STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 investigation on 03/30/22 - 04/01/22 with an exit conference via telephone on 04/01/22. The complaint investigation was initiated by the Buncombe County Department of Social Services on 03/23/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 4 sampled residents (#3, and #4) related to failure to notify the mental health provider (MHP) of three Emergency Department (ED) visits related to suicidal ideation (#4) and missed an audiology appointment for 02/20/22 and wound care appointment for 01/13/22 (#3). The findings are: 1. Review of Resident #4's current FL2 dated 10/25/21 revealed: -Diagnoses included adjustment disorder with depressed mood, borderline personality disorder, complex post-traumatic stress disorder, borderline intellectual functioning, type II diabetes, hypertension, hyperlipidemia and asthma.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 1 Review of the Resident Register for Resident #4 revealed an admission date of 10/18/21. Review of discharge instructions from the hospital Emergency Department (ED) for Resident #4 dated 01/07/22 revealed: -Resident #4 had presented to the ED with suicidal ideation, major depressive disorder, recurrent, unspecified, adjustment disorder with depressed mood, borderline intellectual functioning, borderline personality disorder and post-traumatic stress disorder. -Follow up recommendations from the ED physician included a referral to enhanced services like community support team (CST) or assertive community treatment team (ACTT). -The appointment time for intake to secure a CST or ACTT team was 01/10/2022 at 10:00am. Telephone interview with the provider of the CST/ACTT services on 03/31/22 at 10:38am revealed: -They never received a referral from the facility or completed an intake for Resident #4 on 01/10/22. -Resident #4 had "just presented" to their program on 01/25/22 without an appointment. -The reason Resident #4 presented to their program on 01/25/22 was his desire to be involved in their housing program. -An assessment intake for Resident #4 on 01/25/22 revealed a need for a community support team. -Resident #4 was assigned to a community support team on 03/04/22. -An attempt to schedule Resident #4 for services on 03/07/22 was unsuccessful as the provider was unable to reach anyone to set up services for the CST program. -The CST team provider left a voicemail on a cell	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 273	Continued From page 2	D 273		

phone number of a facility staff on 03/07/22 and the call was not returned.
-The CST team went to the facility on 03/16/22 to initiate mental health services for Resident #4.
-When the CST team arrived at the facility, Resident #4 was being escorted to the hospital by law enforcement.
-They were told that Resident #4 had an outburst earlier that day and that was why he was being taken to the hospital.
-Because Resident #4 could not be initially evaluated on 03/16/22, he was rescheduled to be seen by CST at the facility on 03/25/22.

Review of the Computer Automated Dispatch (CAD, a report which documents 911 calls) dated 01/06/22 at 6:22 am revealed:
-Resident #4 intended to hurt himself.
-There were no specifics, just that Resident #4 had been feeling suicidal.
-Resident #4 had been talking about self-harm, but was also having difficulty breathing.

Review of the CAD report dated 03/16/22 at 9:47pm revealed:
-The call was related to a civil disturbance.
-Resident #4 sustained a cut to the hand and was found standing on the walkway with his hand bleeding.
-Resident #4 had been combative with staff and had broken some items inside the residence.
-Resident #4 was transported to the ED.

Review of the CAD report dated 03/26/22 at 12:23pm revealed Resident #4 attempted suicide by self-inflicting lacerations up and down both arms.

Telephone interview with Resident #4's MHP on 03/31/22 at 2:57pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 273	Continued From page 3 -Resident #4 was admitted to her care in November 2021 with a diagnosis of major depressive disorder and a personality disorder. -She was treating the resident for depression. -She was not notified by the facility when the resident was transported to the ED on 01/06/22, 03/16/22, and 03/26/22. -She found out the resident was admitted to the hospital on 03/26/22 when she came to the facility on 03/29/22 and the resident was not there. -If the facility had informed her of Resident #4's 03/16/22 incident with the resident she could have changed his medications and that may have prevented the suicide attempt on 03/26/22 because 10 days would have been long enough for a change in his medications to become effective. Interview with the Medication Aide (MA) on 03/30/22 at 2:35pm revealed: -On 03/26/22 between 11:00am and 12:00pm, Resident #4 was arguing with another resident. -The two residents were threatening to punch each other. -Resident #4 went to his room and then the MA heard what sounded like glass breaking. -The resident then came out of his room and walked to the kitchen. -He was angry and screaming and there was blood coming from both arms where he had cut himself in approximately eight places. -She called for Emergency Medical Services (EMS) and attempted to calm the resident down until EMS arrived. Interview with the MA on 03/31/22 at 2:00pm revealed: -She did not notify Resident #4's physician of his transport to the ED on 03/16/22 and 03/26/22. -She notified the Administrator.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 273	Continued From page 4	D 273		

-She did not remember if she had been trained to notify the physician.

Interview with the Resident Care Coordinator (RCC) on 04/01/22 at 8:32am revealed:
-She was not aware of the incident on 01/06/22 which resulted in an ED visit for Resident #4.
-She was not aware of the incident on 03/16/22 resulting in Resident #4 being transported to the ED for mental health reasons.
-The Administrator or staff should have made her aware.
-She was aware of the incident with Resident #4 on 03/26/22 when Resident #4 was sent to the ED and she had reached out to the psychiatrist who sees Resident #4 on 03/28/22.
-There had been a lot of changes with staff and a group text had been put into place to notify each other when there were incidents with residents.
-Staff were supposed to give documentation related to ED visits to her.

Interview with the Administrator on 03/31/22 at 1:45pm revealed:
-She did not know that Resident 4's physician had not been notified of his ED visits and hospitalizations on 01/06/22, 03/16/22 and 03/26/22.
-The MA that calls EMS for a resident to be transported to the ED should have contacted the physician to notify them and the MAs had been trained on this procedure.
-She did not have a process to ensure the primary care physician (PCP) was notified when a resident was transported to the ED.

2. Review of Resident #3's current FL2 dated 01/07/22 revealed diagnoses included diabetes mellitus type II, hyperlipidemia, obstructive sleep apnea, acute diastolic congestive heart failure.

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 5 a. Review of a physician order dated 05/15/21 for Resident #3 revealed: -Resident #3 had hearing loss in his right ear. -Resident had bilateral impacted cerumen (earwax). -There was an order to schedule an appointment with audiology. Interview with the audiology office on 03/31/22 at 1:52pm revealed: -Resident #3 had an appointment scheduled on 02/20/22 but had been a no call no show. -There had been no attempt to re-schedule the appointment for Resident #3 by the facility. Interview with Resident #3 on 03/30/22 at 11:10am revealed: -He had a growth in his ear. -His ear had been stopped up and he had some pain and also hearing loss. -He thought that a referral had been made about a year ago. -He had been telling staff about problems with his ear but they "never do anything." Observation of Resident #3's right ear canal with his permission on 03/30/22 at 11:10am revealed a pea sized growth. Interview with the Administrator on 03/31/22 at 3:20pm revealed: -The ENT office called her the day of his appointment in February 2022 and informed her they did not accept his medical insurance. -She did not attempt to find another ENT for the resident because the facility's contracted physician saw the resident, looked at his ear, and cleaned out the ear. -When referrals were made a MA schedules the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 273	Continued From page 6	D 273		

appointment and arranges transportation to the appointment.

b. Observation of Resident #3 on 03/30/22 at 11:10 am revealed:
-He was seated in a wheelchair.
-His right foot appeared very swollen.
-His left foot was wrapped and had a boot over it.

Review of a physician's order from a local hospital dated 12/30/21 for Resident #3 revealed:
-An admission to inpatient status with observation for 24 hours.
-A scheduled appointment for wound care on 01/06/22 at 3:00pm.

Telephone interview with a representative from the wound care clinic for Resident #3 revealed:
-He had not shown up to his scheduled appointment on 01/13/22.
-He was not rescheduled for the missed appointment.

Interview with Resident #3 on 03/30/22 at 11:10am revealed:
-His wounds were currently being addressed by home health.
-He was not aware of any missed appointments.

Interview with the Administrator on 03/31/22 at 3:20pm revealed:
- She did not know the resident had an appointment with wound care in January.
-If there had been paperwork for the new appointment it had been missed.
-When referrals were made a MA scheduled the appointment and arranged transportation to the appointment.
-When a resident returned from the appointment any paperwork was given to the Resident Care

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 273	Continued From page 7 Coordinator (RCC) to review for new appointments or orders. _____ The facility failed to ensure the mental health provider was notified after Resident #4 voiced self harm on 01/06/22 and after being combative with staff and self injury on 03/16/22 which resulted in a suicide attempt on 03/26/22 and hospitalization for 5 days. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/31/22. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 1, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (Residents #1, #3, and #4) related to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 8	D 358		

medications used to treat blood pressure, mood, pain, low thyroid hormone, psychotic behaviors, sleep, and seizures (#1), pain, blood pressure, swelling, high blood sugar, difficulty with urination, and blood clots (#3), and high blood sugar and difficulty sleeping (#4).

The findings are:

Review of the facility's undated Medication Administration Policy and Procedure revealed medications are to be administered and documented on the Medication Administration Record.

1. Review of Resident #1's current FL2 dated 07/19/21 revealed:
-Diagnoses included schizoaffective disorder, traumatic brain injury, and hypothyroidism.
-Medication orders included amlodipine (reduces blood pressure) 10mg daily, divalproex (mood stabilizer) 500mg three times daily, gabapentin (treats nerve pain) 300mg twice daily, levothyroxine (treats low thyroid hormone) 88mcg daily, metoprolol (lowers blood pressure and heart rate) ER 25mg daily, olanzapine (decreases psychotic behaviors) 10mg every morning and 20mg at bedtime, trazodone (induces sleep) 100mg daily, and Vimpat (reduces seizure activity) 200mg twice daily,

Interview with Resident #1 on 03/31/22 at 11:00am revealed he did not remember if his medications were administered on 03/19/22 or not.

Review of Resident #1's electronic Medication Administration Record (eMAR) for March 19, 2022 revealed:

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 9 a. There was an entry for amlodipine 10mg every day with an administration time of 8:00am and there was no documentation the amlodipine was administered on 03/19/22. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -The amlodipine was prescribed for high blood pressure. -Not receiving the amlodipine could cause the resident to have an increase in his blood pressure. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. b. There was an entry for divalproex 500mg three times daily with administration times of 8:00am, 2:00pm and 8:00pm and there was no documentation the divalproex was administered on 03/19/22. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Divalproex was a mood stabilizer medication. -Not receiving three doses of divalproex could have caused the resident to have a manic episode, decompensate and need hospitalization. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 10 Refer to the interview with the Administrator on 03/31/22 at 10:40am. c. There was an entry for gabapentin 300mg twice daily with administration times of 8:00am and 8:00pm and there was no documentation the gabapentin was administered on 03/19/22. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Gabapentin was prescribed for nerve pain. -Not receiving the gabapentin may have caused the resident to have an increase in pain. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. d. There was an entry for levothyroxine 88mcg daily with an administration time of 8:00am and there was no documentation the levothyroxine was administered on 03/19/22. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Levothyroxine was prescribed for low levels of thyroid hormone. -Not receiving the levothyroxine may alter the resident's thyroid levels. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 11	D 358		

Coordinator (RCC) on 03/31/22 at 10:30am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

e. There was an entry for metoprolol 25mg daily with an administration time 8:00am and there was no documentation the metoprolol was administered on 03/19/22.

Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed:
-Metoprolol is a medication that lowers blood pressure and heart rate.
-Missed doses of metoprolol could cause the resident's blood pressure and heart rate to increase.

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

f. There was an entry for olanzapine 10mg every morning with an administration time of 8:00am and 20mg at bedtime with an administration time of 8:00pm and there was no documentation the olanzapine was administered on 03/19/22.

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am.

Refer to the interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 12 03/31/22 at 10:40am. g. There was an entry for trazodone 100mg at bedtime with an administration time of 8:00pm and there was no documentation the trazodone was administered on 03/19/22. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Trazadone was prescribed for sleep. -Not receiving the trazadone could have caused Resident #1 to have sleeplessness. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. h. There was an entry for Vimpat 200mg twice daily with an administration time of 8:00am and 8:00pm and there was no documentation the Vimpat was administered on 03/19/22 at 8:00am or 8:00pm. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Vimpat was prescribed to reduce seizure activity. -Not receiving the Vimpat could have caused the resident to have a seizure. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 13 Refer to the interview with the Administrator on 03/31/22 at 10:40am. 2. Review of Resident #3's current FL2 dated 01/07/22 revealed: -Diagnoses included diabetes mellitus type II, hyperlipidemia, obstructive sleep apnea, and acute diastolic congestive heart failure. -Medication orders included lispro (treats high blood sugar) 13 units three times daily, Allopurinol (treats gout) 100mg daily, amlodipine (reduces blood pressure) 5mg daily, lispro insulin (controls blood sugar) 100 units/ml Sliding Scale Insulin (SSI) three times daily, lantus insulin (treats high blood sugar) 100 units/ml inject 39 units at bedtime, Spironolactone (reduces blood pressure and swelling) 25mg daily, tamsulosin (treats enlarged prostate) 0.4mg daily, trazadone 150mg tablet ½ tablet at bedtime, and Xarelto (used to prevent blood clots) 10mg at bedtime. Interview with Resident #3 on 03/31/22 at 9:00am revealed: -The MA did not administer medications on 03/19/22 the entire day. -The MA informed him she was the only one to administer medications to the residents in this facility and three sister facilities. -It was too late to administer 8:00am medications when the MA arrived at the facility on 03/19/22 approximately 12:00pm. -He had refused his medications because it was too late. Review of Resident #3's electronic Medication Administration Record (eMAR) for March 19, 2022 revealed: a. There was an entry for Allopurinol 100mg daily with an administration time of 8:00am and there	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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D 358	Continued From page 14	D 358		

was no documentation Allopurinol was administered on 03/19/22 at 8:00am.

Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed:
-The Allopurinol was used to treat gout.
-Not receiving the Allopurinol could cause the Resident #3 to have a flare up of gout and worsening pain.

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

b.There was an entry for amlodipine 5mg daily with an administration time of 8:00am and there was no documentation amlodipine was administered at 8:00am on 03/19/22.

Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed:
-The amlodipine was prescribed for high blood pressure.
-Not receiving amlodipine as ordered could result in an increase in Resident #3's blood pressure.

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15 c. There was an entry for insulin lispro 100 units/ml SSI three times daily with administration times of 8:00am, 12:00pm, and 5:00pm and there was no documentation that the 8:00am dose and the 12:00pm doses were administered on 03/19/22. There was documentation of finger stick blood sugar (FSBS) checks on 03/19/22 at 4:30pm with results of 233 and on 03/20/22 at 8:00am of 223. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -Resident #3 was prescribed lispro insulin to control high blood sugar. -If the insulin was not administered as orderd, it could be detrimental and result in uncontrolled high blood sugar (hyperglycemia-a dangerous condition that can lead to coma and/or death). Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. d. There was an entry for Lantus insulin 41 units at bedtime and there was documentation Lanuts 41 units was administered on 03/19/22 at 8:00pm. Interview with Resident #3 on 03/31/22 at 9:00am revealed the MA did not administer medications on 03/19/22 the entire day. Telephone interview with the facility's contracted	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 16	D 358		

physician on 03/31/22 at 5:16pm revealed:
-The lantus was prescribed to control high blood sugar.
-Failure to administer lantus as ordered could result in a worsening uncontrolled high blood sugar (hyperglycemia-a dangerous condition that can lead to coma and/or death).

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

e. There was an entry for Spironolactone 25mg daily with an administration time of 8:00am and there was no documentation Spironolactone was administered on 03/19/22 at 8:00am.

Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed:
-The Spironolactone is prescribed to reduce swelling and blood pressure.
-Failure to administer the Spironolactone as ordered could result in increased blood pressure and
swelling.
-Medications should be administered as ordered.

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 17 f. There was an entry for tamsulosin 0.4mg daily at 8:00am and there was no documentation tamsulosin was administered on 03/19/22 at 8:00am. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -Resident #3 was prescribed to address difficulty with urination. -Failure to administer tamsulosin to Resident #3 as prescribed could result in increased difficulties with urination. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. g. There was an entry for Xarelto (used as a blood thinner) 10 mg tablet to be administered at bedtime with food and was documented as administered on 03/19/22 at 8:00pm. Interview with Resident #3 on 03/31/22 at 9:00am revealed the MA did not administer medications on 03/19/22 to any of the residents in the facility the entire day. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -The Xarelto is used to treat blood clots. -Not receiving Xarelto could result in Resident #3 having blood clots. Refer to the telephone interview with a Medication	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 18 Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. 4. Review of Resident #4's current FL2 dated 10/25/21 revealed: -Diagnoses included adjustment disorder with depressed mood, borderline personality disorder, complex post-traumatic stress disorder, borderline intellectual functioning, type II diabetes, hypertension, hyperlipidemia and asthma. -Medication orders included lispro insulin (to reduce high blood sugar) 100u/ml Sliding Scale Insulin (SSI) four times daily, Januvia (used to treat high blood sugar) 100mg daily, lantus insulin (treats high blood sugar) 100 units/ml, inject 155 units at bed, Humulin insulin (reduces high blood sugar) inject 100 units twice daily, Victoza (treats high blood sugar) 0.6 mg/0.1 ml daily, farxiga (treats high blood sugar) 10mg tablet daily Review of Resident #4's electronic Medication Administration Record (eMAR) for 03/19/22 revealed: a. There was an entry to administer farxiga 10mg at 8:00am and there was no documentation farxiga was administered on 03/19/22 at 8:00am. There was documentation of FSBS on 03/20/22 at 7:30am of 323 and at 7:00pm of 240. Telephone interview with the facility's contracted physician on 03/31/2022 at 5:16pm revealed: -The farxiga was used to treat high blood sugar. -Not receiving the farxiga could result in	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 19	D 358		

potentially increased blood sugar (hyperglycemia-a dangerous condition which can lead to coma and/or death).

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

b. There was an entry for Humulin inject 110 units twice daily with breakfast 8:00am and supper 4:45pm and there was no documentation farxiga was administered at 8:00am and 4:45am.

There was documentation of FSBS on 03/20/22 at 7:30am of 323 and at 7:00pm of 240.

Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed:
-The Humulin was used to treat high blood sugar.
-Not receiving the Humulin as prescribed could be potentially "very bad" resulting in very high blood sugar (hyperglycemia-a dangerous condition which can result in coma and/or death).

Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

c. There was an entry for trazadone 150 mg tablet ½ tablet at bedtime 8:00pm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 20 documented as administered. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -Trazadone is used to treat insomnia. -Not receiving the trazadone could result in trouble sleeping. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. d. There was an entry for Victoza inject 1.5mg daily at 8:00am and there was no documentation Victoza 1.5mg was administered on 03/19/22 at 8:00am.. There was documentation of FSBS on 03/20/22 at 7:30am of 323 and at 7:00pm of 240. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -Victoza is used to treat high blood sugar. -Not receiving the Victoza could result in very high blood sugar (hyperglycemia-a dangerous condition which can lead to coma and/or death). Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am.	D 358		

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 21 e. There was an entry for FSBS twice daily at 7:30am and 7:00pm and FSBS documented on 03/19/22 at 7:00pm of 323. Telephone interview with the facility's contracted physician on 03/31/22 at 5:16pm revealed: -Blood glucose is monitored to guide diabetic management. -Not monitoring blood glucose could have "very bad" consequences. Refer to the telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:40am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. _____ Telephone interview with a Medication Aide (MA) on 03/31/22 at 9:50am revealed: -She and a second MA were scheduled to administer medications on 03/19/22 from 8:00am to 8:00pm. -The second MA did not show up for her shift. -On 03/19/22 she administered medications at the three other facilities and she arrived around noon on 03/19/22 at this facility to administer the 8:00am medications but thought it was too late. -She did not administer any medications to the residents on 03/19/22 because she was the only MA for the facility and three other sister facilities and is was very busy. -She telephoned the Administrator on 03/19/22 at 11:50am to inform her she was the only MA. -The Administrator told her another MA was coming in to assist her. -She texted the Administrator on 03/19/22 at	D 358		

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 358	Continued From page 22 3:00pm and informed her the MA had not come in yet. -The Resident Care Coordinator (RCC) was on vacation. -The Administrator did not come to the facility to assist with the medication pass on 03/19/22. Interview with the RCC on 03/31/22 at 10:30am revealed: -She completed the MA schedule for 03/19/22 before she left for vacation on 03/11/22. -She knew there was only one MA scheduled on 03/19/22 for this facility and the three sister facilities. -She asked for volunteers to work that day and asked the Administrator to follow up to ensure coverage for that day. Interview with the Administrator on 03/31/22 at 10:40am revealed: -There was one MA scheduled on 03/19/22 to administer medications in this facility and the three other sister facilities. -Another MA had agreed to come in and administer medications on 03/19/22. -She thought both MA's had come in to work on 03/19/22 and did not call the facility to check. -She was informed on 03/20/22 that only one MA was there to administer all medications in all the facilities on 03/19/22. -She had not been informed that the medications were not administered in this facility on 03/19/22. _____ The facility failed to ensure medications were administered as ordered on 03/19/22 for 3 of 3 sampled residents which seriously increased the risk to Resident #1 of psychotic behaviors requiring hospitalization, seizures, high blood pressure, and blood clots, and increased the risk to Resident #3 of high blood pressure, blood clots	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 23 and uncontrolled high blood sugar, and a serious risk to Resident #4 of very high blood sugars. This failure placed the residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/30/22. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 1, 2022	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 3 of 3 sampled residents (#1, #2, and #3) resulting in medications with multiple administration times being administered too close to the next scheduled administration time. The findings are: Review of the facility's undated Medication Administration Policy and Procedure revealed medications were to be administered one hour	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 364	Continued From page 24	D 364		

before or one hour after the scheduled administration time.

1. Review of Resident #1's current FL2 dated 07/19/21 revealed diagnoses included schizoaffective disorder, traumatic brain injury, and hypothyroidism.

Review of Resident #1's Physician's orders dated 07/19/21 revealed:
-There was an order for amlodipine (reduces blood pressure) 10mg daily.
-There was an order for divalproex (mood stabilizer) 500mg three times daily.
-There was an order for gabapentin (treats nerve pain) 300mg twice daily.
-There was an order for levothyroxine (treats low thyroid hormone) 88mcg daily.
-There was an order for metoprolol (lowers blood pressure and heart rate) ER 25mg daily.
-There was an order for olanzapine (decreases psychotic behaviors) 10mg every morning.
-There was an order for Vimpat (reduces seizure activity) 200mg twice daily.

Review of Resident #1's electronic Medication Administration Record (eMAR) for 02/01/22 - 03/30/22 revealed:
-There was an entry for amlodine 10mg daily at 8:00am and documentation of administration at 8:00am on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, 03/26/22 and 03/30/22.
-There was an entry for divalproex 500mg three times daily at 8:00am, 2:00pm, and 8:00pm and documentation of administration at 8:00am, 2:00pm, and 8:00pm on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, and 03/26/22 and at 8:00am on 03/30/22.
-There was an entry for gabapentin 300mg twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 364	Continued From page 25	D 364		

daily at 8:00am and 8:00pm with documentation of administration at 8:00am and 8:00pm on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, and 03/26/22 and at 8:00am on 03/30/22.
-There was an entry for levothyroxine 88mcg daily at 8:00am and documentation of administration at 8:00am on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, 03/26/22 and 03/30/22.
-There was an entry for metoprolol 25mg daily at 8:00am and documentation of administration at 8:00am on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, 03/26/22 and 03/30/22.
-There was an entry for olanzapine 10mg at 8:00am and documentation of administration at 8:00am on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, 03/26/22 and 03/30/22.
-There was an entry for Vimpat 200mg twice daily at 8:00am and 8:00pm and documentation of administration at 8:00am and 8:00pm on 02/16/22, 02/23/22, 02/25/22, 03/07/22, 03/14/22, 03/20/22, 03/22/22, and 03/26/22 and at 8:00am on 03/30/22.

Review of Resident #1's Medication Variance Report for 02/01/22 - 03/30/22 revealed:
-Amlodipine, divalproex, levothyroxine, metoprolol, olanzapine, and Vimpat were scheduled to be administered at 8:00am and were documented as administered on 02/16/22 at 9:22am, 02/23/22 at 12:41pm, 02/25/22 at 10:15am, 03/07/22 at 10:40am, 03/14/22 at 10:05am, 03/20/22 at 10:45am, 03/22/22 at 9:25am, 03/26/22 at 9:50am, and 03/30/22 at 9:25am.
-The scheduled 8:00am medications were administered late 8 out of 58 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 364	Continued From page 26 Interview with Resident #1 on 03/31/22 at 11:00am revealed he did not remember if his medications were late. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed: -Medications with multiple dose scheduled during the day should not be late because that would cause the doses to be given too close together and Resident #1 would get too much of the medication. -Taking the divalproex dose too close to the next dose may cause toxicity and oversedation. Refer to the interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with a second MA on 03/31/22 at 10:04am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. 2. Review of Resident #2's current FL2 dated 02/28/22 revealed a diagnosis of schizophrenia. Review of Resident #2's physician's orders dated 02/28/22 revealed: -There was an order for pantoprazole (treats stomach acid) 40mg twice daily. -There was an order for lithium carbonate (treats manic episodes) 450mg twice daily. -There was an order for quetiapine (anti psychotic) 50mg twice daily. Review of Resident #2's electronic Medication Administration Record (eMAR) for 03/01/22 - 03/30/22 revealed: -There was an entry for lithium 450mg twice daily	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 27	D 364		

at 8:00am and 8:00pm with documentation of administration at 8:00am and 8:00pm on 03/22/22.
-There was an entry for pantoprazole 40mg twice daily at 8:00am and 8:00pm with documentation of administration at 8:00am and 8:00pm on 03/22/22.
-There was an entry for quetiapine 50mg twice daily at 8:00am and 8:00pm with documentation of administration at 8:00am and 8:00pm on 03/22/22.

Review of Resident #2's Medication Variance Report for 03/01/22 - 03/30/22 revealed lithium, pantoprazole, and quetiapine were scheduled at 8:00am and documented as administered on 03/22/22 at 9:29am.

Interview with Resident #2 on 03/30/22 at 8:58am revealed sometimes medications were late because there were not enough medication aides (MAs) for the facility and the three sister facilities to administer medications.

Refer to the interview with a Medication Aide (MA) on 03/31/22 at 9:50am.

Refer to the interview with a second MA on 03/31/22 at 10:04am.

Refer to the telephone interview with the facility's contracted physician on 03/31/22 at 9:20am.

Refer to the interview with the Administrator on 03/31/22 at 10:40am.

3. Review of Resident #3's current FL2 dated 01/07/22 revealed diagnoses included diabetes mellitus type II, hyperlipidemia, obstructive sleep apnea, acute diastolic congestive heart failure.

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D 364	Continued From page 28 Review of Resident #3's physician's orders dated 01/07/22 revealed: -There was an order for Allopurinol 100 mg 1 tablet daily for gout. -There was an order for amlodipine (reduces blood pressure) 5 mg tablet 1 tablet daily. -There was an order for docusate (for constipation) 100 mg 1 capsule daily. -There was an order for Escitalopram (for depression) 5 mg tablet 1 daily. -There was an order for furosemide 20mg daily. -there was an order for gabapentin (treats nerve pain) 800 mg 1 tablet three times daily. -There was an order for insulin lispro (controls blood sugar) 100 ml unit pen use as directed per sliding scale. -There was an order for multivitamin 1 tablet daily as a dietary supplement. -There was an order for pantoprazole (reduces stomach acid). -There was an order for pravastatin (reduces cholesterol), 40 mg tablet daily. -There was an order for Spironolactone (for blood pressure and swelling) 25 mg daily. -There was an order for tamsulosin (treats enlarged prostate) 0.4 mg daily. -There was an order for trazadone (treats insomnia) 50 mg 1 tablet at bed. -There was an order for vitamin B-12 1000 mcg 1 tablet daily for supplement. Review of Resident #3's physician's orders dated 01/17/22 revealed lispro insulin (lowers blood sugar) 100 unit/ ml 13 units three times daily with meals. Review of Resident #3's electronic Medication Administration Record (eMAR) for 02/01/22 - 03/30/22 revealed:	D 364		

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D 364	Continued From page 29 -There was an entry for allopurinol 100mg tablet daily at 8:00am and documentation of administration at 8:00am on 03/07/22 and 03/14/22. -There was an entry for amlodipine 5mg daily at 8:00am and documentation of administration at 8:00am on 03/07/22 and 03/14/22. -There was an entry for docusate 100mg daily at 8:00am and documentation of administration at 8:00am on 03/07/22 and 03/14/22. -There was an entry for escitalopram 5mg daily at 8:00am and documentation of administration at 8:00am on 03/07/22 and 03/14/22. -There was an entry for furosemide 20mg daily at 8:00am and documentation of administration at 8:00am on 02/22/22. -There was an entry for gabapentin 800mg at 8:00am and 2:00pm and documentation of administration at 8:00am on 03/07/22 and 03/14/22 and at 2:00pm on 02/15/22. -There was an entry for insulin lispro 100 units at 12:00pm and 5:00pm and documentation of administration at 12:00pm on 02/07/22 and 5:00pm on 03/09/22,03/10/22, 03/20/22 and 03/28/22. -There was an entry for multivitamin tablet at 8:00am and documentation of administration at 8:00am on 02/25/22, 03/07/22 and 03/14/22. -There was an entry for pantoprazole 20mg tablet daily at 8:00am and documentation of administration at 8:00am on 02/25/22, 03/07/22 and 03/14/22. -There was an entry for pravastatin 40mg tablet daily at 8:00am and documentation of administration at 8:00am on 02/25/22, 03/07/22 and 03/14/22. -There was an entry for spironolactone 25mg daily at 8:00am and documentation of administration at 8:00am on 02/25/22, 03/07/22 and 03/14/22.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 30	D 364		

-There was an entry for tamsulosin 0.4mg capsule daily at 8:00am and documentation of administration at 8:00am on 02/25/22, 03/07/22, 03/14/22 and 03/22/22.
-There was an entry for trazadone 50mg tablets daily at 10:00pm and documentation of administration at 10:00pm on 02/09/22, 02/16/22, 02/18/22, 02/19/22 and 02/20/22.
-There was an entry for Vitamin B-12 1000mcg daily at 8:00am and documentation of administration at 8:00am on 02/25/22 and 03/07/22.

Review of the Medication Variance Report for Resident #3 for 02/01/22 - 03/30/22 revealed:
-Allopurinol, amlodipine, docusate, escitalopram, and gabapentin were scheduled to be administered at 8:00 am and were documented as administered on 03/07/22 at 9:59 am on 03/14/22 at 9:47 am.
-Multivitamin, pantoprazole, pravastatin and spironolactone were scheduled to be administered at 8:00am and were documented as administered on 02/25/22 at 10:10am, 03/07/22 at 9:59am and 03/14/22 at 9:47am.
-Vitamin B-12 was scheduled for administration at 8:00am and was documented as administered on 02/25/22 at 10:10am and on 03/07/22 at 9:59am.
-Furosemide was scheduled for administration at 8:00am and was documented as administered on 02/22/22 at 3:48pm.
-Gabapentin was scheduled for administration at 2:00pm and was documented as administered on 02/15/22 at 4:16pm.
-Insulin lispro was scheduled for administration at 12:00pm and was documented as administered at on 02/07/22 at 2:31pm.
-Insulin lispro was scheduled for administration at 5:00pm and was documented as administered on 03/09/22 at 3:05pm. 03/10/22 at 3:07pm,

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D 364	Continued From page 31 03/20/22 at 9:05pm and 03/28/22 at 3:04pm. -Tamsulosin was scheduled for administration at 8:00am and was documented as administered on 02/25/22 at 10:10am, 03/07/22 at 9:59am, 03/14/22 at 9:47am and 03/22/22 at 10:14pm. -Trazadone was scheduled for administration at 10:00pm and was documented as administered on 02/09/22 at 7:46pm, 02/16/22 at 8:10pm, 02/18/22 at 7:55pm, 02/19/22 at 7:33pm, and 02/20/22 at 7:02pm. -Scheduled 8:00am medications were administered late for 5 of 58 days. -Scheduled 12:00pm medications were administered late for 1 of 58 days. -Scheduled 2:00pm medications were administered late for 1 of 58 days. -Scheduled 5:00pm medications were administered late for 1 of 58 days. -Scheduled 5:00pm medications were administered early for 3 of 58 days. -Scheduled 10:00pm medications were administered early for 5 of 58 days. Interview with Resident #3 on 03/31/22 at 9:00am revealed medications were administered late approximately two times weekly. Refer to the interview with a Medication Aide (MA) on 03/31/22 at 9:50am. Refer to the interview with a second MA on 03/31/22 at 10:04am. Refer to the telephone interview with the facility's contracted physician on 03/31/22 at 9:20am. Refer to the interview with the Administrator on 03/31/22 at 10:40am. _____ Interview with a Medication Aide (MA) on	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 32 03/31/22 at 9:50am revealed medications were administered late when she had to administer medications in the facility and a sister facility. Interview with a second MA on 03/31/22 at 10:04am revealed: -There were a few times when she thought the third shift MA administered the 8:00am medications. -She was not aware the residents were not administered 8:00am medications, until the residents told her they needed their medications which was after 8:00am. Telephone interview with the facility's contracted physician on 03/31/22 at 9:20am revealed medications with multiple doses scheduled during the day should not be late because that would cause the doses to be given too close together and the resident would get too much of the medication in their system (medication toxicity). Interview with with Resident Care Coordinator (RCC) on 03/31/222 at 10:30am revealed: -There were not enough MAs on staff to have one in this facility and the three sister facilities. -The MAs were scheduled to administer medications in more than one facility due to being short of staff and that made it difficult to administer medications timely. Interview with the Administrator on 03/31/22 at 10:40am revealed there were times when medications were late because more MAs were needed so that the facility could have a dedicated MA in the building. _____ The facility failed to ensure medications were administered one hour before or after the scheduled times for 3 of 3 sampled residents (#1,	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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D 364	Continued From page 33 #2, and #3). This failure resulted in Resident #1 receiving a mood stabilizer medication too close to the next dose putting the resident at risk of medication toxicity and oversedation and a risk of medication toxicity for Resident #2 and #3. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/31/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2022.	D 364		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an accurate and readily retrievable controlled substance record was maintained for 1 of 3 sampled residents (#2) who was prescribed a controlled medication. The findings are:	D 392		

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	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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D 392	Continued From page 34 Review of Resident #2's current FL2 dated 02/28/22 revealed a diagnosis of schizophrenia. Review of the Resident Register for Resident #2 revealed an admission date of 02/03/22. Review of physician's order for Resident #2 dated 03/08/22 revealed Klonopin 0.5mg daily as needed. Observation of Resident #2's medications on hand on 03/30/22 at 3:14pm revealed: -There was one bubble pack labeled Klonopin 0.5mg tablets take 1 tablet daily as needed. -Thirty tablets were dispensed on 03/08/23. -Twenty tablets remained in the bubble pack. Review of Resident #2's electronic Medication Record (eMAR) for 03/01/22 - 03/30/22 revealed: -There was an entry for Klonopin 0.5mg daily as needed. -There was documentation the Klonopin was administered on 03/10/22, 03/11/22, 03/18/22, 03/23/22 and 03/28/22. Review of the Resident #2 controlled substance records revealed: -There was a printed label with Klonopin 0.5mg daily as needed. -Thirty tablets were dispensed on 03/08/23. -There was documentation 03/10/22 one tablet was removed and 28 tablets remained. -There was no other documentation. Interview with the medication aide (MA) on 03/30/22 at 3:30pm: -She administered Klonopin 0.5mg to Resident #2 on 03/10/22, 03/11/22, 03/18/22, 03/23/22 and 03/28/22. -She did not remember why she had documented	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

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D 392	Continued From page 35 incorrectly on the controlled substance record on 03/10/22. -She knew she should document on the controlled substance record each time she removed a controlled substance. Interview with the Resident Care Coordinator (RCC) on 03/31/22 at 10:30am revealed: -The MA who documented on the eMAR 5 times that Klonopin was administered forgot to document on the controlled substance record. -Shefound 5 loose klonopin tablets in the bottom of the medication cart today (03/31/22). -The MAs were trained to document on the controlled substance record when removing the medication. -The MAs were trained to count the controlled substance medications and compare the number to the declining inventory before starting their medication pass. -If the count was incorrect they were to notify management. -She had not been notified of the incorrect count. Interview with the Administrator on 03/31/22 at 10:40am revealed: -The MAs were trained to document on the controlled substance records when removing the medication from the bubble pack. -She thought the MAs would get in a hurry and intend to document at a later time but would then forget to do so.	D 392		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 36	D 451		

department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on interview and record review the facility failed to notify the department of social services for 1 of 4 sampled residents (Resident #4) related to incidents leading to 2 emergency room visits and 1 hospitalization.

The findings are:

Review of Resident #4's current FL2 dated 10/25/21 revealed:
-Diagnoses included adjustment disorder with depressed mood, borderline personality disorder, complex post-traumatic stress disorder, borderline intellectual functioning, type II diabetes, hypertension, hyperlipidemia and asthma.

Review of the Resident Register for Resident #4 revealed an admission date of 10/18/21.

Review of discharge instructions from the hospital emergency room for Resident #4 dated 01/07/22 revealed Resident #4 had presented to the emergency room with suicidal ideation, major depressive disorder, recurrent, unspecified, adjustment disorder with depressed mood, borderline intellectual functioning, borderline personality disorder and post-traumatic stress disorder.

Interview with the Medication Aide (MA) on 03/30/22 at 2:35pm revealed:

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D 451	Continued From page 37 -On 03/26/22 between 11:00am and 12:00pm, Resident #4 was arguing with another resident. -The two residents were threatening to punch each other. -Resident #4 when to his room and then the MA heard what sounded like glass breaking. -The resident then came out of his room and walked to the kitchen, -He was angry and screaming and there was blood coming from both arms where he had cut himself in approximately eight places. -She called for EMS and attempted to calm the resident down until EMS arrived. Review of the Computer Automated Dispatch (CAD- a report which documents 911 calls) dated 01/06/22 at 6:22 am revealed: -Resident #4 had intended to hurt himself. -There were no specifics, just that Resident #4 had been feeling suicidal. -Resident #4 had been talking about self-harm, but was also having difficulty breathing. Review of the CAD dated 03/16/22 at 9:47pm revealed: -There had been a call for a civil disturbance. -Resident #4 had a cut to the hand. -Resident #4 was found on the walkway with his hand bleeding. -Resident #4 had been combative with staff and had been tearing up the house. -Resident #4 had broken some items inside the residence. -Resident #4 was transported to the emergency room. Review of the CAD dated 03/26/22 at 12:23pm revealed: -Resident #4 had attempted suicide by cut/laceration.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL REST HOME # 2	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 451	Continued From page 38 -Resident #4 had self-inflicted lacerations up and down both arms. Interview with the MA on 03/31/22 at 10:04am revealed: -She had completed an Incident and Accident report for Resident #4 for both the 03/16/22 and 03/26/22 incidents. -She did not remember if she had given the reports to the RCC or the Administrator. Interview with the Administrator on 03/31/22 at 10:40am revealed: -The MA that was on duty when the resident was sent to the hospital was responsible for completing a report and giving the report to the RCC or the Administrator. -The RCC or Administrator would then fax the report to the local Department of Social Services. -She was responsible for following up on the reports but she had forgotten to. Review of documentation submitted to the local Department of Social Services revealed no incident reports related to Resident #4 were submitted for incidents which occurred on 01/06/22, 03/16/22 and 03/26/22.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011375	A. BUILDING: _____ B. WING _____	R 04/01/2022

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D912	Continued From page 39 Based on interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 3 of 3 sampled residents (#1, #2, and #3) resulting in medications with multiple administration times being administered too close to the next scheduled administration time [Refer to Tag 0364 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all residents were free from neglect related to Healthcare and Medication Administration. The findings are: 1. Based on interviews and record reviews, the	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 40 facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 4 sampled residents (#3, and #4) related to failure to notify the mental health provider (MHP) of three Emergency Department (ED) visits related to suicidal ideation (#4) and missed an audiology appointment for 02/20/22 and wound care appointment for 01/13/22 (#3) [Refer to Tag D0273 10A NCAC 13F .0902(b) Healthcare (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (Residents #1, #3, and #4) related to medications used to treat blood pressure, mood, pain, low thyroid hormone, psychotic behaviors, sleep, and seizures (#1), pain, blood pressure, swelling, high blood sugar, difficulty with urination, and blood clots (#3), and high blood sugar and difficulty sleeping (#4) [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		