PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22 22		CONSTRUCTION	(X3) DATE SURVEY · COMPLETED	
	345197	B. WNG			,	C 06/14/2013
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	237 RU	ET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD 1THERFORDTON, NC 28139  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E	(X5) COMPLETION DATE
RELATED SOCIAL S  The facility must proving services to attain or impracticable physical, in well-being of each research to the services of sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services, the facility implement nonpharma prevent 2 of 5 sample and the services and the services and anxiety.  The findings included:  1. Resident the services and anxiety. Note dated 09/20/12 note dated 09/20/12 note dated 09/20/12 note dated 09/20/12 note dated for confusion a services and supervisite and supervisite and was at risk of confirmation and the services and increased redirection from staff.  The current care pland the services or the	ide medically-related social naintain the highest mental, and psychosocial sident.  is not met as evidenced as, record reviews and staff failed to develop and alogical interventions to dod residents (Residents #70 and aggressive behaviors ents (Residents #6, #38, #94, #119 and #153).  dmitted to the facility on es including Alzheimer's The physician's progress oted the resident came atric facility where he was and agitation.  ment for behaviors dated was no immediate the was on the secured unit ion. It was noted that the into other residents' rooms rontation with other dod agitation during		250	This Plan of Corrections is the facilities credible allegation of compliance.  Preparation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  F 250  1-Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 70 and resident #72 had the new Behavioral Assessment Tool completed to determine specific behaviors, probable triggering events, interventions that decrease behaviors.  a) Resident #70 and resident #72 care plan was created to include specific behaviors, probable triggering events, interventions that decreased behaviors.		7.12:13 (X6) DATE 2013

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ORIGINAL SIGNATURE DATE: 7-8-13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1ZYK11

Facility ID: 923438

If continuation sheet Page 1 of 31

by:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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TANGESTON OF STREET	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		.D BE	(X5) COMPLETION DATE	
	the hall and in other replan's interventions in supervision, redirect a and if agitation occurs time to pass and retry encourage him to rest anxious, intervene to it being.  The quarterly Minimum 12/12/12 coded the reimpaired cognitive skill 1-3 days and wandering that he received antips medications daily.  Review of abuse report 6:00 AM, Resident #70 when he wandered into present in the room at was to be observed. The analyze or determine work to avoid another that he received antips medication of another than the received antips medications daily.  Review of abuse report of the nursing upset earlier and talking house. This resident was no indication of an analyze or determined altercation or how to avoid another than the complete than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house. This resident was no indication of an altercation or how to avoid another than the complete and talking house.	of wandering aimlessly on esident rooms. This care cluded providing close and reorient when needed, during care allow a bit of to complete tasks, if he seems fatigued or increase safety and well an Data Set (MDS) dated sident with severely les, having other behaviors and 1-3 days. It was noted sychotic and antianxiety at severaled on 12/31/12 at 0 was hit by Resident #148 of her room. Staff were this time. Resident #70 the investigation did not what caused this altercation or altercation.	F2	2- Corrective action will be accomplished for those residents having potential be affected by the same alleged deficient practice. An audit of residents with behaviors in the facility was completed on 07/05/2013 by the Social Services Department for all resident that exhibited behaviors, their plan of care reviewed to ensure that it contained: the type of behaviors, possible triggering events and specific interventions that decrease the behavior episodes  3-Measures will be put in place or systemic changes made to ensure that the alleged deficient practice will not occur: a) The Social Services Director was in-serviced by the Clinical Consultant on 06/26/2013 on the following: a) The facilities New Behavioral Assessment Tool	o s		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.5	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 250	resident and yelling at placed on 15 minute of evidence of any invest determine what cause avoid another altercate.  Nursing notes dated of revealed another (unk Resident #70 of hitting minute checks from 0 change (Depakote wa 01/28/13 due to behavinvestigation regarding analysis to determine or how to avoid another.  Review of abuse reportion and the eye. 15 minute chimplemented. The next him off the 15 minute chimplemented. The next him off the 15 minute chimplemented. The next him off the 15 minute chimplemented altercation.  The quarterly MDS da resident with severely having physically abus having other behaviors daily. He received and daily. There was no caddress Resident #70 behaviors.	thim. Resident #70 was checks. There was no tigation to analyze or ad this altercation or how to ion.  1/23/13 at 2:10 AM (nown) resident accused (nown) resident or any (nown) what caused this altercation (nown) resident or any (nown) resident of the punched Resident #70 in nown) resident (nown) resident (n	F 250	b) How to and when to complete the tool. c) Documenting and implementing the behavior and interventions used to decrease the behaviors d) The Social Services Director was again inserviced by the Director of Nursing on 07-02-2013, On the following: a) properly investigating each behavior to ascertain the type of behavior, the possible triggering event and what interventions work to decrease the behaviors and documentation of the behavior. b) The New Behavioral Assessment Tool will be completed upon admission, quarterly and upon any behaviors. c) The Social Service Director will complete the New Behavior Quality Assurance tool per occurrence of behaviors and create care plans.  4-Monitoring of the facilities performance to make sure the solution is		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The contract of the contract o	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	10:40 PM, Resident # the face. He was place and the physician order antipsychotic (Haldot is Depakote was increase checks were terminate was no evidence of an or determine what cause to avoid another alteror Review of abuse reports a chair and during star lowered the chair but if the process. Plans we with no description as was provided. There we investigation to analyzicaused this altercation.  Nursing notes dated 0 #70 was agitated and and #6. The notes did abusive behavior. He supervision and given down. There was no expression and given down and the down down down down down down down down	rts revealed on 03/21/13 at 70 slapped Resident #6 in 2d on 15 minute checks ered an intramuscular 5mg) injection. On 03/22/13 sed and the 15 minute end by the physician. There have investigation to analyze used this altercation or how cation.  rts revealed on 03/30/13 at 10 became frustrated, raised ff intervention, Resident #70 hit Resident #119's finger in 2 fire to monitor Resident #70 to what type of monitoring 2 in a revealed on 03/30/13 revealed Resident abusive to avoid another  4/30/13 revealed Resident #153 anot describe the exact was placed on one to one a snack and he calmed evidence of any er or determine what or how to avoid another  ts revealed on 05/21/13 ing up chairs and bedside boks on the floor. Ativan ded basis) was given with	F	2250	a) The IDT (Interdisciplinary Team) will review daily (Monday- Friday) at the morning QA meeting each Behavioral Assessment and Behavioral Quality Assurance Tool for compliance. This will be done as a permanent part of this QA process Any discrepancies, trends or/and triggers, identified will be documented with corrective revisions. b) Monthly QA Committee meeting to assess			

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F 250	mg) to calm him. The investigation to analyze caused this altercation altercation.  The quarterly MDS daresident with severely having physically abuthaving other behavior daily. He received and daily and an antianxie last 7 days. There stitedeveloped to address plan notes dated 06/0 increased behaviors in Con 06/14/13 at 10:04 observed sitting in a feand another gentlema chair. There were no Con 06/14/13 at 2:50 PResident #70 as easy redirect. She stated by you had to make sure Con 06/14/13 at 3:05 PWhen Resident #70 go be and reapproached stated that he was irritaresidents and named Con 06/14/13 at 5:06 PW the social worker hand the MDS, subsequent	scular injection (Haldol 1 re was no evidence of any ze or determine what n or how to avoid another ated 05/29/13 coded the impaired cognitive skills, sive behaviors 1-3 days, as 1-3 days and wandering tipsychotic medications by medication once in the III was no care plan abusive behaviors. Care 15/13 stated there were no noted.  AM, Resident #70 was emale's room on the bed in was sitting in a nearby other residents in the room.  AM Nurse #4 described going and fairly easy to be was hearing impaired and the heard you.  AM Nurse Aide #5 stated of agitated you just let him him later. She further tated by a couple of Resident #153.	F	250				

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F 250	different things. The seredirected him with seredirected him at 5:44 Fedining room, Resident tablemate when she he did not seem to notice. Interview with the Sociolof 14/13 at 5:11 PM in have abusive behavior planned. He also said for investigating abuse ago which informed his behaviors. The SW further alternation occurred the gold and talk to the resist conversation. When a triggers and trends of he felt that was more psychologist/psychiatric. Resident #72 was in the facility on 12/15/10 dementia with behavior disorder, bipolar disorder, bipolar disorder, bipolar disorder, behaviors and requirimmost activities of daily with locomotion. It was	PM Nurse #5 stated riors were triggered by staff watched him close, and backs, television and talking re.  PM while eating dinner in the triggered at the female hit his foot with hers. Staff re or intervene.  Stall Worker (SW) on revealed Resident #70 did res which were not care at he had been responsible re reports up until 2 weeks rim of Resident #70's rither stated that when an re social worker staff would dent and note the resked about checking into behaviors, the SW stated the role of the rist.  The stated that when an responsible resp	F	250			

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F 250	which identified Resid with other residents a was noted that he hit making contact. Inter to solve problem if aboremove him from the aclose supervision, if a with new or change of the resident to talk ab feelings when irritable anger arises to level of the resident was not injured of any investigation to caused this altercation.  Another abuse report 3:45 PM, Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke. Finjured and Resident #7 with his reacher device outside and smoke with his reacher device outside and his reach	developed on 07/11/11 ent #72 having agitation ind/or staff. On 04/10/12 it out at others sometimes ventions included to attempt le to decrease his irritability, area if irritable, provide gitated attempt to distract it topic, spend time allowing out his thoughts and i, and remove resident if if concern.  Interevealed on 02/03/13 at 2 hit Resident #38 while and smoke. Resident #72 his hand and the other and. There was no evidence analyze or determine what in or how to avoid another  Tevealed on 02/20/13 at 2 hit Resident #38 twice an again while waiting to go tesident #72 was not 438 sustained several an 02/20/13 the physician evaluation for Resident #72 (for treatment of iatric evaluation was never as no evidence of any e or determine what or how to avoid another	F	250			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. 22 22		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 250	having physically abucare for one to three cassistance with most and supervision with I took antidepressants, antipsychotic medicat.  Another abuse report PM Resident #72 was Resident #72 hit Resi Nursing notes for 04/2 present during this alt noted swinging fists a racial comments. Nei and Resident #72 was supervision. There was investigation to analyz caused this altercation altercation.  Another abuse report 8:45 PM Resident #75, his root the room at this time a when the altercation caused this altercation.  Another abuse report and Resident #75, his root the room at this time a when the altercation.  Another abuse report 3:00 PM, staff saw Reference was injured and Resident #3:00 PM, staff saw Reference was injured and resident was	vere cognitive impairment, sive behaviors, rejection of days, requiring extensive activities of daily living skills occomotion. It was noted he antianxiety and ions daily.  noted on 04/17/13 at 4:15 to outside smoking when dent #17 in the mouth.  17/13 indicated no staff were ercation and they were teach other and making ther resident was injured as placed on one to one as no evidence of any are or determine what the or how to avoid another  revealed on 04/28/13 at 2 yelled, kicked and hit mmate. Staff had been in and had turned her back occurred. Neither resident what her or how to avoid another  There was no evidence of analyze or determine what he or how to avoid another  revealed on 04/29/13 at 1 yelled, kicked and hit mmate. The or how to avoid another  revealed on 04/29/13 at 1 yelled, kicked and hit may not how to avoid another.	F	250			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 75		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 37 TRYON ROAD RUTHERFORDTON, NC 28139	06/	14/2013
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F 253 SS=B	caused this altercation altercation.  On 06/13/13 at 4:21 F got agitated when reshe would get combation.  On 06/14/13 at 7:20 F was interviewed. The psychologist would more sponsible party had services. The SW states to the responsible party services for Resident stated that he never gresponsible party and to follow up with the restated he just "forgot" evaluation because R improved. The SW stated he just "forgot" evaluation because R improved. The sw stated he just "forgot" evaluation to forgot he forgot he just "forgot" evaluation to forgot he forgot he just "forgot" evaluation to forgot he forgot he just "forgot" evaluation to forgot he just "forgot" evaluation to forgot he just "forgot" evaluation to forgot he just "forgot" evalua	analyze or determine what in or how to avoid another.  I'M, Nurse Aide #6 stated he idents bumped into him and we at times.  I'M, the Social Worker (SW) SW stated that before the eet with a resident, the to sign an agreement for ted he sent the agreement try requesting psychiatric #72 on 02/21/13. The SW ot a response from the did not recall any attempts esponsible party. He further about the psychiatric esident #72's behaviors ated social service staff all abuse investigations up the SW also stated that when do the social worker staff are resident and note the esked about checking into behaviors, the SW stated the role of the ist.  IKEEPING & VICES  Ide housekeeping and necessary to maintain a		250			
		is not met as evidenced					

#### PRINTED: 06/28/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 345197 B. WNG 06/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD WILLOW RIDGE OF NC LLC RUTHERFORDTON, NC 28139 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 7-12-13 F 253 Continued From page 9 F 253 by: 1- Corrective action will be Based on observations, staff interviews and review of maintenance logs, the facility failed to accomplished for those identify and repair wood molding (Room 120) and residents found to have been linoleum on resident room and bathroom doors affected by the alleged (Rooms 126, 121, 105, 219, 215, 213, 209, 204, deficient practice by getting 321, 320, 319, and 315) for 13 of 34 residents' a quote for the resident rooms observed. room doors, resident bathroom doors and resident The findings included: room molding to be repaired During an initial tour of the facility on 06/10/13 from the home office. Ouote from 10:30 AM - 11:00 AM and follow-up has been approved by the observations on 06/14/13 from 2:45 PM to 3:00 home office. Work on the PM the following resident rooms were identified doors has been started. with repairs needed to wood molding, resident molding was fixed on room doors and bathroom doors: 06/13/2013. a. Room 126 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 4 inches. 2- Corrective action will be accomplished for those b. Room 121 was observed with a wood stained residents having potential to linoleum strip missing along the left side of the room door extending approximately 8 inches. be affected by the same alleged deficient practice c. Room 120 was observed with wood molding

nails exposed.

detached from the wall extending approximately

d. Room 105 was observed with a wood stained linoleum strip missing along the left side of the room door extending approximately 3 inches.

e. Room 219 was observed with a wood stained linoleum strip missing on the left side of the room

door extending approximately 3 feet.

2.5 feet with approximately a 1 inch gap and 3

was accomplished by:

for needed repair.

assessing resident rooms

a) the Maintenance Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W 85 8		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC			237 1	T ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD HERFORDTON, NC 28139		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
linoleum strip missir room door extending g. Room 213 was old linoleum strip missir room door extending h. Room 209 was old linoleum strip missir room door extending i. Room 204 was obdinoleum strip missir side of the room door inches. j. Room 321 was obdinoleum strip missin room door extending k. Room 320 was obdinoleum strip missin room door extending left side of the bathrough approximately 4 feet l. Room 319 was obdinoleum strip missin room door extending m. Room 315 was obdinoleum strip missin room door extending m. Room 315 was obdinoleum strip missin room door extending	pserved with a wood stained approximately 3 feet.  beserved with a wood stained approximately 3 inches.  beserved with a wood stained approximately 3 inches.  beserved with a wood stained approximately 3 inches.  served with a wood stained approximately 3 inches.  served with a wood stained approximately 3 inches.  served with a wood stained approximately 3  served with a wood stained approximately 3 feet.  served with a wood stained approximately 3 feet.  served with a wood stained approximately 3 feet.	F 2	253	3-Measures will be put into place or systemic changes made to ensure that the alleged practice will not occur:  a) Identifying needed repairs of doors, molding, walls and floor of the resident rooms has been added to the revised Department Heads daily (Monday – Friday) QA rounds sheet. b) Nurses and CNAs were in-serviced by the Clinical Consultant on 07/03/2013 on: a) the facility repair notification form b) Staff should immediately notify maintenance and nursing of needed repair. c) The Maintenance Director was in-serviced on 07/08/2013 by the Facility Administrator on: a) The facility notification form. b)The need to make repairs to building immediately.		

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F 253	to document repairs the rooms. He stated each log for documentation identified. Review of the revealed these repairs maintenance director logs daily during daily the room doors, bathomolding. He further state this over night, we should it."  An interview on 06/14/administrator revealed maintenance department heads to have needed in reside rounds. She further state form used by staff identifying repairs needed 183.20(b)(1) COMPREASSESSMENTS  The facility must conduct a comprehensive, accorreproducible assessment functional capacity.	in need of repair. The stated that he relied on staff hat were needed in resident in nurses station included a by staff when repairs were he maintenance logs were not documented. The stated he checked these rounds, but had not noticed foom doors or wood ated "things don't get like build have identified this and with the last expected the ent to involve all help identify any repairs that int rooms during their daily ated that she would revise during rounds to include ded in residents rooms. EHENSIVE	F 253	facilities performance to make sure the solution is sustained will be accomplished by: The IDT review daily (Monday-Friday) of the QA round sheets and repair request forms at morning QA meeting. This will be a permanent part of morning QA meeting. Results of the review of the QA Round sheets and repair request forms will be reviewed monthly by the Quality Improvement Committee to assess for any discrepancies, monitoring needs and continued compliance in this area. This will be done every month for 12 months and quarterly there after.		
		ent's needs, using the nstrument (RAI) specified essment must include at		Director of Maintenance or designee will be responsible for maintaining compliance.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	80 8	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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v	ROVIDER OR SUPPLIER	340107	10.710	STRI 23	EET ADDRESS, CITY, STATE, ZIP CODE 37 TRYON ROAD UTHERFORDTON, NC 28139	1 06/	/14/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	900	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 272	Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments an Discharge potential; Documentation of sun the additional assess areas triggered by the Data Set (MDS); and	atterns; ng; and structural problems; d health conditions; status;	F	272	1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: a) Resident #57 was assessed per the new revised Incontinence Management policy regarding the Incontinence Assessment Tool from the newly implemented manual. b) It was identified on 6/17/13 that #57's incontinence was a result of BPH. Uroxatrol HCL ER 10 mg was started on 6/17/13. On 6/20/13 #57 experienced a acute change in condition (pneumonia) in which he was being treated. At this		7-12-13	
	by: Based on observation interview, the facility facontinence for 1 of 5 st #57). The findings included Resident #57 was addressed of 13 with diagnost and heart murmur. The Set (MDS) dated 02/1 was independent with				time due to increased confusion #57 was unable to participate in a formal toileting program. #57 needs were met by staff with toileting and check and change every 2 hours PRN. On 7/2/13 #57 was			

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES  MEDICAID SERVICES		TIDI		OMB N	M APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5- CANDONA S		E CONSTRUCTION	СОМ	E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC LLC				237 TRYON ROAD RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	O2/14/13 indicated the occasional incontinen antipsychotic medicat of incontinence was liwith urgency.  A quarterly MDS date Resident #57 was depand was frequently incompared in the incompared	ant (CAA) summary dated be contributing factors to the ce were the use of ion and dementia. The type sted as stress incontinence and 05/15/13 indicated bendent on staff for toileting continent of bladder.  12/13 at 12:45 PM of Nurse #2 providing incontinence with the resident's lied barrier protective did not have any skin firritation.  14 on 06/12/13 at 1:20 PM ided incontinence care for preakfast. She stated she demorning and his ary. She stated his brief en she checked him. She lecked him about every 2 and provided incontinence en did not take him to the	F	272	discharged to the hospital with a Diagnosis of Exacerbation of Pneumonia and a asymptomatic Urinary Tract infection, which could have also contributed to his increased incontinence. A 3 day bladder diary was unable to be performed to obtain a baseline due to #57 acute decline in condition. To date #57 remains in the hospital and will be reassessed upon his readmission for a proper toileting program.  2-Corrective action will accomplished for those residents having potential to be affected by the alleged deficient practice by:  a) Per the new Incontinence Management policy all residents will be assessed using the 24 Hour Voiding Diary for 3 days upon admission, quarterly or when a resident experiences change in bladder continence status.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 3	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOMBES AS SUBSUES	340137	D. VIIIO_		. 06/14/2013	
	ROVIDER OR SUPPLIER RIDGE OF NC LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	next. When asked if s or a supervisor to do a stated she did not be a special type of progresident to determine the type of incontinent facility did any type of day period to determine the incontinence, she stated the facility did rolleting program such prompted toileting. She "check and change" presidents were checked incontinence and care.  During an interview or the Chief Clinical Office didn't have a program residents for the cause need for an individuality as bladder re-training program.  483.20(d), 483.20(k)(1)  COMPREHENSIVE Comprehensive plan of the facility must use the to develop, review and comprehensive plan of the facility must develop the facility develop the	the notified the charge nurse any further assessment, she cause the facility didn't have arm for assessing a the cause for the decline or ce. When asked if the monitoring for a 7 day or 14 the if there was a pattern to estated they did not. She not utilize any type of as scheduled toileting or the estated they only had a rogram which meant and every 2 hours for was provided as needed.  106/14/13 at 5:00 PM with the er, he stated the facility in place to assess the of incontinence or the care bladder program such for a scheduled toileting.  1 DEVELOP ARE PLANS  Tresults of the assessment revise the resident's	F 2	continence by the Unit Nurse Managers using the new incontinence assessment tool. c) Specific resident care plans and interventions were derived and implemented. Special incontinence toileting schedules were implemented for those residents that meet the criteria per the manual.  3-Measures that will be pu into place or systemic changes made to ensure tha the deficient practice will not occur: a) The policy of	t at	
	The care plan must de	scribe the services that are		07/03/2013. Nurse		

PRINTED: 06/28/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ C 345197 B. WNG 06/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD WILLOW RIDGE OF NC LLC RUTHERFORDTON, NC 28139 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Managers were in-serviced F 272 Continued From page 14 F 272 by the Clinical Consultant next. When asked if she notified the charge nurse on 06/19/2013 regarding the or a supervisor to do any further assessment, she following: stated she did not because the facility didn't have a) The facility's new a special type of program for assessing a Incontinence resident to determine the cause for the decline or Program/Manual and the the type of incontinence. When asked if the Interact "Early Warning facility did any type of monitoring for a 7 day or 14 Tool" day period to determine if there was a pattern to the incontinence, she stated they did not. She b) Completing a stated the facility did not utilize any type of comprehensive toileting program such as scheduled toileting or Incontinence assessment. prompted toileting. She stated they only had a c) How to use the 72 hour "check and change" program which meant voiding diary to obtain a residents were checked every 2 hours for baseline. incontinence and care was provided as needed. d) Care plan specific B&B During an interview on 06/14/13 at 5:00 PM with interventions. the Chief Clinical Officer, he stated the facility e) Care plan on whether or didn't have a program in place to assess not the incontinence is residents for the cause of incontinence or the reversible. need for an individualized bladder program such f) Completing these as bladder re-training or a scheduled toileting assessments upon admission program. or upon change in F 279 | 483.20(d), 483.20(k)(1) DEVELOP F 279 continence patterns and at COMPREHENSIVE CARE PLANS least quarterly. A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 4- Monitoring of the facilities performance to The facility must develop a comprehensive care make sure the solution is plan for each resident that includes measurable sustained will be objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial accomplished by: needs that are identified in the comprehensive a) Use of the Interact "Early assessment. Warning Signs Tool, when any change in condition or The care plan must describe the services that are incontinence is noted.

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	] 06	/14/2013
WILLOV	V RIDGE OF NC LLC			2	237 TRYON ROAD RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	(X5) COMPLETION DATE
F 279 SS=D	next. When asked if so or a supervisor to do stated she did not be a special type of progresident to determine the type of incontinent facility did any type of day period to determine the incontinence, she stated the facility did to to determine the incontinence, she stated the facility did to determine the incontinence, she stated the facility did to determine the incontinence and care prompted to determine the incontinence and care in	she notified the charge nurse any further assessment, she cause the facility didn't have gram for assessing a the cause for the decline or ice. When asked if the f monitoring for a 7 day or 14 ne if there was a pattern to stated they did not. She not utilize any type of as scheduled toileting or it is stated they only had a program which meant ed every 2 hours for awas provided as needed.  In 06/14/13 at 5:00 PM with ever, he stated the facility in place to assess a of incontinence or the incontinence or the incontinence of the incontinence	F 2	779	b) All assessments and care plans will be reviewed by the IDT at the care plan meeting, to ensure that all components of the Incontinence program are assessed and the results of documented and care planned. c) The Interact tool will be reviewed daily by the IDT at morning QA meeting as a permanent process to the morning QA meeting and reviewed monthly by the Quality Improvement Committee for 12 months then quarterly there after to assess for discrepancies, monitoring needs and continued compliance. This will be done every month for 12 months then quarterly there after.  Director of Nurses or designee will be responsible		
	The facility must devel	op a comprehensive care			for continued compliance.		

assessment.

plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive

The care plan must describe the services that are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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WILLOW	ROVIDER OR SUPPLIER RIDGE OF NC LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139		37 TRYON ROAD RUTHERFORDTON, NC 28139	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	highest practicable phesychosocial well-beir §483.25; and any sender equired under §48 due to the resident's es §483.10, including the under §483.10(b)(4).  This REQUIREMENT by: Based on record reviet facility failed to develop behaviors for 1 of 5 see exhibited behaviors. (If the findings included: Resident #70 was admo9/17/12 with diagnosobisease and anxiety. Note dated 09/20/12 nefrom a geriatric psychit treated for confusion at the care area assess on 10/21/12 stated there in intervention needed. If for safety and supervisite resident may wander in and was at risk of confiresidents and increase redirection from staff.  The current care plant addressed behaviors of a staff and addressed behaviors of the current care plant addressed behaviors of	in or maintain the resident's pysical, mental, and and as required under vices that would otherwise 33.25 but are not provided exercise of rights under a right to refuse treatment is not met as evidenced ew and staff interview, the pacare plan for aggressive ampled residents who Resident #70).  Initted to the facility on es including Alzheimer's The physician's progress oted the resident came atric facility where he was and agitation.  In ment for behaviors dated was no immediate de was on the secured unit sion. It was noted that the into other residents' rooms frontation with other ad agitation during	F	279	I-Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by:  a) Resident #70 had the new Behavioral Assessment Tool completed to determine specific behaviors, probable triggering events, interventions that decrease behaviors. Interventions implemented through the care plan process. b) Resident #70 and residents care plan was created to include specific behaviors, probable triggering events, interventions that decreased behaviors, probable triggering events, interventions that decreased behaviors.  2-Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice. An audit for residents with behaviors in the facility was completed 07/04/2013 by:	•	71219

PRINTED: 06/28/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 345197 B. WNG 06/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD WILLOW RIDGE OF NC LLC **RUTHERFORDTON, NC 28139** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY a) The Social Services F 279 Continued From page 16 F 279 Department for all residents plan lacked any goal and the interventions that exhibited behaviors, included providing close supervision, redirect and their plan of care reviewed reorient when needed, and if agitation occurred by the IDT at morning QA during care allow a bit of time to pass and retry to meeting to ensure that it complete tasks, encourage him to rest if he contained: the type of seems fatigued or anxious, intervene to increase behaviors, possible safety and well being. triggering events and The quarterly Minimum Data Set (MDS) dated specific interventions that 12/12/12 coded the resident with severely decrease the behavior impaired cognitive skills, having other behaviors episodes.. 1-3 days and wandering 1-3 days. It was noted that he received antipsychotic and antianxiety 3-Measures will be put in medications daily. place or systemic changes Review of abuse reports revealed on 12/31/12 at made to ensure that the 6:00 AM, Resident #70 was hit by Resident #148 alleged deficient practice when he wandered into her room. Staff were will not occur: present in the room at this time. Resident #70 was to be observed. No other specifics were a) The Social Services available. Director was in-serviced by the Chief Clinical Officer Review of nursing notes dated 01/07/13 at 9:20 on 06/26/2013 on the PM revealed Resident #70 pulled a resident out following: of his bed. This resident was not identified and b)The facilities New there was no indication of any followup. Behavioral Assessment Review of abuse reports revealed on 01/21/13 at 12:45 AM, Resident #70 pushed Resident #93 up c) How to and when to against the door frame and balled his fists at him.

It was noted Resident #70 had been following the

resident and yelling at him. Resident #70 was

revealed another (unknown) resident accused Resident #70 of hitting him. He remained on 15 minute checks from 01/21/13. A medication

Nursing notes dated 01/23/13 at 2:10-AM

placed on 15 minute checks.

complete the tool.

d) Documenting and

implementing the behavior

and interventions used to

decrease the behaviors

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESIGNATIONS

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 100		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B. WNG				C
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139	j. 0i	6/14/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
	change was made 1/2 (Depakote was added  Review of abuse report 7:00 AM Resident #70 Resident #153 who the the eye. 15 minute ch implemented. The nex medication changes an minute checks and red evaluation.  The quarterly MDS dat resident with severely having physically abus having other behaviors daily. He received anti- daily. There was no be established.  Review of psych consu- revealed no recent agg  Review of abuse report 10:40 PM, Resident #7 the face. He was place and the physician order antipsychotic (Haldol) in Depakote sprinkles was minute checks were ter  Review of abuse report 4:30 PM Resident #70 It a chair and during staff	8/13 due to behaviors ).  Ints revealed on 03/01/13 at was pulling on the feet of en punched Resident #70 in ecks were then t day the physician made and took him off the 15 uested a psychiatric  ed 03/06/13 coded the mpaired cognitive skills, ive behaviors 1-3 days, 1-3 days and wandering psychotic medications ehavior care plan  Its dated 03/20/13 ression.  Its dated 03/20/13 at 0 slapped Resident #6 in d on 15 minute checks ed an intramuscular njection. On 03/22/13 increased and the 15 minated.  Its revealed on 03/30/13 at pecame frustrated, raised intervention, Resident #70 it Resident #119's finger in et to monitor Resident ecifics regarding what	F	279	e) The Social Services Director was again inserviced by the DON on 07/02/2013 on the following:  a) Properly investigating each behavior to ascertain the type of behavior, the possible triggering event and what interventions work to decrease the behaviors. b) The New Behavioral Assessment Tool will be completed upon admission, quarterly and upon any behaviors. c) The Social Service Director will complete the New Behavior Quality Assurance tool per occurrence and upon admission.		

		ND HUMAN SERVICES				FOR	D: 06/28/2013 M APPROVED
STATEMENT	RS FOR MEDICARE & I OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		PLE CONSTRUCTION	(X3) DATE	O. 0938-0391 E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC LLC				237 TRYON ROAD		
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F 279	Continued From page		F	27	4- Monitoring of the facilities performance to make sure the solution is		
		4/30/13 revealed Resident			sustained will be		
	#70 was agitated and				accomplished by:		
		as nondescript regarding He was placed on one to			a) The IDT		
	one supervision and g				(Interdisciplinary Team)		
	calmed down. The ler				will review each Behavioral		
	supervision lasted was				Assessment Tool for		
					compliance with any		
	Review of abuse repor	ts revealed on 05/21/13				J.	1
		ing up chairs and bedside			discrepancies, trends or/and		
		ooks on the floor picking up			triggers identified at the	1	
		throwing books on floor.			morning QA meeting as a		
		given with little effect and			permanent process of the		
	the physician ordered				morning QA meeting		
	intramuscular injection	(naidor) to carn him.	1		b) The Behavioral		
	The quarterly MDS det	ed 05/29/13 coded the			Assessment Tool will be		
		impaired cognitive skills,			reviewed by the Quality		
1		ive behaviors 1-3 days,			Improvement Committee to		
		1-3 days and wandering			assess for any discrepancies,		
	daily. He received anti				monitoring needs and		
	daily and an antianxiet	y medication once in the			continued compliance. This		
	last 7 days. There still				will be done monthly for 12		
	developed to address a	abusive behaviors.			months and quarterly there		1
	0- 004440 -10 50 0	4.1.			after.	1	
	On 06/14/13 at 2:50 PM Resident #70 as easy of redirect.	M Nurse #4 described going and fairly easy to					
	be and reapproach him	agitated you just let him later. She further stated a couple of residents and			Director of Nurses or designee will be responsible for continued compliance.		
1			1		1		

On 06/14/13 at 5:06 PM, the MDS nurse stated the social worker handled the behavior section in

NAME OF PROVIDER OR SUPPLIER  WILLOW RIDGE OF NC LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  C  C 06/14/2013  STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE DEFICIENCY)  F 315	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  WILLOW RIDGE OF NC LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  237 TRYON ROAD  RUTHERFORDTON, NC 28139  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 315			345197			10.70 III	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315			,	237	TRYON ROAD	1 06/14/2013	
F 315 7 - 12	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		
the MDS, subsequent assessments and the development of care plans addressing behaviors.  Interview with the Social Worker (SW) on 06/1/4/13 at 5:11 PM revealed.Resident #70 did have abusive behaviors which were not care planned. He also said he had been responsible for investigating abuse reports up until 2 weeks ago which informed him of Resident #70's behaviors.  F 315 483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function or restore as much normal bladder function or 1 of 3 residents to maintain bladder function for 1 of 3 residents reviewed for incontinence (Resident #57). The findings included:  Resident #57 was admitted to the facility on 02/06/13 with diagnoses including dementia, gout and heart murmur. The admission Minimum Data Set (MDS) dated 02/13/13 indicated Resident #57 was an independent with ambulation and toliet use	SS=D	the MDS, subsequent development of care  Interview with the Socio6/14/13 at 5:11 PM is have abusive behavior planned. He also said for investigating abus ago which informed his behaviors.  483.25(d) NO CATHE RESTORE BLADDER  Based on the resident assessment, the facility resident who enters the indwelling catheter is resident's clinical condicatheterization was not who is incontinent of but treatment and service infections and to resto function as possible.  This REQUIREMENT by:  Based on observation interview the facility fato maintain bladder fur reviewed for incontinent findings included:  Resident #57 was admo2/06/13 with diagnose and heart murmur. The Set (MDS) dated 02/13	t assessments and the plans addressing behaviors.  cial Worker (SW) on revealed.Resident #70 did for which were not care do he had been responsible to reports up until 2 weeks im of Resident #70's  ETER, PREVENT UTI, Restrain the facility without an interest that a fer facility without an interest that the excessary; and a resident colladder receives appropriate is to prevent urinary tract for as much normal bladder is not met as evidenced in the facility of the facility on the facility of the facility on the facility on the facility of the facility on the facility on the facility of	F 279	1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: 1- Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice by: a) Resident #57 was assessed per the new revised Incontinence Management from the newly implemented manual. b) It was identified on 6/17/13 that #57's incontinence was a result of BPH. Uroxatrol HCL ER 10 mg was started on 6/17/13. On 6/20/13 #57 experienced a acute change in condition (pneumonia) in which he was being treated. At this time due to increased confusion #57 was unable to participate in a formal toileting program. #57 needs were met by staff with toileting and check and change every 2 hours PRN.	7.12.13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Test Works	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345197	B. WING		C	
	ROVIDER OR SUPPLIER RIDGE OF NC LLC			TREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139	[ 06/1	14/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	and was occasionally Care Area Assessmen 02/14/13 indicated the occasional incontinence antipsychotic medicati of incontinence was lis with urgency.  Review of a care plan updated 05/13/13 whice incontinence included pericare when incontine void, change clothes a cream after incontinen changes in voiding pat to nurse.  A quarterly MDS dated Resident #57 was depe and was frequently inco A review of the Nursing Sheet did not indicate I incontinent but indicate I incontinent but indicate bathroom and ambulate staff.  An observation on 06/1 and NA #2 providing incontinence brief was An interview with NA #1 revealed that she provid Resident # 57 before br checked him again mid- ncontinence brief was o wasn't always wet wher	incontinent of bladder. A at (CAA) summary dated contributing factors to the ce were the use of on and dementia. The type sted as stress incontinence  dated 02/14/13 and ch addressed bladder the following interventions: tent, remind resident to s needed, apply barrier t episodes and report tern or appearance of urine  1 05/15/13 indicated endent on staff for toileting ontinent of bladder.  2 Assistant Information Resident #57 was d the resident went to the ed with the assistance of 1  2/13 at 12:45 PM of NA #1 continence care revealed vas wet.  I on 06/12/13 at 1:20 PM ded incontinence care for reakfast. She stated she	F 31	discharged to the hospital with a Diagnosis of Exacerbation of Pneumonia and a asymptomatic Urinary Tract infection, which could have also contributed to his increased incontinence. A 3 day bladder diary was unable to be performed to obtain a baseline due to #57 acute decline in condition. To date #57 remains in the hospital and will be re- assessed upon his re- admission for a proper toileting program.  2-Corrective action will be accomplished for those residents having potential to be affected by the alleged deficient practice by: a) Per the new Incontinence Management policy all  residents will be assessed using the 24 Hour Voiding Diary for 3 days upon admission, quarterly or when a resident experiences change in bladder continence status.		

STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	77 TO 10 10 10 10 10 10 10 10 10 10 10 10 10	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
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	hours for incontinence care if he was wet. Sh bathroom or offer him  During an interview or MDS Assessment Nur additional assessment for a resident who had from the admission MI MDS. The nurse revea additional assessment decline in continence to next. When asked if sh or a supervisor to do a stated she did not beca a special type of program resident to determine to the type of incontinence did not utilize any type as scheduled toileting stated they only had a program which meant every 2 hours for incorprovided as needed. See Resident #57's contine prompted her to revise didn't develop a care paddressed incontinence interventions that addresincluded in the care plaintegrity.  During an interview on the Chief Clinical Office didn't have a program i residents for the cause	e and provided incontinence le did not take him to the the urinal.  106/14/13 at 4:45 PM the se was asked about any it that would be conducted If a decline in continence DS to the first quarterly aled she did not do any it of a resident who had a from one assessment to the ne notified the charge nurse any further assessment, she ause the facility didn't have am for assessing a the cause for the decline or the stated the facility of toileting program such or prompted toileting. She "check and change" residents were checked attinence and care was the stated a decline in a the care plan because she lan that individually the care plan because she lan that individually the stated any the stated any the stated the facility of 106/14/13 at 5:00 PM with the r, he stated the facility of incontinence or the the dolladder program such	F	315	b) Incontinent residents were assessed regarding continence by the Unit Nurse Managers using the new incontinence assessment tool. c) Specific resident care plans and interventions were derived and implemented. Special incontinence toileting schedules were implemented for those residents that meet the criteria per the manual. 3-Measures that will be put into place or systemic changes made to ensure that the deficient practice will not occur: a) The policy of Incontinence Management regarding Bladder incontinence was reviewed and revised by the Clinical Consultant b) Nursing Supervisors, Nursing and CNAs were in- serviced on the policy and the utilization of 24 Hour Voiding Diary 06/19/2013 and the Interact Early warning Tool on 07/03/2013. Nurse		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES BY TATEMENT OF DEFICIENCIES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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OF SECULORS WITH A SECULORS OF SECULORS	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139	06/14/2013	
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	hours for incontinence care if he was wet. She bathroom or offer him  During an interview or MDS Assessment Nur additional assessment for a resident who had from the admission MI MDS. The nurse reveal additional assessment decline in continence from the admission of the continence of the first or a supervisor to do a stated she did not becar a special type of programesident to determine the type of incontinence did not utilize any type as scheduled toileting as scheduled toileting as stated they only had a program which meant a levery 2 hours for incomprovided as needed. Since the formation of the continence didn't develop a care plad addressed incontinence didn't develop a care plad addressed incontinence didn't develop a care plad addressed incontinence didn't develop a care plad integrity.  During an interview on the Chief Clinical Office didn't have a program in the sidents for the cause	and provided incontinence e did not take him to the the urinal.  106/14/13 at 4:45 PM the se was asked about any that would be conducted a decline in continence OS to the first quarterly alled she did not do any of a resident who had a rom one assessment to the the notified the charge nurse any further assessment, she ause the facility didn't have am for assessing a the cause for the decline or the easted the facility of toileting program such to prompted toileting. She "check and change" residents were checked tinence and care was the stated a decline in a the angle of the care plan because she and that individually the stated any the stated any the stated the facility of bladder stated the facility of the care plan because she and that individually the stated the facility of the stated the f	F 315	Managers were in-serviced by the Clinical Consultant on 06/19/2013 regarding the following:  a) The facility's new Incontinence Program/Manual and the Interact "Early Warning Tool"  b) Completing a comprehensive Incontinence assessment.  c) How to use the 72 hour voiding diary to obtain a baseline.  d) Care plan specific B&B interventions.  e) Completing these assessments upon admission or upon change in continence patterns and at least quarterly.  4- Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by:  a) Use of the Interact "Early Warning Signs Tool, when any change in condition or incontinence is noted.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	(X3) DATE SURVEY COMPLETED	
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	hours for incontinence care if he was wet. She bathroom or offer him.  During an interview of MDS Assessment Nu additional assessment for a resident who had from the admission M MDS. The nurse reveradditional assessment decline in continence next. When asked if stor a supervisor to do a stated she did not becare a special type of progresident to determine the type of incontinence did not utilize any type as scheduled toileting stated they only had a program which meant every 2 hours for incorprovided as needed. See Resident #57's contine prompted her to revise didn't develop a care paddressed incontinence interventions that addresincluded in the care platintegrity.  During an interview on the Chief Clinical Office didn't have a program in residents for the cause need for an individualization.	e and provided incontinence the did not take him to the the urinal.  In 06/14/13 at 4:45 PM the rese was asked about any to that would be conducted at a decline in continence DS to the first quarterly aled she did not do any to fa resident who had a from one assessment to the the notified the charge nurse any further assessment, she cause the facility didn't have arm for assessing a the cause for the decline or ce. She stated the facility of toileting program such or prompted toileting. She "check and change" residents were checked attinence and care was the stated a decline in a sence would not have the care plan because she alan that individually e. She stated any essed incontinence were an that addressed skin  106/14/13 at 5:00 PM with ear, he stated the facility	F 315	b) All assessments and care plans will be reviewed by the IDT at the care plan meeting weekly as permanent process, to ensure that all components of the Incontinence program are assessed and the results of documented and care planned. c) The Interact tool will be reviewed daily by the IDT at morning QA meeting as a permanent process to the morning QA meeting and reviewed monthly by the Quality Improvement for 12 months and quarterly there after.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 315 F 323 SS=E	program. 483.25(h) FREE OF HAZARDS/SUPERV The facility must ens environment remains as is possible; and e	ACCIDENT ISION/DEVICES		3315	Director of Nurses or designee will be responsible for continued compliance.  F 323  1- Corrective action will be accomplished for those residents found to have been affected of the alleged deficient practice:		7.12:13
	by: Based on observation interviews the facility to stand lifts in working transferred with sit to wheelchair. (Resident The findings included A review of a facility putitled Mechanical Lifts problems noted in the lift should be immore maintenance department from service. Each lifts afety by the maintenance A review of facility do inspections for patient 2013 through May 20 to stand lifts.	coolicy that was not dated and indicated in part: any emechanical performance of ediately reported to the nent and the lift removed fit is routinely inspected for ance department.			a) For resident #25 and #33 the standup lift in question was taken out of service and disposed of during the survey. b) The facility rented a functioning standup lift during the survey. Will continue to rent lift until one can be purchased.  2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice was accomplished by: a) All Hoyer and standup lifts were inspected and all were found to be functioning properly.		

PRINTED: 06/28/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 345197 B. WNG 06/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD WILLOW RIDGE OF NC LLC RUTHERFORDTON, NC 28139 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 323 Continued From page 23 F 323 3- Measures will be put into assisted Resident #25 to the side of her bed and place or systemic changes placed a sit to stand lift in front of her. The made to ensure that the number 006 was written in black ink on the side alleged practice will not of the lift. A cloth sling was placed around occur: Resident #25's back and NA #3 hooked one side of the sling to a lift arm and hooked the other side 1) The nurses and CNAs of the sling to the other lift arm. NA #3 held a were educated by the Nurse hand control in her hand and pushed a button on Manager on 07/03/2013 on a hand control and raised Resident #25 off the the following: bed. NA #3 removed her finger from the lift a) The facility repair control but the lift arms continued to rise and lifted notification form. Resident #25 to a semi standing position and stopped. NA #3 stated "see this lift has a mind of b) In no instance must any its own, it just keeps going on its own." RA #1 equipment that is positioned a wheelchair directly under Resident malfunctioning be used. #25 and NA #3 pushed a button on the hand c) Staff should immediately control and lowered Resident #25 into the notify maintenance and wheelchair. nursing of the During an interview on 06/12/13 at 11:17 AM with malfunctioning equipment. NA #3 she explained when she went to look for a d) The Maintenance sit to stand lift to transfer Resident #25 she saw a Director was in-serviced on handwritten note on a piece of paper taped to the 06/19/2013 by the Clinical lift labeled 006 that said it was out of order. She Consultant on: stated she put a new battery in the lift and it a) The facility's Hoyer seemed to work so she took it to Resident #25's

006 had been reported.

room to use it to transfer her from her bed to a

couldn't find it and that's why she used the one

explained staff was supposed to write a note on

the maintenance log when equipment didn't work

know if it the problem with the hand control for lift

During an interview on 06/12/13 at 11:32 PM with

or call maintenance to look at it but she did not

that had the out of order sign on it. NA #3

wheelchair. She further stated there was one other sit to stand lift that she usually used but she

lift/stand up lift inspection

b) Inspections of the Hoyer

and standup lift will occur

malfunctioning it must be

taken out of service and stored in an area employees

Policy and Quality

Assurance tool.

at least monthly.

can not access.

c) If equipment is

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CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	RA #1 she stated they equipment when it wa but now they were supmaintenance log becaknow about it they coudid not know if mainte about lift 006.  During a review of ma at 11:41 AM at the nurstorage area there we regarding sit to stand I During an interview on NA #4 she explained to lifts in the facility. She on one of the sit to stap properly. She further con the hand control was up it went all the way us button on the hand conwouldn't lower the resident. She the lift at its maximum wouldn't go down it wo unsafe position. NA #4	y used to put signs on as broken or needed repair pposed to write it on the ause if maintenance didn't uldn't fix it. She stated she enance had been notified aintenance logs on 06/12/13 arse's station next to the lift are no notes on the logs lifts that needed repair.  In 06/12/13 at 11:42 AM with they have two sit to stand a explained the hand control and lifts did not work explained when the button as pushed to lift the resident to but when you pushed the ident down. She described the emergency release the main column of the lift to be stated if a resident was in position and the lift buld put a resident in an 4 stated she had told the did not work properly but	F	323	4-Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by:  4- The Maintenance Quality Assurance tool will be monitored by the morning QA for compliance as permanent process of the morning QA meeting. The monthly Quality Improvement Committee will assess for discrepancies, monitoring needs and continued compliance, monthly for 12 months then quarterly on a permanent basis.  4- The Medical Director has reviewed the Plan of Corrections and has accepted it. The facility will continue to seek guidance and support from the Medical Director on facility practices.  The Maintenance Director/designee is		
	During an observation #4 took a sit to stand life	on 06/12/13 at 2:33 PM NA ft with the number 007			responsible for continued compliance.		

written in black ink on the side of the lift into Resident #33's room. Resident #33 was

assisted to sit on the side of the bed and the sit to stand lift was placed in front of him. A solid

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	back and NA #4 attact one of the lift arms and side of the sling to the the lift control in her har raise the lift arms and semi-standing position button on the hand co go down. NA #4 then of the lift and pushed at the lift and the lift arms a wheelchair.  During an interview on Maintenance Director sit to stand lifts. He explose on the hand con and it needed new ele lift control would lower Maintenance Director control was broken on confirmed he saw a not earlier that morning the and he took the note of can but he should have service. He explained labeled 006 to the main busy and forgot about order a part to fix lift 00 service until it was represented in the service on Director of Nursing stafor staff to fill out a main maintenance when equence the staff of the stated sit to the staff of the staff of the stated sit to the staff of the	the behind the resident's the one side of the sling to do then attached the other other lift arm. NA #4 held and and pushed a button to lifted Resident #33 into a management. NA #4 pushed the down of the side at black switch on the side of solwered Resident #33 into a management. The confirmed the facility had 2 explained the wires were trol for the lift labeled 007 cotrical connections so the state of the resident. The continuation of the lift labeled 006 at said it was out of order of the meant to take the lift intenance shop but he got aired because it could be side of the side of the stated he had to 06 and it should be out of aired because it could be	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ITIEICATION NI IMPED:		E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
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SS=E	immediately to prever 483.60(b), (d), (e) DR LABEL/STORE DRUG.  The facility must empty a licensed pharmacist of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is mareconciled.  Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable.  In accordance with Stafacility must store all docked compartments controls, and permit or have access to the key.  The facility must proving permanently affixed controlled drugs listed Comprehensive Drug. Control Act of 1976 an abuse, except when the package drug distribut	nt injury to residents. UG RECORDS, GS & BIOLOGICALS  oy or obtain the services of who establishes a system and disposition of all fficient detail to enable an any and determines that drug and that an account of all intained and periodically  used in the facility must be with currently accepted and include the and cautionary expiration date when the and Federal laws, the rugs and biologicals in under proper temperature and authorized personnel to a separately locked, ompartments for storage of in Schedule II of the		323	1-Corrective action will be accomplished for those residents found to have been affected of the alleged deficient practice by: a) All undated, improperly labeled and or expired medication identified in the 2567 were destroyed.  2- Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice was accomplished by: a) All medication carts, medication refrigerators and medication storage areas were immediately inspected and any open non-dated or expired medications were destroyed.  3-Measures will be put into place or systemic changes made to ensure that the alleged practice will not occur:		7-12-13

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F 431	by: Based on observation interview, the facility for medications from 3 of rooms and 2 of 5 mediabel a unit dose pack medication carts. The A review of the facility Storage revealed the discontinued, outdated medications are availated All such medications are availated and an availated and an availated and are the manufacturer's insuppositive and an availated and availated availated and avai	is not met as evidenced  as, record review and staff ailed to remove expired 3 medication storage dication carts and failed to age of medication in 2 of 5 findings included:  's policy on Medication following statement: "No do, or deteriorated able for use in this facility.  are destroyed." A review of atructions for Tuberculin vials in use for more than carded.  1/13 at 4:39 PM of the A Hall perator revealed a box of tories in the refrigerator apositories with an 1 2013.  1/13 at 4:40 PM with Nurse ding who was responsible and dates on stock and as revealed all the nurses hecking expiration dates and the medication. She specific person being and refrigerated do medications.  13/13 at 4:51 PM of the B and refrigerator revealed a illiliter (ml) vial with a label	F 43	a) The Unit Managers were in-serviced 06/19/2013. The licensed nurses were inserviced on 07/03/2013 on the following: b) Any time a medication is opened it must be dated. c) Omnicare's expiration date medication list. d) Expiration dates should be checked before administrating to any resident and if expired the medication/treatment should be destroyed. e) The need to keep the medication carts and medication room clean. f) The nurse managers will conduct weekly random rounds while in the facility and check all medication carts, medication refrigerators and medication storage areas and check for materials not dated when opened, expired medication, improper labels. These medications will be properly discarded. g) Medication administration and storage in-servicing will continue to be conduced at least quarterly.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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F 431	the vial. Another vial of not have a label indical and contained approximate Also, in the refrigerate suppositories with an 2013.  b. An unopened bottle milligrams (mg) contained expiration date of Janucommingled with othe counter medications of medication room.  An interview on 06/13/42 regarding the expiral Aplisol revealed it was date it was opened. We person designated to counter medications for stated she guessed it was date it was guessed it was guessed it was date it was guessed it w	of solution was remaining in of Tuberculin Aplisol 1 ml did ating when it was opened imately 0.25 ml of solution. In were 6 hemorrhoidal expiration date of April of Zinc Sulfate 220 ining 100 tablets with an uary 2013 was stored r unexpired over the	F	431	4-Monitoring of the facilities performance to make sure the solution is sustained will be accomplished by:  a) The QA tools will be reviewed at the Morning Quality Assurance Meeting weekly as permanent process, when medication is reviewed. Any discrepancies noted will be identified and further education and or monitoring will be implemented.  Discrepancies, education needed, monitoring will be reviewed by the monthly QA meeting for 12 months and quarterly there after.		
	Hall medication room a lock box containing 2 p for specific residents. On syringes of Lorazepam date of 06/01/13. The of Lorazepam 2 mg/ml May 2013.  4. Inspection on 06/13/medication cart reveals Prednisone 1 mg with a lock box containing the second sec	And refrigerator revealed a colastic storage bags labeled one bag contained 6 a 2 mg/ml with an expiration other bag contained 1 vial with an expiration date of April 12 at 6:06 PM of the B-1 and 1 unit dose package of an expiration date of April 15 at 6:06 PM of the Cart.			The Director of Nursing/designee will be responsible for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	name or directions for An interview on 06/13, #2 regarding the Pred medication cart reveal any resident on her ha receiving Prednisone.  5. Inspection on 06/13 medication cart reveal suppository with an ex 2012, laying loose in the and not labeled with a directions for use.  An interview on 06/13/ Manager #1 revealed to suppository should not medication cart and sh  An interview on 06/14/ Chief Clinical Officer a (DON) revealed the Ur expected to check the refrigerators at least m medications and to dis The DON stated once pharmacist and/or nurs medication carts for ex  An interview on 06/14/ Administrator revealed the Unit Managers to c and refrigerators week She stated she also ex	labeled with a resident's use.  /13 at 6:20 PM with Nurse nisone on the B-1 ed she was not aware of all who was currently  /13 at 6:33 PM of the B-2 ed 1 Phenergan 12.5 mg spiration date of October the top drawer of the cart resident's name or  /13 at 6:35 PM with Unit the Phenergan 12.5 mg thave been on the nould have been discarded.  /13 at 6:24 PM with the not the Director of Nursing nit Managers were medication rooms and onthly to check for expired card expired medications.  a month the Unit Manager, se consultant checked the pired medications.	F	431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG	СОМ	COMPLETED	
		345197	B. WNG			/14/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
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