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WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

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D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey, follow-up and complaint investigation from 04/15/26 - 04/17/26 and 04/20/26.	D 000		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure residents were given the opportunity to participate in at least one outing every other month. Review of the facility's March 2026 activity calendar revealed there were no resident outings scheduled for the month. Review of the facility's April 2026 activity calendar posted in the facility hallway revealed there were no resident outings scheduled for the month. Review of facility's Activity Log notes revealed: -On 01/08/26 there was an entry that a resident was taken into the community to go shopping. -On 03/10/26 there was an entry that the Activity Log book had been found. -There was no other entries indicating the	D 319		

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D 319	Continued From page 1 residents were being taken on outings. Interview with a resident on 04/15/26 at 9:07am revealed: -He had resided at the facility since December 2025 and had never been on an outing. -The facility did not offer any outings to him. -He did not think the facility offered transportation to take any of the residents on outings. Interview with a second resident on 04/15/26 at 9:10am revealed: -There used to be a facility bus for group activities off the facility grounds. -The facility management no longer had the bus so they had not been on a group trip in several months. Interview with a third resident on 04/15/26 at 9:18am revealed he had never been on an outing or offered to go on an outing since moving into the facility a couple of weeks ago. Interview with a fourth resident on 04/15/26 at 9:31am revealed: -He moved into the facility about two months ago. -The facility had never offered to take him on an outing. -He had a family member that took him on outings sometimes. -He would like the facility to take him to the store and/or on an outing to a baseball game. Interview with a fifth resident on 04/15/26 at 10:18am revealed: -She had resided at the facility for a couple of years. -A staff member took her to the gas station before, but it was not a group outing. -The Activity Director quit about 6-7 months ago	D 319		

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and there has been no one offering any outings since then.

Interview with a sixth resident on 04/16/26 at 10:00am revealed:
-She has not been given the opportunity to go for an outing once every two months.
-Staff took her to the store yesterday but that only happened because the state came to the facility.
-Staff would purchase things she needed for her but she liked to go out and do the shopping herself.

Interview with the Resident Care Coordinator (RCC) on 04/16/26 at 1:50pm revealed:
-She did most of the activities with residents.
-Staff kept a log of provided activities and documented who participated but a resident took the log off the medication cart and it was missing for a while.
-It was not possible to take residents on outings every other month because one staff worked per shift.
-An additional staff member would occasionally take a few residents to the store to buy things they needed or staff would get a list from the residents and shop for them.
-Some residents had family members that provided outings.

Interview with the Activity Director on 04/16/26 at 10:45am revealed:
-She was responsible for making the monthly activity calendar and assuring that activities were being offered.
-Not all residents wanted to go for outings but there were a few residents that were regularly taken to the store by their family members.
-She could not guarantee that residents were given the opportunity to have an outing every

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D 319	Continued From page 3 other month. -It was difficult to have outings because typically one staff was scheduled to work at the facility and they also no longer had a van for transportation. Interview with the Administrator on 04/20/26 at 1:54pm revealed: -Residents were sometimes provided the opportunity to go to the store. -He thought resident outings likely happened once every two months. -There was nothing officially scheduled for residents to have outings. -If residents said they did not have outings it may have been because they were confused because they did not think going to the store was considered an outing.	D 319		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, and interviews, the facility failed to ensure the necessary services were provided to maintain the mental health for 1 of 1 resident (#1) who informed staff she was suicidal and wanted to go to the hospital for assistance; and to ensure residents were treated with dignity and respect by staff (Resident Care Coordinator) who was using profanity and yelling at the residents.	D 338		

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D 338	Continued From page 4 The findings are: Review of the Escalation of Self-Harm Risk and Suicidal Ideation facility policy dated 03/24/25 revealed: -All expressions or indications of self-harm risk or suicidal ideation shall be treated as a priority clinical matter requiring prompt assessment, appropriate escalation, and coordination with qualified healthcare providers. -The immediate staff response upon identification of verbal expressions of self-harm or suicidal thoughts included engaging the resident in a calm, supportive manner; ensuring the resident was not left alone if there was a concern for safety; and notify a supervisor immediately. -Staff must promptly notify: Supervisor or Administrator on duty, Licensed nurse (if applicable) and appropriate clinical leadership. 1. Review of Resident #1's current FL-2 dated 08/01/25 revealed: -Diagnoses included diabetes, chronic lung disease, anemia, dysthymia (persistent mild to moderate depressive disorder) and obesity. -The recommended level of care was rest home. -The resident was intermittently confused. Review of the Resident Register for Resident #1 revealed an admission date of 07/26/23. Review of the 30-day discharge notification for Resident #1 was dated 10/22/25. Review of a signed and dated statement from Resident #1 were she agreed to move out on 11/18/25 instead of 11/22/25 as indicated on her 30-day discharge notification.	D 338		

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Review of an Advanced Primary Care Management Services consent form dated 09/24/25 revealed Resident #1 was "capable of making her own health care decisions."

Review of staff charting notes for October 2025 revealed there were no staffing notes specific to Resident #1 documented between 10/10/25 and 10/22/25.

Review of video surveillance footage dated 10/21/25 at 5:55pm revealed:
-Resident #1 independently entered the lobby from the exterior to the main entrance in her wheelchair and told the Resident Care Coordinator (RCC) she was "suicidal."
-The RCC was speaking to someone on the phone but asked Resident #1 if she wanted to be sent out.
-Resident #1 responded "yes, please."
-The RCC responded "I don't think you need to be sent out", "I think you will be fine", and "I think you need to calm down and relax."
-The RCC told Resident #1 "You always ignore what I say and you continue to do what you want to do."
-Resident #1 responded "because I don't want to argue with you."
-A medication aide (MA) entered the lobby from the interior of the facility at 5:56pm.
-The RCC told the MA while Resident #1 was present that Resident #1 was going to "go to her room", was going to "calm down", and was "going to eat dinner."
-The RCC told the MA to administer Resident #1 a medication used to treat anxiety and she knew the medication was scheduled (to be administered at a different time) but to administer it anyway.
-The RCC told Resident #1 "if I send you out, you

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won't come back."
-Resident #1 responded "I want to come back."
-The RCC told Resident #1 she knew she would want to come back to the facility, but if she went out because she was suicidal she would not return.
-The RCC told Resident #1 the Administrator and the Activity Director would not allow her to return if she went to the hospital because she was suicidal.
-Resident #1 was observed independently using her wheelchair to exit from the lobby into the facility.
-The RCC was observed to continue her conversation with someone on the phone and told them if Resident #1 went out for suicidal ideations she would not be coming back to the facility.
-The RCC said "I'm not sending her out because I don't feel like dealing with that."
-The RCC proceeded to tell the person on the phone that she was going to put Resident #1 on hourly checks.
-The RCC was observed exiting the lobby at 5:59pm while still talking on the phone.

Interview with the MA on 04/17/26 at 4:10pm revealed:
-The RCC told her to administer a medication to treat anxiety to Resident #1 on 10/21/25.
-When she checked the electronic medication adminstration record (eMAR), she observed the medication was not due and she did not adminster it.

Interview with Resident #1 at the facility where she currently resided on 04/16/26 at 8:40am revealed:
-She and the RCC had been arguing all week prior to her feeling suicidal.
-She told the RCC she was suicidal on 10/21/25,

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but the RCC would not send her out to the hospital.
-The RCC told her if she went out to the hospital she would not return because the Administrator and the Activity Director would not allow it.
-She had a knife and planned on "cutting her wrists or her throat."
-She gave the knife to the RCC but still felt suicidal but did not have another way to end her life, but she still wanted to.
-She spoke with a clinical social worker the next day who told her she deserved to live and gave her a journal to write her thoughts in.
-She felt better after speaking with the clinical social worker and no longer felt suicidal.
-She received a 30 day discharge notice on 10/22/25 which she kept a copy of in her room.
-She was informed in her discharge notice that she was being discharged for "displaying unsafe behavior towards herself and staff, and her needs could no longer be met."
-She had never threatened staff.
-She tried to be nice to everyone.
-She was friendly with the Kitchen Manager/Dietary Manager and she did not feel her behavior toward him was inappropriate.
-She was upset that they gave her the discharge notice.

Interview with the RCC on 04/16/26 at 1:50pm revealed:
-Approximately 30-45 days prior to Resident #1's discharge, she started demonstrating inappropriate behaviors toward the Kitchen Manager/Dietary Manager.
-She spoke with Resident #1's primary care provider (PCP) and the mental health provider about her concerns with Resident #1's behavior.
-She tried to redirect Resident #1 when she would demonstrate inappropriate behaviors toward the

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Kitchen Manager/Dietary Manager and Resident #1 would get upset.
-She did not remember Resident #1 stating that she was suicidal on 10/21/25.
-She did not know Resident #1 wanted to go to the hospital on 10/21/25.
-She did not contact the mental health provider or the PCP on 10/21/25 after Resident #1 said she was suicidal.

Interview with the Administrator on 04/17/26 at 2:52pm revealed:
-He first became aware of the incident between Resident #1 and the RCC on 03/06/26 after reviewing the video surveillance footage of the interaction.
-Their facility policy directed staff to contact the PCP immediately and if the situation warranted it, the resident should be sent out.
-The RCC executed poor judgement in how she reacted to Resident #1 on 10/21/25.
-The RCC had not contacted the PCP and mental health provider after former Resident #1 said she was suicidal.

Second interview with the RCC on 04/20/26 at 11:40am revealed:
-She could not remember if Resident #1 had told her she was suicidal on 10/21/25.
-Resident #1 was upset and she was able to talk with her and de-escalate the situation on 10/21/25.
-She knew she could not determine whether Resident #1 needed to be sent to the local hospital for an evaluation for being suicidal, but "I just didn't think she needed to go out."
-She placed Resident #1 on hourly checks, but she "probably" saw her more frequently than that.
-Resident #1 did not give her a knife and she was not aware of a knife being in Resident #1's room.

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-Resident #1 had never talked about suicide before.
-She did not remember saying that she did not want to deal with sending Resident #1 out to the hospital to the person she was talking to on the phone.

Second interview with the Administrator on 04/20/26 at 2:04pm revealed:
-The RCC should have contacted the PCP or the mental health provider.
-The RCC should not have made an independent judgment not to send Resident #1 to the hospital on 10/21/25 without contacting the PCP or the mental health provider.
-Resident #1 should have been sent out to the hospital for an evaluation on 10/21/25.

Attempted telephone interview with the mental health provider on 04/16/26 at 10:47am was unsuccessful.

2. Interview with a resident on 04/15/26 at 9:32am revealed he heard the Resident Care Coordinator (RCC) yelling at a resident one day the previous week but had not reported it to anyone.

Interview with a second resident on 04/15/26 at 9:50am revealed:
-The RCC made very snide remarks to her.
-The RCC was not friendly.
-She had heard the RCC yelling at other residents.

Interview with a third resident on 04/15/26 at 10:25am revealed he had heard the RCC cuss in the past, but he had not heard her recently.

Interview with a fourth resident on 04/16/26 at 8:40am revealed the RCC used to yell at her

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regularly.

Interview with the RCC on 04/16/26 at 1:50pm revealed:
-She had never yelled or cursed at a resident.
-She had a very loud voice.

Review of video surveillance footage dated 10/22/25 at 7:59am revealed:
-The RCC was working at the medication cart outside the nurse's station.
-The RCC yelled for three specific residents by name to come and get their medication.

Review of a second video surveillance footage dated 10/22/25 at 5:11pm revealed:
-The RCC told an underage child to "get your "(expletive)!" down that hall."
-There were two residents present in the hallway when this profanity was used.

Review of a third video surveillance footage dated 12/06/25 at 1:13pm revealed:
-The RCC was speaking to a male visitor and said "(expletive)!" she had to redo something for work.
-There was a resident present in the hallway when this profanity was used.

A second interview with the RCC on 04/20/26 at 11:41am revealed she had probably used profanity in front of the residents at times when she felt overwhelmed, but it was not directed toward them.

Interview with the Administrator on 04/20/26 at 2:04pm revealed he had seen the RCC talk and interact with the residents and had no concerns regarding her interactions with the residents.

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D 338	Continued From page 11 The facility failed to provide the necessary services to maintain Resident #1's mental health when she informed the Resident Care Coordinator (RCC) she was suicidal and wanted to go to the hospital for assistance. The RCC refused to send her to the hospital and told her if she went to the hospital for being suicidal she would not be allowed to return to the facility. The RCC told Resident #1 to return to her room and calm down and instructed the Medication Aid (MA) to give Resident #1 a scheduled medication early. The RCC proceeded to talk to the Kitchen Manager/Dietary Manager (DM) on the phone telling him she was not sending Resident #1 to the hospital for being suicidal because she "did not want to deal with it." This failure resulted in serious neglect and constitutes a Type A1 Violation. The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 04/16/26 for this Type A1 Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 20, 2026.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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D 438	Continued From page 12 TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to notify the Department, via the Health Care Personnel Registry (HCPR), within 24 hours of being notified of an allegation of neglect, submit the results of an investigation within 5 working days and failed to protect residents from harm during the investigation related to 1 of 1 sampled residents (Resident #1) who was suicidal and requested to go to the hospital for assistance. The findings are: Review of the Escalation of Self-Harm Risk and Suicidal Ideation facility policy dated 03/24/25 revealed: -All expressions or indications of self-harm risk or suicidal ideation shall be treated as a priority clinical matter requiring prompt assessment, appropriate escalation, and coordination with qualified healthcare providers. -The immediate staff response upon identification of verbal expressions of self-harm or suicidal thoughts included engaging the resident in a calm, supportive manner; ensuring the resident was not left alone if there was a concern for safety; and notify a supervisor immediately. -Staff must promptly notify: Supervisor or Administrator on duty, Licensed nurse (if applicable) and appropriate clinical leadership. Review of Resident #1's current FL2 dated 08/01/25 revealed: -Diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, anemia, dysthymia (persistent mild to moderate depressive disorder) and obesity. -The recommended level of care was rest home.	D 438		

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D 438	Continued From page 13 -Resident #1 was intermittently confused. Interview with Resident #1 at the facility where she currently resided on 04/16/26 at 8:40am revealed: -She and the Resident Care Coordinator (RCC) had been arguing all week prior to her feeling suicidal. -She told the RCC she was suicidal on 10/21/25, but the RCC would not send her out to the hospital. -The RCC told her if she went out to the hospital she would not return because the Administrator and the Activity Director would not allow it. -She had a knife and planned on "cutting her wrists or her throat." -She gave the knife to the RCC and still felt suicidal but did not have another way to end her life. Review of video surveillance in the facility living room dated 10/21/25 revealed: -The RCC was sitting in a rocking chair near the front entrance talking on a cellular phone with the Kitchen Manager/Dietary Manager (DM) with the phone on speaker. -At 5:55pm, Resident #1 was in her wheelchair and entered the facility through the front doors and approached the RCC. -The RCC asked Resident #1 "What"? -Resident #1 told the RCC she was suicidal. -The RCC asked Resident #1 if she wanted to be sent to the hospital and Resident #1 said "yes, please". -Resident #1 said "there's no way I can fix this" and the RCC responded "with a better behavior but you can't keep being like this towards me". -The RCC told Resident #1 she tried to send her out "the other day" and said Resident #1 would not go.	D 438		

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	HAL011377	A. BUILDING: _____ B. WING _____	R-C 04/20/2026

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D 438	Continued From page 14 -At 5:56pm, the RCC told Resident #1 she did not think Resident #1 needed to be sent to the hospital and "I think you will be fine". -The RCC proceeded to tell Resident #1 that she needed to calm down, relax, and instructed her to "think about it". -A medication aide (MA) walked up to the RCC and Resident #1 and the RCC told the MA that Resident #1 was going to go to her room, calm down, and eat dinner. -The RCC told the MA to administer Resident #1 a medication used to treat anxiety, and she knew the medication was scheduled (to be administered at a diffirent time) but to administer it anyway. -The RCC told Resident #1 if she went to the hospital that she would not be allowed to return to the facility because of inappropriate behaviors towards a staff member. -Resident #1 told the RCC that she wanted to come back to the facility and the RCC said she knew that but "you won't". -At 5:57pm, Resident #1 self-propelled in her wheelchair out of sight in the video footage. -At 5:58pm, the RCC continued talking on the cellular phone to the Kitchen Manager/DM while the phone was still on speaker and said Resident #1 was suicidal, but if she sent Resident #1 out to the hospital that she would not be allowed to return to the facility. -The RCC proceeded to say to the Kitchen Manager/DM, "I'm not sending her out" because "I don't feel like dealing with that". Review of Resident #1's record revealed: -There were no chart notes documenting Resident #1 was suicidal on 10/21/25. -There was no documentation Resident #1's primary care provider (PCP) or mental health provider (MHP) were notified Resident #1 was	D 438		

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D 438	Continued From page 15 suicidal on 10/21/25. Interview with the RCC on 04/20/26 at 11:40am revealed: -She knew the facility was equipped with video surveillance devices. -She did not remember hearing Resident #1 tell her she was suicidal on 10/21/25. -She had not seen the video footage dated 10/21/25 of Resident #1 telling her that she was suicidal. -She remembered Resident #1 was upset and she was able to calm Resident #1 down. -Resident #1 went to eat dinner on 10/21/25 and then "she was fine". -She knew she could not determine whether Resident #1 needed to be sent to the local hospital for an evaluation for being suicidal but "I just didn't think she needed to go out". -She was talking to the Kitchen Manager/DM on the phone on 10/21/25 when she had the verbal interaction with Resident #1. -She did not remember telling the Kitchen Manager/DM on the phone that she was not sending Resident #1 out to the hospital because she did not want to deal with it. -She did not receive any formal training for her position. -The Administrator told her he saw the video footage from 10/21/25 and asked her about the situation in which she explained Resident #1 had behavioral issues earlier that day (but not after resident #1 told her she was suicidal) and she notified Resident #1's provider. -The Administrator told her she did not respond appropriately. Interview with the Kitchen Manager/DM on 04/17/26 at 10:47am revealed he did not remember talking to the RCC on the phone on	D 438		

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D 438	Continued From page 16 10/21/25 when Resident #1 told the RCC she was suicidal. Review of an employee disciplinary action report dated 03/06/26 revealed: -On 03/02/26, the Administrator was made aware of an incident that occurred on 10/21/25 during which the RCC demonstrated an inability to appropriately de-escalate a situation involving Resident #1. -The RCC's interaction with Resident #1 during the incident did not meet the facility's expectations for professionalism or proper conflict resolution techniques. -The facility staff were expected to maintain composure, utilize de-escalation strategies, and prioritize the safety, dignity, and well-being of residents at all times and the handling of the situation did not align with those expectations. -There was documentation the RCC was reminded to not take part in an extended period back and forth with residents. -The RCC and the Administrator signed the final written warning of the employee disciplinary action report on 03/06/26. -There was no documentation the RCC was reported to the HCPR and the 24-hour and 5-day investigative reports were completed and sent to the HCPR. Review of a a letter dated 03/12/26 from the Administor's attorney to the co-owner's attorney revealed after the co-owner had a allegation of abuse and neglect on the RCC; the Administrator conducted an invesitgation and determined that the actions of the RCC do not constitute reportable abuse or neglect within the meaning of 10A NCAC 13F .0102 (Reporting to the HCPR). Interview with the Administrator on 04/17/26 at	D 438		

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D 438	Continued From page 17 2:51pm and 04/20/26 at 11:30am revealed: -He was the Administrator and one of the owners of the facility. -He received a letter from an attorney for co-owners of the facility on 03/02/26 with allegations including abuse and neglect involving the RCC asking him to report the RCC to the proper authorities within 7 days or they would report the allegations. -There were no videos attached to the email to support the allegations. -He contacted his attorney and the videos were requested from the co-owner's attorney. -The only video he received at that time was on 03/06/26 and it was of Resident #1 telling the RCC that she was suicidal. -He was not aware Resident #1 told the RCC she was suicidal until he received the video. -Resident #1 was not sent to the hospital to be evaluated on 10/21/25. -He received more videos on 03/09/26 from the co-owner's attorney. -He did not report the RCC to the HCPR because it had been 7 days since he received all the videos and he thought it was already being reported by the co-owners per what was stated in the letter that was sent to him by the co- owners attorney. -He did not contact the co-owners to see if the RCC was reported because all communication was completed through the attorneys. -He completed an investigation after receiving the videos on 03/09/26 including reviewing the video footage that was sent to him, reviewed records including progress notes from providers, chart notes submitted by staff, looked at Resident #1's care provided and notifications to Resident #1's providers, reviewed Department of Social Services (DSS) reports of investigations and monitoring at the facility, reviewing the RCC's	D 438		

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D 438	Continued From page 18 telephone records, and he completed an employee disciplinary action report with a final warning for the RCC on 03/06/26. -He did not know he needed to complete the 24-hour and 5-day reports for the HCPR. _____ The facility failed to notify the Department, via the Health Care Personnel Registry (HCPR), within 24 hours of being notified of an allegation of neglect, submit the results of an investigation within 5 working days and failed to protect residents from harm during the investigation related to Resident #1 telling the RCC that she was suicidal and wanted to be sent to the hospital for assistance. The RCC told Resident #1 that she would not be allowed to return to the facility if she went to the hospital and told her to go to her room to calm down. The RCC also instructed a MA to administer a medication to Resident #1 that was not due at that time. The RCC proceeded to talk to the Kitchen Manager/Dietary Manager (DM) on the phone telling him she was not sending Resident #1 to the hospital for being suicidal because she did not want to deal with it. The owner, after investigation, did not believe the allegations constituted reporting to the HCPR. This failure was detrimental to the safety and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided an amended plan of protection in accordance with G.S. 131D-34 on April 21, 2026, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 4, 2026.	D 438		