STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 survey and complaint investigation on 05/07/24 - 05/09/24. The complaint investigation was initiated by the Buncombe County Department of Social Services on 04/30/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff A, B and C) who administered medications, completed the state approved medication clinical skills validation checklist and completed the state approved 5-hour and 10-hour or 15-hour medication training as required (Staff A, B, C) and 1 staff who did not complete her medication aide test (Staff C). The findings are:	D 125	See page 4	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Greg Bourshe, Administrator 06/20/24

Reviewed and acknowledged 7/3/24

RP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 125	Continued From page 1 1. Review of Staff A's personnel record revealed: -She was hired 03/27/24 as a medication aide (MA). -There was no documentation Staff A completed the 15-hour medication aide training. -There was no documentation Staff A completed the medication clinical skills validation checklist. Interview with a resident on 05/08/24 at 9:44am revealed Staff A administered her medications sometimes. Interview with Staff A on 05/08/24 at 6:54am revealed: -She worked 05/06/24 on third shift and administered morning medications to Residents on 05/07/24. -She had not completed her MA training. -She had been administering medications at this facility until she found out that morning (05/08/24), she could no longer administer medications. Review of a resident's May 2024 electronic Medication Administration Record (eMAR) revealed: -Staff A's initials were not documented as administering medications on 05/07/24. -There was documentation a staff' member who was not working administered medications on 05/07/24. Refer to the interview with the Resident Care Coordinator on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 2. Review of Staff B's personnel record revealed: -She was rehired 04/29/24 as a medication aide	D 125	See page 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 125	Continued From page 2 (MA). -There was documentation Staff B completed the medication clinical skills validation checklist in 02/13/24, when she worked at the facility previously. Refer to the interview with the RCC on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 01/31/24 as a medication aide (MA). -There was no documentation Staff C completed the 15-hour medication training. -There was no documentation Staff C completed the medication clinical skills validation checklist. -There was no documentation Staff C completed the medication aide test. Review of a Resident's February 2024, March 2024, April 2024 and May 2024 electronic Medication Administration Record (eMAR) revealed there was documentation Staff C administered medications. Refer to the interview with the RCC on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration Type A2 Violation. Interview with the RCC on 05/09/24 at 11:05am revealed: -She was responsible for completing part of the	D 125	See page 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 125	Continued From page 3 training for all newly hired MAs and ensuring MA testing was scheduled. -She did not know anything about the requirements for validation. Interview with Owner #1 on 05/09/24 at 1:23pm revealed: -He was doing the training for the MAs. -MAs were not authorized to pass medications until he completed their training. -He did not know how or why MAs were put on the schedule if their training was not completed. The facility failed to ensure 3 of 3 staff completed the necessary medication aide training and clinical skills validation and medication aide testing before they started administering medications. This failure was a substantial risk to the health, safety, and welfare of the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/24. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2024.	D 125	All clinical staff have recieved extensive training according to NC regulations. All staff have recieved the appropriate training for their specific job functions in accordance with NC DHSR regulations. In-house training has been implemented for the onboarding procedures related to med staff qualifications. This new process is being implemented directly by licensed healthcare professionals.	06/08/24
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity	D 129	see page 6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 129	Continued From page 4 directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C; (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting; (c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or (d) be certified as an Activity Director by the National Certification Council for Activity Professionals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have an Activity Director (AD). The findings are: Observations of the May 2024 activities calendar posted in the hallway on 05/07/24 at 9:30am revealed: -There were various actvities listed on the calendar with no beginning or end times. -Some activities listed just had the wording, "Free Day, Choose your Activity," or had "Free Day,"	D 129	See page 6.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 129	Continued From page 5 with no start or end times. -Bingo was listed on the calendar many times with no start or end times, or if it had a start time, there would be no end time. -Some days just had one activity listed for the whole day, such as Poker, Bingo, Birthday Celebration, Trivia, and Ice Cream Social. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 9:53am revealed: -The person filling in for AD had not completed her certification for AD. -Other staff filled in to do activities sometimes when the other person was not at the facility. -The person who filled in as AD did more evening activities when she was there. -Some days they did not have any activities. Interview with Owner #4 on 05/07/24 at 3:37pm revealed: -They did not have an AD. -They had someone filling in to do activities. -They are working on finding someone certified to do activities, but currently they do not have an AD. Interview with Owner #1 on 05/09/24 at 1:22pm revealed: -They currently do not have an AD. -He was aware of not having enough activities for the residents. -He was aware the calendar did not have start and end times for all activities. -He was aware the facility needed 14 hours a week of activities offered to the residents. Interview with a resident on 05/08/24 at 9:44am revealed the facility did not have an activity director; just a volunteer who was at the facility on Tuesdays and Thursdays to play Bingo in the	D 129	New activity director started w/ the facility on 5/9/24 in accordance w/ NC DHSR regulations. Activity Calendar has been altered to reflect start and end times for activities to appropriately track the amount of hours of activities held at the facility to meet the requirement. In accordance with 10A NCAC 13f. 0404 the activity director has 9 months to complete the course after assignment to this position. The dates for enrollment in the basic activity course are 07/08/2024 - 09/27/2024.	06/08/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 129	Continued From page 6 evening.	D 129		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -There was a hire date of 03/22/24. -There was no documentation of a HCPR check upon hire. Refer to interview with Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. Refer to the interview with Owner #4 on 05/09/24 at 1:30pm. Request for a HCPR check for Staff A on 05/08/24 at 2:07pm was not provided.	D 137	See page 8.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 137	Continued From page 7 2. Review of Staff C's, medication aide (MA) personnel record revealed: -There was a hire date of 01/31/24. -There was no documentation of a HCPR check upon hire. Attempted telephone interview with Staff C unsuccessful on 05/08/24 at 3:17pm. Refer to interview with RCC on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. Refer to the interview with Owner #4 on 05/09/24 at 1:30pm. Request for a HCPR check for Staff C on 05/08/24 at 2:07pm was not provided. Interview with the RCC on 05/09/24 at 11:05am revealed: -The RCC was responsible to make sure HCPR checks are completed. -She did not think about completing HCPR checks on staff she knew personally. -She was aware that all staff were required to have HCPR checks completed. Interview with Owner #1 on 05/09/24 at 1:22pm revealed: -The RCC or any of the Owners were responsible to complete HCPR checks. -Lack of training and lack of communication could be reasons why the HCPR checks were not completed on all staff. Interview with Owner #4 on 05/09/24 at 1:30pm	D 137	HCPR checks have been Completed for all staff at the facility. since annual survey, Wilham Ridge has experienced a 90%+ turnover in staff. All staff have undergone HCPR checks. HCPR Checks have been reaffirmed in the onboarding process, and oversight of its completion has changed to that of an Owner.	06/08/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 137	Continued From page 8 revealed personnel records were not audited.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 staff (Staff A, B, and C) had criminal background checks completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 03/22/24. -Staff A was hired as a medication aide (MA). -There was no criminal background completed upon hire. Refer to interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. Refer to the interview with Owner #4 on 05/09/24 at 1:30pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/29/24. -Staff B was hired as a MA. -There was no criminal background completed	D 139	See page 11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 139	Continued From page 9 upon hire. Refer to interview with the RCC on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. Refer to the interview with Owner #4 on 05/09/24 at 1:30pm. 3. Review of Staff C's personnel record revealed: -Staff C was hired on 01/31/24. -Staff C was hired as a MA. -There was no criminal background completed upon hire. Refer to interview with the RCC on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. Refer to the interview with Owner #4 on 05/09/24 at 1:30pm. Interview with the RCC on 05/09/24 at 11:05am revealed: -The Owners were responsible for obtaining criminal background checks on employees. -She did not have anything to do with making sure criminal background checks were completed on employees. Interview with Owner #1 on 05/09/24 at 1:22pm revealed: -The Owners were responsible to make sure criminal background checks were completed on all employees. -He was not aware criminal background checks	D 139	See page 11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 139	Continued From page 10 were not completed on all staff. -He believed lack of training and lack of communication could be the reason criminal background checks were not completed on all employees. Interview with Owner #4 on 05/09/24 at 1:30pm revealed personnel records were not audited.	D 139	Background checks have been completed on all employees. The oversight of the background check Process has been passed to a member of ownership.	06/08/24
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164	Audits of employee records will occur at least monthly going forward to ensure Compliance. See page 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 164	Continued From page 11 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff A, B, and C) completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 03/27/24. -There was no documentation of training on diabetic care for residents. Interview with Staff A on 05/8/24 at 8:00am revealed: -She worked in the facility as a MA and administered insulin to residents. -There was no documentation of her administrations of medications because she used another MAs sign in code to document in the electronic medication administration records (eMAR). -She only had some diabetic training from the Resident Care Coordinator (RCC). -She was not supervised when she administered medications. Review of a resident's eMAR for March and April 2024 revealed: -In March there were 120 opportunities for sliding scale insulin (SSI) administration and 20 times the SSI was given incorrectly or not at all. -In April there were 114 opportunities for SSI administration and 4 times the SSI was given	D 164	See page 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 164	Continued From page 12 incorrectly. Review of a second resident's eMAR for March 2024 revealed: -There was documentation the scheduled insulin was not administered 8 times and no documentation why it was not administered. -There was documentation the sliding scale scale insulin (SSI) was not administered 5 times and no documentation why it was not administered. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was rehired on 04/29/24. -There was no documentation of training on diabetic care for residents. Review of a resident's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was documentation that Staff B administered insulin on 03/01/24 at 11:30am, 03/06/24 at 7:30am and 11:30am, 03/12/24 at 11:30am and 4:30pm, 03/17/24 at 4:30pm and 03/27/24 at 4:30pm. Interview with Staff B on 05/07/24 at 2:25pm revealed: -She administered medications to the residents including diabetic medications -She knew how much medication to administer because she double checked the order. -She had diabetic training.	D 164	See page 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 164	Continued From page 13 Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 3. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired 01/31/24. -There was no documentation of training on diabetic care for residents. Review of a resident's electronic Medication Administration Record (eMAR) for 03/23/24 at 8:00am revealed Staff C documented she administered an incorrect dose of sliding scale insulin (SSI) at 8:00am. Attempted telephone interview with Staff C on 05/08/24 at 3:17pm was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration Type A2 Violation. Interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am revealed: -She trained newly hired MAs by having the MAs observe her during the medication pass for three days then on the fourth day the MA was able to administer medications. -She gave the MAs training on insulin but did not document it. -She did not know who was responsible for providing the required diabetic training.	D 164	See page 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 164	Continued From page 14 Interview with Owner #1 on 05/09/24 at 1:23pm revealed: -He was responsible for diabetic training on newly hired MAs but had missed some of the trainings. -The MAs were not authorized to administer medications until they had all the required training. The facility failed to ensure 3 of 3 sampled staff (A, B, and C) completed training on the care of residents with diabetes, resulting in the MAs giving incorrect doses of insulin and not administering the insulin as ordered. This failure resulted in substantial risk to the health, safety, and welfare of the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2024.	D 164	All staff who administered insulin have undergone training on care of diabetic residents in accordance with state regulations. A quality improvement plan around this care has been implemented that consists of refresher instruction every quarter. All instruction provided by 06/8/24 License Health Care Professional	
D 182	10A NCAC 13F .0602 (b) Management Of Facilities with a Capacity of 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (b) When the administrator is not on duty in the facility, there shall be a person designated as administrator-in-charge on duty in the facility who has the responsibility for the overall operation of the facility and meets the qualifications for administrator-in-charge required in Rule .0602 of	D 182	To immediately rectify this finding, Wilham Ridge has ensured at least one A-1-C/SIC has been present at all times. Many instances, there have been two licensed administrators at the building at all times. A PharmD or RN have been present full time at the building.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 15 this Section. The personal care aide supervisor, as required in Rule .0605 of this Subchapter, may serve simultaneously as the administrator-in-charge. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure there was always one Administrator or Administrator-In-Charge (AIC) in the facility at all times who was responsible for the overall operations of the facility related to qualifications of medication aide staff and medication administration including diabetic care training and correct administration of insulin, not notifying primary care providers when medications were administered incorrectly or not at all, and resident rights related to third shift staff sleeping in the facility during their shift. The findings are: Review of the facility census dated 05/07/24 revealed there were 33 residents residing in the facility as of 05/07/24. Interview with the Facility Owner #4 on 03/07/24 at 3:15pm revealed: -Since January 2024, she was on site at the facility from 8:00am - 2:00pm daily during the week except for Tuesday and Fridays because she owned another business.	D 182	To prevent this issue from occuring again in the future on day shift, there will always be an SIC on-sight. The facility administrator is and will be at the building daily to stabilize the operations, with an RN serving as the designee when administrator unable to be present. SIC requirements have been met for other staff members as well.	06/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 16 -The Owners met weekly for a board meeting in the facility. -When she was at the facility she would "hang out", help clean the kitchen, resident rooms, and bathrooms, and assisted the Resident Care Coordinator (RCC) with paperwork. -She was not a "medical person" and did not understand the processes related to medication administration. -She did not know where staff would document if they contacted the residents' PCPs but she knew the RCC was responsible for it. -No one in management knew the process. -She did not know how often the Administrator was in the facility. Interview with Facility Owner #3 on 03/07/24 at 4:00pm revealed: -She was a Registered Nurse (RN). -She was at the facility one time per week for a board meeting with the other Owners. -She would ask another Owner for assistance if she had questions. -She did not know if there was a process to ensure the residents at the facility were receiving the right medications. -She did not have a role in the daily operations of the facility. Interview with Facility Owner #2 on 05/08/24 at 9:17am and 11:50am revealed: -He was at the facility on weekly for board meetings with the other Owners. -Initially, the facility was purchased as an "investment opportunity", but now he knew it was more of a day to day operation. -He thought the facility was in "better shape" than it was when it was purchased and did not have as many issues with medication administration and staffing.	D 182	See page 16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 17 -He never met the Administrator but may have spoken to her on a conference call. -He did not know how often the Administrator was in the facility, but he did not expect her to be there. -Another Owner (Owner #1) was working on becoming a licensed Administrator. -They had been in touch with the owner of a local facility who gave guidance on rules they were not clear on. Interview with Facility Owner #1 on 05/09/24 at 1:23pm revealed: -He was a Pharmacist. -He was at the facility at least 3 days per week since the facility was purchased in July 2023. -When he was at the facility, he worked on staff certifications and facility renovations. -Another Owner was in the facility 4 days per week. -The RCC was responsible for the daily operations of the facility. -He was attempting to obtain his Administrator license and the current Administrator trained him. Telephone interview with the Administrator on 05/09/24 at 12:20pm revealed: -She was currently the Administrator of the facility since the end of 2023. -She assisted one of the Owners with obtaining his Administrator license but there was a delay with the paperwork. -She was made aware of numerous medication issues via a pharmacy audit that was conducted, and it was "overwhelming". -One of the Owners informed her they were "working on the charts" and had made a chart checklist. -She had emailed the RCC several times the past few months to give her resources about putting a	D 182	See page 16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 18 resident record together. -She was in the facility monthly and was there more often when she was precepting the Owner. -She assumed the RCC and the Owners were responsible for the day to day operations of the facility. Interview with the RCC on 05/07/24 at 4:06pm and 05/09/24 at 11:05am revealed: -Owner #1 was at the facility 3-4 times per week to file, clean, interact with residents and staff, and would come to the facility and assist her if she telephoned for assistance. -Another Owner came to the facility 2- 3 times per week and helped with resident haircuts, cleaning, paperwork, and assisted with emails from the pharmacy. -She had seen the Administrator at the facility two times since January 2024. -She did not have the qualifications to be the AIC of the facility and she had a lot she was responsible for. Non-compliance was identified at a violation level in the following areas: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed for 3 of 6 sampled residents (#3, #5, and #6) related to medications used to control elevated blood glucose (#3, #5, and #6), a medication that treats depression (#5), and medications used to control pain and an elevated heart rate (#3). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration Type A2 Violation]. Based on interviews and record reviews, the facility failed to ensure notification to the primary care provider (PCP) for 4 of 6 sampled residents	D 182	See page 16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 19 (Residents #3, #4, #5, and #6) related to medications to treat elevated blood sugar not administered (#3, and #5), inaccurate doses of medications to treat elevated blood sugar, blood sugar readings greater than 400, a pain medication not administered, a heart medication given outside of parameter (#3), and refusals of medications that treat high ammonia levels (#4) and blood sugar (#6). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care Type A2 Violation]. Based on observations and interviews, the facility failed to ensure all residents were free from neglect related to third shift staff sleeping and a delay in residents getting medications or not getting their medications. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights Type A2 Violation]. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff A, B, and C) completed training on the care of diabetic residents prior to the administration of insulin. [Refer to Tag 0164 10A NCAC 13F .0505 Training on Care of Diabetic Residents Type A2 Violation]. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff A, B and C) who administered medications, completed the state approved medication clinical skills validation checklist and completed the state approved 5-hour and 10-hour or 15-hour medication training as required (Staff A, B, C) and 1 staff who did not complete her medication aide test (Staff C). [Refer to Tag 0125 10A NCAC 13F .0403(a) Qualifications of Medication Staff Type A2 Violation].	D 182	See page 16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 182	Continued From page 20 Based on interviews and record review the facility failed to ensure a licensed health professional participated in the review and evaluation for 2 of 5 residents (#3 and #5) at least quarterly. [Refer to Tag 0280 10A NCAC 13F .0903(c) Licensed Health Professional Support Type B Violation]. The facility failed to ensure there was an Administrator or Administrator-In-Charge in the facility at all times who was responsible for the daily operations of the facility which resulted in third shift staff sleeping during their shift, residents that were administered incorrect doses of medications, residents who were not administered doses of medications, primary care providers were not notified of medication errors and refusals of medications, and medication aide staff administering medications without the required training. This failure resulted in serious neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 8, 2024	D 182	See page 16	
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 A2 VIOLATION Based on interviews and record reviews, the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 21 facility failed to ensure notification to the primary care provider (PCP) for 4 of 6 sampled residents (Residents #3, #4, #5, and #6) related to medications to treat elevated blood sugar not administered (#3, and #5), inaccurate doses of medications to treat elevated blood sugar, blood sugar readings greater than 400, a pain medication not administered, a heart medication given outside of parameter (#3), and refusals of medications that treat high ammonia levels (#4) and blood sugar (#6). The findings are: Review of the facility's Medication Policy and Procedure dated 06/21/23 revealed: -The resident's primary care provider (PCP) would be notified after 3 missed/refused doses of medications. -In the event of medication errors, facility staff would notify the PCP or appropriate health professional. 1. Review of Resident #3's current FL2 dated 12/29/23 revealed diagnoses included diabetes (a chronic condition that impairs the body's ability to process blood glucose). Review of Resident #3's Resident Register revealed an admission date of 07/26/23. a. Review of physician's orders for Resident #3 dated 12/21/23 revealed Novolog insulin (reduces blood sugar) 100units/ml three times daily per sliding scale insulin (SSI), parameters for continuous glucose monitoring device (CGM) 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 351-400 = 10 units, greater than 400 notify the primary care provider (PCP).	D 273	See Page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 22 Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was documentation on 03/02/24 at 4:00pm of CGM result 450 and 03/17/24 at 12:00pm of 443 and no documentation the PCP was notified. -There was documentation for 13 times out of 90 opportunities of incorrect SSI or no insulin administered and no documentation the PCP was notified. Review of Resident #3's April 2024 eMAR revealed: -There was documentation on 04/03/24 at 4:00pm of CGM result of 410, and 04/04/24 at 4:00pm of 562 and no documentation that the PCP was notified. -There was no documentation of a CGM result or SSI administered on 03/04/24 at 12:00pm or documentation that the PCP was notified. Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/07/24 at 4:20pm revealed: -Resident #3 was prescribed insulin for labile blood glucose. -He was not notified of BG readings greater than 400 or incorrect doses of SSI which could cause complications like vision changes, vascular changes, kidney damage, coma, or death. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. b. Review of physician's orders for Resident #3 dated 12/21/23 revealed Novolog insulin	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 23 100units/ml at bedtime per sliding scale insulin (SSI), parameter continuous glucose monitoring device (CGM) result 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 notify PCP. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed there was no documentation of a CGM result or SSI on 03/01/24 - 03/07/24 at 7:00pm and no documentation the PCP was notified. Review of Resident #3's April 2024 eMAR revealed there was documentation of a CGM result of 416 on 04/11/24 and no documentation the PCP was notified. Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/07/24 at 4:20pm revealed: -Resident #3 was prescribed insulin for labile blood glucose. -He was not notified of missed doses of insulin and not receiving her insulin put her at risk of vision changes, vascular changes, kidney damage, coma, or death. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. c. Review of physician's orders for Resident #3 dated 12/21/23 revealed hydrocodone-acetaminophen (used to treat pain) 7.5-325mg three times daily. Review of Resident #3's March 2024 electronic	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 24 Medication Administration Record (eMAR) revealed: -There was documentation the hydrocodone-acetaminophen was not administered 21 out of 93 opportunities in March 2024 with no documentation the PCP was notified. Review of Resident #3's April 2024 eMAR revealed there was documentation the hydrocodone-acetaminophen was not administered 6 out of 90 opportunities in April 2024 with no documentation the PCP was notified. Review of Resident #3's eMAR for 05/01/24 - 05/07/24 revealed there was documentation the hydrocodone-acetaminophen was not administered 5 out of 19 times 05/01/24 - 05/07/24 with no documentation the PCP was notified. Telephone interview with Resident #3's PCP on 05/07/24 at 4:20pm revealed: -He was not notified Resident #3 had missed any doses of hydrocodone. -He was concerned because she had intractable back pain and missed doses could cause her to have narcotic withdrawals. Refer to the interview with the RCC on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. d. Review of physician's orders for Resident #3 dated 12/21/23 revealed metoprolol tartrate (reduces heart rate and blood pressure) 25mg take ½ tablet (12.5mg) twice daily. Hold for heart	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 25 rate less 60, systolic blood pressure (SBP) less than 100, and/or diastolic blood pressure less than 50. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was documentation 4 out of 62 opportunities of SBP less than 100 and the metoprolol was administered and no documentation the PCP was notified. -There was documentation on 03/03/24 at 8:00am of a BP of 90/76 and the metoprolol was administered. -There was documentation on 03/09/24 at 8:00am of a BP of 93/70 and the metoprolol was administered. -There was documentation on 03/16/24 at 8:00am of a BP of 95/72 and the metoprolol was administered. -There was documentation on 03/27/24 at 8:00am of a BP of 92/62 and the metoprolol was administered. Review of Resident #3's April 2024 eMAR for revealed: -There was documentation 10 out of 60 opportunities of SBP less than 100 in April 2024 and the metoprolol was administered and no documentation the PCP was notified. -There was documentation on 04/03/24 at 8:00am of a BP of 93/73 and the metoprolol was administered. -There was documentation on 04/12/24 at 6:00pm of a BP of 77/56 and the metoprolol was administered. -There was documentation on 04/23/24 at 8:00am of a BP of 80/32 and the metoprolol was administered. -There was documentation on 04/28/24 at	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 26 8:00am of a BP of 73/45 and the metoprolol was administered. Review of Resident #3's eMAR for 05/01/24 - 05/07/24 revealed there was documentation 4 out of 13 opportunities of SBP less than 100 from 05/01/24 - 05/07/24 and the metoprolol was administered and no documentation the PCP was notified. Telephone interview with Resident #3's PCP on 05/07/24 at 4:20pm revealed he was not notified that Resident #3 was administered metoprolol when her SBP was less that 100. Refer to the interview with the RCC on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 2. Review of Resident #5's current FL2 dated 12/21/23 revealed diagnoses included diabetes. Review of Resident #5's Resident Register revealed an admission date of 07/26/23. a. Review of physician's orders for Resident #5 dated 02/15/24 revealed Lispro insulin (reduces elevated blood sugar) 100units/ml inject 8 units with meals. Review of Resident #5's March 2024 electronic Medication Administration Record (eMAR) revealed: -There no documentation the insulin was administered on 03/02/24 at 7:30am, 03/04/24 at 11:30am, 03/11/24 at 11:30am, 03/15/24 at 7:30am and 11:30am, 03/19/24 at 11:30am, and 03/26/24 at 11:30am and no documentation the	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 27 PCP was notified. Review of Resident #5's eMAR for 05/01/24 - 05/07/24 revealed there was no documentation the insulin was administered on 05/07/24 at 4:30pm, and there was no documentation the PCP was notified. Interview with Resident #5's Primary Care Provider (PCP) on 05/09/24 at 10:30am revealed: -Resident #5 was prescribed insulin due to a long history of poorly controlled diabetes. -He was not notified of missed doses of insulin and the resident was at risk of skin infections, vision changes, and organ damage, coma, or death. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. b. Review of physician's orders for Resident #5 dated 02/15/24 revealed Lispro insulin 100units/ml inject per sliding scale insulin before meals and at bedtime for continuous glucose monitoring device (CGM) parameters 250-299 = 4 units, 300-350 = 6 units, greater than 350 = 8 units, greater than 500 notify PCP. Review of Resident #5's March 2024 electronic Medication Administration Record (eMAR) revealed there was no documentation of a CGM result or SSI on 03/02/24 at 8:00am, 03/04/24 at 12:00pm, 03/11/24 at 8:00pm, 03/29 /24 at 8:00am or 4:00pm and no documentation the PCP was notified. Review of Resident #5's eMAR for 05/01/24 -	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 28 05/07/24 revealed there was no documentation of a CGM result or SSI on 05/06/24 at 8:00pm, 05/07/24 at 4:00pm and no documentation the PCP was notified. Interview with Resident #5's PCP on 05/09/24 at 10:30am revealed: -Resident #5 was prescribed insulin due to a long history of poorly controlled diabetes. -He was not notified of missed doses of insulin and the resident was at risk of skin infections, vision changes, and organ damage, coma, or death. Refer to the interview with the RCC on 05/09/24 at 11:05am Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. 3. Review of Resident #4's current FL2 dated 03/11/24 revealed diagnoses included schizophrenia. Review of Resident #4's physician's orders dated 01/02/24 revealed an order for lactulose (used to reduce ammonia levels) 10ml daily. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 10ml, once daily. -There was documentation lactulose was refused from 02/01/24 through 02/21/24. -There was documentation lactulose was refused from 02/23/24 through 02/27/24. -There was no documentation lactulose was administered on 02/22/24. -There was documentation Resident #4 was in	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 29 the hospital on 02/28/24. -There was no documentation the Primary Care Provider (PCP) was notified of the lactulose refusals. Review of Resident #4's March 2024 eMAR revealed: -There was an entry for lactulose 10ml, once daily. -There was documentation Resident #4 was in the hospital from 03/01/24-03/13/24. -There was documentation lactulose was administered as ordered six times: on 03/15/24, 03/16/24, 03/19/24, 03/21/24, 03/28/24 and 03/29/24. -All other days of the month lactulose was documented as not administered due to resident refusal or medication was on order from the pharmacy. -There was no documentation the PCP was notified of the lactulose refusals. Review of Resident #4's April 2024 eMAR revealed: -There was an entry for lactulose 10ml, once daily. -There was documentation lactulose was administered as ordered six times: on 04/06/24, 04/17/24, 04/19/24, 04/23/24, 04/29/24 and 04/30/24. -All other days of the month lactulose was documented as not administered due to resident refusal or medication was on order from the pharmacy. -There was no documentation the PCP was notified of the lactulose refusals. Review of Resident #4's May 2024 eMAR revealed: -There was an entry for lactulose 10ml, once	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING. _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 30 daily. -There was documentation lactulose was not administered due to resident refusal or medication was on order from the pharmacy on 05/01/24 through 05/03/24 and 05/05/24 through 05/07/24. -There was no documentation the PCP was notified of the lactulose refusals. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/07/24 at 1:56pm revealed: -A 300ml bottle (30 doses) of lactulose was dispensed and delivered to the facility on 01/02/24. -A refill request was received from the facility on 03/20/24 and another 300ml bottle of lactulose was dispensed and delivered to the facility on 03/20/24. Interview with Resident #4 on 05/08/24 at 8:13am revealed: -He did not need the lactulose daily. -He took lactulose 2 times a week, when he felt like he needed it. Interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:07pm revealed: -Resident #4 usually refused his lactulose. -She attempted to get the lactulose discontinued because he rarely took it. -She asked the PCP if it could be discontinued but he told her that he wanted to keep it ordered as Resident #4 would occasionally take it. -She had a conversation with the PCP in the hall one day, so it was not documented anywhere that she had asked him about it. -The facility was never waiting on the medication from the pharmacy and if it was documented that way it was because the medication aides (MAs)	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 31 documented it incorrectly. Telephone interview with Resident #4's PCP on 05/07/24 at 4:10pm revealed: -He was not told by staff that Resident #4 was refusing to take his lactulose. -He did not remember a conversation with the RCC informing him that Resident #4 refused his lactulose frequently and she wanted it discontinued. -He expected to be notified if a medication was being refused. -Resident #4 was ordered lactulose due to increased ammonia levels. -Increased ammonia levels may cause mental and/or neurological deficits. -He did not think Resident #4's hospitalization in February - March 2024 was related to the lactulose refusal. Interview with Owner #1 on 05/09/24 at 1:23 revealed: -The RCC was responsible for monitoring and notifying the PCP of medication refusals. -The RCC was responsible for monitoring the eMAR and checking for medication refusals. 4. Review of Resident #6's current FL2 dated 12/29/23 revealed diagnoses included diabetes (a chronic condition that impairs the body's ability to process blood glucose). Review of Resident #6's physician's orders dated 01/12/24 revealed there was an order for sliding scale (SSI) insulin aspart (used to control blood sugar levels) inject subcutaneous before meals: fingerstick blood sugar (FSBS) checks less than 150 = 0 units, 150-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units, 450 or greater = call provider.	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 32 Review of Resident #6's May 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for SSI Aspart inject subcutaneous before meals: less than 150 = 0 units, 150-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units, 450 or greater = call provider. -There was documentation Resident #6 refused his insulin on 05/1/24, 05/02/24, 05/04/24-05/07/24. -There was no documentation the PCP was notified. Interview with Resident #6's PCP on 05/9/24 at 10:33am revealed: -No one from the facility had ever reported to him that Resident #6 regularly refused his insulin. -He saw Resident #6 every two weeks and Resident #6 told him he occasionally refused his insulin. Interview with the RCC on 05/09/24 at 11:05am revealed: She was responsible for informing the PCP when a resident refused medication. -She documented it with a telehealth visit but she was unable to retrieve that report and she did not print out the report at the time. -She reviewed the eMARS to be sure medications were being administered but she mostly focused on new medications. Telephone interview with the Administrator on 05/09/24 at 12:28pm revealed she only became was aware recently there were many medication errors and refusals because there was a recent pharmacy audit.	D 273	See page 34	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 33 Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. _____ Interview with the RCC on 05/09/24 at 11:05am revealed: -She was responsible for notifying the PCP when residents were administered incorrect medication doses or medications were not administered. -She documented the notifications electronically in the "telehealth" record but she did not know how to access the history to retrieve the notifications. Interview with Owner #1 on 05/09/24 at 1:23pm revealed: -The RCC was responsible for monitoring medication administration and notifying the PCP. -He did not know why the RCC did not notify the PCP about missed medications and incorrect doses. _____ The facility failed to notify the primary care provider (PCP) for insulin doses that were not administered and inaccurate doses of insulin, missed doses of a pain medication, and a medication for heart rate which put Resident #3 at risk of complications of diabetes which are kidney damage, coma, or death, increased pain and narcotic withdrawal, missed doses of insulin which put Resident #5 at risk of kidney damage, coma, or death, refusals of a medication to lower ammonia levels for Resident #4, and refusals of insulin which put Resident #6 at risk of kidney damage, coma, or death. This failure resulted in substantial risk to the health, safety, and welfare of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 05/08/24	D 273	Facility meets weekly with the primary care provider. The meeting is held by either the administrator or an alternative designee. The facility has implemented a "care audit" process overseen by the administrator/ PharmD that covers any medical related issues Pertaining to all parties. Findings of these care audit are communicated weekly, unless clinical judgement of licensed health care professional deems earlier contact is required. All staff has recieved training related to job functions, medication administration, and provider follow-up. This Process continues to be refined for gaps in health care delivery. Further training will be provided immediately when these gaps are identified. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 34 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2024	D 273	Staff has recieved training on the use of the telehealth tool to communicate with the providers of residents. Training will reoccur every instance a gap is identified. Administrator, health care Professionals, and staff management have, and will continue to, work with providers to implement appropriate parameters.	06/8/24
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (Resident #5) related to daily and weekly weights. The findings are: Review of Resident #5's current FL2 dated 12/21/23 revealed diagnoses included diabetes and chronic obstructive pulmonary disease. Review of Resident #5's Resident Register revealed an admission date of 07/26/23. Review of a physician's progress note for Resident #5 dated 01/25/24 revealed: -Resident #3 had an additional diagnosis of edema and congestive heart failure (CHF). -Resident #3 appeared stable though she was a high risk for exacerbation of CHF due to high chronic disease burden and poor health. -Resident had been evaluated recently and daily	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 276	Continued From page 35 weights were ordered for chronic edema (swelling). -No daily weights were documented by the facility. -There was an order for daily weights x 7 days then weekly. Review of Resident #5's electronic Medication Administration Record (eMAR) for February, March, and April 2024 and 05/01/24 - 05/07/24 revealed there was not an entry for daily or weekly weights and no documentation of weights. Interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am revealed: -Physician's progress notes with orders were faxed to the pharmacy. -The pharmacy would enter the order for weights onto the eMAR electronically. -It was her responsibility to fax the progress notes with orders to the pharmacy. -She missed faxing Resident #5's order for weights to pharmacy. -Resident #5 was not weighed according to the order. Interview with Resident #5's Primary Care Provider (PCP) on 05/09/24 at 10:30am revealed: -Resident #5 had a diagnosis of CHF. -Weights were ordered for fluid accumulation and to assess for worsening cardiac function. -He expected the staff to obtain the weights as ordered. Interview with Resident #5 on 05/09/24 at 9:25am revealed staff did not weigh her. Interview with Owner #1 on 05/09/24 at 1:23pm revealed the RCC was responsible for monitoring the eMARs and faxing orders to the pharmacy.	D 276	Resident orders have been incorporated into a new filing system with checks and balances from ownership. Any order for weights while using current quickmar system are being double checked by RCC and triple checked by Administrator. 6/8/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 280	Continued From page 36	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record review the facility failed to ensure a licensed health professional participated in the review and evaluation for 2 of 5 residents (#3 and #5) at least quarterly. The findings are: 1. Review of Resident #3's current FL2 dated	D 280	New process of completing LHPS reviews has been implemented. The process was begun in May of 2024, following state survey. All residents in facility underwent new LHPS review by qualified RN, regardless of last or next due LHPS. This was performed to "reset" all LHPS reviews on the same cycle. All reviews will now occur during the same month, with new residents recieving a review with 30 days and then another during the next cycles LHPS review date. This process ensures no resident will miss their review.	6/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 280	Continued From page 37 12/29/23 revealed diagnoses included chronic obstructive pulmonary disease and diabetes. Review of Resident #3's Resident Register revealed an admission date of 07/26/23. Review of Resident #3's record revealed: -There was a Licensed Health Professional Support (LHPS) review and evaluation dated 10/05/23. -There was documentation of a review of Resident #3's health status and care provided and to continue current plan of care. -LHPS tasks included blood glucose checks and insulin injections. -There was a LHPS review and evaluation dated 01/26/24. -There was documentation of a review of Resident #3's health status and care provided and to continue current plan of care. -LHPS tasks included blood glucose checks and insulin injections. -There were no other LHPS reviews after 01/26/24. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the telephone interview with the Administrator on 05/09/24 at 12:28pm. 2. Review of Resident #5's current FL2 dated 12/21/23 revealed diagnoses included chronic obstructive pulmonary disease, diabetes, and anemia. Review of Resident #5's Resident Register revealed an admission date of 07/26/23. Review of Resident #3's record revealed:	D 280	See page 37	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 280	Continued From page 38 -There was a Licensed Health Profession Support (LHPS) review and evaluation dated 01/26/24. -There was documentation of a review of Resident #3's health status and care provided and to continue current plan of care. -LHPS tasks included blood glucose checks, insulin injections, and oxygen as needed. -There were no other LHPS reviews after 01/26/24. Refer to the interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the telephone interview with the Administrator on 05/09/24 at 12:28pm. _____ Interview with the Resident Care Coordinator (RCC) on 05/09/24 at 11:05am revealed: -She knew residents needed a LHPS nurse review. -She was hired in January 2024 and did not know when the last time the LHPS reviews were completed. -She was busy with other things. Telephone interview with the Administrator on 05/09/24 at 12:28pm revealed: -She was a Registered Nurse (RN) and was responsible for completing the LHPS reviews. -She had just been busy with so many other issues with the facility and did not have the time to do the LHPS reviews since January 2024. _____ The facility failed to ensure the LHPS Registered Nurse performed a physical assessment at least quarterly to Residents #3 and #5 who had a diagnosis of diabetes and required blood glucose checks and insulin injections. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B violation.	D 280	See page 37	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 280	Continued From page 39 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/24. CORRECTION DATE OF THE TYPE B VIOLATION SHALL NOT EXCEED 06/23/24.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure therapeutic diet menus were available for 2 of 2 sampled residents (#4 & #5) who had orders for a no concentrated sweets (NCS) diet. The findings are: Review of the facility's menus on 05/07/24 revealed: -There was a week at a glance menu posted on the food pantry door. -The menu was for a regular diet. -There were not any therapeutic diet menus available for review.	D 296	Wilham Ridge has procured the services of registered dietician to fully overhaul the menus for our residents to ensure compliance. RD will be reviewing/creating the menus for Wilham Ridge moving forward. RD began working on menu 06/04/2024. The menus are expected to be returned by 06/28/24	expected: 06/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 296	Continued From page 40 1. Review of Resident #3's current FL2 dated 12/29/23 revealed diagnoses included diabetes (a chronic condition that impairs the body's ability to process blood glucose). Review of Resident #3's physician's orders dated 02/15/24 revealed an order for a NCS diet. Review of the facility's undated therapeutic diet list revealed Resident #3 received a NCS diet. Observation of the lunch meal service on 05/07/24 at 12:30pm revealed: -Resident #3 was served a bologna and cheese sandwich with lettuce on white bread, a scoop of potato salad, 6 round crackers. a dish of pineapple, and glasses of milk, water and fruit punch. -Without a therapeutic diet menu it could not be determined if Resident #3 received the correct diet. Refer to interview with the Food Service Director (FSD) on 05/07/24 at 11:02am. Refer to interview with an Owner of the facility on 05/08/24 at 9:17am. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 1:20pm. 2. Review of Resident #5's current FL2 dated 12/21/23 revealed: -Diagnoses included diabetes (a chronic condition that impairs the body's ability to process blood glucose). Review of Resident #5's physician's orders dated 01/04/24 revealed an order for a NCS diet.	D 296	See page 40	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 296	Continued From page 41 Review of the facility's undated therapeutic diet list revealed Resident #5 received a NCS diet. Observation of the lunch meal service on 05/07/24 at 12:30pm revealed: -Resident #5 was served two bologna and cheese sandwiches with lettuce on white bread, a scoop of potato salad, 6 round crackers. a dish of pineapple, and glasses of water and fruit punch. -Without a therapeutic diet menu it could not be determined if Resident #5 received the correct diet. Refer to interview with the Food Service Director (FSD) on 05/07/24 at 11:02am. Refer to interview with an Owner of the facility on 05/08/24 at 9:17am. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 1:20pm. Interview with the Food Service Director (FSD) on 05/07/24 at 11:02am revealed: -The facility had one menu that was used for all residents. -No added sugar items and sugar free items were the only types of foods the facility used so they were appropriate for all diets. -Sugar was available upon request. Interview with an Owner of the facility on 05/08/24 at 9:17am revealed: -He had been in contact with another local facility provider who supplied him with a menu. -The same menu was used for residents who were ordered either a regular diet or a NCS diet because they only purchased foods that did not contain added sugars. -He was not aware a separate menu was needed	D 296	See page 40	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 296	Continued From page 42 for a NCS diet order. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 1:20pm revealed: -The facility did not have any therapeutic diet orders. -She did not think NCS was a therapeutic diet, only "something" like a puree or ground was considered therapeutic. -She thought the menu that was used at the facility was appropriate for everyone because they only purchased food items that were sugar free and regular sugar was available upon request.	D 296		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 33 of 33 residents were offered activities designed to promote active resident involvement with each other and the community. The findings are: Interview with a resident on 05/07/24 at 8:49am	D 315	See page 40	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 315	Continued From page 43 revealed: -The facility did not provide activities he liked. -He enjoyed singing and prayer time, but those types of activities were never offered. -Bingo was what they offered most of the time, and he would like more of a variety. -He was bored a lot during the day. Interview with a second resident on 05/07/24 at 9:11am revealed: -Playing Bingo was what they did most of the time. -He had not been outside of the facility for an outing. -He was never asked to go out in the community for outings. Interview with a third resident on 05/07/24 at 9:19am revealed: -He had resided at facility for almost 14 years. -The only activity he had participated in was Bingo. -He was unaware of any other types of activities that were offered. Interview with a fourth resident on 05/08/24 at 7:56am revealed: -She was only aware of Bingo as an activity that was offered. -She enjoyed doing crafts, but she had never participated in crafts at the facility because she was unsure if they offered crafts. -She completed her own crafts in her room that she enjoyed giving to people as gifts. -She did not see activities happening often. Interview with a fifth resident on 05/07/24 at 8:47am revealed: -The previous activities director was in a different role, and no longer led activities.	D 315	See page 46	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 315	Continued From page 44 -There were not any good activities to keep him busy, so he just listened to music. Interview with a sixth resident on 05/07/24 at 8:57am revealed the staff who was in charge of providing activities frequently ended up doing chores like mopping the floors or doing laundry rather than providing activities for residents. Interview with a seventh resident on 05/08/24 at 9:44am revealed: -Bingo was usually played on Tuesdays and Thursdays in the evening. -Residents sit outside and in their rooms as there was not usually anything to do during the day. -It would be nice to have something to do because usually just pass the day bored. Observation of of the facility on 05/07/24, 05/08/24, and 05/09/24 from 8:00am - 4:00pm revealed: -No activities were observed during the day. -Residents were either in their rooms or watching TV in the dayroom, but no structured activities were taking place. -One resident was observed jogging around the building alone. Interview with a personal care aide (PCA) on 05/09/24 at 9:24am revealed: -There were no actvities offered during the day. -Most of the residents complained of being bored. -The person who covered activities was not there much. -She observed activities during the day about twice a week. -She observed only one activity per day two times a week. -She observed Bingo as the activity that occurred twice a week, and had not seen any other	D 315	See page 46	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 315	Continued From page 45 activities take place. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 9:53am revealed: -There were not many activities going on during the day. -Bingo was offered at night. -Some days they did not have any activities. -The person filling in for activities did not have her certification for Activities Director (AD). -The person filling in as AD mostly did evening activities. Interview with Owner #4 on 05/07/24 at 3:37pm revealed: -They did not have an AD. -They are working on getting an AD. -They do have a person filling in as AD, but was not certified. Interview with Owner #1 on 05/09/24 at 1:22pm revealed: -They had a person who did activities, but her official role was quality coordinator. -He was aware activities had been an issue and residents did not have enough to do. -He felt they are making progress because they had more going on now than they did in the past. -They were in the process of working on getting more activities for the residents.	D 315	Wilham Ridge has always offered more activities than just "Bingo" as indicated on this survey. Wilham Ridge has, and will continue to, offer bible study, Motorcycle Club, community volunteers, holiday events (i.e. halloween, easter, independence day, etc.), adopt a grandparent (covered by local news), and obtains evidence of these activities at each occurence. Facility has, and will continue to, offer other activities such as crafts, fire pit nights, smores, water balloon days, Karaoke, outdoor fun and game days, easter egg hunt, and more. We are unable to transport residents into the community due to financial constraints but	
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.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 46 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to ensure all residents were free from neglect related to third shift staff sleeping and a delay in residents getting medications or not getting their medications. The findings are: Observation of the facility front entrance on 05/08/24 at 5:00am revealed one staff sitting in a chair on the porch smoking a cigarette. Interview with the staff on 05/08/24 at 5:02am revealed: -She worked at the facility as a personal care aide (PCA). -She was sent from a local staffing agency to work third shift. -The facility medication aide (MA) was in a room and she would go and get her. Observation of the facility 100 hall on 05/08/24 at 5:04am revealed: -The PCA walked into resident room 105. -The MA walked out of the room and she was rubbing her right eye and appeared disoriented as she walked down the hall. Observation of room 105 on 05/08/24 at 5:10am revealed: -There were no residents or resident belongings in the room. -There was a single bed, blanket, and pillow. Interview with the MA on 05/08/24 at 5:05am revealed:	D 338	have brought the community to Wilham Ridge. 06/8/24 See page 50	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 47 -She was not sleeping in room 105, she was "decorating" the room. -She used to sleep on her break but was told by management sleeping during her shift was no longer allowed. Interview with a resident on 05/07/24 at 9:15am revealed: -Staff slept on office floors or on the couch at night. -She needed some medication at night for anxiety and could not locate any staff so she just went back to bed. -She did not remember the date she needed the anxiety medication at night. -Usually two people work at night and they both slept. Interview with a second resident on 05/08/24 at 9:44am revealed: -Staff sometimes slept on third shift in the vacant rooms on the 100 hall. -If two staff were working on third shift they would alternate sleeping in the vacant room. Interview with a third resident on 05/08/24 at 7:56am revealed: -She woke up on 04/26/24 in the middle of the night in pain and was looking for staff. -She could not find staff anywhere for one hour and a half. -She stated her pain level was an 8 or 9 out of 10, with 10 being the worst. -After looking for an hour and a half, she found staff in 2 different resident rooms, in bed, asleep. -She woke one staff member up and told them she was in pain. -The staff member told her to ask someone else, and rolled back over and went back to sleep. -She found the next staff member in the adjoining	D 338	See Page 50	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 48 room in bed asleep. -She woke up that staff member and they got up and gave her something for pain. -She had never had issues with 1st shift staff, only 3rd shift staff. Interview with fourth resident on 05/08/24 at 2:13pm revealed: -She had seen 3rd shift med aids (MA) asleep on the job. -She had observed a MA asleep on the couch in the living area about a month ago, but was unsure of the exact date. -She had heard complaints from other residents about them seeing staff sleep. -She did not know names of the staff who sleep because they "come and go a lot." Interview with fifth resident on 05/08/24 at 2:19pm revealed: -She was aware staff go into unoccupied resident rooms and sleep on 3rd shift. -She was up last night and could not find any staff for awhile. -She had gotten up to get some water and she did not see staff anywhere. Interview with sixth resident on 05/08/24 at 2:25pm revealed: -She had seen 2 staff members on 3rd shift sleeping in the office. -She could not recall the date when it occurred. Interview with a seventh resident on 04/30/24 at 10:15am revealed: -Staff sleep day and night in empty resident rooms. -She frequently observed staff sleeping in empty resident rooms next door to her own. -Staff did not check on residents at night.	D 338	See Page 50	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 49 -If residents need staff during the night, they have to wake them up. -She was concerned that the front doors were unlocked and anyone could enter the facility and there were no staff awake to keep the resident safe. Interview with an eighth resident on 04/30/24 at 9:45am revealed: -A staff that worked at night slept during her shift. -Another staff slept on the couch at night. -He needed pain medication for hip pain and neuropathy in his legs in the night and always had to wake staff up in the night to get his medication. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 4:06pm revealed staff were not allowed to sleep on third shift. Interview with Owner #1 on 05/08/24 at 7:00am revealed: -Staff were not authorized to sleep during their shifts and he had addressed it several times. -The two rooms staff were sleeping in were locked in the past to prevent the staff from going in, but then when he came back into the facility someone unlocked the doors. -It was reported to him that staff were not making rounds on third shift and some residents were found by first shift with their incontinence briefs full of urine. The facility failed to ensure all residents rights were maintained related to neglect due to third shift staff sleeping during their shift which caused residents to get up in the night to search for staff, caused a delay in a resident getting her pain medication, a resident did not get her anxiety medication, and a resident was concerned for her safety. This failure resulted in substantial risk to	D 338	Administrator and ownership have instituted 2 hour checks around the clock w/ a notification being sent to all staff devices when the check should occur. Ownership has been making random visits to the facility over night to address the issue.	6/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 50 the health, safety, and welfare of the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2024	D 338	See page 50	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed for 3 of 6 sampled residents (#3, #5, and #6) related to medications used to control elevated blood glucose (#3, #5, and #6), a medication that treats depression (#5), and medications used to control pain and an elevated heart rate (#3). The findings are: Review of the facility's Medication Administration Policy and Procedure dated 06/21/23 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 51 -Medications would be administered in accordance with the prescribing practitioner's orders. -Staff who have demonstrated competency according to State rules may administer medications. -Documentation would be provided by staff who administered the medication. -Facility would ensure that all medications were in stock and ready for use at the time the prescribed by the resident's primary care provider (PCP). 1. Review of Resident #3's current FL2 dated 12/29/23 revealed diagnoses included diabetes (a chronic condition that impairs the body's ability to process blood glucose). Review of Resident #3's Resident Register revealed an admission date of 07/26/23. a. Review of Resident #3's physician's orders revealed there was not an order for Semglee insulin (used to lower elevated blood sugar). Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Semglee insulin 100 unit/ml inject 32 units twice daily with administration times of 8:00am and 6:00pm. -There was no documentation the Semglee insulin 32 units was administered on 03/29/24 at 6:00pm or reason why it was not administered. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Semglee insulin 100 unit/ml inject 32 units twice daily with administration times of 8:00am and 6:00pm. -There was documentation the Semglee insulin	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 52 32 units was not administered on 04/10/24 - 04/11/24 at 8:00am and 6:00pm due to medication on order from pharmacy. Review of Resident #3's eMAR for 05/01/24 - 05/07/24 revealed: -There was an entry for Semglee insulin 100 unit/ml inject 32 units twice daily with administration times of 8:00am and 6:00pm. -There was documentation the Semglee insulin 32 units was not administered on 05/05/24 at 6:00pm, 05/06/24 at 8:00am and 6:00pm, and 05/07/24 at 8:00am due to medication on order from pharmacy. -There was no documentation the Semglee insulin 32 units was administered on 05/07/24 at 6:00pm or reason why. Observation of Resident #3's medications available for administration on 05/08/24 at 9:25am revealed there was not any Semglee insulin available for administration. Interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm revealed: -She knew Resident #3 did not have any Semglee insulin to administer. -She requested a refill of the insulin electronically via the eMAR on 05/05/24 and the pharmacy informed her the medication was on back order. -She did not know the pharmacy was closed on Sundays and that there was a 24-hour pharmacist on call who would be able to dispense the medication. -She knew medications should be refilled before they ran out. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/07/24 at 2:57pm revealed:	D 358	See Page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 53 -The pharmacy received an electronically signed physician's order for Semglee insulin 32 units On 03/13/24 for Resident #3 and they dispensed a 30 day supply on 03/14/24 and on 04/10/24. -The pharmacy received an electronic refill request via the eMAR on 05/05/24 which was a Sunday when the pharmacy is closed. -The Semglee insulin was not on back order. -The facility should have telephoned the on-call pharmacy telephone number on the weekend and the 24-hour pharmacist would have been able to dispense the insulin the same day. -The pharmacy encouraged staff at the facility to reorder medications before they ran out. Telephone interview with Resident #3's Home Health Registered Nurse (RN) on 05/09/24 at 11:38am revealed Resident #3's hemoglobin A1C (test that measures the average range of blood glucose for the past 3 to 4 months) laboratory results on 05/08/24 were 8.1 (normal range is below 5.7). Telephone interview with Resident #3 Primary Care Provider (PCP) on 05/07/24 at 4:20pm revealed: -Resident #3 had a diagnosis of diabetes and her blood glucose levels were labile. -Resident #3 not receiving the ordered doses of insulin could cause complications with her diabetes like vision changes, vascular changes, kidney damage, coma, or death. Interview with Resident #3 on 05/09/24 at 10:54am revealed she did not know if there were times when she did not receive her Semglee insulin. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm.	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 54 Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. b. Review of Resident #3's physician's orders dated 12/21/23 revealed Novolog insulin (used to treat elevated blood sugar) 100units/ml use sliding scale insulin (SSI) three times daily with parameters for continuous glucose monitoring device (CGM) readings 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 notify PCP. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog insulin 100units/ml use sliding scale insulin (SSI) three times daily with parameters for CGM 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 notify PCP, with administration times of 8:00am, 12:00pm, and 4:00pm. -There was documentation on 03/01/24 at 12:00pm of a CGM result of 299 and no Novolog insulin was administered; Novolog 6 units should have been administered. -There was documentation on 03/02/24 at 4:00pm of a CGM results of 450 and 8 units were administered, and there was no order for CGM results greater than 400. -There was no documentation on 03/04/24 at	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 55 12:00pm of a CGM result or insulin administered. -There was documentation on 03/05/24 at 4:00pm of a CGM result of 257 and 4 units were administered; Novolog 6 units should have been administered. -There was documentation on 03/06/24 at 8:00am of a CGM result of 215 and 2 units were administered; Novolog 4 units should have been administered. There was documentation on 03/06/24 at 12:00pm of a CGM result of 245 and no Novolog insulin was administered; Novolog 4 units should have been administered. -There was documentation on 03/07/24 at 12:00pm of a CGM result of 242 and 2 units were administered; Novolog 4 units should have been administered. -There was documentation on 03/08/24 at 8:00am of a CGM result of 322 and 6 units were administered; Novolog 8 units should have been administered. -There was documentation on 03/08/24 at 12:00pm of a CGM result of 277 and no Novolog insulin was administered; Novolog 6 units should have been administered. -There was documentation on 03/08/24 at 4:00pm of a CGM result of 253 and no Novolog insulin was administered; Novolog 6 units should have been 6 administered. -There was documentation on 03/23 at 8:00am of a CGM result of 150 and 2 units were administered, when no Novolog insulin should have been administered. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Novolog insulin 100units/ml use sliding scale insulin (SSI) three times daily with parameters for continuous glucose monitoring device (CGM) readings	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 56 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 400 notify PCP, with administration times of 8:00am, 12:00pm, and 4:00pm. -There was documentation on 04/03/24 at 4:00pm of a CGM result of 410 and 15 units were administered and there was no order for CGM result greater than 400. -There was documentation on 04/04/24 at 4:00pm of a CGM result of 562 and 10 units were administered and there was no order for CGM result greater than 400. -There was documentation on 04/21/24 at 12:00pm of a BG of 410 and 10 units were administered and there was no order for CGM result greater than 400. Observation of Resident #3's medications available for administration on 05/08/24 at 9:25am revealed there was one Novolog insulin pen available for administration. Telephone interview with Resident #3 Primary Care Provider (PCP) on 05/07/24 at 4:20pm revealed: -Resident #3 had a diagnosis of diabetes and her blood glucose levels were labile. -Resident #3 not receiving the ordered doses of insulin could cause complications with her diabetes like vision changes, vascular changes, kidney damage, coma, or death. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING. _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 57 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. c. Review of Resident #3's physician's orders dated 12/21/23 revealed Novolog 100units/ml SSI daily at bedtime with parameters for continuous glucose monitoring device (CGM) readings 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 notify PCP. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog 100units/ml SSI CGM parameters at bedtime 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 notify PCP with an administration time of 7:00pm. -There was documentation on 03/01/24 - 03/07/24 that the Novolog insulin was administered but there was no documentation of a CGM result or the amount of insulin administered. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Novolog 100units/ml SSI CGM parameters at bedtime 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 notify PCP, with an administration time of 8:00pm. -There was documentation on 04/11/24 at 8:00pm of a CGM result of 416 and 8 units were administered and there was no order for CGM result greater than 400. Review of Resident #3's eMAR for 05/01/24 -	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 58 05/07/24 revealed: -There was an entry for Novolog 100units/ml SSI CGM parameters at bedtime 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400 notify PCP, with an administration time of 8:00pm. -There was documentation on 05/04/24 at 8:00pm of a CGM result of 409 and 8 units were administered and there was no order for CGM result greater than 400. Observation of Resident #3's medications available for administration on 05/08/24 at 9:25am revealed there was one Novolog insulin pen available for administration. Telephone interview with Resident #3 Primary Care Provider (PCP) on 05/07/24 at 4:20pm revealed: -Resident #3 had a diagnosis of diabetes and her blood glucose levels were labile. -Resident #3 not receiving the ordered doses of insulin could cause complications with her diabetes like vision changes, vascular changes, kidney damage, coma, or death. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. d. Review of physician's orders for Resident #3	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 59 dated 12/21/23 revealed hydrocodone-acetaminophen (used to treat pain) 7.5-325mg 1 tablet three times daily. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydrocodone-acetaminophen 7.5-325mg 1 tablet three times daily with administration times of 8:00am, 1:00pm, 6:00pm. -There was documentation the hydrocodone-acetaminophen was not administered on 03/22/24 at 8:00am and 1:00pm, 03/23/24 - 03/25/24, and 03/29/24 - 03/31/24 due to medication on order from pharmacy. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 7.5-325mg 1 tablet three times daily with administration times of 8:00am, 1:00pm, 6:00pm. -There was documentation the hydrocodone-acetaminophen was not administered on 04/01/24 at 8:00am, 1:00pm, 04/02/24 at 8:00am, 1:00pm, and 04/03/24 at 8:00am due to medication on order from pharmacy. Observation of Resident #3's medications available for administration on 05/08/24 at 9:25am revealed there was hydrocodone-acetaminophen 7.5-325mg available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/07/24 at 2:57pm revealed: -The pharmacy did not receive a refill request for	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 60 Resident #3's hydrocodone from the facility. -The pharmacy notified the facility on 03/25/24 to inform the PCP that a new prescription for the hydrocodone would be needed before any more would be dispensed. -The pharmacy dispensed and delivered a 3 day emergency supply on 03/25/24. -The pharmacy received a new prescription from the PCP on 03/30/24 and dispensed 90 tablets. -It was the facility's responsibility to notify the PCP when a medication required a new prescription before the medication ran out. Interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm revealed: -The medication aides (MA) were newly hired and required more training so she was responsible for contacting the PCP for refill prescriptions of medications. -She knew she contacted the PCP and requested a new prescription for the hydrocodone and she documented it but did not know how to access the electronic documentation. Telephone interview with Resident #3's PCP on 05/07/24 at 4:20pm revealed: -Resident #3 had intractable back pain and was prescribed hydrocodone for pain relief. -He had no way to know when a resident required a refill prescription until the facility informed him. -The facility should have informed him before Resident #3 ran out of hydrocodone and required a 3 day emergency supply. -No one should ever run out of pain medication. -Not being administered her scheduled doses of hydrocodone could cause Resident #3 to have symptoms of withdrawal like nervousness and anxiety and she would have an increase in back pain.	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 61 Interview with Resident #3 on 05/09/24 at 11:54am revealed: -She was taking the hydrocodone for back pain. -She remembered when the facility informed her the pharmacy would not send the medication. -She had back pain of an 8 on a 0-10 scale (10 being the worst pain) and could only get some relief by lying down of her bed. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. e. Review of Resident #3's physician's orders dated 12/21/23 revealed metoprolol tartrate (used to treat fast heart rate) 25mg take ½ tablet (12.5mg) twice daily and hold for heart rate less 60, systolic blood pressure (SBP) less than 100, and/or diastolic blood pressure (DBP) less than 50. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5mg) twice daily and hold for heart rate less 60, systolic blood pressure (SBP) less than 100, and/or diastolic blood pressure (DBP) less than 50, with an administration time of 8:00am and 6:00pm. -There was documentation on 03/03/24 at	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 62 8:00am of a blood pressure (BP) of 90/76 and the metoprolol was administered. -There was documentation on 03/09/24 at 8:00am of a BP of 93/70 and the metoprolol was administered. -There was documentation on 03/16/24 at 8:00am of a BP of 95/72 and the metoprolol was administered. -There was documentation on 03/27/24 at 8:00am of a BP of 92/62 and the metoprolol was administered. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5mg) twice daily and hold for heart rate less 60, systolic blood pressure (SBP) less than 100, and/or diastolic blood pressure (DBP) less than 50, with an administration time of 8:00am and 6:00pm. -There was documentation on 04/02/24 at 6:00pm of a BP of 95/65 and the metoprolol was administered. -There was documentation on 04/03/24 at 8:00am of a BP of 93/73 and the metoprolol was administered. -There was documentation on 04/04/24 at 6:00pm of a BP of 95/60 and the metoprolol was administered. -There was documentation on 04/10/24 at 6:00pm of a BP of 99/59 and the metoprolol was administered. -There was documentation on 04/12/24 at 6:00pm of a BP of 77/56 and the metoprolol was administered. -There was documentation on 04/19/24 at 6:00pm of a BP of 98/60 and the metoprolol was administered. -There was documentation on 04/20/24 at 8:00am of a BP of 98/55 and the metoprolol was	D 358	See Page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 63	D 358		

administered.
-There was documentation on 04/23/24 at 8:00am of a BP of 80/32 and the metoprolol was administered.
-There was documentation on 04/27/24 at 6:00pm of a BP of 97/55 and the metoprolol was administered.
-There was documentation on 04/28/24 at 8:00am of a BP of 73/45 and the metoprolol was administered.

Review of Resident #3's eMAR for 05/01/24 - 05/07/24 revealed:
-There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5mg) twice daily and hold for heart rate less 60, systolic blood pressure (SBP) less than 100, and/or diastolic blood pressure (DBP) less than 50, with an administration time of 8:00am and 6:00pm.
-There was documentation on 05/03/24 at 8:00am of a BP of 98/70 and the metoprolol was administered.
-There was documentation on 05/03/24 at 6:00pm of a BP of 98/70 and the metoprolol was administered.
-There was documentation on 05/04/24 at 8:00am of a BP of 98/74 and the metoprolol was administered.
-There was documentation on 05/06/24 at 6:00pm of a BP of 94/63 and the metoprolol was administered.

Observation of Resident #3's medications available for administration on 05/08/24 at 9:25am revealed there was metoprolol tartrate 25mg 1/2 tablets available for administration.

Interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm revealed:
-She always checked Resident #3's BP and

See page 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 64 would only administer the metoprolol when the BP was within the parameters. -She did not know why she had documented she administered the medication when the BP was not within the parameters. -She knew the MAs required more training and maybe that is why they documented they administered the metoprolol when they should not have. Telephone interview with Resident #3's PCP on 05/07/24 at 4:20pm revealed: -Resident #3 was prescribed metoprolol for heart rate control. -The medication slowed the heart rate and lowered blood pressure. -He was concerned that administering metoprolol to Resident #3 when she had a low blood pressure would further depress her blood pressure which could cause her to faint and fall. Interview with Resident #3 on 05/09/24 at 10:54am revealed: -She knew her blood pressure readings were low at times but she never felt faint or dizzy. -She did not know if the staff administered the metoprolol to her or not. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm.	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 65 2. Review of Resident #5's current FL2 dated 12/21/23 revealed diagnoses included diabetes. Review of Resident #5's Resident Register revealed an admission date of 07/26/23. a. Review of physician's orders for Resident #5 dated 02/15/24 revealed Lispro insulin (used to treat high blood glucose) 100units/ml inject 8 units with meals. Review of Resident #5's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lispro insulin 100units/ml inject 8 units with meals, with administration times of 7:30am, 11:30am, and 4:30pm. -There no documentation the insulin was administered on 03/02/24 at 7:30am, 03/04/24 at 11:30am, 03/11/24 at 11:30am, 03/15/24 at 07:30am and 11:30am, 03/19/24 at 11:30am, 03/26/24 at 11:30am, and 03/31/24 at 4:30pm, and there was no documentation why the insulin was not administered. Review of Resident #5's eMAR for 05/01/24 - 05/07/24 revealed: -There was an entry for Lispro insulin 100units/ml inject 8 units with meals, with administration times of 7:30am, 11:30am, and 4:30pm. -There was no documentation the insulin was administered on 05/07/24 at 4:30pm, and there was no documentation why the insulin was not administered. Observation of Resident #5's medications available for administration on 05/08/24 at 9:25am revealed there was Lispro insulin available for administration.	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 66 Interview with Resident #5's primary care provider (PCP) on 03/09/24 at 10:30am revealed: -Resident #5 was prescribed insulin because she had a history of poorly controlled diabetes. -Resident #5 had skin infections in the past and not receiving her doses of insulin put her at risk of more skin infections as well as vision changes and organ damage. -He expected staff to administer the insulin as he ordered it. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. b. Review of physician's orders for Resident #5 dated 01/04/24 revealed Lispro Insulin 100units/ml per sliding scale insulin (SSI) before meals and at bedtime for continuous glucose monitoring device (CGM) parameters 250-299 = 4 units, 300-350 = 6 units, greater than 350 = 8 units, greater than 500 notify PCP. Review of Resident #5's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lispro Insulin 100units/ml per sliding scale insulin (SSI) before meals and at bedtime for CGM parameters 250-299 = 4 units, 300-350 = 6 units, greater than 350 = 8 units, greater than 500 notify PCP. -There was no documentation of a CGM result or insulin administration on 03/02/24 at 8:00am,	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 67 03/04/24 at 12:00pm, 03/11/24 at 8:00pm, 03/29/24 at 8:00am and 4:00pm, or reason the CGM result was not obtained and insulin administered if required. Observation of Resident #5's medications available for administration on 05/08/24 at 9:25am revealed there was Lispro insulin available for administration. Interview with Resident #5's primary care provider (PCP) on 03/09/24 at 10:30am revealed: -Resident #5 was prescribed insulin because she had a history of poorly controlled diabetes. -Resident #5 had skin infections in the past and not receiving her doses of insulin put her at risk of more skin infections as well as vision changes and organ damage. -He expected staff to administer the insulin as he ordered it. Refer to the interview with a medication aide (MA) on 05/07/24 at 2:24pm. Refer to the interview with a second MA on 05/07/24 at 2:28pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. c. Review of physician's orders for Resident #5 dated 01/04/24 revealed escitalopram (used to treat depression) 10mg daily in addition to 20mg for 30mg dose. Observation during the morning medication pass	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 68 on 05/08/24 at 8:01am revealed the RCC administered escitalopram 20mg to Resident #5 and did not administer escitalopram 10mg. Observations of Resident #5's medications on hand for administration on 05/08/24 at 9:25am revealed: -There was one bubble pack of medications labeled escitalopram 20mg and 30 tablets were dispensed on 04/15/24 with 6 tablets remaining. -There was one bubble pack of medications labeled escitalopram 10mg and 30 tablets were dispensed on 04/15/24 with 7 tablets remaining. Review of Resident #5's electronic Medication Administration Record (eMAR) for 05/08/24 revealed: -There was an entry for escitalopram 20mg take 1 tablet daily in addition to 10mg for 30mg dose with an administration time of 8:00am and documentation the 20mg was administered at 8:00am. -There was an entry for escitalopram 10mg take 1 tablet daily in addition to 20mg for 30mg dose with an administration time of 8:00am and documentation the 10mg was administered at 8:00am. Interview with the RCC on 05/08/24 at 1:00pm revealed she knew Resident #5 was to be administered both the 20mg and 10mg tablets of escitalopram and it was an oversight on her part. Telephone interview with Resident #5's PCP on 05/07/24 at 4:20pm revealed Resident #5 was prescribed escitalopram to treat depression and she should be administered the entire dose. 3. Review of Resident #6's current FL2 dated 12/29/23 revealed diagnoses included diabetes (a	D 358	See Page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 69 chronic condition that impairs the body's ability to process blood glucose). Review of Resident #6's Resident Register revealed an admission date of 12/05/23. Review of Resident #6's physician's orders dated 01/12/24 revealed there was an order for sliding scale insulin aspart inject subcutaneous before meals: Fingerstick blood sugar (FSBS) less than 150 = 0 units, 150-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units, 450 or greater = call provider. Review of Resident #6's May 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for sliding scale insulin Aspart inject subcutaneous before meals: FSBS less than 150 = 0 units, 150-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 5 units, 351-400 = 7 units, 450 or greater = call provider. -There was documentation on 05/01/24 at 8:15am that 6 units was administered for a FSBS result of 371 when 7 units should have been administered. -There was documentation on 05/03/24 at 12:45pm that 4 units was administered for a FSBS result of 204 when 2 units should have been administered. -There was documentation on 05/04/24 at 8:15am that 6 units was administered for a FSBS result of 331 when 5 units should have been administered. -There was no documentation on 05/04/24 at 12:45pm that any insulin was administered for a FSBS result of 331 when 5 units should have been administered. -There was documentation on 05/06/24 at 12:45pm that 0 units were administered for a	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 70 FSBS result of 199 when 1 unit should have been administered. Observation of Resident #6's medications available for administration on 05/08/24 at 3:22pm revealed Aspart insulin was available for administration. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 11:39am revealed: -It did not matter how many units were scheduled per the sliding scale order; Resident #6 would tell her how many units to administer based on his FSBS. -Resident #6's Primary care Provider (PCP) was aware Resident #6 told staff how to administer his insulin. -The PCP instructed her to be sure to document how many units of insulin were administered, even if it was different from the ordered sliding scale. Interview with Resident #6's PCP on 05/9/24 at 10:33am revealed: -Resident #6 had a long-term diagnosis of diabetes that required insulin to manage. -He was not told Resident #6's insulin doses were not being administered according to the orders. -He was not surprised Resident #6 was telling staff how much insulin he should be administered but he expected the staff to follow the sliding scale that was ordered. -Not receiving the correct dose of insulin could cause complications with his diabetes like vision changes, vascular changes, kidney damage, coma, or death. Refer to the interview with a second MA on 05/07/24 at 2:28pm.	D 358	see page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 71 Refer to the interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:23pm. _____ Interview with a medication aide (MA) on 05/07/24 at 2:24pm revealed: -She could not remember medications she administered in March or April 2024. -She did not administer insulin doses incorrectly. -Her initials were on the eMAR with the incorrect doses because sometimes she forgot to log out of the eMAR computer and another staff would use her log in which would put her initials on the eMAR when they administered medications. Interview with a second MA on 05/07/24 at 2:28pm revealed: -She probably documented inaccurately on the eMAR. -The residents knew how much insulin they were to get. -She knew to double check the medication order on the eMAR before administering medications. Attempted telephone interview with a third MA on 05/08/24 at 3:17pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 05/07/24 at 2:50pm and 05/09/24 at 11:05am revealed: -The MAs were new to the facility and "need a lot more training". -She thought the MAs documented incorrectly. -All the residents that required insulin knew how much based on their SSI that should be administered. -She was responsible for supervising the MAs.	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 72 -She was responsible for auditing the eMARs for missed or incorrect doses and she did that by just looking at the medication bubble packs to see how many pills were left. -She should have reviewed the eMARs to ensure residents were being administered their medications correctly. -She usually paid more attention to discontinued and new medications. -She had a lot of roles in the facility. Interview with Owner #1 on 05/09/24 at 1:23pm revealed: -The RCC was responsible for supervising the MAs. -The RCC was responsible for monitoring the eMARs. -He only authorized the MAs to administer medications when they completed all their training and at that time, he gave them a log in code. -MAs that were using another MAs log in code were not authorized to administer medications. -He thought the issues with medications was more training was needed. -He did not know why unauthorized MAs were scheduled to administer medications. -The RCC was responsible for the schedule. -He knew there were issues with medication administration because there had been a pharmacy audit previously. The facility failed to ensure medications were administered as ordered which resulted in Residents #3, #5, and #6 being administered incorrect or missed doses of insulin putting them at risk for vision changes, vascular changes, kidney damage, coma or death, Resident #3 not receiving her pain medications which caused her to have acute pain and risk for narcotic withdrawals, and being administered a	D 358	See page 74	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 73 medication for heart rate control outside of parameters and risk for fainting and falls. This failure resulted in substantial risk to the residents health, safety, and welfare and constitutes as Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 8, 2024.	D 358	All staff have undergone extensive training related to medication administration by licensed healthcare professionals. Importance of appropriate administration was instructed. PharmD and RN have been integrated into medication administration process to continually enhance quality of services provided by MAs. 6/8/24	
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a medication aide (MA) observed 2 of 2 residents (#6, and #7) take medications administered, resulting in medications being left on the both residents' bedside tables in their rooms. The findings are: Review of the facility's Policy and Procedures for	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 74 Medication Administration dated 06/21/23 revealed: -Medications would be administered in accordance with the prescribing practitioner's orders. -Staff who have demonstrated competency according to State rules may administer medications. -Documentation would be provided by staff who administered the medication. -Staff documented on the eMAR after observing the resident take the medication. 1. Review of Resident #7's current FL2 dated 04/18/24 revealed diagnoses of generalized anxiety disorder, depression, anemia, hyposmolality (condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal), and hyponatremia (low blood sodium). Review of Resident #7's physician's orders dated 05/08/24 revealed there were medication orders for Effexor (used to treat depression) 75mg., Oxybutynin (used to treat overactive bladder) 5 mg., Metoprolol (used to treat hypertension) 25 mg., Losartan Potassium (used to treat hypertension) 50 mg., Gabapentin (an anticonvulsant medication sometimes used to treat nerve pain) 600 mg., Ferosul (used to treat iron deficiency) 325mg., Dicyclomine (used to treat irritable bowel syndrome) 20 mg., Clopidogrel (used to prevent blood clotting) 75mg., Buspirone (used to treat anxiety) 30mg., Baclofen (used to prevent muscle spasms) 10mg., Aspirin (cardiovascular protection) 81mg. Observation during the initial tour on 05/07/24 at 9:09am revealed: -There were medications in a cup next to	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 75 Resident #7's bed. -The MA was not in the room. -Resident #7 was in the room, in bed, asleep. Interview with Resident #7 on 05/08/24 at 7:56am revealed: -Medications have been left in her room 2 to 3 times since her admission on 04/15/24. -She saw her medications on her bedside table and took them when she woke up. -Sometimes MAs would leave her medications if she was sleeping. -The medications in the cup were her morning medications. Review of Resident #7's electronic medication administration record (eMAR) for 05/07/24 revealed: -There was an entry for Effexor 75mg daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Oxybutynin 5mg. daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Metoprolol 25mg. daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Losartan Potassium 50mg. daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Gabapentin 600mg. three times daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Ferosul 325mg. daily with an administration time of 8:00am and	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 76 documentated as administered at 8:00am on 05/07/24. -There was an entry for Dicyclomine 20mg. three times daily daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Clopidogrel 75mg. daily with an administration time of 8:00am and documented as administered at 8:00am on 05/07/24. -There was an entry for Buspirone 30mg. twice daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Baclofen 10mg. twice daily with an administration time of 8:00am and documentated as administered at 8:00am on 05/07/24. -There was an entry for Aspirin 81mg. daily with an administration time of 8:00am and documented as administered at 8:00am on 05/07/24. Observation of Resident #7's medications available for administration on 05/08/24 at 11:04am revealed: -There was one bubble pack labeled Effexor 75mg take one tablet daily. -There was one bubble pack labeled Oxybutynin 5mg take one tablet daily. -There was one bubble pack labeled Metoprolol 25mg take one tablet daily. -There was one bubble pack labeled Losartan Potassium 50mg take one tablet daily. -There was one bubble pack labeled Gabapentin 600mg take one tablet three times daily. -There was one bubble pack labeled Ferosul 235mg take one tablet daily. -There was one bubble pack labeled Dicyclomine 20mg take one tablet three times daily.	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 77 -There was one bubble pack labeled Clopidogrel 75mg take one tablet daily. -There was one bubble pack labeled Buspirone 30 mg take one tablet twice daily. -There was one bubble pack labeled Baclofen 10mg take one tablet twice daily. -There was one bubble pack labeled Aspirin 81mg take one tablet daily. Interview with the MA on 05/08/24 at 6:54am revealed: -She worked 5/07/24 and administered morning medications to resident #7. -She put the medications in a cup and left them beside her bed because she was sleeping. -She did not watch her take her medications. -She attempted to wake Resident #7 up to take her medications, but Resident #7 went back to sleep, so she left the medications. -Resident #7 "always" asked MAs to leave the medications in her room, so that is why she left them. -She was not aware there was anything wrong with leaving medications in the room. -Resident #7 complained a lot, so that is why she left the medications in her room without watching her take them. Refer to interview with Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to interview with Owner #1 on 05/09/24 at 1:22pm. 2. Review of Resident #6's current FL2 dated 12/29/23 revealed diagnoses included cerebral infarction, acute kidney failure, diabetic neuropathy, hypertension and hypotension. Observation of Resident #6's room during initial	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 78 tour on 05/07/24 at 9:07am revealed: -There was a paper medicine cup on Resident #6's bedside table. -There were 9 pills inside the medication cup. -No facility staff were in the room with him. Interview with Resident #6 on 05/07/24 at 9:05am revealed: -His morning medications were on his bedside table because his stomach hurt and he did not want to take them when the Medication Aide (MA) brought them earlier. -The MA left them with him so he could take them when he ate breakfast. Review of Resident #6's physician orders dated 12/29/23 revealed: -An order for aspirin (used as a blood thinner) 81mg daily. -An order for farxiga (used to slow the progression of kidney failure) 10mg daily. -An order for levetiracetam (used to prevent convulsions) 500mg twice daily. -An order for losartan potassium (used to treat elevated blood pressure) 25mg daily. -An order for metoprolol Succinate extended release (used to treat elevated blood pressure) 25mg, 1/2 tablet daily. -An order for midodrine HCL (used to treat low blood pressure) 5mg twice daily. -An order for Vitamin B1 (used to treat vitamin deficiency) 100mg daily. Review of Resident #6's physician orders dated 5/06/24 revealed an order for gabapentin (used to treat nerve pain) 600mg three times daily and an order dated 05/06/24 for gabapentin 600mg four times a day. Review of Resident #6's physician orders dated	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 79 03/30/24 revealed an order for docusate sodium (used to treat constipation) 100mg daily. Review of Resident #6's 05/07/24 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg daily at 8am and documented as administered. -There was an entry for docusate sodium 100mg at 8am and documented as administered. -There was an entry for farxiga 10mg at 8am and documented as administered. -There was an entry for gabapentin 600mg at 8am and documented as administered. -There was an entry for levetiracetam 500mg at 8am and documented as administered. -There was an entry for losartan potassium 25mg at 8am and documented as administered. -There was an entry for metoprolol Succinate extended release 25mg, 1/2 tablet at 8am and documented as administered. -There was an entry for midodrine HCL 5mg at 8am and documented as administered. -There was an entry for Vitamin B1 100mg at 8am and documented as administered. Observation of Resident #6's medications available for administration on 05/08/24 at 3:27pm revealed: -There was one bubble pack labeled aspirin 81mg daily. -There was one bubble pack labeled docusate sodium 100mg daily. -There was one bubble pack labeled farxiga 10mg daily. -There was one bubble pack labeled gabapentin 600mg four times a day. -There was one bubble pack labeled levetiracetam 500mg twice daily. -There was one bubble pack labeled losartan	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 80 potassium 25mg daily. -There was one bubble pack labeled metoprolol Succinate extended release 25mg, 1/2 tablet daily. -There was one bubble pack labeled midodrine HCL 5mg twice daily. -There was one bubble pack labeled Vitamin B1 100mg daily. Interview with the MA on 05/08/24 at 6:54am revealed: -She worked third shift on 05/06/24 and passed morning medications to residents on 05/07/24. -She was not aware there was anything wrong with leaving medications in the room. Interview with a medication aide (MA) on 05/08/24 at 8:34am revealed leaving medications at bedside rather than observing the resident take them was against facility policy. Refer to the interview with Resident Care Coordinator (RCC) on 05/09/24 at 11:05am. Refer to the interview with Owner #1 on 05/09/24 at 1:22pm. Interview with Resident Care Coordinator (RCC) on 05/09/24 at 11:05am revealed: -She had never seen medications left in the room. -MAs should watch each resident take medications and not leave medications in the room for residents to take later. -She thought the medication aide might have left the medications in the room because they were not fully trained to pass the medications. -All MAs and the RCC were responsible to ensure medications were never left in the rooms.	D 366	See page 82	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 366	Continued From page 81 Interview with Owner #1 on 05/09/24 at 1:22pm revealed: -MAs were supposed to watch the Residents take medications and never leave the medications for residents to take later; it was against facility policy. -He was not aware MAs were not observing resident take there medication and leaving the pills in the room for them to take later. -He believed lack of training could be why the incidents happened. -The staff that documented she administered medications, but left them at bedside, was not a MA and should not have been passing medications.	D 366	Medication administration by a MA to a resident has undergone extensive training. Review of company policy related to med administration has occured. Facility administrator performs random reviews and supervision of med passes. Trainings to occur, at minimum every quarter. More frequent as needed. 6/8/24	