tropical fruit mix, and orange Kool-Aid. -Three of the residents were served approximately 6 ounces of milk and one resident was served about 3 ounces of milk. -At 12:10pm, a resident was observed pulling the burnt breading from the hot dog while shaking her head. -At 12:12pm, a resident held his plate over to another resident and gave his fries to the other resident. -None of the residents ate any of the tropical fruit mix. -Most of the residents did not eat any of the sweet potato fries.	D 338		

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D 338	Continued From page 75 Interview with a resident after the lunch meal on 03/03/26 at 12:25pm revealed: -She pulled the breading off her corn dog because it was burnt and she could not eat it. -The sweet potato fries were overcooked and she could not eat them. -She did not like the tropical fruit mix that the facility served all the time and had told staff that several times. -She could not get any milk for lunch because they ran out. -She did not ask for an alternative for lunch because she had asked in the past and could not get different food. Interview with a second resident after the lunch meal on 03/03/26 at 12:30pm revealed: -He did not eat much because he did not like the food. -He did not like the tropical fruit mix at all. -His corn dog was burnt, and he could not eat it. -He could not get something different when he asked so he did not ask anymore. -The PCA working today would usually get him something different to eat if the PCA had something else to fix. -He gave his sweet potato fries to another resident at his table because the other resident told him he was still hungry. Interview with a third resident after the lunch meal on 03/03/26 at 12:42pm revealed: -He ate another resident's sweet potato fries at lunch because the other resident offered them to him. -He was not served enough food most of the time. -The food never tasted good because the oven burnt it.	D 338		

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D 338	Continued From page 76 Interview with a PCA on 03/03/26 at 4:10pm revealed: -She did not ask for someone to bring bread from the storage area in another facility because she did not know what foods were kept in there. -She usually had bread in the facility. -Only certain staff had access to the food storage area. Observation of the refrigerator on 03/04/26 at 8:40am revealed: -There was an unopened pack of hot dogs with 8 hot dogs in the package. -There was a plastic bag with corn dogs inside. Interview with a second PCA on 03/04/26 at 8:34am revealed: -The night shift staff put some corn dogs in a plastic bag and stuck them in the refrigerator for her to make for the lunch meal service today. -The lunch meal on the menu for today listed she should serve chicken breast, mashed potatoes, and fire roasted vegetables. -She had a bag of chicken nuggets in the freezer and would serve them instead of the corn dogs because she worked at a sister facility on 03/03/26 and knew all the residents were served corn dogs the day before. -She was supposed to fix chili dogs for dinner on 03/04/26 but she did not know how she would fix the dinner meal either because there were only 8 hot dogs in the pack and she had 11 residents residing at the facility. -The oven in the kitchen would get hot and would often burn the food. -Residents complained to her "all the time" that the food was not cooked good and it was either burnt or undercooked and some complained they did not get enough food.	D 338		

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-Management knew about the issues with food because residents told them and nothing was done about it.
-She did not work in the facility often because she usually worked at a sister facility on the property.

Interview with the Maintenance Director on 03/04/26 at 11:30am revealed:
-He was responsible for printing weekly menus, ordering food weekly through the facility's contracted food service provider, unloading food deliveries, storing the food in the storage room and freezers.
-The meals got "off track the other day" and that was why the foods listed on the menu were not available.
-There was plenty of food available locked in the storage room at a sister facility.

Interview with the Administrator on 03/04/26 at 11:34pm revealed:
-The food supplies were moved to a sister facility on the property because staff or residents were stealing the food.
-She was not aware that the PCA did not know extra food such as bread was stored in the storage room.
-Only certain staff had keys for the food storage room and the PCAs were supposed to ask for whatever they needed.
-If residents did not like what was served, they should be offered soup and sandwiches as an alternative.
-She was not aware that tropical fruit mix and frozen mixed vegetables were being served often and the residents did not like them.
-The Maintenance Director was responsible for ordering the food each week from the facility's contracted food supply company and ordered by what was listed on the menu each week.

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RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 78 -She did not know why the food listed on the menu was not available. -She did not know that some residents complained about not getting enough food, not being able to ask for seconds or alternatives, and that food was being served burnt or undercooked. -She expected staff to serve what was on the menu and adequate portion sizes. [Refer to tag 0282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service] [Refer to tag 0292 10A NCAC 13F .0904(c)(3) Nutrition and Food Service] _____ The facility failed to ensure residents were treated with respect and dignity by serving food that was overcooked or undercooked, serving food that was not liked by residents repeatedly and not offering alternatives. The lunch meal on 03/03/26 of corn dogs were burnt and not palatable due to the oven not working properly which staff made management aware of in the past. In addition, residents who were still hungry after meals with no extra foods available because the food storage room was located at a sister facility on the property but only certain staff had access to the food. 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 03/04/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2026.	D 338		

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D 358	Continued From page 79	D 358		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (Resident #2 and #3) related to medications used to treat increased heart rate and blood pressure (#2), to control blood sugar levels (#2 and #3), to stabilize mood (#2), to treat schizophrenia (#2), to treat drug-induced movement disorders caused by antipsychotic medications (#2), to treat depression (#2), and to treat shortness of breath (#2). The findings are: 1. Review of Resident #3's current FL2 dated 05/14/25 revealed diagnoses included diabetes mellitus type 2 and dementia. a. Review of Resident #3's unsigned physician order dated 01/21/26 revealed an order for Novolog (an insulin medication used to treat high blood sugar levels) 100u/ml inject 3 units before each meal.	D 358		

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D 358	Continued From page 80 Review of Resident #3's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 100u/ml inject 3 units (U) before each meal at 7:30am, 11:30am, and 4:30pm. -On 02/02/26 at 7:30am, there was documentation Novolog 3u was not administered with a comment stating Resident #3's fingerstick blood sugar (FSBS) was 93 and he did not need the insulin. -On 02/05/26 at 7:30am, there was documentation Novolog 3u was not administered with a comment stating Resident #3's FSBS was 95 and he did not need the insulin. -On 02/06/26 at 7:30am, there was documentation Novolog 3u was not administered with a comment stating Resident #3 did not need the insulin because the FSBS was 111. Interview with Resident #3 on 03/06/26 at 9:50am revealed: -He thought his insulin and diabetic medications were administered as ordered. -Sometimes his blood sugar ran low and sometimes it ran high. -He did not know if he had any missed doses of his scheduled Novolog insulin in February 2026. Telephone interview with a medication aide (MA) on 03/05/26 at 8:29am revealed: -She became a MA in November 2025 and was trained by a day shift MA. -She did not administer Resident #3's scheduled Novolog before breakfast on 02/02/26, 02/05/26, and 02/06/26 because Resident #3 did not need it. -She did not call Resident #3's primary care provider (PCP) to get a verbal order to hold Resident #3's scheduled Novolog on 02/02/26,	D 358		

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D 358	Continued From page 81 02/05/26, and 02/06/26 or see if the insulin should be administered as ordered. -Resident #3 had orders for Novolog sliding scale insulin (SSI) and if the FSBS value was less than 150 she knew she was supposed to not administer SSI to Resident #3. -Since Resident #3's FSBS was 93 on 02/02/26, 95 on 02/05/26, and 111 on 02/06/26, she thought she was supposed to hold the scheduled 3u since the FSBS was less than 150 per the order on the SSI. -She was confused by the insulin orders and when to administer or not administer Resident #3's insulin. -She worked night shift and only administered Resident #3's 7:30am doses of scheduled insulin and/or SSI if it was needed. -She thought she was administering or holding Resident #3's 7:30am doses of insulin correctly. Interview with a Resident Care Coordinator (RCC) on 03/05/26 at 10:10am revealed: -There was no one assigned to complete MAR audits to make sure Resident #3's insulin was administered correctly. -She instructed staff to make sure to pay attention to orders for residents with medication parameters and to not administer the medications when warranted. -The MAs were expected to administer medications as ordered. Telephone interview with Resident #3's PCP on 03/05/26 at 10:33am revealed: -He ordered Resident #3 Novolog 3u to be administered before each meal on 01/26/26. -He could not remember what Resident #3's most current A1C (a blood test to measure the average blood sugar level over a 2-3-month period to indicate how well diabetes was being managed)	D 358		

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value was.
-The facility staff "may" have called him when medication errors were made but he could not remember.
-The MA should have called him to see if Resident #3's scheduled Novolog 3u should have been administered on 02/02/26, 02/05/26, and 02/06/26 at 7:30am.
-He expected the MAs to administer medications as ordered.
-Resident #3's missed scheduled doses of Novolog insulin could cause his FSBS to be high which could result in weakness, dizziness, increased urine output, dehydration, or diabetic coma.

Interview with the Administrator on 03/06/26 at 3:12pm revealed:
-She was not aware a MA did not administer Resident #3's scheduled Novolog insulin without an order from the PCP to hold the insulin.
-If a MA questioned whether to administer or not administer medications, they should contact either RCC 1, RCC 2, or herself so that the PCP could be contacted to see if the medications should be held or administered.
-There were no eMAR audits completed by management to make sure medications were being administered or being withheld per orders on the parameters for the medications.
-She expected the MAs to administer medications as ordered.

b. Review of Resident #3's physician orders dated 10/30/25 revealed there was an order for pioglitazone (a medication used to treat high blood sugar levels) 15mg take 1 tablet daily and hold for fingerstick blood sugars (FSBS) less than 100.

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Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for pioglitazone 15mg take 1 tablet daily and hold for FSBS less than 100.
-On 01/18/26, there was documentation pioglitazone was administered at 8:00am with a FSBS value of 77.
-On 01/26/26, there was documentation pioglitazone was administered at 8:00am with a FSBS value of 49.

Review of Resident #3's February 2026 eMAR revealed:
-There was an entry for pioglitazone 15mg take 1 tablet daily and hold for FSBS less than 100.
-On 02/01/26, there was documentation pioglitazone was administered with a FSBS value of 86.

Interview with Resident #3 on 03/06/26 at 9:50am revealed:
-He thought his diabetic medications were administered as ordered.
-Sometimes his blood sugar ran low and sometimes it ran high.

Telephone interview with a medication aide (MA) on 03/05/26 at 8:49am revealed:
-She knew Resident #3 had orders to hold pioglitazone for FSBS values less than 100.
-She thought there was a "glitch" in the computer charting system and the computer documented Resident #3's pioglitazone as administered on 01/18/26 by mistake.
-She would have not administered the medication to Resident #3 for a FSBS value of 77 at 8:00am on 01/18/26.

Interview with a MA on 03/05/26 at 8:57am

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revealed:
-She used to document medication administration on the eMAR using her cellular telephone but there were issues with the phones documenting on the eMAR accurately so now she used the computer.
-She did not know why Resident #3's pioglitazone was documented correctly on the other days in February 2026 when she administered Resident #3's medications.

Interview with a Resident Care Coordinator (RCC) on 03/05/26 at 10:10am revealed:
-There was no one assigned to complete MAR audits to make sure Resident #3's diabetic medications were administered correctly or held when the FSBS values were outside the ordered parameters.
-She instructed staff to make sure to pay attention to orders for residents with medication parameters and to not administer the medications when warranted.
-The MAs were expected to administer medications as ordered.

Telephone interview with Resident #3's PCP on 03/05/26 at 10:33am revealed:
-The facility staff may have called him when medication errors were made but he could not remember.
-He was not notified that Resident #3 was administered pioglitazone on 01/26/26 at 8:00am when the FSBS value was 49 and he should have been notified.
-He expected the MAs to administer medications as ordered.
-If Resident #3 was administered pioglitazone when the FSBS value was less than 100 it could cause his blood sugar to be low which could result in Resident #3 becoming confused or

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D 358	Continued From page 85 hospitalized. Interview with the Administrator on 03/06/26 at 3:12pm revealed: -She was not aware of any medication errors for Resident #3. -If a MA questioned whether to administer or not administer medications, they should contact either RCC 1, RCC 2, or herself so that the PCP could be contacted to see if the medications should be held or administered. -There were no eMAR audits completed by management to make sure medications were being administered or being withheld per orders on the parameters for the medications. -She expected the MAs to administer or hold medications as ordered. Attempted telephone interview with a second MA on 03/05/26 at 8:55am was unsuccessful. c. Review of Resident #3's physician's orders dated 10/30/25 revealed there was an order for Januvia (a medication used to treat high blood sugar levels) 50mg take 1 tablet daily and hold for fingerstick blood sugars (FSBS) less than 100. Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Januvia 50mg take 1 tablet daily and hold for FSBS less than 100. -On 01/31/26 at 8:00am, there was documentation Januvia 50mg was administered with a FSBS value of 86. Interview with Resident #3 on 03/06/26 at 9:50am revealed: -He thought his diabetic medications were administered as ordered.	D 358		

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D 358	Continued From page 86 -Sometimes his blood sugar ran low and sometimes it ran high. Interview with a Resident Care Coordinator (RCC) on 03/05/26 at 10:10am revealed: -There was no one assigned to complete MAR audits to make sure Resident #3's diabetic medications were administered correctly or held when the FSBS values were outside the ordered parameters. -She instructed staff to make sure to pay attention to orders for residents with medication parameters and to not administer the medications when warranted. -The MAs were expected to administer medications as ordered. Telephone interview with Resident #3's PCP on 03/05/26 at 10:33am revealed: -The facility staff may have called him when medication errors were made but he could not remember. -He expected the MAs to administer medications as ordered. -If Resident #3 was administered Januvia when the FSBS value was less than 100 it could cause his blood sugar to be low which could result in Resident #3 becoming confused or require hospitalization. Interview with the Administrator on 03/06/26 at 3:12pm revealed: -She was not aware of any medication errors for Resident #3. -If a MA questioned whether to administer or not administer medications, they should contact one of the RCCs, or herself so that the PCP could be contacted to see if the medications should be held or administered. -There were no eMAR audits completed by	D 358		

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management to make sure medications were being administered or being withheld per orders on the parameters for the medications.
-She expected the MAs to administer or hold medications as ordered.

Attempted telephone interview with a second MA on 03/05/26 at 8:44am was unsuccessful.

d. Review of Resident #3's physician's orders dated 10/30/25 revealed there was an order for glucose (a medication used to treat low blood sugar levels) 3.75-gram chew 1 tablet every 15 minutes as needed for FSBS values less than 60.

Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for a glucose tablet 3.75-gram chew 1 tablet every 15 minutes as needed for fingerstick blood sugar (FSBS) values less than 60 and recheck a FSBS 15 minutes after administration.
-There was documentation on 01/26/26 at 8:00am that Resident #3's FSBS value was 49 and there was no documentation a glucose tablet was administered.

Interview with Resident #3 on 03/06/26 at 9:50am revealed:
-He thought his diabetic medications were administered as ordered.
-Sometimes his blood sugar ran low and sometimes it ran high.

Telephone interview with Resident #3's PCP on 03/05/26 at 10:33am revealed:
-The facility staff may have called him when medication errors were made but he could not remember.

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-He was not notified when Resident #3's FSBS value was 49 on 01/26/26 at 8:00am and he should have been notified.
-He expected the MAs to administer medications as ordered.
-If Resident #3 did not receive the glucose tablets when his FSBS was less than 60 it could cause Resident #3's blood sugar level to drop lower which could result confusion or hospitalization.

Interview with the Administrator on 03/06/26 at 3:12pm revealed:
-She was not aware of any medication errors for Resident #3.
-If a MA questioned whether to administer or not administer medications, they should contact either RCC 1, RCC 2, or herself so that the PCP could be contacted to see if the medications should be held or administered.
-There were no eMAR audits completed by management to make sure medications were being administered as ordered.
-She expected the MAs to administer Resident #3 the ordered glucose tablets when Resident #3's FSBS was less than 60.

Attempted telephone interview with a second MA on 03/05/26 at 8:55am was unsuccessful.

2. Review of Resident #2's current FL2 dated 05/19/25 revealed diagnoses included asthma, chronic obstructive pulmonary disease, hypertension, and gastroesophageal reflux disease.

Interview with one resident during the initial tour on 03/03/26 at 9:04am revealed the facility ran out of medications "sometimes" when it was time for the restock to come in from the pharmacy.

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D 358	Continued From page 89 a. Review of Resident #2's physician's order dated 11/18/25 revealed amlodipine (used to treat high blood pressure) 5mg one tablet daily. Review of Resident #2's March 2026 electronic medication administration record (eMAR) from 03/01/26-03/03/26 revealed: -There was an entry for amlodipine 5mg one tablet daily scheduled at 8:00am. -Amlodipine 5mg was documented as administered for 2 occurrences out of 3 opportunities. -On 03/01/26, amlodipine 5mg was documented as not administered due to drug/item unavailable. Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed amlodipine 5mg was available for administration. Telephone interview with Resident #2's physician on 03/04/26 at 3:44pm revealed: -Amlodipine was ordered to lower the residents blood pressure. -Resident #2's blood pressure was normal his last visit on 02/26/26. -The staff notified him when they needed a medication for a resident. -Medications would be delivered from the pharmacy on the same day it was ordered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/05/26 at 8:51am revealed Resident #2 was dispensed a 28 day supply of amlodipine on 12/04/25, 01/01/26, 01/29/26, and 02/26/26. Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am. Refer to the interview with a Resident Care	D 358		

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D 358	Continued From page 90 Coordinator (RCC) on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with the Administrator on 03/05/26 at 10:06am. Refer to the interview with a RCC on 03/05/26 at 11:01am. b. Review of Resident #2's physician's order dated 02/20/26 revealed glipizide extended release (ER) 2.5mg one tablet daily. Review of Resident #2's March 2026 eMAR from 03/01/26-03/03/26 revealed: -There was an entry for glipizide ER (used to control blood sugar) 2.5mg one tablet daily scheduled at 8:00am. -Glipizide ER 2.5mg was documented as administered for 2 occurrences out of 3 opportunities. -On 03/01/26, glipizide ER 2.5mg was documented as not administered due to drug/item unavailable. Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed there were eight glipizide ER 2.5mg tablets available. Telephone interview with Resident #2's physician on 03/04/26 at 3:44pm revealed: -Glipizide was ordered to control blood sugar and missed doses could cause an increase in blood sugar levels. -The staff notified him when they needed a medication for a resident. -Medications would be delivered from the pharmacy on the same day it was ordered.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 91 Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am. Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with the Administrator on 03/05/26 at 10:06am. Refer to the interview with a RCC on 03/05/26 at 11:01am. c. Review of Resident #2's physician order dated 11/18/25 revealed Januvia (used to improve blood sugar control) 100mg one tablet daily. Review of Resident #2's March 2026 eMAR from 03/01/26-03/03/26 revealed: -There was an entry for Januvia 100mg one tablet daily scheduled at 8:00am. -Januvia 100mg was documented as administered for 2 occurrences out of 3 opportunities. -On 03/01/26, Januvia 100mg was documented as not administered due to drug/item unavailable. Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed Januvia 100mg was available for administration. Telephone interview with Resident #2's physician on 03/04/26 at 3:44pm revealed: -Januvia was ordered to help control Resident #2's blood sugar levels and missed doses could cause an increase in blood sugar levels. -The staff notified him when they needed a	D 358		

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medication for a resident.
-Medications would be delivered from the pharmacy on the same day it was ordered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/05/26 at 8:51am revealed Resident #2 was dispensed a 28 day supply of Januvia on 12/04/25, 01/01/26, 01/29/26, and 02/26/26.

Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am.

Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with the Administrator on 03/05/26 at 10:06am.

Refer to the interview with a RCC on 03/05/26 at 11:01am.

d. Review of Resident #2's physician order dated 11/18/25 revealed metoprolol extended release (ER) 25mg one half tablet once daily.

Review of Resident #2's March 2026 eMAR from 03/01/26-03/03/26 revealed:
-There was an entry for metoprolol ER 25mg one half tablet once daily scheduled at 8:00am.
-Metroprolol ER 25mg was documented as administered for 2 occurrences out of 3 opportunities.
-On 03/01/26, metoprolol ER 25mg was documented as not administered due to drug/item unavailable.

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Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed metoprolol ER 25mg was available for administration.

Telephone interview with Resident #2's physician on 03/04/26 at 3:44pm revealed:
-Metoprolol was ordered to decrease heart rate and blood pressure.
-Missed doses of metoprolol could cause heart rate and blood pressure to increase.
-The staff notified him when they needed a medication for a resident.
-Medications would be delivered from the pharmacy on the same day it was ordered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/05/26 at 8:51am revealed Resident #2 was dispensed a 28 day supply of metoprolol on 12/04/25, 01/01/26, 01/29/26, and 02/26/26.

Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am.

Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with the Administrator on 03/05/26 at 10:06am.

Refer to the interview with a RCC on 03/05/26 at 11:01am.

e. Review of Resident #2's physician order dated 11/18/25 revealed Symbicort HFA (used to treat asthma and chronic obstructive pulmonary disease) aerosol inhaler 80-4.5mcg/actuation

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D 358	Continued From page 94 inhale two puffs twice a day rinse mouth after use. Review of Resident #2's March 2026 eMAR from 03/01/26-03/03/26 revealed: -There was an entry for Symbicort HFA 80-4.5mcg inhale two puffs twice a day scheduled at 8:00am and 8:00pm. -Symbicort was documented as administered 3 occurrences out of 5 opportunities. -On 03/01/26 at 8:00am, Symbicort HFA was documented as not administered due to drug/item unavailable. -On 03/02/26 at 8:00pm, Symbicort HFA was documented as not administered due to drug/item unavailable. Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed a Symbicort HFA 80-4.5mcg inhaler was available for administration. Telephone interview with Resident #2's physician on 03/04/26 at 3:44pm revealed: -Symbicort was ordered to treat shortness of breath. -Missed doses of Symbicort could cause shortness of breath. -Resident #2 did not complain of shortness of breath on his last visit on 02/26/26. -The staff notified him when they needed a medication for a resident. -Medications would be delivered from the pharmacy on the same day it was ordered. Interview with Resident #2 on 03/04/26 at 4:10pm revealed: -She had to have her Symbicort. -She would get to "wheezing" without it.	D 358		

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Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/05/26 at 8:51am revealed Resident #2 was dispensed a 28-30 day supply for two puffs two times a day of Symbicort which would be one inhaler on 12/04/25, 01/01/26, 01/29/26, and 02/26/26.

Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am.

Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with the Administrator on 03/05/26 at 10:06am.

Refer to the interview with a RCC on 03/05/26 at 11:01am.

f. Review of Resident #2's mental health provider (MHP) order dated 11/18/25 revealed divalproex extended release (ER) (used to treat mood disorders) 500mg one tablet at bedtime.

Review of Resident #2's March 2026 eMAR revealed:
-There was an entry for divalproex ER 500mg one tablet at bedtime scheduled for 8:00pm.
-Divalproex ER 500mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities.
-Divalproex ER 500mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy."

Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of

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Resident #2's medications missing from the medication cart.

Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed there was no divalproex ER 500mg available.

Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of divalproex 500mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.

Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed:
-Divalproex was ordered for Resident #2 as a mood stabilizer for schizoaffective disorder.
-The divalproex needed to be given consistently.

Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am.

Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on 03/04/26 at 10:30am.

Refer to the interview with the Administrator on 03/05/26 at 10:06am.

Refer to the interview with a RCC on 03/05/26 at 11:01am.

g. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for fluphenazine (used to treat schizophrenia) 2.5mg one tablet at bedtime.

Review of Resident #2's March 2026 eMAR

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revealed:
-There was an entry for fluphenazine 2.5mg one tablet at bedtime scheduled for 8:00pm.
-Fluphenazine 2.5mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities.
-Fluphenazine 2.5mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy."

Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of Resident #2's medications missing from the medication cart.

Observation of Resident #2's medications on hand on 03/03/26 at 4:05pm revealed there was no fluphenazine 2.5mg available.

Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of fluphenazine 2.5mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.

Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed:
-Fluphenazine 2.5mg was ordered for Resident #2 as an antipsychotic for schizoaffective disorder.
-The fluphenazine needed to be given consistently.

Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am.

Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am.

Refer to the interview with the Administrator on

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D 358	Continued From page 98 03/04/26 at 10:30am. Refer to the interview with the Administrator on 03/05/26 at 10:06am. Refer to the interview with a RCC on 03/05/26 at 11:01am. h. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for benztropine (used to treat drug-induced movement disorders caused by antipsychotic medications) 0.5mg one tablet at bedtime. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for benztropine 0.5mg one tablet at bedtime scheduled for 8:00pm. -Benztropine 0.5mg was documented as administered from 03/01/26-03/02/26 for 1 occurrence out of 2 opportunities. -Benztropine 0.5mg was documented as not administered on 03/02/26 at 8:00pm due to "drug/item unavailable waiting on pharmacy." Interview with a medication aide (MA) on 03/03/26 at 4:03pm revealed there were some of Resident #4's medications missing from the medication cart. Observation of Resident #4's medications on hand on 03/03/26 at 4:05pm revealed there was no benztropine 0.5mg available. Telephone interview with the facility's contracted pharmacy on 03/05/26 at 8:51am revealed a 28 day supply of benztropine 0.5mg tablets were sent to the facility for Resident #2 on 12/04/25, 1/1/26, 1/29/26, and 02/26/26.	D 358		

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D 358	Continued From page 99 Telephone interview with Resident #2's MHP on 03/06/26 at 2:18pm revealed the benztropine needed to be given consistently. Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am. Refer to the interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with the Administrator on 03/05/26 at 10:06am. Refer to the interview with a RCC on 03/05/26 at 11:01am. i. Review of Resident #2's mental health provider's (MHP) order dated 11/18/25 revealed there was an order for duloxetine (used to treat depression) 60mg one capsule daily. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for duloxetine 60mg one capsule daily scheduled for 8:00am. -Duloxetine 60mg was documented as administered from 03/01/26-03/03/26 for 1 occurrence out of 3 opportunities. -Duloxetine 60mg was documented as not administered on 03/01/26 at 8:00am due to "drug/item unavailable." Refer to the interview with a medication aide (MA) on 03/04/26 at 9:00am. Refer to the interview with a Resident Care	D 358		

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D 358	Continued From page 100 Coordinator (RCC) on 03/04/26 at 10:07am. Refer to the interview with the Administrator on 03/04/26 at 10:30am. Refer to the interview with the Administrator on 03/05/26 at 10:06am. Refer to the interview with a RCC on 03/05/26 at 11:01am. _____ Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed: -Routine or cycle medications were delivered to the facility from the contracted pharmacy monthly. -The new medication supply was not supposed to start until the 5th day of each month. -The medication supply had to be started early each month, because the medication supply ran out early on so many residents medications. -If a medication was not available, she would let the RCCs know. Interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am revealed: -The medication supply was delivered to the facility on 03/02/26. -The medication supply should last cycle to cycle. -She did not know why they were running out of cycle medications early. -It was happening for multiple residents where they were running out of medications early before the new cycle was placed in the medication cart. Interview with the Administrator on 03/04/26 at 10:30am revealed: -She was aware the monthly cycle fill medication supplies were running out early for multiple residents before cycle fill medications could be placed in the medication carts.	D 358		

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D 358	Continued From page 101 -She was working with the facility's contracted pharmacy to get an extra three day supply of all resident medications and have the pharmacy bill the facility for those medications. -This would ensure a three extra doses for every medication. -Her plan was to increase the RCCs medication cart audits to weekly versus monthly to ensure medications were available. Interview with a RCC on 03/05/26 at 11:01am revealed: -Upon receipt of cycle, the medications had to be scanned in. -Then she and the other RCC made sure medications were received for all of the residents. -They would write down any medications that did not come in from the pharmacy. -They would deliver them to the facility and place them in the medication cart. Interview with the Administrator on 03/05/26 at 10:06am revealed: -The cycle fill medications had always had to be put in early. -She did not know how the cycle fill medications were getting "off track." -At the beginning of each month, they were having to put cycle fill medications in early. -She did not know if the MAs were dropping medications in the cart. -When she had cleaned out the medication cart, there were "a good amount" of loose pills in the bottom of the cart. -Because cycle fill medications were having to be put in the medication carts early the RCC's did not have time to check the medications against the eMAR. -The cycle fill medications had to be checked in by the RCCs before they could be stored in the	D 358		

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D 358	Continued From page 102 medication cart. The facility failed to administer scheduled doses of Novolog insulin to Resident #3 which could cause his blood sugar to be high and result in weakness, dizziness, increased urine output, dehydration, or diabetic coma and failed to administer glucose tablets to Resident #3 when his FSBS was less than 60 which could cause Resident #3's blood sugar level to drop lower which could result in confusion or in the resident being hospitalized. The failure to administer amlodipine and metoprolol increased Resident #2's risk of increased blood pressure and heart rate, missed doses of glipizide and Januvia increased the risk of increased blood sugar, and missed doses of Symbicort could result in shortness of breath. These failures were detrimental to the health, safety, and welfare and constituted a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2026.	D 358		
D 420	10A NCAC 13F .1104 (b) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (b) No employee of a facility shall handle the personal funds for a resident, except for the facility administrator or the administrator's designee after having received prior written	D 420		

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RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 420	Continued From page 103 authorization from the resident or the resident's authorized representative. The facility administrator or their designee shall maintain an accurate account balance and accounting of all funds received, disbursements, and the balance on hand which shall be available upon request to the resident or their authorized representative during the facility's regular business office hours. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure an accurate accounting of all funds received, disbursements, and the balance on hand to 2 of 3 sampled residents (Residents #3 and #5). The findings are: Review of the facility's Resident Funds Policy revised 10/15/20 revealed: -Residents had a right to manage their own financial affairs. -Situations in which a resident was unable to manage their funds, the Administrator will contact a family member or the county department of social services regarding the need for a legal representative or payee. -The Administrator and other staff will not serve as your legal representative, payee, or executor of a will except as indicated in the following	D 420		

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	HAL011373	A. BUILDING: _____ B. WING _____	R-C 03/06/2026

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D 420	Continued From page 104 sentence. -In the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies, the facility Administrator may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies. -The facility does not require you to deposit your personal funds in the trust account. -However, if you wish, and upon your written authorization, the facility will withhold, safeguard, manage, and account for your personal funds deposited in your account at the facility in accordance with the guidelines set out above. -Situations in which we manage your funds, we will give your legal representative or payee receipts for any monies received on your behalf. -If you receive special assistance funds, a statement shall be signed or otherwise marked by you (unless you have been adjudicated incompetent), your legal representative or payee with two witnesses' signatures to document receipt of the special assistance personal needs allowance. -The facility will maintain these statements. -Upon your written authorization or the written authorization of your legal representative or payee or our Administrator may manage your personal money. -If we handle your personal money, we will provide you an accurate accounting of monies received and disbursed and the balance on hand upon your request or upon request of your legal representative or payee. -A record of each transaction involving the use of your personal funds shall be signed or otherwise marked by you, your legal representative or payee with two witnesses' signatures at least monthly verifying the accuracy of the	D 420		

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D 420	Continued From page 105	D 420		

disbursement of personal funds.
-The facility will maintain these records.
-The facility will maintain a system that assures a complete and separate accounting of your personal funds entrusted to us.
-Your individual financial record is available monthly on request by you or your legal representative.

1. Review of Resident #5's FL2 dated 04/10/25 revealed diagnoses included mild mental retardation, anxiety, dyslipidemia, and depression.

Review of Resident #5's Resident Register revealed the resident was their own responsible person.

Review of Resident #5's Resident Contract dated 07/17/25 revealed the resident received funds for special assistance.

Review of Resident #5's Fund Authorization revealed:
-The facility name was handwritten on the form authorizing the facility to manage Resident #5's personal funds.
-Resident Responsible Party was highlighted in yellow on the form.
-There was no signature of a responsible party on the form.

Review of Resident #5's Resident Trust Transactions Log dated 05/21/25-10/23/25 revealed:
-On 05/21/25, there was a withdrawal of $80 leaving a balance of $10.
-There was undated entry of a withdrawal of $10 to pharmacy leaving a balance of 0.
-On 06/20/25, there was a withdrawal of $10 to

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pharmacy leaving a balance of $80.
-There was an undated entry of a withdrawal of $80 leaving a balance of 0.
-On 07/18/25, there was a withdrawal of $90 to resident funds leaving a balance of 0.
-On 08/18/25, there was a withdrawal of $80 to resident funds leaving a balance of $10.
-There was an undated entry of a withdrawal of $10 to pharmacy bill leaving a balance of 0.
-On 09/25/25, there was a withdrawal of $90 to resident funds leaving a balance of 0.
-On 10/23/25, there was a withdrawal of $90 to resident funds leaving a balance of 0.
-The entries dated 05/21/25-10/23/25 were signed by Resident #5, the Administrator, and a verifying witness.

Review of Resident #5's Personal Funds form dated 11/18/25 revealed:
-There were two entries on the form.
-On 11/18/25, there was a withdrawal of $10 to pharmacy bill and a withdrawal of $80 to resident with a balance of 0.
-The entry dated 11/18/25 was signed by Resident #5 and the Administrator.
-There was an undated entry with a withdrawal of $10 to pharmacy bill and a withdrawal of $80 with a balance of 0.
-The undated entry was signed by Resident #5.

Review of Resident #5's Personal Funds form dated 01/15/26-02/20/26 revealed:
-There were two entries on the form.
-On 01/15/26, there was a withdrawal of $90 with a balance of 0.
-On 02/20/26, there was a withdrawal of $90 with a balance of 0.
-The entries dated 01/15/26-02/20/26 were signed by Resident #5.

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D 420	Continued From page 107 Interview with Resident #5 on 03/04/26 at 2:00pm revealed he was not getting his personal funds money. Interview with Resident #5 on 03/06/26 at 10:12am revealed: -He did not get $80 on 11/18/25. -He did not get $80 as the undated entry below the 11/18/25 entry indicated. Review of Resident #5's Pharmacy Bill statement date 02/27/26 revealed: -Resident #5's balance was $446.58. -Resident #5's amount owed for 01/29/26-02/06/26 was $29.77. -No payments were received from 01/29/26-02/06/26. -Resident #5's ending balance was $476.35. Review of a handwritten note with no date provided by the Administrator revealed: -There was a list of six resident names with dollar amounts next to their names. -Resident #5's name was the fifth name on the list with the amount of $20 written beside his name. -The final listing was the facility's stock account number with the amount of $185.00 listed beside the entry. -The total of all the listed resident amounts and the stock account amount totaled $275.00. -A check number was written out beside the amount of $275.00. Telephone interview with the facility's contracted pharmacy's Collections Supervisor on 03/06/26 at 10:41am revealed: -The Administrator would send one check for all residents. -There would be a list of residents and how much	D 420		

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to apply to each resident account.
-The last check they had received from the facility of any kind was in August 2025.
-They received a check for $275 on 08/08/25.
-On 06/02/23, a payment of $35 was paid to Resident #5's account.
-On 03/20/25, a payment of $10 was paid to Resident #5's account.
-On 08/08/25, a payment of $20 and a payment of $10 were paid to Resident #5's account.
-There had been no payments since 08/08/25.

Review of Resident #5's record revealed 5 ten dollar withdrawals from Resident #5's Resident Trust Transactions Log and his personal funds; $10.00 on 05/21/25, $10.00 on 06/20/25, $10.00 on 08/18/25, $10.00 on 11/18/25 and $10.00 on an undated entry between 11/18/25 and 01/15/26 which documented the withdrawals for "pharmacy bill".

Observation in the Administrator's office and interview with the Administrator on 03/04/26 at 2:15pm revealed:
-The Administrator pulled a black zippered bag out of a cabinet in the right corner of her office.
-She opened the black bag and pulled out one $10 dollar bill and two $5 dollar bills ($20).
-The cash belonged to Resident #5.
-It was to be used to pay his pharmacy bill.
-She had not written a check to send to the pharmacy, because she had been out of checks.
-The Owner had brought her some more checks on 03/03/26 when he visited the facility.

Interview with the Administrator on 03/05/26 at 10:06am revealed:
-Resident #5 received the withdrawal amounts documented on the logs.
-She did not know why Resident #5 would say he

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D 420	Continued From page 109 did not get the money. Interview with the Administrator on 03/06/26 at 3:04pm revealed: -She was responsible for Business Office Manager (BOM) duties as they did not have a BOM. -Her responsibilities included resident personal funds distributions each month. _____ 2. Review of Resident #3's current FL2 dated 05/14/25 revealed diagnoses included dementia, traumatic brain injury, chronic kidney disease, diabetes mellitus type 2, hypertension, chronic obstructive pulmonary disease, history of mental and behavioral disorder, epilepsy, and major depressive disorder. Review of Resident #3's Resident Register revealed the resident had a power of attorney (POA). Review of Resident #3's Resident Contract dated 10/24/19 revealed the resident received special assistance. Review of Resident #3's Fund Authorization contract revealed: -The facilty name was handwritten on the form authorizing the facilty to manage Resident #3's personal funds. -Resident #3 signed and dated the form on 10/24/19. -The Administrator/Representative line was signed and dated on 10/24/19. -Resident #3's responsible party/POA signature line was blank. Interview with Resident #3 on 03/06/26 at 9:50am	D 420		

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D 420	Continued From page 110 revealed: -The Administrator gave him his money every month and had him sign a form. -The Administrator gave him a pharmacy bill and would tell him how much to pay. -He would give her $10 or $20 to pay towards the pharmacy bill after the Administrator told him how much to pay. -He did not know the last time he made a payment to the pharmacy or gave the Administrator money for his pharmacy bill. -He was never given a receipt for any monies given to the Administrator. -He did not know if he currently owed anything on his pharmacy bill. -If the Administrator told him he was behind on his payments, he would tell her he would "catch them up" the next time he made a payment. Review of Resident #3's Personal Funds form revealed: -On 11/18/25, there was documentation $10 was paid towards the pharmacy bill and $80 was given to the resident with Resident #3's initials written under the signature box and the Administrator's signature next to the line. -On 12/18/25, there was documentation $10 was paid towards the pharmacy bill and $80 was given to the resident with Resident #3's initials written under the signature box. -On 01/15/26, there was documentation $5 was paid towards the pharmacy bill and $85 was given to the resident with Resident #3's initials written under the signature box. -On 02/20/26, there was documentation $0 was paid towards the pharmacy bill and $90 was given to the resident with Resident #3's initials written under the signature box. Review of Resident #3's pharmacy bill statement	D 420		

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D 420	Continued From page 111 dated 02/27/26 revealed: -Resident #3's previous balance on his account was $1,102.51. -Resident #3 owed $48 for prescription medications and $51.66 for over-the-counter medications for a total balance of $99.66 from 01/29/26-02/20/26. -There were no entries of payments made on the statement from 01/29/26-02/20/26. -Resident #3's total balance as of 02/27/26 was $1,202.17. Review of a handwritten note with no date provided by the Administrator revealed: -There was a list of six resident names with dollar amounts next to their names. -Resident #3's name was not included on the list. -The final listing was the facility's stock account number with the amount of $185.00 listed beside the entry. -The total of all the listed resident amounts and the stock account amount totaled $275.00. -A check number was written out beside the amount of $275.00. Telephone interview with facility's contracted Pharmacy Collections Supervisor on 03/06/26 at 10:41am revealed: -The Administrator last sent a check (check # 2167) to the pharmacy for $275 on 08/08/25 and wrote on a piece of paper a list resident names and how much to apply to each resident's account. -The Administrator instructed the pharmacy to pay $185 towards the facility's stock account and the remaining funds to the residents listed on the piece of paper. -Resident #3's account was credited $20 on 08/08/25 per the amount documented on the paper from the Administrator.	D 420		

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D 420	Continued From page 112 -Resident #3 still owed $1202.17 on his pharmacy bill. -There had been $2000 written off of Resident #3's bill in the past 5 years. -Resident #3's bill was sent to the facility's address. -There had been no additional payments since 08/08/25. Review of Resident #3's record revealed there were three withdrawls from Resident #3's personal funds from 11/18/25-01/15/26 including $10 on 11/18/25, $10 on 12/18/25, and $5 on 01/15/26 which documented the withdrawls were for "pharmacy bill". Telephone interview with the Collections Supervisor from the facility's contracted pharmacy on 03/06/26 at 10:41am revealed a payment of $20 was made on Resident #3's account on 08/08/25 and no other payments had been made from 08/08/25-03/06/26. Interview with the Administrator on 03/06/26 at 2:20pm revealed: -Resident #3 had a POA but she always gave Resident #3 his money every month and Resident #3 signed his initials on the personal funds form. -She paid some towards Resident #3's pharmacy bill when the pharmacy sent a bill. -She did not know why the list of residents with credits to pay towards the pharmacy bill she created that was given to the surveyor did not match the list that was given to the pharmacy in August 2025. -She did not have on her list that Resident #3 paid any money towards his pharmacy bill in August 2025. -She was responsible for creating the list of residents and the amount of money to credit each resident when she sent a check to the pharmacy.	D 420		

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D 420	Continued From page 113 -She did not give residents' receipts for monies given to her to pay towards pharmacy bills because she did not know that she needed to. -She did not collect any money from the residents in February 2026 to pay towards pharmacy bills because she did not have any checks and had to wait on the Owner to bring her a new checkbook. Attempted telephone interview with Resident #3's power of attorney (POA) on 03/06/26 at 10:01am was unsuccessful. _____ The facility failed to ensure there was an accurate record of residents' personal funds accounted for by documenting the funds received, disbursements, and pharmacy account payments for 2 of 3 sampled residents. Monies were collected from 2 of 3 sampled residents which were to be paid towards pharmacy bills; however no payments had been made to the pharmacy since 08/08/25. No receipts were provided to residents when they gave funds to the Administrator. This failure was detrimental to the 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 03/06/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2026.	D 420		
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	D 433		

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D 433	Continued From page 114 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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This Rule is not met as evidenced by:
Based on observation and interviews, 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 #1, #2, #3 and #4).

The findings are:

Observation in the facility on 03/03/26 at 8:55am revealed there were no resident records in the facility.

Observation in the Administrator's office on 03/03/26 at 11:30am revealed:
-The Administrator's office was in a building separate from the facility.
-The resident records were stored in a bookcase outside the Administrator's office.

Interview with the Administrator on 03/03/26 at 11:33am revealed:
-The resident records were kept outside her office instead of in the facility.
-Documents kept coming up missing from resident records when the records were left in the building.
-The Owner of the facility told her to keep the records in the office instead of the facility.

Interview with a medication aide (MA) on 03/04/26 at 9:00am revealed:
-The resident records were kept in the Administrator's office.
-The resident records had not been stored in the facility since she started working there three years ago.

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RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 433	Continued From page 116 Interview with a Resident Care Coordinator (RCC) on 03/04/26 at 10:07am revealed: -The resident records had always been kept at the office since she had started to work there. -The resident records had never been stored in the facility. Interview with the Administrator on 03/04/26 at 10:30am revealed: -The Owner would not allow her to put the resident records back in the facility. -There had been "disgruntled" employees in the past who had taken documents out of resident records. -The documents could not be replaced. -There was a lockable storage alcove in the facility where the resident records could be stored. -She and the two RCCs were the only ones with keys to unlock the storage alcove. -She was working on an electronic version of each resident record. -Creating an electronic resident record was "tedious" and required her to upload each page separately. -Once the electronic records were uploaded medication aides and personal care aides could access the resident records. -A seven-page document had recently taken her one hour to upload into the electronic record. -She had reached out to the electronic medical record application support team to schedule training on how to more efficiently upload the documents into the system.	D 433		