Rec'd via email 4/21/26

PRINTED: 03/27/2026
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011372	A. BUILDING: _____ B. WING _____	R 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 5	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 and the Buncombe County Department of Social Services conducted an annual and follow up survey and complaint investigations on 03/03/26 - 03/04/26. The complaint investigations were initiated by the Buncombe County Department of Social Services on 01/02/26, 02/18/26, and 02/19/26.	D 000		
D 076	10A NCAC 13F .0306 (a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture that is clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 8 of 8 dining room chairs were clean and in good repair. The findings are: Review of the facility's census report dated 03/03/26 revealed there were 9 residents residing in the facility. Observation of the dining room on 03/03/26 at 9:00am revealed: -There were 8 dining room chairs.	D 076		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacey Rusell — TITLE: Administratn — (X6) DATE: 4/21/2026

STATE FORM 6899 5IN711 If continuation sheet 1 of 20

Reviewed & acknowledged 4/22/26
RP

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D 076	Continued From page 1 -The upholstered fabric on the seats and backs of 8 chairs were heavily stained with brown and gray grime. -One chair had 4 large horizontal tears across the seat with the foam material visible. -Five chairs had 1 large horizontal tear across the seat with the foam material visible. -The stain on the wood of the chairs was faded and coming off in areas and scratched throughout. Review of the facility's local county environmental health department report dated 02/16/26 revealed photos were reviewed of bed bugs inside the dining room. Interview with one resident on 03/04/26 at 4:07pm revealed the chairs had looked the same way for a long time and thought they should look better. Interview with a second resident on 03/04/26 at 4:11pm revealed: -The chairs were damaged. -The chairs needed to be cleaned or replaced. Interview with a third resident on 03/04/26 at 4:09pm revealed he did not like sitting on the dining room chairs to eat his meals so he ate all his meals in his room. Interview with the Resident Care Coordinator (RCC) on 03/03/26 at 2:21pm revealed: -She would not sit on the dining room chairs because of the condition they were in. -She was not responsible for making decisions about purchasing new furniture. Interview with the Administrator on 03/03/26 at 2:30pm revealed: -She was aware of the condition of the chairs	D 076	Maintenance Director has ordered new chairs for the facility. Once arrived they will be swapped with the current chairs, and the old chairs will be disposed of.	4-25-2026

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D 076	Continued From page 2 because it was brought to her attention from staff from DHSR Construction on 02/18/26. -She was looking at options for the chairs. -The staff never reported the condition of the chairs to her. -She walked through the facility at least two times per week and she never noticed the chairs.	D 076		
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 B 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 bugs. The findings are: Review of the facility's local county environmental	D 079		

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D 079	Continued From page 3 health department report dated 02/16/26 revealed: -There were 12 residents residing in the facility. -The facility received 22 demerits (approved score is 40 demerits or less). -Bed bugs were currently an active issue at the facility. -Photos were reviewed of bed bugs inside the dining room. -Staff observed bed bugs in the laundry room, in one resident's room, on the couches in the living room, and on a resident's clothing and in his beard. Review of the facility census report on 03/03/26 revealed there were 9 residents currently in the facility. Review of information about bed bugs from the Centers for Disease Control (CDC) dated 04/26/24 revealed: -Bed bug infestations usually happened around where people slept. -Bed bugs hid during the day in the seams of mattresses, box springs, bed frames, headboards, dressers, in cracks, in crevices, and behind wallpaper. -Bed bugs could travel over 100 feet at night but tended to live within eight feet of where people slept. -Signs of infestations included bites on the face, neck, arms, and other parts of the body, exoskeletons and live bed bugs in the folds of mattresses and sheets, rusty colored blood spots on mattresses, sheets, and nearby furniture, and a sweet musty odor. -Professional pest control companies should be contacted to treat bed bug infestations. Observation of an empty office in the facility on	D 079		

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D 079	Continued From page 4 03/04/26 at 9:34am revealed there were multiple dead bedbugs on the floor near the walls. Interview with one resident on 03/03/26 at 9:20am revealed the Maintenance Director sprayed his room for bed bugs on 03/02/26 and he saw bed bugs in a common bathroom one month ago. Interview with a second resident on 03/03/26 at 9:30am revealed he saw bed bugs in the living room last week and the staff had sprayed for the bugs, but professional pest control had not been to the facility "in a while". Telephone interview with a third resident on 03/03/26 at 3:34pm revealed: -He left the facility the previous weekend and went to a family member's home because he was "terrified" of the bed bugs. -He found a bed bug on the ace bandage on his lower leg and some fell out of the ace bandage as it was being removed. -He received a new electric wheelchair and did not want it infested with bed bugs. -There were not a lot of bed bugs in his room until the room next door was sprayed for the bugs and then the bugs "came running" to his room. Review of text messages from the third resident on 02/23/26 and 02/27/26 revealed: -There was a photo of a bed bug on his ace bandage on his leg. -There was a photo of 4 bed bugs on a sheet that fell out of the ace bandage on the leg. Interview with a fourth resident on 03/04/26 at 4:09pm revealed: -He saw bed bugs in his room on 03/03/26. -Staff came to take his mattress and there were about 20-30 live bed bugs under it.	D 079		

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D 079	Continued From page 5 Interview with a fifth resident on 03/04/26 at 2:15pm revealed: -He first saw bed bugs about 3 months ago. -He saw the bugs in the kitchen, living room, and in his room. -There had not been any treatment for the bed bugs until last week. Interview with a sixth resident on 03/04/26 at 2:27pm revealed: -He first saw bed bugs 2 months ago and reported it to staff. -He saw bed bugs in his bed. -He knew the staff treated bed bugs in one resident's room in the past but not the entire facility. -The facility did not do anything about the bugs until this past week. Interview with a personal care aide (PCA) on 03/03/26 at 9:40am and 03/04/26 at 2:30pm revealed: -The facility started treatment for the bed bugs last week. -The bed bugs were in the facility for at least 1 to 2 months. -The facility sprayed for the bugs one time, but then the bugs came back. -One resident complained about bed bugs in his room. -Another resident's room was treated for bed bugs and his room changed two times. -She saw a bed bug in a resident's room and in the staff's bathroom in the last 7 days. -The facility was treated for bed bugs last year about mid year. Interview with a medication aide (MA) on 03/04/26 at 2:45pm revealed:	D 079	After initial treatments that was completed by maintenance director and staff, a local pest control company, [redacted], was contracted and has been doing follow up visits and treatments on a bi-weekly basis. This will continue to occur as long as necessary.	4-1-26

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D 079	Continued From page 6 -There were bed bugs in the facility. -Some staff had bed bugs on them. -Staff reported the bed bugs to the Administrator. Interview with a second MA on 03/04/26 at 2:52pm revealed: -The facility had bed bugs for at least 6 months. -She saw bed bugs in the kitchen and residents showed her bed bugs. -She was bitten by the bed bugs in this facility several times and reported it to management and now worked at a sister facility. -She was informed by management that the pest control company was coming to spray. -Pest control had not been to the facility for at least 2 months. Interview with a third MA on 03/04/26 at 2:56pm revealed: -There were bed bugs in the facility. -She saw some bed bugs in a resident's room two months ago and reported it to the Administrator. -She saw bed bugs again about 3 weeks ago. Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 2:16pm revealed: -Staff reported to the Administrator there were bed bugs in the facility 1 - 2 months ago. -Her office was in another building, but she walked through the facility daily and did not see any bugs. Interview with the Maintenance Director on 03/03/26 at 10:48am and 03/04/26 at 11:35am revealed: -The facility had bed bugs and he emailed the Owner and he responded that pest control sprayed for the bugs. -There were two different pest control companies	D 079		

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D 079	Continued From page 7 that came out to the facility last year and sprayed for the bugs. -The treatment that the pest control companies did was not effective. -He researched on the internet how to get rid of the bed bugs and found a company to purchase a heat tent from. -The tent was delivered on 02/24/26 and the recommendation was to put all the resident's belongings in the tent and heat them to above 120 degrees Fahrenheit for 1-3 hours. -He started this procedure last week on Friday (02/27/26). -He did not consult with anyone from a professional pest control company about the bed bug treatment he found on the internet. -All items were removed from the resident's room and heat treated for 1 - 3 hours at 132 degrees Fahrenheit outside in a tent. -They were completing 3 rooms at a time and would be done by the end of the day on 03/03/26. -The floors were swept, and mopped, and the entire room to include outlets and vents were sprayed with an insecticide. -All the mattresses and couches were covered in a flame-resistant plastic, and it would be left like that for 1 month to kill any bed bugs. -He purchased new sheets, blankets, and pillows for the residents. -He thought the facility was bug free now. -The facility did not have a contract with a pest control company. Observation of the outside grounds of the facility on 03/03/26 at 10:49am revealed there was a large black tent that contained mattresses and dead bed bugs on the floor of the tent. Review of Service Reports from a local pest control company revealed:	D 079		

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D 079	Continued From page 8 -Room 11 was treated for bed bugs on 03/31/25. -The facility's resident rooms, and common areas were treated for bed bugs on 04/10/25. -The facility's resident rooms were treated for bed bugs on 05/02/25. Review of Service Reports from a second local pest control company revealed: -The facility was treated for bedbugs on 08/27/25. -The common areas and resident rooms were treated for bed bugs on 11/30/25. Review of an email from the second pest control company dated 12/11/25 revealed: -He inspected the facility and found live bed bugs. -He recommended an initial treatment and then an on-going monthly service to prevent future bed bug problems. Interview with the Administrator on 02/18/26 at 2:00pm revealed: -She was unaware of the magnitude of the bed bug situation. -She was going to make arrangements for pest control to evaluate the facility, which included the use of a vacuum cleaner. -The facility did not own a vacuum cleaner. Interview with a Field Inspector with a third local pest control company on 02/18/26 at 3:30pm revealed: -He inspected the facility that same day and confirmed bed bugs were in rooms 2, 3, 7, and 9. -He gave written treatment recommendations to the Administrator and which included removing resident belongings, vacuuming the mattresses, cleaning and vacuuming the common areas. -Nothing should be taken back into the facility until treatment was completed. -He was scheduled to return to begin the	D 079		

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D 079	Continued From page 9 treatment the following week. Observation of the facility on 02/20/26 at 2:00pm revealed: -Resident rooms 2, 3, 7, and 9 still contained resident belongings. -One resident was in bed where bed bugs had been observed on the mattress by the Field Inspector two days earlier. Interview with a PCA on 02/20/26 at 2:15pm revealed they had not received instructions to prepare the facility for bed bug treatment. Interview with the Adminstrator on 02/20/26 at 2:30pm revealed: -There were plans to prepare the facility for bed bug treatment the weekend of 02/21/26. -The pest control personnel were supposed to be begin treatment on 02/27/26. -She had been unable to prepare the facility for bedbug treatment due to "meetings." Interview with the Field Inspector from the third pest control company on 02/20/26 at 3:00pm revealed: -The pest control company was available to treat the facility on 02/23/26. -The facility scheduled treatment for 02/27/26. Review of an email from the Administrator to the Field Inspector from a local pest control company dated 02/26/26 revealed: -The Administrator postponed the scheduled treatment for bedbugs. -The Owner and Maintanance Director were doing "some kind of heat treatment" for the bedbugs. Telephone interview with the same Field	D 079		

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D 079	Continued From page 10	D 079		

Inspector at the third local pest control company on 03/04/26 at 9:53am revealed:
-The facility had a "major" bed bug infestation.
-His company was scheduled to start their procedure to rid the facility of the bed bugs on 02/25/26 but the facility postponed it.
-He tried to speak with the Administrator, but she would not return his telephone calls, so he drove out to the facility on Friday (02/27/26) and saw the facility was in the process of heat treating items themselves.
-The heat treatment the facility did would not exterminate all the bed bugs as heat treating only worked if the entire building was heat treated at once with a temperature greater than 140 degrees Fahrenheit.
-The chemical spray the facility used was a disinfectant and not the same chemicals the pest control company would use to exterminate the bedbugs.
-The chemical spray the facility used would not be effective long term because the bed bugs retreated into the walls only to come out into the open at a later date.

Interview with the Administrator on 03/04/26 at 10:00am and 2:34pm revealed:
-The bed bugs were always contained in one resident's room.
-She and the Maintenance Director sprayed an over-the-counter bed bug insecticide every 1 - 2 weeks.
-The staff sprayed daily in the facility.
-She thought the bed bug problem was resolved because they no longer saw any bugs.
-She informed the Owner that pest control was needed one month earlier.
-She made a contract with a local pest control company, and they assessed that there were bugs in 4 rooms and recommended the entire

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D 079	Continued From page 11 facility be treated but the Owner of the facility decided on a different treatment. Telephone interview with the facility's Owner on 03/04/26 at 3:30pm revealed: -He knew there were bed bugs in the facility and the staff continuously sprayed insecticide in the facility and multiple pest control companies had been out to the facility last year to spray for the bed bugs. -He thought the pest control companies were incompetent or wanted more business because what they did to get rid of the bed bugs was not effective. -He and the Maintenance Director started a new heat treatment, and he knew it worked because he saw the dead bed bugs. -All items in the residents' rooms were heat treated in a tent outside and the rooms were cleaned and sprayed with insecticide. -He would contact a pest control company if the heat treatment did not work, but he knew it worked because he saw the dead bed bugs. -He was doing much more to get rid of the bed bugs than the pest control companies. -He had spent $15,000 - $20,000 on the bed bug issue. _____ Management failed to ensure that the facility was clean and free of hazards related to long term bedbug presence. Resident complained to staff of bed bug activity in the facility periodically for approximately 10 months. The facilty contacted a pest control company on 12/11/25 that recommended an initial treatment and then monthly services thereafter to prevent future issues; services were never completed. On 2/18/26, another pest control company was contacted and completed a site visit where active bedbugs were found in multiple rooms. This pest	D 079		

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D 079	Continued From page 12 control company gave written treament recommendations, instructions on how to prepare the facility for treatment and scheduled a treatment date. On 2/26/26, the Administrator canceled the appointment for treatment indicating the Owner decided to complete their own alternative treatment which began on 2/27/26. The delay of treatment from 12/11/25 - 02/27/26 resulted in continued bed bugs throughout the facility, including bedrooms, eating areas and other common areas. In addition, during this time, bed bugs were found on resident's bodies with some residents having bites and skin irritation. This failure was detrimental to the health safety and welfare of the residents and constitutes a B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/26. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 18, 2026	D 079		
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.	D 282		

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D 282	Continued From page 13 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure food stored and served to all residents was protected from contamination related to foods stored that were not labeled, dated or discarded, the sanitation of the refrigerators and freezers, and proper storage of chemicals. The findings are: 1. Observation of the kitchen on 03/03/26 from 9:00am to 3:45pm revealed: -There were two large, plastic zipper bags of sliced cheese that were opened, removed from their original packaging and located in the refrigerator that were not labeled with the date they were opened or placed in the refrigerator. -There were two plastic zipper storage bags of deli meat that were opened and unlabeled in the refrigerator. -There were two gallons of unopened milk located in the refrigerator and had expiration dates of 03/01/26 and 03/02/26. -There were loose food particles and food stains located on the refrigerator floor. -There were two containers of cleaning chemicals stored on the counter near the stove where food served to residents was being prepared. -There were five large, zipped bags of pancakes and waffles that had been removed from their original packaging and located in the storage freezer in the living room that were not labeled and not dated.	D 282		

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	HAL011372	A. BUILDING: _____ B. WING _____	R 03/04/2026

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D 282	Continued From page 14 Interview with a PCA on 03/03/26 at 12:10pm revealed: -The personal care aides (PCA) were responsible for preparing the meals served to residents. -The food for each meal was delivered daily to the home from another facility on the premises. -She temporarily stored the chemicals on the counter near the stove and planned to place them under the sink. -She did not know opened containers and food items stored in the refrigerators, freezers or cabinets and served to residents, were supposed to be labeled with the date they were opened/ stored. -She was not aware there were gallons of expired milk in the refrigerator. -The PCAs were responsible for cleaning and sanitizing the refrigerator and kitchen to ensure spills were cleaned up. -She did not know when the last time the refrigerator was sanitized. Refer to interview with the Maintenance Director on 03/04/26 at 11:40am. Refer to interview with the Resident Care Coordinator (RCC) on 03/04/26 at 10:45am. Refer to interview with the Administrator on 03/04/26 at 12:20pm. 2. Observation of the food storage room located in another facility on the premises on 03/03/26 at 2:31pm revealed: -There was ice buildup on the reach-in freezer floor and ice buildup on raw frozen food located on the reach-in freezer floor. -There were three large boxes of oranges and bananas that were covered with gray and green	D 282	Staff has been instructed on proper storage of food. Night shift staff has been assigned the task of cleaning out the fridge and discarding expired foods/drinks. SIC/RCC/ED monitor this to ensure that it is being completed.	4-1-26

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D 282	Continued From page 15 fuzz. -There were two containers of chemicals stored above food served to residents. Refer to interview with the Maintenance Director on 03/04/26 at 11:40am. Refer to interview with the RCC on 03/04/26 at 10:45am. Refer to interview with the Administrator on 03/04/26 at 12:20pm. --- Interview with the Maintenance Director on 03/04/26 at 11:40am revealed: -He was responsible for placing weekly food orders through the facility's contracted food service provider, unloading food deliveries, storing the delivered food in the storage freezers and completing weekly menus. -He did not know he was required to label and date food items when they were removed from their original packaging and stored in the resident homes on the premises. -He rotated older food to the front of the freezers when new food deliveries arrived. -The RCC was responsible for cleaning the overstock storage room. -Night shift and day shift PCAs were responsible for obtaining food from the storage room and delivering to their assigned house to prepare the following day. -He believed the unopened expired milk found in the kitchen that serviced residents had been previously frozen. -He expected a better system for identifying expired foods, labeling / dating opened foods stored for residents and sanitation of the storage room.	D 282		

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D 282	Continued From page 16 Interview with the RCC on 03/04/26 at 10:45am revealed: -She was responsible for overseeing all PCAs and their duties such as sanitation of the kitchens and storing chemicals separately from resident food and discarding expired foods. -There was not a log or schedule for staff to sign when sanitation of the kitchen was conducted. -She did not know opened foods stored for resident consumption should have been dated or labeled. -She expected all staff to discard spoiled foods appropriately and sanitize kitchens daily. Interview with the Administrator on 03/04/26 at 12:20pm revealed: -The RCC was responsible for overseeing food distribution to resident homes, sanitation of the food storage room and the PCAs who prepared meals for residents. -The Maintenance Director was responsible for placing food orders with the facility food provider, stocking the food deliveries and distributing menus to the resident homes. -She was not aware opened foods stored for consumption needed to be dated and labeled. -The PCAs were responsible for sanitizing the kitchen and discarding expired foods.	D 282		
D 290	10A NCAC 13F .0904(c)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule.	D 290		

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D 290	Continued From page 17 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements. The findings are: Observation of the kitchen on 03/03/26 at 9:10am revealed: -There was no prepared menu available for the following week. -The current week's menu was posted and did not have serving quantities specified. Observation of the lunch meal served to residents on 03/03/26 at 12:05pm revealed residents were served a cheeseburger, mixed vegetables, onion rings, an orange, a glass of milk and a glass of water. Interview with a personal care assistant (PCA) who prepared and served the lunch meal on 03/03/26 at 12:15pm revealed: -She prepared and served breakfast, lunch and snacks to residents when she worked the day shift. -She was not aware the menu was supposed to have serving quantities listed as a guide.	D 290	Menus have been obtained from Groves and include portion sizes and include up to a week of meals. These menus are printed by the administrator and passed to the facility at the beginning of each week. Administrator also sends via email the menus to maintetence director so he can order food supply accordingly. During daily rounds, SIC, MTs and RCCs as well as ED will monitor meal times to ensure that proper food portions are being served.	4-1-26 4-1-26

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D 290	Continued From page 18 -She did not measure how much food she served on each plate before serving it. Interview with the Maintenance Director on 03/04/26 at 11:40am revealed: -He was responsible for placing weekly food orders through the facility's contracted food service provider, unloading food deliveries, storing the delivered food in the storage freezers and completing weekly menus. -He usually completed menus for the following week by Wednesday of each week after he received them electronically from the Administrator. -He did not know menus were supposed to be completed one week in advance with serving quantities specified. Interview with the Administrator on 03/04/26 at 12:20pm revealed: -She was responsible for receiving the menus from the contracted food provider. -The Maintenance Director was responsible for distributing the menus to the kitchen for the PCAs to post. -She did not know menus were supposed to be completed one week in advance with serving quantities specified. -She expected menus provided by the contracted food provider to show portion sizes for kitchen staff guidance.	D 290		
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	D 292		

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D 292	Continued From page 19 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. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure any substitutions made in the menu shall be of equal nutritional value, maintaining the daily dietary requirements and documented in records maintained in the kitchen to indicate the foods served to residents. The findings are: Observation of the kitchen on 03/03/26 at 09:15pm revealed: -The current week's menu dated February 26 - March 4, 2026, was posted in the kitchen and was signed by a dietician on 2/13/26. -The lunch menu for Tuesday 03/03/26 listed residents were to be served beef and pork kielbasa with onions, peppers and a dinner roll. -The substitution log was posted with the weekly menu with no dates of meal substitutions. -The substitution log did not show the lunch meal was being substituted for Tuesday 03/03/26. -There was documentation written on the bottom of the menu to use overstock to increase nutrition if available.	D 292	Staff has been instructed that any substitution MUST be written on the substitution log supplied to them by administrator and failure to do so will result in corrective actions for them. Administrator is also to approve any substitutions that are made. Logs will be monitored by RCCs and Ed.	4-1-26

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D 292	Continued From page 20 Observation of the lunch meal on 03/03/26 at 12:05pm revealed the lunch meal served to residents on 03/03/26 at 12:05pm revealed residents were served a cheeseburger, mixed vegetables, battered onion rings, an orange, a glass of milk and a glass of water. Interviews with residents eating lunch in the dining room on 03/03/26 at 12:10pm revealed: -They were not made aware when menu items were changed and did not know what the menu was unless they asked staff. -They were not offered alternatives. Interview with the personal care aide (PCA) on 03/03/26 at 12:20pm revealed: -She did not review the menu to ensure the correct items were being prepared. -Day and night shift staff were responsible for pulling the food items from the storage room for the following day. -She prepared the meals according to what was delivered the previous day from the storage room. -She did not write the substitution food items on the substitution log or date it. -She was aware there was a substitution log and that it should be filled out. Interview with the Maintenance Director on 03/04/26 at 11:40am revealed: -He usually completed menus for the following week by Wednesday of each week after he received them electronically from the Administrator. -Substitution menu items were made if the listed menu items were not available when the PCA pulled the meal items from the storage room. -The PCAs who prepared and served resident meals were responsible for completing the substitution log.	D 292		

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D 292	Continued From page 21 Interview with the Administrator on 03/04/26 at 12:20pm revealed: -Substitutions were determined when the listed menu items were not available and were based on resident preferences. -The meal substitution log was placed in all kitchens and she expected those logs to be completed as needed.	D 292		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews, interviews and observation, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #3) related to medications to treat cholesterol, tremors, and post-traumatic stress disorder. The findings are: Review of Resident #3's current FL2 dated 05/22/2025 revealed: -Diagnoses included post-traumatic stress disorder (PTSD), tardive dyskinesia, and hyperlipidemia. -There were medication orders for atorvastatin	D 358		

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D 358	Continued From page 23 due to it not being available. -There was documentation on 03/03/26 at 9:13am, the drug was not administered due to it being available. Observation of Resident #3's medications available for administration on 03/03/2026 at 3:00pm revealed: -There was no atorvastatin medication available. -There was no prazosin medication available. -There was no propranolol medication available. Interview with an medication aide (MA) on 03/04/2026 at 10:15am revealed: -She worked as the MA on 03/02/2026. -She did not remember Resident #3 running out of any medications. -If a resident runs out of medication, the MAs were supposed to notify the Resident Care Coordinator (RCC) and Administrator by text in the MA group chat. -Many of the residents ran out of medications a few days before the delivery of the monthly cycle fill almost every month. -She did not know why they are always running out early. -She did inform the MA group chat. -MAs may have dropped a medication and then popped another medication to replace the wasted one. -If the MA wasted a medication and did not let the MA group chat know they cannot replace the wasted medication and would always be running out early. Interview with a second MA on 03/04/2026 at 10:30am revealed: -She administered medications to Resident #3 on 03/03/2026. -She did not remember the resident running out	D 358		

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D 358	Continued From page 24 of any medications. -At the beginning of the month prior to the cycle fill arriving, many of the residents ran out of medications. -She believed some of the MAs would get careless and drop medications and they did not notify anyone so the medication could be replaced. -The MAs were supposed to notify the MA group chat when a resident was out of a medication. Interview with the Pharmacy on 03/04/2026 at 10:47am revealed: -The facility received a cycle fill for all routine medications every 28 days. -The cycle fill for the month of March was delivered on 03/03/2026 with a start date for administering the medications on 03/05/2026. -If a resident ran out of routine medications prior to the cycle fill start date the facility could have notified the pharmacy and the pharmacy could have provided the medication to bridge the gap and not missed any medications. Interview with the RCC on 03/04/2026 at 11:00am revealed: -The MAs must notify the RCC in the MA group chat when a resident is out of a medication. -There had always been a problem with residents running out of medications a couple of days prior to the delivery of the cycle fill medications for the facility. -This had been happening since she started working in the office about 1 year ago. -This had been reported to the Administrator. -She was not sure why the residents ran out before the cycle fill delivery. -The MAs probably dropped a medication and that is why they ran out early.	D 358		

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D 358	Continued From page 25 Interview with Resident #3's Primary Care Physician (PCP)on 03/03/2026 at 3:30pm revealed: -He does not have any concerns about Resident #3 missing his atorvastatin, prazosin or the propranolol. -None of the medications would have a significant impact after missing a few days. Interview with Resident #3 on 03/04/2026 at 4:30pm revealed: -He ran out of one of his medications yesterday (03/03/2026). -He did not remember missing any other medications for this month. -He did not have any problems due to missing his medication yesterday. Interview with the Administrator on 03/03/2026 at 11:00am revealed: -They received the cycle fill medications for the facility from the pharmacy today (03/03/26). -There should have been medications available for 2 days since the new cycle start date was 03/05/2026. -The MA was supposed to send a text message on the MA group chat to inform the Administrator and the RCC when a resident was out of a medication. -The RCC would order the medication from the pharmacy. -The RCC relied on the MA to inform them via text when a resident was out of a medication otherwise, they had no way of knowing. -They had not performed medication cart audits.	D 358	RCCs are ensuring that all meds are available by checking the med carts weekly. Any medications that may not have an appropriate supply are being ordered/requested from the pharmacy to ensure that there is an adequate supply. Staff is also ensuring to report to RCCs when medications are running low by reporting how many tablets of a medications are remaining when they do med passes using the 5 day supply method....which is: 5 tablets remaining for QD orders, 10 tablets remaining for BID orders and 15 tablets remaining for TID or greater orders. If there are any issues obtaining meds, RCCs are reported to PCPs.	4-1-26
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records	D 433		

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D 433	Continued From page 26 (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the 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),	D 433	RCCs have put together a large binder that contains each residents facesheet, DNR (if applicable), FL2, medication lists, diet orders, care plans for review upon request or as staff my need. We will continue to electronically upload ordes so that they are available to med techs as needed.	4-1-26

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D 433	Continued From page 27 (6) and (7) above may be sent with the resident. 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 3 of 3 sampled residents (Resident #1, #2, and #3). The findings are: Observation in the facility on 03/03/26 at 9:00am revealed there were no resident records in the facility. Interview with a personal care aide (PCA) on 03/04/26 at 9:40am revealed: -The residents' records were kept in the office building. -She would call the Resident Care Coordinator (RCC) if she had a question about a resident's care. Interview with the RCC on 03/03/26 at 2:21pm revealed: -The resident records were always kept in management office building. -She knew the records should be in the facility but the Administrator made the decision to keep them in the office building. Interview with the Administrator on 03/03/26/ at 2:30pm revealed: -She knew the residents' records should be kept in the facility but they were not. -The facility had a history of "disgruntled" staff that removed documents from resident records	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011372	A. BUILDING: _____ B. WING _____	R 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 5	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 28 and so it was not safe to have the records in the facility. -There was a binder in the facility for staff to use that contained copies of residents' facesheets and code status but she found the binder in residents' rooms and then it was removed from the facility.	D 433		