STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 000	INITIAL COMMENTS 483.25 (F323) at J Immediate jeopardy began on 04/30/14 when Resident #122, with a known history of unsafe smoking behaviors, smoked on the facility's premises in a nondesignated smoking area and unsupervised while having an oxygen tank, located on the back of his wheelchair, turned on and the nasal cannula hanging on the wheelchair. The administrator was notified of the immediate jeopardy on 09/23/14 at 3:20 PM. Immediate jeopardy was removed on 09/24/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to resident smoking and for noncompliance for examples #2 and #3.	F 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156	**F 156** **Corrective action for residents found to have been affected by this deficiency:** No specific residents were affected. **Corrective action for residents that may be affected by this deficiency:** All residents have the potential to be affected by these identified concerns.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne Washburn — TITLE: Administrator — (X6) DATE: 10/28/14

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: 10-17-14

NC DHSR Black Mountain RECEIVED OCT 28 2014 by: SKH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 156	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156	The facility posted correct contact information for the State's Complaint Intake Unit while the survey was still in progress on 9/19/14. **Measures that will be put into place to ensure that this deficiency does not recur:** The Administrator or Director of Nursing will audit the posting and ensure the correct number is posted weekly, times 3 months and then monthly thereafter; to ensure the contact information for the State's Complaint Intake Unit is correct and posted. This practice will continue until the Quality Assurance Committee determines that the deficient practice has been corrected. On 10/13/14, the facility staff were in-serviced regarding the State's Complaint Intake Unit posting and where the posting was located in the facility. On 10/16/14, the Administrator met with the resident council regarding the State's Complaint Intake Unit posting and where the posting was located in the facility. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to post correct contact information for the State's Complaint Intake Unit. The findings included: The survey team entered the facility on 09/15/14 at 10:00 AM. Observations of the lobby area revealed a glass-enclosed bulletin board. A	F 156	Any discrepancies identified in the audits will be documented, investigated and corrected immediately by the Administrator. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 156	Continued From page 3 paper titled "Division of Health Service Regulation Complaint Intake Unit (919) 733-8499" was posted. When dialed, a recording was reached that indicated (919) 733-8499 was no longer in service. On 09/19/14 at 2:25 PM Social Worker #1 and Social Worker (SW) #2 were interviewed. They reported that the facility posted contact information in the front lobby. SW #1 stated that information for filing a complaint was in the front lobby inside the glass case. Observations were made of the glass case with SW #1 and SW #2 that revealed there was no contact information and the glass case was unlocked and opened. On 09/19/14 at 2:30 PM the Administrator was interviewed and reported that she was aware the contact information for filing a complaint was to be posted in the facility. She explained that she assumed the telephone number posted was correct and explained that someone must have removed the posting. She stated that she would have the correct number posted throughout the facility.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain the dignity	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 4 for 2 of 2 residents who were observed in the dining room eating with disposable dishware. (Residents #19 and #85). The findings included: 1. Resident #85 was admitted to the facility on 09/27/10 with diagnoses including dementia and bipolar disorder. Nursing notes dated 12/09/13 at 6:50 PM revealed Resident #85 was brought back to the nursing station from supper and "Resident was then noted asking staff and visitor for a knife so he could cut off his wanderguard." Nursing notes dated 02/28/14 at 5:55 PM stated Resident #85 rolled to the B station and was asking for knives to cut his wanderguard off. He was also asking visitors and family members for knives. Review of the care plans revealed behavior interventions to address problems related to his risk of elopement and being verbally disruptive at times. The goal for risk of elopement originated on 08/28/13 and was last updated on 04/22/14. One of the goals was for the resident to not remove the wanderguard. There was no intervention on any care plan which addressed the need for plastic utensils. The annual Minimum Data Set (MDS) dated 07/16/14, coded Resident #85 as having severely impaired cognitive skills and no behaviors. On 09/15/14 during observation of the main dining room made between 12:00 PM and 1:00 PM, Resident #85 was observed eating lunch	F 241	**F 241** **Corrective action for residents found to have been affected by this deficiency:** Resident #19 and #85 were assessed by a nurse for safety and the necessity of disposable dishware. The disposable dishware was replaced with regular dishware while the survey was still in progress. Resident #19 and #85 will be served regular dishware with meals, unless deemed unsafe to have regular dishware due to harmful behaviors towards self or others. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. Prior to the use of disposable dishware: the Director of Nursing or the Assistant Director of Nursing or a Nurse Manager or a Charge Nurse will assess for the necessity of disposable dishware, a physician's order will be obtained for the disposable dishware, a care plan will be implemented for the disposable dishware and a dietary slip will be completed by the Director of Nursing or the Assistant Director of Nursing or a Nurse Manager or a Charge Nurse and given to the dietary department.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 5 using plastic utensils. On 09/16/14 at 8:31 AM, Resident #85 was observed eating in the main dining room using plastic utensils. Review of the tray card revealed a notation to send plastic utensils at each meal. On 09/17/14 at 12:19 PM, Resident #85 was served his meal with plastic utensils. At 12:32 PM Nurse Aide (NA) #4 stated she regularly was in the dining room during meals. When asked why Resident #85 was served with plastic utensils, she stated that she did not know why and that sometimes he had regular utensils and sometimes he had plastic. The Dietary Manager was unable to explain why Resident #85 had plastic utensils when asked on 09/17/14 at 2:01 PM. She further sated he had used the plastic utensils for a long time. Interview on 09/17/14 at 2:47 PM with the Director of Nursing revealed Resident #85 had an occurrence on 12/09/13 of trying to remove his wanderguard with silverware and then again on 02/28/14 it occurred again so staff decided to provide him with only plastic utensils. She was unable to explain who made this decision or provide any documentation related to his need for plastic utensils. Interview with NA #1 on 09/17/14 at 3:23 PM revealed that in the 3 months she has worked with Resident #85, he has always had plastic utensils but she did not know the reason. She further stated she had never known him to request scissors or a knife to remove his wanderguard.	F 241	Any resident identified as needing disposable dishware will be evaluated, monitored and re-evaluated for the discontinuation of the disposable dishware by the Interdisciplinary Team weekly. On 10/13/14, nursing and dietary staff were in-serviced on the identified concerns regarding disposable dishware; who will complete the initial assessment to implement disposable dishware; physicians order for disposable dishware; care plan for disposable dishware; dietary slip for disposable dishware; monitoring and re-evaluation of disposable dishware. On 10/16/14, the Administrator reviewed the deficient practice with the resident council regarding the use of disposable dishware. **Measures that will be put into place to ensure that this deficiency does not recur:** Currently, no resident are residing in the facility which use disposable dishware. If a resident is identified as needing disposable dishware, the Director of Nursing or the Assistant Director of Nursing or a Nurse Manager or a Charge Nurse will implement the use of disposable dishware for as long as the physician orders. The Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 6 Interview on 09/17/14 at 4:00 PM with Social Worker (SW) #1 revealed she could not say why Resident #85 needed plastic utensils. She further stated plastic utensils were sometimes provided to residents with suicidal issues but even then the plastic utensils were usually not kept as an ongoing intervention. She stated she was unaware Resident #85 was using plastic utensils. On 09/17/14 at 4:56 PM, the Administrator , DON and the Director of Clinical Services stated that the psychologist or psychology nurse practitioner would determine the necessity of plastic utensils for a resident's safety. The DON further stated that wanderguards were checked for placement on residents every shift. The Director of Clinical Services stated she could not locate information relating to the initiation of plastic utensils. On 09/18/14 at 8:27 AM Resident #85 was observed eating with plastic utensils. Interview with NA #2 on 09/18/14 at 2:17 PM revealed Resident #85's behaviors included talking loud especially in the early evening. She stated she was unaware of a time when he tried to hurt himself or try to remove his wanderguard. The psychiatric nurse practitioner who reviewed Resident #85's psychotropic medications monthly was interviewed on 09/19/14 at 3:32 PM. She stated she and the psychologist work closely out of the same office with each other. She stated the facility referred residents for a specific reason and would tell us the symptoms and why the facility was concerned. She stated she has seen Resident #85 for inappropriate assaultive behaviors. She stated with the addition of depakote, Resident #85 was doing better. She	F 241	Nursing or the Assistant Director of Nursing or a Nurse Manager or a Charge Nurse in conjunction with the Interdisciplinary Team will monitor the use of the disposable dishware weekly and determine how long the disposable dishware will need to be used based on the residents condition and physician's order. Between 10/20/14 and 10/23/14 the Administrator observed all facility residents during a meal to ensure that disposable dishware was not being used. No concerns were identified. The Administrator or the Director of Nursing or a facility Department Head will audit five random meals, weekly times four weeks, and then monthly thereafter for three months to ensure all residents are served their meals on appropriate dishware. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Currently, no resident are residing in the facility which use disposable dishware. Any discrepancies identified in the audits will be documented, investigated and corrected immediately by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 7 further stated she had never had concerns about him harming himself. She also stated she was never consulted regarding the need for plastic utensils. On 09/22/14 at 2:14 PM the psychologist was interviewed. She relayed that Resident #85 was never seen for psychotherapy sessions as he was cognitively not suitable for therapy. She stated the facility referred him to her in July 2014 for irritability and being noncompliant at times. She told SW #1 if behaviors continued she could meet with staff for a behavior plan but has not done so. 2. Resident #19 was admitted to the facility on 02/08/11. Diagnoses included depressive disorder. The annual Minimum Data Set (MDS) dated 10/09/13 coded him with moderately impaired cognition, feeling hopeless nearly every day and having no behaviors. The Care Area Assessment (CAA) dated 10/07/13 for cognition stated there would be no care plan because he was alert and oriented, knew the day of the week, season, location of room, staff names and faces. He also knew when and where to eat and smoke. The CAA for psychosocial dated 10/15/13 noted that Resident #19 does not think family visits enough and at times had thoughts of suicide. A nursing note dated 06/22/14 at 7:59 PM stated Resident #19 came to the nursing desk and handed the nurse an aluminum soda can that was smashed in the middle and had a sharp edge. The resident then showed the nurse multiple superficial lacerations to his left wrist and stated "look what I did'. The note stated when	F 241	Administrator. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 8 asked why, he just shrugged his shoulders. When the police arrived he asked for the police officer's gun as it would be a lot easier and quicker. He was subsequently sent to the hospital for an evaluation and placed on 15 minute checks upon his return. A physician ordered psychotherapy on 06/24/14. Review of the psychotherapy notes revealed on 06/30/14 he had fair to good insight to his problem and desired help. Weekly sessions were documented. No other indications of suicidal thoughts were mentioned in the psychologist's notes. The quarterly MDS dated 07/30/14 coded him as being cognitively intact, having no behaviors, and feeling bad about himself for several days. Review of social notes dated 08/05/14 at 6:16 PM stated the resident was sitting on the side of the bed while an aide made up the other bed. He was laughing and talking with the aide and the social worker. He then handed over his metal silver ware from his dinner tray . When asked if he was having thoughts of harming himself, he stated "Today. That's why I'm giving these to you." He stated he wanted his wife to come see him. The note indicated the social worker spoke with resident several minutes and then called the psychiatric nurse practitioner. After he smoked, the resident reported to the social worker he did not have thoughts of harming himself anymore. Social notes dated 09/10/14 at 11:41 AM revealed Resident #19 was not having recent thoughts of depression or hopelessness and he was undergoing psychological treatment for this. The note stated he currently reported no thoughts of	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 9 self harm or harm to others. A care plan, originally developed 10/15/13 and last reviewed on 09/16/14 identified the problem of disturbance in self concept and potential for self harm. The goal was to remain safe and will try not to have thoughts of self harm. One intervention was to monitor room for items that Resident #19 could potentially harm himself with, such as metal silverware and glassware. Resident #19 was observed in the main dining room on 09/15/14 between 12:00 PM and 1:00 PM eating out of a Styrofoam "to go" box, with an attached lid and using plastic silverware. The tray card indicated he should have all paper products. On 09/17/14 at 12:54 PM Resident #19 was observed in his room with his meal tray. The main entree was served in a Styrofoam container with an attached lid and he was provided plastic utensils. He also had a can of tomato juice. Resident #19 was asked why he had plastic and Styrofoam and he replied that he tried to cut his wrist with a knife and a tin can (at which time he pointed to the can of tomato juice.) He further stated that occurred 5 months ago but he was feeling much better and did not feel like he would hurt himself. Interview with Social Worker (SW) #1 on 09/17/14 at 4:05 PM revealed the plastic wear and Styrofoam were due to his suicidal thoughts. She stated Resident #19 has had plastic ware since she came to work at the facility for over a year. She further stated that Resident #19 liked to talk and have family visits. He did much better when he has had company. She further stated that at times he uses metal utensils but the	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 10 decision to use disposable plates and utensils and how long to use them was made by the nursing department. SW #1 stated that when he gave her the metal silverware in August he was laughing and joking. Interview on 09/17/14 at 5:28 PM with the Administrator and Director of Clinical Services stated they could not locate information relating to the start and reason for disposable plates and utensils. On 09/18/14 at 8:05 AM, Resident #19 stated having plastic and Styrofoam at each meal made him feel "weak". On 09/18/14 at 1:53 PM Nurse Aide (NA) #6 stated she had been employed by the facility for 8 months. She stated she was not informed about any special needs or what to observe related to any behaviors. She further stated she was unaware he used plastic utensils and was not sure why he would have them. During follow up interview on 09/18/14 at 2:08 PM, NA #6 stated she was unaware of past suicide tendencies but would report if she heard him talking about hurting himself. An interview was conducted on 09/19/14 at 3:32 PM with the psychiatric nurse practitioner who conducted psychotropic medication reviews. She stated she and the psychologist work closely out of the same office with each other. She stated the facility referred residents for a specific reason and tell us the symptoms and why the facility is concerned. She stated that she met with Resident #19 regularly and stated he had chronic intermittent thoughts and self injurious behaviors and gestures. She stated she did not	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 241	Continued From page 11 recommend the disposable dinnerware and had not been consulted about it. She stated Resident #19 benefited from talking regularly with staff and asking him about any suicidal tendencies. She described him as insightful about what made him feel better. She further stated that she did not think he needed or should have disposable dinnerware. She stated she would be concerned about him handing over metal utensils and expressing thoughts of harming himself if he was also sullen and tearful, not that was accompanied by laughter and smiles. Interview with the psychologist on 09/22/14 at 2:14 PM revealed she saw Resident #19 weekly. She stated he did not pose a threat to himself currently and did not need disposable dinnerware.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to honor the choices for 4 of 4 sampled residents. The facility's policy did not allow any resident to smoke without supervision including 2 residents (Residents' #10 and #44) who were assessed as being safe to smoke independently. In addition,	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 12 the facility failed to honor the choice regarding the number of showers 2 residents preferred to have each week. (Residents #167 and #26). The findings included: 1. Review of the facility's undated Resident Smoking Policy revealed "ALL SMOKERS MUST BE SUPERVISED!" In addition the policy stated "A smoking assessment will be completed to determine your ability to smoke independently"; "Smoking will be allowed at designated times, as determined by Administration and the Smoking Committee"; and "Residents must be assisted at all times when smoking by either a family member or an employee." Each resident who smoked also signed a Resident Smoking Behavior Contract. This contract included that the resident agreed to only smoke in designated areas at designated times. Resident #44 was admitted to the facility on 06/21/13. Her diagnoses included a fracture femur, neurogenic bladder, chronic obstructive pulmonary disease and diabetes. Her admission Minimum Data Set dated 06/20/13 coded her as cognitively intact and having no behaviors. Review of the Smoking Assessment for Resident #44 revealed she had no known history of problems handling smoking materials, understood the facility's rules and restrictions on smoking, had no discolored fingers, had no clothing with holes, extinguished smoking materials in ashtrays, smoked in designated areas, responded to instructions, was not observed giving or selling smoking materials to/or from peers, had not been observed taking butts from ashtrays, floors or peers, had not been	F 242	**F 242** **Corrective action for residents found to have been affected by this deficiency:** The facility's smoking policy, smoking behavior contract and smoking assessment were reviewed and revised in areas of safety tied to a point system to ensure safety and honoring privileges for residents deemed safe to smoke independently. Resident #10 and #44 were re-assessed by the Director of Nursing, Administrator and Social Service Worker for smoking safety and smoking privileges on 10/23/14. Resident #10 was assessed as a supervised smoker. On 10/24/14, the Administrator, Social Worker and Resident #10 attended a care plan meeting. They reviewed the assessment and implemented a plan for resident #10 to become an independent smoker within a month. Resident #44 was assessed as a supervised smoker. On 10/24/14, the Administrator and Social Worker approached Resident #44 to hold a care plan meeting. Resident # 44 stated she did not want to pursue independent smoking at this time because she has plans to discharge home on or around 10/29/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 13 observed using nonsmoking materials to smoke, and was noted with no other problems. The "Conclusion of information" checked that Resident #44 can responsibly handle smoking materials. The assessment noted that the care plan would reflect smoking as supervised. The section relative to the need for protective gear was not marked as needed. This assessment was originally signed as completed on 09/05/13 and remained unchanged when reviewed on 12/10/13, 02/10/14, 05/06/14 and 07/30/14. The annual Minimum Data Set (MDS) dated 05/07/14 coded her as being cognitively intact and having no behaviors. Review of the Care Area Assessments dated 05/15/14 stated Resident #44 was alert and oriented times 3, utilized a motorized wheelchair daily, and smoked 3 to 4 times per daily. Her most recent MDS, a quarterly dated 07/30/14, coded her with having intact cognition. On 09/16/14 at 11:34 AM, Resident #44 stated during interview that she wanted to smoke independently without having a nurse aide always in attendance. She stated there were specific times she was allowed to smoke. She stated the smoking times had decreased and now she only got to smoke 4 times a day. On 09/17/14 at 9:24 AM, Resident #44 was observed outside in the smoking area smoking with a family member. Resident #44 stated at this time that she was allowed to smoke outside the designated smoking times only if accompanied by a family member or visitor. After finishing smoking, Resident #44 was observed	F 242	Resident #26 no longer resides in the facility. Resident #167 no longer resides in the facility. Upon Admission, the Admission's Coordinator or a licensed nurse will interview the resident and/or responsible party regarding the shower preference, using the facility's new Shower Preference form. Residents who are unable to communicate their shower preferences, the responsible party will be asked this information. Quarterly, the Social Worker on the Interdisciplinary Care Team will review the resident's shower preference. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. On 10/21/14, the Staff Development Coordinator in-serviced the nursing staff and nurse aides on the smoking policy and Shower Preference Form. No changes were made to shower refusals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 14 propelling her electric wheelchair back in the building with no problems. On 09/17/14 at 10:23 AM, central supply staff was observed returning from supervising the smoke break. She stated that all smoking materials were kept locked at the A nursing station as no resident was permitted to keep lighters or cigarettes. She stated there was a smoking schedule and no one was permitted to smoke outside of the designated times unless accompanied by a family member. Interview with Social Worker (SW) #1 on 09/17/14 at 10:26 AM revealed all residents who smoke must sign a smoking contract and policy. The facility policy included that no resident was permitted to smoke independently. She further stated assessments were completed to determine who needed a smoking apron. During a follow up interview on 09/17/14 at 4:15 PM, SW #1 stated Resident #44 had been assessed as being able to smoke independently but per the policy in effect when she came to work at the facility, no resident was permitted to smoke unsupervised. She further stated that Resident #44 attended the smoking committee meetings, done in conjunction with resident council and her only voiced complaint was that often staff kept the residents waiting for their designated smoking times. On 09/17/14 at 3:22 PM, Nurse Aide #1 stated she had been here 3 months and had never seen unsafe smoking behaviors involving Resident #44. On 09/17/14 at 4:15 PM Social Worker (SW) #1 stated she assessed Resident #44 and found her	F 242	Upon admission, the Admission Coordinator or a Licensed Nurse will complete the Shower Preference Form. Quarterly, the Social Worker during the Interdisciplinary Team meeting will review the Shower Preference Form to ensure the resident preferences are being honored. The Quality Assurance Committee will audit the residents' smoking and shower preferences monthly. On 10/13/14, the Administrator and residents whom smoke held a meeting and created a new smoking schedule based on safety and resident's preferences. On 10/23/14, the Administrator held a Residents Council Meeting with the residents. The Administrator reviewed the smoking policy, the smoking behavior contract, the smoking assessment and the smoking schedule. **Measures that will be put into place to ensure that this deficiency does not recur:** The Administrator and/or the Director of Nursing will interview 10 random residents, weekly, times four weeks and then monthly thereafter for 3 months to ensure all resident choices regarding shower preferences and smoking, based on safety, are being honored.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 15 to be safe to smoke independently but no one was permitted to smoke independently in the facility per policy. Interview with the Administrator and the Director of Clinical Services on 09/17/14 at 4:49 PM revealed that the policy was developed for safety and it was a company policy not to allow any resident to smoke unsupervised. On 09/18/14 at 2:20 PM Nurse Aide #2 stated she had taken Resident #44 out several times to smoke and described Resident #44 as being very cautious and further stated she had not seen any unsafe smoking practices by Resident #44. Interview with Social Worker (SW) #1 on 09/18/14 at 4:18 PM revealed she was responsible for doing the smoking assessments and observed smoking every Friday. At this time she watched residents to determine their safety needs while smoking. She also stated Resident #44 did not need a smoking apron. 2. Review of the facility's undated Resident Smoking Policy revealed "ALL SMOKERS MUST BE SUPERVISED!" In addition the policy stated "A smoking assessment will be completed to determine your ability to smoke independently"; "Smoking will be allowed at designated times, as determined by Administration and the Smoking Committee"; and "Residents must be assisted at all times when smoking by either a family member or an employee." Each resident who smoked also signed a Resident Smoking Behavior Contract. This contract included that the resident agreed to only smoke in designated areas at designated times.	F 242	The Administrator will interview 2 random smokers, weekly times 3 months, to ensure designated smoking times are being followed by staff. On 10/14/14, the smoking schedule was updated with staff responsible for each designated smoking times. Upon Admission, the Admission's Coordinator or a licensed nurse will interview the resident and/or responsible party regarding the shower preference, using the facility's new Shower Preference form. Residents who are unable to communicate their shower preferences, the responsible party will be asked this information. Quarterly, the Social Worker on the Interdisciplinary Care Team will review the resident's shower preference. In addition, quarterly the Interdisciplinary Team will re-assess the residents whom smoke for smoking safety and smoking preferences, based off of that assessment. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 16 Resident #10 was admitted to the facility on 12/12/13. His diagnoses included chronic pain, pressure ulcers and paraplegia. Review of the Smoking Evaluation dated 12/13/13 noted Resident #10 could safely utilize lighter and matches. Review of the Smoking Assessment, originally dated 12/13/13, for Resident #10 revealed he had no known history of problems handling smoking materials, understood the facility's rules and restrictions on smoking, had no discolored fingers, had no clothing with holes, extinguished smoking materials in ashtrays, smoked in designated areas, responded to instructions, was not observed giving or selling smoking materials to/or from peers, had not been observed taking butts from ashtrays, floors or peers, had not been observed using nonsmoking materials to smoke, and was noted with no other problems. The "Conclusion of information" checked that Resident #10 can responsibly handle smoking materials. The assessment noted that the care plan would reflect smoking as supervised. The section relative to the need for protective gear was not marked as needed. This assessment was originally signed as completed on 12/13/13 and remained unchanged when reviewed on 02/10/14 (on readmission), on 05/07/14 and on 07/30/14. The admission Minimum Data Set dated 12/19/13 coded him as being cognitively intact and having no behaviors. A care plan was originally developed on 12/19/13 for the problem of smoking. This care plan was last reviewed on 07/30/14 with no changes made. The goal was for the resident to remain safe and	F 242	From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 17 smoke at designated times and place under supervision. Interventions included to observed the resident to make sure he complies with the facility policy for smoking and to assist him to and from smoke breaks if necessary. On 09/17/14 at 4:15 PM Social Worker (SW) #1 stated she assessed Resident #10 and found him to be safe to smoke independently but no one was permitted to smoke independently in the facility per policy. The most recent MDS, a quarterly dated 07/30/14, coded him as having intact cognition and no behaviors. On 09/17/13 at 10:52 AM during an interview with Resident #10, the resident stated at times he goes out to smoke and utilizing a vapor cigarette to cut down smoking. He stated he has no desire to quit smoking and thinks he is capable of smoking on his own, unsupervised. He stated he followed all the rules. He further stated the smoking times were set up and sometimes he missed his smoke breaks because the nurse aides were too busy to assist him. He stated it annoyed him. He further stated he had been in 6 other nursing facilities and has had to keep his cigarettes at the desk but was permitted to smoke when he wanted. On 09/17/14 at 10:23 AM, central supply staff was observed returning from supervising the smoke break. She stated that all smoking materials were kept locked at the A nursing station as no resident was permitted to keep lighters or cigarettes. She stated there was a smoking schedule and no one was permitted to smoke outside of the designated times unless accompanied by a family member.	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 18 On 09/17/14 at 3:21 PM Nurse Aide #1 stated she usually has Resident #10 and has never seen unsafe smoking behavior from him. Interview with Social Worker (SW) #1 on 09/17/14 at 10:26 AM revealed all residents who smoke must sign a smoking contract and policy. The facility policy included that no resident was permitted to smoke independently. She further stated assessments were completed to determine who needed a smoking apron. During a follow up interview on 09/17/14 at 4:15 PM, SW #1 stated Resident #10 had been assessed as being able to smoke independently but per the policy in effect when she came to work at the facility, no resident was permitted to smoke unsupervised. She further stated that Resident #10 attended the smoking committee meetings, done in conjunction with resident council and his only voiced complaint was that often staff kept the residents waiting for their designated smoking times. Interview with the Administrator and the Director of Clinical Services on 09/17/14 at 4:49 PM revealed that the policy was developed for safety and it was a company policy not to allow any resident to smoke unsupervised. On 09/24/14 at 1:49 PM SW #1 stated that although she completed the smoking assessments she was never trained in how she was to complete them. 3. Resident #26 was admitted to the facility on 01/14/14. Her diagnoses included cerebral vascular accident, being hard of hearing, arthritis, depression and hypertension.	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 19 The admission Minimum Data Set (MDS) dated 1/22/14 coded her as being cognitively intact and having no behaviors. The most recent quarterly MDS dated 07/09/14 coded her as being cognitively intact and having no behaviors. On 09/16/14 at 9:27 AM during interview, Resident #26 stated she was not offered a choice of the number of times a week she received showers. She further stated she would prefer them more often. On 09/17/14 at 3:13 PM Nurse Aide (NA) #3 stated that she has not heard Resident #26 voice concerns about showers but that if a resident requested an extra shower, staff would provide it. The nursing department made up the shower schedule. On 09/17/14 at 3:52 PM The MDS nurse stated during interview that nursing sets up the shower schedules and social services handled any problems about showers that arise. Anyone on the interdisciplinary team was able to adjust shower schedules to meet a resident's preference. On 09/17/14 at 4:21 PM Social Worker (SW) #1 stated residents usually get 2 showers a week and residents could get more showers upon request. She further stated the nursing department handled the preferences for showers. Social service staff told the residents that if they have any concerns they should tell someone. On 09/17/14 at 5:35 PM, the Administrator stated that when she started here, she utilized a resident interview satisfaction survey to gain an idea of what the residents thought were some of the	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 20	F 242		

problems in the facility. She stated the questions on the survey were directly taken from the surveyor questions which included questions about shower preferences. The Administrator further stated that Resident #26 was never interviewed with the satisfaction survey as Resident #26 was identified by staff as not being alert and oriented.

During a follow up interview with Resident # 26 on 09/18/14 at 2:00 PM, the resident stated she would like 3 showers per week.

On 09/22/14 at 10:22 AM the Director of Nursing stated that she was not sure how the shower schedule was selected. She further stated that when the administrator came, she wanted to do interviews to determine resident's preferences and satisfaction with things. The DON confirmed Resident #26 was interviewable.

4. Resident #167 was admitted on 09/03/14. His diagnoses included diabetes, hypertension, cerebral vascular accident and post surgical repair of a ruptured hernia.

The admission Minimum Data Set dated 09/10/14 coded him as having intact cognitive skills.

Resident #167 was interviewed on 09/15/14 at 3:51 PM. During this interview, the resident stated he only received 2 showers a week and would like one every other day. This choice remained consistent when interviewed again on 09/17/14 at 2:30 PM.

Interview with Nurse Aide (NA) #7 revealed since admission, Resident #167 had been given 2 showers per week. She had never heard him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 21	F 242		

request additional showers. She further stated that if a resident requested more showers per week, they would be given extra showers.

On 09/17/14 at 3:52 PM The MDS nurse stated during interview that nursing sets up the shower schedules and social services handled any problems about showers that arise. Anyone on the interdisciplinary team can adjust shower schedules to meet a resident's preference.

On 09/17/14 at 4:21 PM Social Worker (SW) #1 stated residents usually get 2 showers a week and residents can get more showers upon request. She further stated the nursing department handled the preferences for showers. Social service staff tell the residents that if they have any concerns they should tell someone.

On 09/17/14 at 5:35 PM, the Administrator stated that when started here, she utilized a resident interview satisfaction survey to gain an idea of what the residents thought were some of the problems in the facility. She stated the questions on the survey were directly taken from the surveyor questions which included questions about shower preferences. The Administrator subsequently provided the satisfaction survey which had been completed by the medical record clerk for Resident #167.

On 09/19/14 at 2:15 PM, the medical record clerk stated she had talked with Resident #167 and completed the satisfaction survey. She recalled family was in the room with him at the time. The medical record clerk and the surveyor reviewed the completed satisfaction survey which was dated 09/10/14. Per this survey, Resident #167 indicated that he did not have a choice as to how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 242	Continued From page 22 many times a week he received a shower. The medical record clerk stated that she recalled the conversation and verified that the resident and/or his family stated he did not get to choose the number of times he received a shower each week. She further stated she failed to follow up with a concern form which would have been reviewed with him and a new shower schedule arranged. On 09/22/14 at 10:22 AM the Director of Nursing stated that she was not sure how the shower schedule was selected. She further stated that when the administrator came, she wanted to do interviews to determine resident's preferences and satisfaction with things. On 09/22/14 at 2:15 PM Resident #167 stated that he was used to taking showers at least 5 times per week when at home. He stated he probably did not need a shower that many times in the facility, however, no one had ever come in and asked his preferences for the number of times he would like to shower. Usually someone just comes in and says, its time for your shower and he goes.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 23 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview, and staff interview, the facility failed to comprehensively assess 5 of 26 sampled residents identifying how the condition affected each resident's function and quality of life. This included assessing psychotropic medications for Resident #19, #26 and #44; dental for Resident #84; and catheter for Resident #10.	F 272	**F 272** **Corrective action for residents found to have been affected by this deficiency:** Resident #84's RAI (Resident Assessment Instrument) was updated by an MDS (Minimum Data Set) Nurse to reflect that the resident has no natural teeth. The RAI was updated to reflect the resident's past condition to the last comprehensive assessment condition. Resident #84's dentist appointment is scheduled for 10/30/14. Resident #19, #26 and #44's RAI's were updated to reflect the resident's past condition to the last comprehensive assessment condition. Including dental needs, catheters and psychotropic medications. Resident #10's RAI was updated to identify the resident's past condition to the last comprehensive assessment condition. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. All Residents had their RAI updated to reflect the resident's past condition to the last comprehensive assessment condition. This was completed by 10/23/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 24 The findings included: 1. Resident #84 was admitted to the facility on 03/11/14 with diagnoses including cerebral atherosclerosis, obstructive sleep apnea, diabetes, and chronic airway obstruction. The admission Minimum Data Set (MDS) dated 03/19/14 coded her with having intact cognition, receiving a mechanically altered diet and having no natural teeth. The Care Area Assessment (CAA) dated 03/21/14 for nutrition indicated a mechanical soft, no added salt and low concentrated sweet diet was ordered due to diabetes and chewing problems. The CAA for dental dated 03/24/14 stated the resident required assistance with hygiene and that staff set up and assist her with oral care. The CAA continued stating that no care plan would be developed because oral care was provided routinely by nursing staff in the morning and evening. The CAA did not mention that Resident #84 had no natural teeth or dentures. The CAA failed to identify the individual's condition, strengths, needs, the causes and contributing factors for the lack of natural teeth, and analyze how the lack of natural teeth affected the resident's function and well-being. On 09/15/14 at 5:08 PM Resident #84 stated during interview that she did not have any teeth and would like dentures. She was observed at this time with no natural teeth or dentures in place.	F 272	The former MDS RN was replaced with a new MDS RN. The former MDS Licensed nurse is no longer completing the MDSs. **Measures that will be put into place to ensure that this deficiency does not recur:** On 10/21/14, the Staff Development Nurse in serviced the new MDS RN and the Licensed Nurse on Chapter 4 -Care and Assessments (CAA) Process and Care Planning of CMS's RAI Version 3.0 Manual. The new MDS RN changed the way MDS's are being completed; who will complete them; how the information is gathered; how the CAA's will be gathered. In addition, a MDS nurse will document a RAI note with every assessment. The MDS Nurses will audit all new MDS's and quarterly assessments for accuracy which will include but is not limited to psychotropic medication, dental problems and catheter issues. The MDS nurse will ensure the assessments are accurate, complete and solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 25 On 09/17/14 at 1:06 PM Resident #84 was observed eating her meal. She was picking out the carrots and peppers from the macaroni salad and was not eating the cabbage. She stated these items were too hard to chew without teeth. She further stated that if she had dentures, she could eat everything on her tray. Resident #84 was not included in the list of residents who saw the facility dentist on 04/08/14 per interview with the medical record clerk on 09/17/14 at 4:38 PM and per telephone interview with the dental staff conducted on 09/19/14 at 12:13 PM. Interview with the former MDS nurse on 09/22/14 at 11:20 AM revealed that sometimes the information for a specific CAA was located in another CAA. Review of the other CAAs for Resident #84 revealed no other information related to her dental needs. 2. Resident #19 was admitted to the facility on 02/08/11. Diagnoses included depressive disorder, history of drug abuse, and cerebral vascular accident. The annual Minimum Data Set (MDS) dated 10/09/13 coded him with moderately impaired cognition, feeling hopeless nearly every day, having thoughts of being better off dead and feeling bad about himself nearly everyday, and having no behaviors. The Care Area Assessment (CAA) for psychotropic medications dated 10/14/13 stated that Resident #19 received antipsychotic, antidepressant, antianxiety, and sedative medications. The description of the problem was	F 272	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The MDS RN will report the findings to the Quality Assurance Committee monthly. Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Director of Nursing. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 26	F 272		

that he had a history of depression and neuralgia, a history of arthritis and irritable bowel syndrome. He currently received the medications of Abilify, Xanax, Wellbutrin and Ambien. He was noted to also take hydrocodone, Fentanyl patches and neurontin daily (pain medications). He was at risk for oversedation, falls and adverse reactions. This CAA included adverse consequences to the different medication categories. The CAA failed to identify the individual's condition, strengths, needs, progress and prognosis, and address the causes and contributing factors for the need of each medication, and analyze how the psychotropic medications affected the resident's function and well-being.

Interview with the former MDS nurse on 09/22/14 at 11:20 AM revealed that sometimes the information for a specific CAA was located in another CAA. Review of Resident #19's other CAAs revealed he had impulsivity, depression, increased irritability or frustration, behaviors that impact interpersonal relationships and thoughts of suicide. The former MDS nurse could not show how these issues were analyzed with strengths and weakness when assessing the psychotropic medications.

3. Resident #26 was admitted to the facility on 01/14/14. Her diagnoses included cerebral vascular accident, arthritis, depression and hypertension.

The admission Minimum Data Set (MDS) dated 1/22/14 coded her as being cognitively intact and having no behaviors. The most recent quarterly MDS dated 07/09/14 coded her as being cognitively intact, having no behaviors. She was coded as receiving antianxiety and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 27 antidepressant medication for the previous 7 out of 7 days. The Care Area Assessment (CAA) dated 01/27/14 for psychotropic medications described the problem as Resident #26 being admitted to the facility with diagnoses of depression, anxiety , hypertension, and cerebral atherosclerosis. She was admitted on Ativan routinely and cymbalta daily. Her osteoarthritis was very painful to her and she required extensive to total assistance with activities of daily living skills. The note CAA continued stating Resident #26 was at risk for oversedation and side effects. The CAA noted she was on an antidepressant, antianxiety and sedative and listed the adverse effects and consequences of the medications. The CAA failed to identify the individual's condition, strengths, needs, progress and prognosis, and address the causes and contributing factors for the need of each medication, and analyze how the psychotropic medications affected the resident's function and well-being. Interview with the former MDS nurse on 09/22/14 at 11:06 PM revealed that sometimes the information for a specific CAA was located in another CAA. Reviewing the other CAAs, the former MDS nurse could not show how these issues were analyzed with strengths and weakness when assessing the psychotropic medications. 4. Resident #44 was admitted to the facility on 06/21/13. Her diagnoses included a fracture femur, neurogenic bladder, chronic obstructive pulmonary disease and diabetes. Her admission Minimum Data Set dated 06/20/13 coded her as cognitively intact and receiving antianxiety and	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 28 antidepressant medication 7 out of the last 7 days. The Care Area Assessment (CAA) dated 05/15/14 identified her fractured ankle, a fusion of the cervical spine, hip replacements, stents in her femoral arteries, activities of daily living skills, history of skin issues, incontinence, and lack of pain. The only mention of psychotropic medications included that she received Ativan and Effexor daily for anxiety and depression. The CAA noted her desire to go home but that inability due to having no care giver. The CAA failed to identify the individual's condition, strengths, needs, progress and prognosis, and address the causes and contributing factors for the need of each medication, and analyze how the psychotropic medications affected the resident's function and well-being. Interview with the former MDS nurse on 09/22/14 at 11:06 PM revealed that sometimes the information for a specific CAA was located in another CAA. She reviewed the other CAAs but was unable to show where the psychotropic medications were comprehensively assessed. 5. Resident #10 was admitted to the facility on 12/12/13. His diagnoses included pressure sores, spinal cord injury, chronic airway obstruction, chronic pain, depressive disorder, neurogenic bladder and bowel obstruction secondary to adhesions. The admission Minimum Data Set 12/19/13 coded him as being cognitively intact, and having an ostomy and catheter. The Care Area Assessment (CAA) dated	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 272	Continued From page 29 12/23/14 for incontinence described the problem of resident having a colostomy and suprapubic catheter and being at risk for infection and skin irritation. The CAA dated 12/23/14 for Activities of Daily Living skills stated he had paraplegia and required assistance for all movements and had a colostomy and suprapubic catheter that was cared for by staff. The CAA failed to identify the individual's condition, strengths, needs, the causes and contributing factors for the colostomy or suprapubic catheter, and analyze how this affected the resident's function and well-being. Interview on 09/22/14 at 11:20 AM with the previous MDS nurse confirmed the area of the catheter was not comprehensively addressed.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 30 each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family and staff interviews, the facility failed to inform 1 of 9 residents, deemed competent, of a change in treatment. (Resident # 24). Findings included: Resident #24 was admitted to the facility on 08/30/12. Resident #24 ' s diagnoses included vascular dementia, cerebral vascular disease with paraplegia, depression, hypertension and diabetes mellitus. The most recent Minimum Data Set (MDS) dated 11/12/13 and 07/22/14 coded Resident #24 as cognitively intact, able to understand and be understood. Record review of Resident #24 ' s face sheet listed him as his own responsible party with his family member as his durable health power of attorney. Review of a nurses note dated 12/13/13 at 3:59 PM revealed a nurse observed Resident #24 with his hands between a female resident's legs. As the nurse walked toward Resident #24 the resident removed his hand from the female's legs. The note further documented that the nurse separated the 2 residents immediately and Resident #24 was returned to his room and placed on 15 minute checks. On 12/13/13 at 7:30 PM resident #24 was transported to the hospital for a psych evaluation and treatment and	F 280	**F 280** **Corrective action for residents found to have been affected by this deficiency:** Resident #24 will be informed of any change of treatment. The resident is no longer on the medication identified in this deficiency; it was discontinued on 12/22/13, prior to the survey. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. On 10/13/14. the Staff Development Coordinator in serviced the nursing and social service staff on each resident's right to participate in their plan of care (unless incapacitated) which includes being informed of changes or additions in their care, treatment, medications and that resident and/or RP (responsible party) must be informed anytime there is a change to care/treatment/medication and documented in the medical record. The Director of Nursing, or the Assistant Director of Nursing, or a nurse Manager, or the charge nurse or the resident's nurse will address with the prescribing medical practitioner the need to obtain informed consent for medications/treatments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 31 returned to the facility at 10:00 PM with diagnoses of aggression. Resident #24 denied the allegation of inappropriate touching. Resident #24 was placed on 1:1 supervision from 12/20/13 until discontinued on 01/02/14. On 01/30/14 the psychiatric nurse practitioner evaluated him and indicated resident #24 ' s insight was questionable. Review of the medical record revealed a physician order dated 12/19/13 for Resident #24 to receive estrace 1 milligram po daily related to sexual behaviors. Record review of the December 2013 Medication Administration Record revealed Resident #24 received estrace 1 milligram po daily from 12/20/13 through 12/22/13 until an order was written to discontinue the estrace 1 milligram po daily on 12/22/13. On 09/17/14 at 5:01 PM an interview was conducted with Resident #24. He revealed he did not recall whether he had received a hormone or not. He knew he had received insulin shots for his diabetes. He stated staff had not discussed an order for a hormone. He reported that if staff had told him he had an order to receive a hormone he would tell them to get out of his room. On 09/24/14 at 2:21 PM a follow-up interview was conducted with Resident #24. He revealed he was his own health power of attorney and his family member was his health durable power of attorney. He stated that his family member would make decisions about his health care treatment only if he was not capable of doing it. He reported the facility physician had not talked with	F 280	**Measures that will be put into place to ensure that this deficiency does not recur:** The Nursing Department was re-organized from a three Unit Coordinator model to an Assistant Director of Nursing, a Charge Nurse and a Staff Development model in August 2014. The Director of Nursing and the Administrator put this new system into place on an ongoing basis. The Director of Nursing, or the Assistant Director of Nursing, or a Nurse Manager, will monitor the changes thru an audit of five random medical records every week, times four weeks for three months to ensure all residents and/or responsible parties are informed of any change in medication/treatment. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Director of Nursing. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 32 him about an order for a hormone medication. On 09/19/14 at 11:40 AM an interview was conducted with Resident #24's family member. She said she was notified by the facility on 12/13/13 that an incident had occurred where Resident #24 was observed to have placed his hands between a female resident's legs. She reported staff told her they had put Resident #24 on 24 hour watch and he was going to be sent to the hospital for a psychological evaluation. The family member revealed she had been called by a nurse at the facility on 12/19/13 about an order for a female hormone. The family member stated the nurse told her the medication was prescribed by the physician to address the resident's sexual inappropriateness. The family member stated she did not want the resident to have the medication until an evaluation was completed by the physician. She reported that Resident #24 would not have wanted to take a female hormone. The family member said she had not talked with the physician about the order. She had called the former Administrator and found out Resident #24 had taken a dose or two and he had assured her it had been discontinued. The family member said she talked with Resident #24 about the order for the female hormone and asked him if any staff had talked to him about the medication. She said he told her no one had talked to him about the medication and he told his family member he would not have taken the medication. Review of Resident #24 ' s medical record revealed no documentation in nurse's notes, or physician progress notes that staff or the physician had discussed with the resident an order for a female hormone.	F 280	If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 33 On 09/19/14 at 2:05 PM an interview was conducted with Nurse #2 on Resident #24's hall. She revealed Resident #24 had inappropriate touching with staff and residents and the family member had been notified by phone on 12/19/13 of the order for a female hormone medication. The nurse stated the family member had no complaint about the order and she thought the order had been discontinued on 12/22/13 by an on call physician. The Nurse Unit Manager stated that if a resident was their own responsible party for health care decisions medication treatment orders and treatment changes should have been discussed with the resident. On 09/22/14 at 4:43 PM an interview was conducted with Nurse #6 who had received, by telephone, an order from the physician for a female hormone after she had told the physician about the incident of Resident #24 being sexually inappropriate with a female resident. The nurse said she remembered calling the family member to inform her of the order for the female hormone to address Resident #24 ' s sexual inappropriate behavior toward a female resident and to prevent any possible incidents in the future. She said the family member told her she was going to research the hormone medication for side effects. The nurse stated she told the family member she was free to talk with the Director of Nursing or Administrator if she had questions. The nurse said the family member never told her not to start the medication and the conversation ended. She said she had not remembered talking to the resident about the medication. She revealed the resident should have been notified of the treatment order. She further revealed she had not talked to the physician about the concerns the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 34	F 280		

family had raised about the medication. The nurse stated when the physician does rounds with residents the physician would discuss with a resident who was alert and oriented and his/her own responsible party a medication treatment order and reasons for the treatment order.

On 09/23/14 at 10:00 AM an interview was conducted with Nurse #7 who had discontinued the female hormone order for Resident #24. The nurse said she had been at the nurses station when Resident #24's family member approached her and requested a list of Resident #24's medication. The nurse stated she gave the medication list to the family member and when the family member read the list she noted Resident #24 had received the female hormone and she had not wanted him to have it and wanted it discontinued. The nurse said the family member knew the reason for the medication treatment order but she wanted the nurse to call the Administrator to have the physician discontinue the medication. The nurse said it was a weekend and she called the on call physician to have the female hormone medication discontinued because the family requested that Resident #24 not be on it. The nurse revealed a telephone order was received to discontinue the medication on
12/22/13. The nurse stated she had not discussed the medication treatment order with Resident #24, only the family member. The nurse reported the medication treatment order should have been discussed with Resident #24 since he was his own responsible party for health care decisions.

On 09/23/14 at 12:35 PM an interview was conducted with the physician (Medical Director)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 35 who had prescribed the order for the female hormone. He stated it was not unusual for a resident sexually acting out to consider the use of estrogens to decrease the sexual drive. He said a female hormone was not meant to be used in males for prolonged periods of time and only used for a short period of time to suppress the sex drive. The physician revealed the last time he had seen Resident #24 was on 12/02/13. He stated he did not talk with the daughter or the resident about the medication treatment order. The physician reported the nurse would have called one of the physicians to discontinue the order. On 09/24/14 at 5:00 PM an interview was conducted with the Director of Nursing DON) and Administrator. They both revealed the expectation was that if a resident had been designated as his/her own responsible party for health care decisions the resident should be notified by staff and the physician about medication treatment orders, changes in medication, and any other health care decisions. .	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 280	Continued From page 36	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to supervise and implement interventions for 2 of 10 residents, (Residents #122 and #101), who were non-compliant regarding the facility's smoking rules. In addition the facility failed to keep chemicals out of the reach of the residents residing on 1 of 3 units. (Unit C). Immediate Jeopardy began on 04/30/14 when	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 37 Resident #122, with a known history of unsafe smoking behaviors, smoked on the facility's premises in a nondesignated smoking area and unsupervised while having an oxygen tank, located on the back of his wheelchair, turned on and the nasal cannula hanging on the wheelchair. Immediate Jeopardy was removed on 09/24/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to resident smoking and for noncompliance for examples #2 and #3. The findings included: The facility's undated Resident Smoking Policy stated "All smoking materials are required to be maintained at the nursing station", "Residents must be assisted at all times when smoking by either a family member or an employee", "Smoking will be allowed at designated times, as determined by Administration and the Smoking Committee." 1. Resident #122 was admitted to the facility on 01/16/13 with diagnoses including acute chronic respiratory failure, chronic obstructive pulmonary disease, and tobacco use. A care plan dated 08/09/13 identified the problem of Resident #122 not abiding by the smoking policy, smoking without staff supervision and during non-smoking times. Interventions were to monitor him closely when observed going to the	F 323	**F 323** **Corrective action for residents found to have been affected by this deficiency:** Resident #122 no longer resides at this facility. 1. On 7/7/14, the Administrator became aware that Resident #122 was caught smoking after his smoking privileges had been revoked. 2. On 7/7/14, the Administrator met with Resident #122 and informed him that he would be issued a 30 day notice for failure to adhere to the facilities Smoking Policy. He was informed at that time that the facility had found placement for him at another facility. He was given the option of the 30 day notice or placement at another facility. The resident choose placement at another facility and was discharged to that facility on 7/9/14. 3. On 7/7/14, 7/8/14 and 7/9/14, Resident #122 had a room search completed by the Administrator and Director of Nursing for smoking material- no smoking material was found during those searches.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 38 smoking area during non-smoking times, alert the supervisor, advise him if caught smoking against the rules that he is non-compliant with smoking rules and his smoking times would be suspended. An additional intervention included to ask the resident if he had any tobacco products on his person or if he was in possession of a lighter. A smoking assessment dated 09/03/13, signed by Social Worker (SW) #1 included that Resident #122 did not extinguish smoking materials in an ashtray, smoked in non-designated areas, and had been observed giving smoking materials to and /or from peers. The conclusion was "Resident can responsibly handle smoking materials." This assessment included that a care plan would indicate he needed supervision. Review of social service notes revealed Resident #122 smoked against the rules as follows: *On 11/04/13 it was reported to the SW the resident was sitting on the patio with another resident smoking. When approached, the resident dropped his cigarette down by his side. Explained to the resident he was smoking unattended and at a time that was not designated. The residents were sitting in an area where there were no ash trays, they were sharing cigarettes and had cigarettes and a lighter on them. Due to violating the smoking policy, Resident #122's smoking privileges were suspended for 24 hours. Reviewed the smoking policy and the smoking behavior contract with the resident. Resident #122 stated his understanding. *On 11/13/13 after all the smokers ended their designated smoke break, Resident #122 was noted off to the side of the building with his	F 323	4. On 7/7/14, 7/8/14 and 7/9/14, Resident 122 was frequently monitored every hour during business hours by the Administrator and Director of Nursing- There were no further smoking incidents identified. 5. On 7/7/14, the Resident Smoking Policy was enforced and resident 122 had immediate discontinuation of his smoking privileges. **Resident #101 smoking privileges have been revoked due to failure to follow the facilities smoking policy and behavior contract.** **On 9/18/14, a unit sweep, which included a room sweep on the dementia unit was completed. Any items which could be potentially hazardous to residents were removed so that they were not accessible to residents.** **On 10/21/14, all staff were in serviced by the Staff Development Coordinator on the new smoking policy and assessment.** **On 10/21/14, all staff were in serviced by the Staff Development Coordinator on hazardous chemicals which must be kept out of residents reach.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 39 oxygen tank on the back of his wheelchair smoking a cigarette. The nurse was notified and took the cigarette and lighter from him. This was his second offense and under the policy his smoking privileges were to be revoked. Will arrange to have his room searched for more cigarettes and lighters. *On 11/27/13 Resident #122 was observed by the Administrator outside smoking in the B station patio. This was the resident's third offense. Explained the dangers of smoking with oxygen. His room was searched and cigarettes and a lighter were found. A cigarette was found in the resident's jacket pocket. Administrator explained he would be issued a 30 day discharge notice. Interview with SW #2 on 09/22/14 at 2:05 PM revealed that Resident #122 had his smoking privileges taken away at least twice and the former Administrator would always give him back the privileges. He was unable to provide any time frames or documentation of when the resident's smoking privileges were removed or reinstated. Interview on 09/22/14 at 4:01 PM with SW #1 revealed the Administrator was supposed to give the resident a 30 day notice but never did. She stated that during a search of his room, unknown date, a lighter and cigarette was found. After this, nurse aides were to search his room but SW #1 did not know of any set schedule or set person responsible for searches. Interview on 09/23/14 at 11:39 PM with SW #2 and SW #1 revealed no discharge notice was ever given to Resident #122 because no alternative placement for him could be located and then looking for alternative placement was dropped. On 12/04/13 the smoking care plan for Resident	F 323	**A new smoking assessment was created to allow residents to smoke independently based on safety and preferences. The last smoking policy did not allow for independent smoking. The new assessment was implemented on 10/23/14.** **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. On 7/7/14, the Administrator reviewed the Resident Smoking Policy, the Resident Smoking Behavior Contract and the Resident Smoking Schedule. In addition, the Administrator ensured all resident smoking material was kept behind lock and key in the medication room, the Administrator visualized the "smoking box" and went out to the "smoking area" to ensure staff were present during the resident's smoke break, "designated smoking area" and "no oxygen in use" signs were posted, how staff distributed and collected the smoking paraphernalia and how residents disposed of cigarettes butts. In addition, the Administrator ensured the facility had a fire blanket and smoking aprons available for resident use. 1. On 7/9/14, the Administrator, Director of Nursing and Social Service Worker met with all the facility residents who smoke	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 40 #122 was reviewed with no changes to the interventions. The care plan reviewed on 12/04/13 was not changed to reflect his smoking privileges had been revoked. The smoking assessment was reviewed on 12/10/13 with no changes . The Care plan conference note dated 12/11/13 noted he was caught smoking in his room recently. This note made no mention of interventions related to his unsafe smoking. The Minimum Data Set, a quarterly dated 03/10/14, coded Resident #122 as cognitively intact, having no delirium, no behaviors, and needing supervision to limited assistance with most activities of daily living skills. He utilized a wheelchair for mobility and was on oxygen. No changes were made to the care plan in relation to smoking issues. The smoking assessment was not reviewed at this time. Nursing notes dated 04/30/14 at 6:44 PM revealed at 5:05 PM while out of the facility at a friend's house, Resident #122 had his oxygen on while smoking. He returned to the facility with burns to the left and right side of his face next to his nose and a burn noted to the tip of his nose. Additional nursing notes dated 05/01/14 at 12:26 AM revealed that at approximately 6:15 PM (on 04/30/14) Resident #122 asked to go outside and sit for a few minutes. The resident was directed to go to the B station patio. Before he went outside the nurse asked if he had any cigarettes in his pocket, which he denied. Approximately 10 minutes later he was observed smoking a cigarette with an oxygen tank on his wheelchair and his nasal cannula removed from his nose. Resident #122 stated he found the cigarette on the ground already burning. He was re-educated	F 323	and reviewed the Resident Smoking Policy, the Resident Behavior Contract, Resident Smoking Schedule and answered all questions regarding the enforcement of the Resident Smoking Policy. It was stressed to all of the residents who smoke that the facilities Resident Smoking Policy would be enforced from here on out. 2. On 9/22/14, the Resident Smoking Assessment was updated to read "has the resident been observed giving/selling/offering smoking material to and/or from peers". The word "offering" was added to the assessment and would be considered an unsafe behavior. 3. On 9/23/14, an audit was started by the facilities Social Service Workers to ensure all residents whom smoke were re-assessed for smoking safety and have reviewed and signed the Resident Behavior Contract regarding the Resident Smoking Policy. The audit was completed on 9/24/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 41 on smoking in nondesignated areas and the risk of smoking with oxygen. The care plan was updated on 05/01/14 for burning himself while smoking. New interventions included Resident #122's smoking privileges were revoked, periodic room checks for contraband in relation to smoking were to be completed, and the resident was educated on revoking his smoking privileges. The care plan was updated on 05/01/14 noting Resident #122 had smoking privileges revoked. Review of physician orders revealed nicotine patches were ordered on 05/01/14 and the Medication Administration Record revealed the patch was started on 05/02/14. A physician progress note dated 05/02/14 noted he had blisters, a second degree burn, from smoking with his nasal cannula in place. The note stated the resident's smoking privileges were then revoked as he "is obviously a danger." The smoking assessment was reviewed on 05/02/14 with no changes made. Social notes dated 05/02/14 at 11:39 AM revealed the DON, Administrator and unit manager met with Resident #122 and told his smoking privileges were revoked indefinitely and his room and person would be subject to periodic searches for any smoking material, lighters and/or matches. Interview with SW #2 on 09/22/14 at 2:28 PM revealed upon his return with the burns, his room was searched and a lighter and cigarettes were found and removed. she was unsure if the room was ever searched again. Interview with SW #2 on 09/22/14 at 2:38 PM	F 323	4. On 9/23/14, all residents who use oxygen have had a sign placed on their wheelchair which states "No Smoking". Any ambulatory residents will have a "No Smoking" sign placed on their portable oxygen E-tanks. o The facility has 13 residents who smoke. Out of those 13 residents- 1 resident uses a BiPAP at night, two residents use oxygen in their room as needed and one resident returned from the hospital on 9/22/14 with a new order for continuous oxygen. For the residents who use oxygen, when they go outside to smoke the oxygen will be left inside the facility while they are smoking. 5. On 9/24/14, the nursing notes and the social service notes from 9/23/14 at 6:00 AM through 9/24/14 at 6:00	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 42 revealed he was unaware if the room was ever searched after he burned himself. Interview with the Director of Nursing on 09/23/14 at 11:24 AM revealed the Administrator was responsible for the daily rounds and checking on Resident #122's smoking paraphernalia and she would check a couple of times per week. An inservice for all nursing staff was held on 05/14/14 to review the smoking policy, smoking areas and inform the staff a camera was placed at B station to ensure smoking policies were being followed. The quarterly MDS dated 06/04/14 coded Resident #122 as cognitively intact and having no behaviors. The care plan was updated 06/05/14 to monitor closely during smoking times to ensure he does not place tobacco products on his person. Monitor smoking area randomly during non-smoking times to ensure he is not smoking. If seen smoking when he is not supposed to approach him and explain the violation. Another addition was that his smoking privileges were revoked indefinitely on 05/02/14. No documentation of room or personal searches for contraband were found in the medical record or provided by staff. There was no documentation of monitoring of the nonsmoking area or the smoking area at non designated times in the medical record. SW #1 stated on 09/22/14 at 2:28 PM that as of 05/01/14, Resident #122 was never allowed to smoke again on facility premises. At that time he had a nicotine patch, used skoal and vapor cigarettes.	F 323	AM, were reviewed by the Director of Clinical Services. No concerns were identified with residents smoking inside the facility and/or smoking while wearing oxygen and/or unsupervised. **On 10/13/14, the Administrator had a meeting with the residents who smoke and other Resident Council members and revised the smoking schedule to better meet the resident's preferences.** **On 10/21/14, all staff were in serviced by the Staff Development Coordinator on the new smoking policy and assessment. Included in the in service was that no portable O2 can be in the smoking area during smoke breaks.** **On 10/21/14, all staff were in serviced by the Staff Development Coordinator that hazardous chemicals must be kept out of residents reach.** **On 10/23/14, the Administrator met with the residents who smoke and other members' of the Residents Council and reviewed the smoking policy, the smoking behavior contract, the smoking assessment and the new smoking schedule.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 43 The Medication Administration Record revealed Resident #122 had refused the nicotine patch on 06/25/14, 06/26/14 and on 06/27/14. Physician orders revealed that the nicotine patch was discontinued on 06/27/14 due to resident refusal. Nursing notes dated 07/06/14 at 7:12 PM stated at approximately 6:00 PM Resident #122 was outside on the patio off B station with one cigarette lit. The nurse went out, explained concern he was smoking with oxygen on. This nurse noted she did not find any other cigarettes on him. Telephone interview on 09/23/14 at 10:41 AM with the nurse who observed this (Nurse #1) revealed she had heard him ask someone to pick him up some cigarettes earlier in the shift. She became suspicious when he was being pushed around in his wheelchair by another resident and went to check on him while he was outside B station patio. The second check she made on him was when she observed him smoking. She stated the nasal cannula was off his face, however, the oxygen tank was turned on and running. Nurse #1 stated she told the other nurses and reported it to the oncoming nurse. She did not tell the Administrator or the Director of Nursing. She further stated she never checked his room for additional cigarettes or lighters. A social service note dated 07/07/14 at 11:07 AM stated SW #2 observed Resident #122 sitting in his wheelchair on the sidewalk outside B hall. The SW noted he observed smoke coming from the resident's mouth. As the social worker approached, the resident dropped the cigarette on the ground and stepped on it then quickly replaced his oxygen nasal cannula. Interview with SW #2 on 09/22/14 at 4:01 PM revealed he could not recall if the oxygen tank was running at	F 323	**On 9/18/14, the facility Department Heads completed a facility sweep and ensured any items which could be potentially hazardous to residents were removed so that they were not accessible to residents.** **<u>Measures that will be put into place to ensure that this deficiency does not recur:</u>** 1. In-servicing for all staff was started on 9/23/14, by the facility Staff Development Coordinator. At this point 67 out of 146 have been in-serviced. Facility staff will not be able to work until they are in-serviced. The in-service addressed the following: a. Resident Smoking Policy, which included steps taken for violation of policy b. Resident Smoking Behavior Contract, which included resident acknowledgement and understanding of the facilities Resident Smoking Policy c. Resident Smoking Schedule	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 44 the time he was caught smoking. At this time, the new administrator who came to work on 07/07/14 instructed SW to discharge Resident #122. Resident #122 was discharged from the facility on 07/09/14. On 09/23/14 at 11:39 AM, SW #1 and #2 were interviewed. This conversation revealed that Resident #122 did not want to quit smoking. His smoking privileges were revoked multiple times but the previous administrator reinstated the privileges multiple times. Interview with the Administrator and Director of Nursing (DON) on 09/22/14 at 4:01 PM revealed that as soon as the new Administrator started working, the DON told her Resident #122 had to be discharged. The Administrator immediately told the SWs to find an alternative placement for Resident #122. The Administrator stated that she met with all the residents who smoke in the facility. The rules and behavior contracts were reviewed and the residents were informed that the smoking rules would be strictly enforced. Both the Administrator and the DON revealed that they were aware of no other times a resident was observed smoking unsupervised or in a nondesignated area since Resident #122 was discharged on 07/09/14. Both stated the issue was resolved based on Resident #122 being discharged. Credible Allegation of Compliance for F323 The facility provides the following information to show that all the residents at Willow Ridge Rehabilitation and Living Center are safe from the discrepancies identified.	F 323	d. Smoking Assessment, which will be completed quarterly e. Hazards of smoking, which included smoking with oxygen f. Smoking material to be kept behind lock and key g. Staff are to smoke in designated staff smoking areas only h. Staff to ensure their personal belongings, including but not limited to smoking material are kept out of the reach of the residents at all times. i. Reporting incidents, in which residents and/or staff fail to follow the facilities Smoking Policy to the Administrator and/or Director of Nursing immediately, via in person or by phone 24/7 and documenting the incident in the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 45 RESIDENT IDENTIFIED 1. Resident #122 no longer resides at this facility. 2. On 7/7/14, the Administrator became aware that Resident #122 was caught smoking after his smoking privileges had been revoked. 3. On 7/7/14, the Administrator met with Resident #122 and informed him that he would be being issued a 30 day notice for failure to adhere to the facilities Smoking Policy. He was informed at that time that the facility had found placement for him at another facility. He was given the option of the 30 day notice or placement at another facility. The resident choose placement at another facility and was discharged to that facility on 7/9/14. 4. On 7/7/14, 7/8/14 and 7/9/14, Resident #122 had a room search completed by the Administrator and Director of Nursing for smoking material- no smoking material was found during those searches. 5. On 7/7/14, 7/8/14 and 7/9/14, Resident 122 was frequently monitored every hour during business hours by the Administrator and Director of Nursing- There were no further smoking incidents identified. 6. On 7/7/14, the Resident Smoking Policy was enforced and resident 122 had immediate discontinuation of his smoking privileges. IDENTIFYING OTHER RESIDENTS AT RISK 1. On 7/7/14, the Administrator reviewed the Resident Smoking Policy, the Resident Smoking Behavior Contract and the Resident Smoking Schedule. In addition, the Administrator ensured all resident smoking material was kept behind lock and key in the medication room, the Administrator visualized the " smoking box " and	F 323	2. The Facility Department Heads were in-serviced by the Director of Clinical Services on 9/24/14 on the following: a. Follow-up on Incident/Accidents is the responsibility of the Administrator and/or Director of Nursing. b. As well as all areas in 1a-1i above. 3. For those residents assessed as requiring supervision during smoking staff will distribute and light their cigarettes during the scheduled smoke breaks. For those residents assessed as being safe to smoke independently staff will distribute cigarettes and smoking paraphernalia as requested by the resident- the resident will return the paraphilia when they are finished smoking. a. There are 13 residents who smoke in the facility. All 13 of the residents are assessed as being unsafe to smoke independently.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 46 went out to the " smoking area " to ensure staff were present during the resident ' s smoke break, " designated smoking area " and " no oxygen in use " signs were posted, how staff distributed and collected the smoking paraphernalia and how residents disposed of cigarettes butts. In addition, the Administrator ensured the facility had a fire blanket and smoking aprons available for resident use. 2. On 7/9/14, the Administrator, Director of Nursing and Social Service Worker met with all the facility residents who smoke and reviewed the Resident Smoking Policy, the Resident Behavior Contract, Resident Smoking Schedule and answered all questions regarding the enforcement of the Resident Smoking Policy. It was stressed to all of the residents who smoke that the facilities Resident Smoking Policy would be enforced from here on out. 3. On 9/22/14, the Resident Smoking Assessment was updated to read " has the resident been observed giving/selling/offering smoking material to and/or from peers " . The word " offering " was added to the assessment and would be considered an unsafe behavior. 4. On 9/23/14, an audit was started by the facilities Social Service Workers to ensure all residents whom smoke were re-assessed for smoking safety and have reviewed and signed the Resident Behavior Contract regarding the Resident Smoking Policy. The audit was completed on 9/24/14. 5. On 9/23/14, all residents whom use oxygen have had a sign placed on their wheelchair which states " No Smoking " . Any ambulatory residents will have a " No Smoking " sign placed on their portable oxygen E-tanks. o The facility has 13 residents who smoke. Out of those 13 residents- 1 resident uses a BiPAP at	F 323	4. The facilities Admission Coordinator will ensure prior to admit that the resident and their responsible party are aware of the Resident Smoking Policy, Resident Smoking Behavior Contract, Resident Smoking Schedule and Smoking Assessment. 5. The facilities Social Service Workers will ensure all new admissions have had a Smoking Assessment completed at time of admit and have received the Resident Smoking Policy, Resident Smoking Schedule and have signed the facilities Resident Smoking Behavior Contract. 6. The Director of Nursing or the nurse management team member will review the shift to shift 24 hour daily report ongoing in AM clinical meeting (Monday – Friday) to ensure any smoking incidents have been reported to the Administrator and/or Director of Nursing immediately. 7. The Administrator and/or Director of Nursing will ensure all smoking incidents have been reported,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 47 night, two residents use oxygen in their room as needed and one resident returned from the hospital on 9/22/14 with a new order for continuous oxygen. For the residents who use oxygen, when they go outside to smoke the oxygen will be left inside the facility while they are smoking. 6. On 9/24/14, the nursing notes and the social service notes from 9/23/14 at 6:00 AM through 9/24/14 at 6:00 AM, were reviewed by the Director of Clinical Services. No concerns were identified with residents smoking inside the facility and/or smoking while wearing oxygen and/or unsupervised. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENCES 1. In-servicing for all staff was started on 9/23/14, by the facility Staff Developer Coordinator. At this point 67 out of 146 have been in-serviced. Facility staff will not be able to work until they are in-serviced. The in-service addressed the following: a. Resident Smoking Policy, which included steps taken for violation of policy b. Resident Smoking Behavior Contract, which included resident acknowledgement and understanding of the facilities Resident Smoking Policy c. Resident Smoking Schedule d. Smoking Assessment, which will be completed quarterly e. Hazards of smoking, which included smoking with oxygen f. Smoking material to be kept behind lock and key g. Staff are to smoke in designated staff smoking areas only h. Staff to ensure their personal belongings,	F 323	investigated and have appropriate follow up, including but not limited to revoking smoking privileges, if indicated. The facility alleges the immediacy of these discrepancies have been abated on 9/24/14. **The Facility Department Heads will complete a weekly room sweep on all residents who smoke to ensure they do not have smoking material in their rooms or on their person.** **The Administrator or a facility Department Head will do random audits of the designated smoking area weekly for four weeks and then monthly thereafter for three months to ensure the smoking policy and smoking behavior contract is being enforced for all residents based on their smoking assessment. Any identified concerns will immediately be investigated and any violation of the policy and behavior contract will result in progressive discipline including but not limited to a discharge notice being issued due to unsafe smoking which could result in injuries to self and/or others.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 48 including but not limited to smoking material are kept out of the reach of the residents at all times. i. Reporting incidents, in which residents and/or staff fail to follow the facilities Smoking Policy to the Administrator and/or Director of Nursing immediately, via in person or by phone 24/7 and documenting the incident in the medical record. 2. The Facility Department Heads were in-serviced by the Director of Clinical Services on 9/24/14 on the following: a. Follow-up on Incident/Accidents is the responsibility of the Administrator and/or Director of Nursing. b. As well as all areas in 1a-1i above. 3. For those residents assessed as requiring supervision during smoking staff will distribute and light their cigarettes during the scheduled smoke breaks. For those residents assessed as being safe to smoke independently staff will distribute cigarettes and smoking paraphernalia as requested by the resident- the resident will return the paraphernalia when they are finished smoking. a. There are 13 residents who smoke in the facility. All 13 of the residents are assessed as being unsafe to smoke independently. 4. The facilities Admission Coordinator will ensure prior to admit that the resident and their responsible party are aware of the Resident Smoking Policy, Resident Smoking Behavior Contract, Resident Smoking Schedule and Smoking Assessment. 5. The facilities Social Service Workers will ensure all new admissions have had a Smoking Assessment completed at time of admit and have received the Resident Smoking Policy, Resident Smoking Schedule and have signed the facilities Resident Smoking Behavior Contract. 6. The Director of Nursing or the nurse	F 323	**The Administrator, DON or facility Department Head will do a weekly facility audit of all units and 5 random resident rooms to ensure any potentially hazardous materials are not within reach of the residents. These audits will be completed weekly times four weeks and then monthly thereafter for at least three months.** **The Administrator and Quality Assurance Committee have put this new system into place and will monitor it weekly for four weeks and then monthly for at least three months. The Quality Assurance Committee is responsible for monitoring and making changes to the new system of monitoring to sustain compliance.** **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Administrator. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 49 management team will review the shift to shift 24 hour daily report ongoing in AM clinical meeting (Monday - Friday) to ensure any smoking incidents have been reported to the Administrator and/or Director of Nursing immediately. 7. The Administrator and/or Director of Nursing will ensure all smoking incidents have been reported, investigated and have appropriate follow up, including but not limited to revoking smoking privileges, if indicated. The facility alleges the immediacy of these discrepancies have been abated on 9/24/14. Immediate Jeopardy was removed on 09/24/14 at 7:00 PM when interviews with nursing staff and residents confirmed they had received inservice training on the facility's smoking policy and procedures and the expected action to take when a resident was found to not follow the smoking policy. Record reviews confirmed that all current residents who smoke had updated smoking assessments and care plans. Observations confirmed that all smoking materials were secured, smoking was supervised per individual smoking assessments and in the designated area. 2. Resident # 101 was readmitted to the facility on 11/18/13 with diagnoses including pancreatic cancer, hypertension, history of brain aneurysm, diabetes, right kidney lesion, seizure disorder and end stage renal disease. Resident #101's most recent assessment was a significant change Minimum Data Set (MDS) dated 07/09/14 which indicated he was cognitively intact for daily decision making. The MDS indicated he had no behavioral symptoms or rejection of care, was independent with transfers,	F 323	As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 50 walking in his room and locomotion on and off the unit. A Care Area Assessment (CAA) summary dated 07/14/14 addressing cognitive loss indicated Resident # 101 smoked and routinely attended supervised smoking times. The summary did not mention that he had a history of smoking in non-designated areas or at non-designated times. A Care Plan for Resident # 101 which was last updated 07/10/14 addressed risk of elopement and indicated Resident was forgetful, required information or facts to be repeated, had poor insight and judgment, impaired cognition, limited mental functioning, was impulsive at times and had poor insight to safety. Interventions included: Nurse Aide (NA) - remind Resident of smoking rules and times, when warranted; Social Services - observe Resident closely to ensure he is complying with smoking policy and rules. Remind him of smoking times. Involve family if needed, as well as make referrals. Provide supervision when able, during smoking times. The Care Plan also indicated he was at risk for burns from smoking. Interventions included: Nursing Staff - Supervise during smoke breaks at all times, report unsafe environment to supervisor, encourage use of aprons, Resident not allowed to use lighter. Do not allow Resident to pick up cigarette butts off the ground. Supervise Resident closely, and only allow him one cigarette to smoke at a time. Remind him of rules, and continue to discourage him from picking up butts, explaining that it is staff's responsibility to clean smoking area. Explain health risks of picking up other's used cigarette butts. Social Services - review smoking policy per protocol. Remind him of scheduled smoking times, when forgetful. Remind him that	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 51 no cigarettes or lighters are allowed on his person or in room. Praise Resident for being compliant and cooperative. Repeat smoking rules, as needed. Review of Smoking Assessments from 09/05/13 - 07/15/14, which were completed by SW # 1 indicated Resident # 101 was assessed as a safe smoker and could responsibly handle smoking materials. The assessment dated 09/05/13 indicated Resident did not need a safety device such as a smoking apron. The smoking assessment completed 09/23/14 indicated Resident # 101 appeared to understand the facility's rules/restrictions on smoking. It also indicated he had asked others for cigarettes and had picked up butts from floor and ashtray. It indicated Resident was not able to responsibly handle smoking materials because he asked others for cigarettes and picked up butts and that he required supervision with smoking. Further review of Resident #101's medical record revealed a note dated 06/24/14 at 2:32 PM by Social Worker (SW) # 2 which indicated Resident # 101 was observed in the courtyard that morning smoking without staff supervision before the designated smoking time. According to the note, the SW advised Resident # 101 that he had violated the smoking policy and that his smoking privileges were being suspended for 24 hours. Review of the Nurse's Notes revealed an entry dated 07/26/14 at 6:26 PM which indicated Resident # 101 was observed smoking in a non-designated area (the hallway) at a non-designated time. The note further stated the Resident had a lit cigarette in the hallway and stated someone lit it for him. The note indicated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 52 staff did not locate a lighter in Resident # 101's possession. Review of a 24 hour Nursing Report dated 07/26/14 revealed the following notation: "(Resident # 101's Name) - smoking in hall." On 09/18/14 at 1:50 PM during an interview with Resident # 101, he stated he could go out and smoke any time he wanted to go but had to have a staff member go with him. When asked if staff were available when he wanted to go out, he stated they had been so far. He also stated he could smoke in his room if he wanted to if he had a cigarette. He stated staff kept his cigarettes behind the desk and he didn't know why they kept them but thought it was probably to keep him from smoking in his room. When asked if he was allowed to have cigarettes and lighters in his room, he stated he could keep them in his room. During an interview on 09/23/14 at 3:17 PM with the Administrator she was asked how she addressed the problem with residents violating the facility's smoking policy. The Administrator stated she did an inservice with all residents who smoked on 07/09/14 and all the residents who smoked were at the inservice. She stated Social Worker # 1 made sure they were all there. She stated she did not have a list of the residents who were at the inservice. She stated she reviewed the smoking policy and emphasized to them that the policy would be enforced. An additional interview on 09/23/14 at 5:45 PM with the Administrator revealed she had not provided any inservices to staff about the smoking policy until 09/22/14 and 09/23/14 when the Staff Development Coordinator did an	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 53 inservice with staff on the smoking policy and procedures. On 09/24/14 at 9:00 AM a second interview was done with Resident # 101. When asked if there were certain times he could smoke, he stated he could smoke anytime he wanted to. When asked if there was a particular place designated for smoking, he stated: "No. I can smoke in here or go outside." When asked if there were any rules about smoking, he stated: "Not that I know of." When asked if he remembered going to a meeting with the Administrator about the smoking rules, he stated: "I remember going to a meeting but it's been a long time." When asked if he remembered what she said, he stated: "No, not really." When asked where he kept his cigarettes and lighter, he stated: "I don't have a lighter but I keep my cigarettes in my drawer." When asked to show surveyor, he opened his drawer and stated: "I don't have any right now." Then, he stated: "We go outside at 10:00 AM to smoke. I probably have some in the box." On 09/24/14 at 11:35 AM an interview with NA # 10 about the incident of Resident # 101 smoking at a non-designated time without staff supervision on 06/24/14 revealed she recalled the incident. When asked what the facility protocol was for addressing a violation of the smoking policy: NA # 10 stated she brought the Resident back in the building and notified SW # 2. She stated SW #2 talked to the Resident. When asked how she was made aware of the smoking policy, NA # 10 stated the smoking policy was reviewed during orientation. NA # 10 stated the door to the designated smoking area was kept locked at all times but they were told that someone had given the code to a family member who in turn had	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 54	F 323		

given the code to the Resident. NA # 10 stated the key code was changed that same day and hasn't been changed since that time. When asked if there were any inservices done throughout the year, NA # 10 stated there were periodic inservices throughout the year and also any time there was an incident, such as violation of the smoking policy.

On 09/24/14 at 12:20 PM an interview with Nurse # 5 about the incident on 07/26/14 with Resident # 101 smoking inside the facility revealed she was unable to determine where he got the cigarette and lighter. Nurse # 5 stated she and a NA searched him and didn't find any cigarettes or lighter. She stated the Resident came out of the activity room and around the nurse's station with a lit cigarette. Nurse # 5 said she asked him where he got a lighter and he said someone lit it for him. She said it was a small part of a cigarette, less than half a cigarette and she thought he might have picked it up off the ground because staff said he had a habit of doing that. Nurse # 5 stated she reported it to the DON. Nurse # 5 said she told Resident # 101 that he was losing his smoking privileges for 24 hours, as she was instructed to do by the DON. When asked if she had received any training on the facility's smoking policy, Nurse # 5 stated she was told that residents must have staff with them when they go outside to smoke; there are 4 designated smoking times; residents are allowed 2 cigarettes per time; cigarettes and lighters are kept locked in the Medication room at A nurses station. When asked how suspension of smoking privileges was communicated to staff, Nurse # 5 stated she put a note on top of the smoking box where residents cigarettes are kept. She stated residents' family members bring cigarettes to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 55 desk when they bring them in for the resident. Nurse # 5 stated the Administrator met with all the residents who smoke so they knew the rules. Nurse #5 stated Resident # 101 didn't remember being caught smoking in the facility when she informed him that his smoking privileges had been suspended. During an interview on 09/24/14 at 1:03 PM Interview with the Administrator and DON, both were asked if there had been any other incidents of unsafe smoking and how they determined if there had been. The Administrator stated she had talked to Department. Managers, NAs and nurses yesterday (09/23/14) and today and asked if they were aware of any incidents of unsafe smoking since July. She stated staff told her there had not been any other incidents as far as they could recall. When asked if any type of audit had been completed to determine if the residents who currently smoke had a history of unsafe smoking, the Administrator stated she had not reviewed any records to audit for unsafe smoking. When asked where she expected incidents of unsafe smoking to be documented, she stated she expected whichever discipline observed the behavior to document it. When asked if she expected smoking violations to be listed on the 24 hour report, she stated she did expect them to be listed on the 24 hour report regardless of which discipline was involved. When asked who reviewed 24 hour reports, the DON stated until the first week in August it was the Unit Managers. The DON stated since second week of August, she had been checking 24 hour reports every morning Monday through Friday. When asked if they were aware of any incidents involving Resident # 101 violating the smoking policy, both the DON and Administrator stated they weren't	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 56	F 323		

aware of any violations. When the DON was asked if she was aware of the incident on 06/24/14 involving Resident # 101, she stated she didn't recall knowing about the incident. When the DON and Administrator were asked if they were aware of the 07/26/14 incident of Resident # 101 smoking in the facility, both stated they weren't aware of the incident. When asked how cognitively impaired residents are being monitored to prevent unsafe smoking, the Administrator stated they were supervised when smoking.

3. Observations of the locked dementia unit in the facility included the following:
The nurses station was circular shaped and had a counter which was just below chest level (to the average person standing) and approximately 1 1/2 foot wide. The interior of the nurses station contained a work desk which adjoined the wall of the counter, but was below the counter level. The majority of the residents on the locked dementia unit were observed to be ambulatory and often congregated at the nurses station.

On 09/15/14 at 3:00 PM a container of Microkill was stored on the nurses work desk, at the edge of the counter. The Microkill container had a bright red top and was easily visible and accessible to residents standing outside the nurses station. The MicroKill container at the nurses station was a pop top type dispenser with pre-saturated cloths that pull out of the top of the container. The manufacturer label on the container included the following precautionary statements: Warning: Causes substantial, but temporary eye injury. Do not get in eyes or on clothing. Wear (specific appropriate protective eyewear such as goggles, face shield or safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 57 glasses). Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum or using tobacco. Wear disposable latex gloves, gowns, masks and eye coverings. Avoid contamination of food. Remove and wash contaminated clothing before reuse. First Aid: If in eyes: Hold eye open and rinse slowly and gently with water for at least 15-20 minutes. Call a poison control center or doctor for treatment advice. If on skin or clothing take off contaminated clothing. Rinse skin immediately with plenty of water for 15 to 20 minutes. Call a poison control center or doctor for treatment advice. Wash contaminated clothing before reuse. Wash thoroughly after handling wipes. The manufacturer label indicated Microkill is a virucidal, bactericidal, pseudomonicidal, tuberculocidal, fungicidal and to keep out of reach of children and to not use as a baby wipe. On 09/16/14 at 2:00 PM a container of MicroKill was stored at the nurses desk in the same location as seen on 09/15/14. On 09/17/14 from 9:13 AM-11:00 AM a container of MicroKill was stored at the nurses desk in the same location as seen on 09/15/14. On 09/18/14 at 9:33 AM Nurse #3 stated although the door to the nurses station was locked, residents know how to open the door and get into the nurses station. At the time of the interview the container of MicroKill was stored at the nurses desk in the same location as seen on 09/15/14. On 09/18/14 at 10:07 AM the DON stated a room sweep was done on the locked dementia unit 08/24/14 to check for any items that might be a potential hazard to residents. The DON stated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 323	Continued From page 58 staff were instructed to not leave anything accessible to residents that indicated to "keep out of reach of children" or that had "poison control" warnings. At the time of the interview the container of MicroKill was stored at the nurses desk in the same location as seen on 09/15/14. The DON stated staff used the MicroKill to clean any items that needed to be decontaminated. The DON stated the MicroKill should not be stored at the nurses station. On 09/24/14 at 4:00 PM the administrator and DON stated staff were inserviced again on 09/18/14 to not store items labeled as harmful to children or with poison control warnings in areas accessible to residents.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 329	Continued From page 59 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to decrease a mood stabilizer as ordered by the physician for 1 of 7 sampled residents with medications reviewed. (Resident #108) The findings included: Resident #108 was originally admitted to the facility 07/08/11 with diagnoses which included depression and behaviors with dementia. The current care plan for Resident #108 included a problem area initiated 10/02/13, "I am at risk for adverse medication effects related to anti-depressant, anti-anxiety medication manifested by lethargic, loss of appetite". The goal to this problem area was, "I will remain on the lowest therapeutic dose of psychotropic medications" with an approach for "pharmacy review per protocol." Review of September 2014 physician orders and the Medication Administration Record (MAR) noted medications taken by Resident #108 included: 50 milligrams of Zoloft every day (an anti-depressant) 25 milligrams of Lamictal every day (a mood stabilizer)	F 329	**F 329** **Corrective action for residents found to have been affected by this deficiency:** Resident #108 mood stabilizers (depakote) have been reviewed and clarified with the attending physician by the Unit Coordinator on 9/19/14.. A Medication Error Report was completed on 9/22/14 by the Director of Nursing and the Unit Coordinator. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. All residents in-house will be reviewed by the pharmacist and any identified issues will be addressed appropriately. On 10/17/14, the Staff Development Coordinator in-serviced the licensed nursing staff on unnecessary drugs, their adverse effects, and resident/responsible party notification. The Director of Nursing, the Assistant Director of Nursing, Nurse Managers and Unit Coordinator reviewed all residents for order accuracy this was completed on 10/23/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 329	Continued From page 60 250 milligrams of Depakote every day (a mood stabilizer which had been in place since 10/03/11) 500 milligrams of Depakote at bedtime (a mood stabilizer which had been in place since 10/03/11) .5 milligrams of Ativan every four hours as needed (an anti-anxiety) Review of the consultant pharmacists drug regimen review for Resident #108 noted an entry on 03/29/14 which read, (Resident's name) who has a diagnosis of dementia, has taken Depakote 250 milligrams every AM and 500 milligrams at bedtime since 10/03/11. He has failed one dose reduction attempt. Please consider another gradual dose reduction, if appropriate. 1. Discontinue Depakote 250 milligrams every AM and 500 milligrams at bedtime. 2. Begin Depakote 250 milligrams twice a day for behaviors due to dementia. This recommendation was noted to be accepted by the physician with orders written on 04/25/14 to, Discontinue Depakote 250 milligrams every AM and 500 milligrams at bedtime. Depakote Sprinkles, 125 milligrams, give 2 to equal 250 milligrams twice a day for behaviors. Review of the April 2014 MAR, May 2014 MAR, June 2014 MAR, July 2014 MAR, August 2014 MAR and September 2014 MAR for Resident #108 noted the Depakote order dated 04/25/14 was never implemented. Resident #108 continued to receive the 250 milligrams of Depakote every morning and 500 milligrams at bedtime. On 09/19/14 at 11:35 AM the Director of Nursing (DON) reviewed the 04/25/14 order for Resident #108 in conjunction with the 2014 MARs from	F 329	On 9/26/14 through 9/30/14 the Pharmacist reviewed all resident medication regimens for medication irregularities. On 10/20/14 through 10/22/14, the Pharmacist reviewed all resident medication regimens for medication irregularities. **Measures that will be put into place to ensure that this deficiency does not recur:** The pharmacy consultant will complete a monthly medication regimen and review on all residents and report the findings to the Director of Nursing monthly. The Director of Nursing, or the Assistant Director of Nursing, or a Nurse Manager or the Unit Coordinator will ensure the monthly recommendations are reviewed by the attending physician and physician orders are implemented as ordered. The Director of Nursing, or the Assistant Director of Nursing, or a Nurse Manager or the Unit Coordinator will audit ten random medical records every week, times four weeks and then monthly thereafter for three months to ensure all residents have medications transcribed correctly and medications are being administered as ordered by the attending physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 329	Continued From page 61 April-September and verified the order was not implemented as written by the physician. The DON stated because she was not employed by the facility at the time of the order she was not sure what system had been in place to check physician orders. The DON stated currently there was a double check system in place for orders with the first check done by the nurse that takes the order. The DON stated all orders are then checked by third shift nursing staff and initialed after verification of the order. The DON stated a copy of the order was Fax' d to the pharmacy. The DON stated the monthly recapitulation of physician orders for each resident was printed in house by the medical records department. The DON stated this recapitulation and the electronic MAR were not accessible by the dispensing pharmacy. The DON stated since the facility used an electronic MAR they did not do a monthly check of orders. Instead, the DON stated they relied on the double check system to ensure medications were administered as ordered. The DON identified Nurse #2 as the nurse that took the order on 04/25/14. The DON stated she did not see any initials on the 04/25/14 order to indicate it had been double checked. On 09/19/14 at 11:54 AM Nurse #2 reviewed the 04/25/14 order for the change of Depakote for Resident #108. Nurse #2 reviewed the April 2014-September 2014 MARs for Resident #108 and stated she must have missed putting the change order for Depakote in to the facility electronic MAR. Nurse #2 stated at the time of the order the unit managers were doing the second check of all orders but she didn't know which unit manager might have checked the order since it was not signed and, at the time, there were three unit managers. Nurse #2 stated	F 329	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Director of Nursing. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 329	Continued From page 62 at the time of the order a double check system was the system used to verify physician orders were followed. On 09/19/14 at 12:25 PM the consultant pharmacist stated she had written the recommendation for the change in Depakote dosing for Resident #108 on 03/29/14. The consultant pharmacist stated when the monthly review was done on 04/29/14 she saw the order to change the Depakote on 04/25/14 and assumed it had been implemented as ordered. On 09/19/14 at 1:20 PM Nurse #3 pulled the Depakote dose pack for Resident #108 from the medication cart. The Depakote for Resident #108 was dispensed in 125 milligram doses and the pharmacy sticker order on the packaging indicated to give 250 milligrams of Depakote twice a day. Nurse #3 stated she worked from 7:00 AM-7:00 PM and only gave the AM dose which was 250 milligrams of Depakote. Nurse #3 looked at the electronic MAR for Resident #108 and noted the order at bedtime read to give 4, 125 milligram doses of Depakote to total 500 milligrams. Nurse #3 stated she could not speak for the night nurse but that she always went by what was in the electronic MAR because medication orders change so much you can not depend on what was dispensed from the pharmacy at the time the medication order was filled. Review of the September 2014 MAR for Resident #108 noted Nurse #4 administered the bedtime Depakote to Resident #108 on 09/16/14 and 09/17/14. On 09/19/14 at 3:00 PM in a telephone interview, Nurse #4 verified she did work on 09/16/14 and 09/17/14 on the unit	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 329	Continued From page 63 Resident #108 resided. Nurse #4 stated she always administered medication based on what was in the electronic MAR, not what was on the dose pack. Nurse #4 stated if the electronic MAR indicated to administer 4, 125 doses of Depakote for a total of 500 milligrams that was what she would have given to Resident #108 on 09/16/14 and 09/17/14.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to taper an anti-depressant medication as ordered by the physician for 1 of 7 sampled residents with medications reviewed. (Resident #159) The findings included: Resident #159 was admitted to the facility 07/22/14 after hospitalization for a fall with a pelvic fracture and senile delusion. The admission Minimum Data Set (MDS) dated 07/29/14 assessed Resident #159 with impairment of short and long term memory and moderately impaired cognition. A Care Area Assessment associated with the MDS noted Resident #159 "is currently being treated for depression and psychosis with psychotropic medication in combination with weakness and poor safety awareness. She is at increased risk for falls. These medications in addition increase	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 333	Continued From page 64 her risk for adverse side effects and behaviors". The admission care plan in place for Resident #159 included a problem area dated 07/29/14 for, Potential of adverse medication side effects due to psychotropic medication used. Resident #159 was admitted to the facility with a physician's order for medications which included 5 milligrams of Lexapro (an anti-depressant) every day. . A physician's progress note dated 08/22/14 included the following: The patient is seen regarding a fall. She was treated and released from the emergency room with no acute fracture. At this point in time she is extremely lethargic and medications are all reevaluated regarding mental status acuity effects and fall propensity. This is a situation with high complexity secondary to patient's fall, fracture, mental status and multiple medications where I must reconsider risks and benefits regarding mental acuity, pain management, fall and severe consequences for possible further injury. She is on low dose Lexapro; will discontinue with weaning protocol. Physician orders on 08/22/14 included, 1) discontinue Lexapro, 5 milligrams every day 2) Lexapro 5 milligrams every other day for 2 weeks, then discontinue. Review of the August 2014 and September 2014 Medication Administration Record (MAR) for Resident #159 noted the daily dose of 5 milligrams of Lexapro was discontinued on 08/22/14. A new order was written 08/22/14 for 5 milligrams of Lexapro every day for 2 weeks, then	F 333	**F 333** **Corrective action for residents found to have been affected by this deficiency:** Resident #159 is no longer on the medication identified in this deficiency; it was discontinued on 9/4/14, prior to this survey. On 9/23/14, the Director of Nursing completed a medication error report on the identified error. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. The Director of Nursing, the Assistant Director of Nursing, the Nurse Managers and the Unit Manager did a 100% chart audit for order accuracy, this was completed by 10/23/14. On 10/17/14, the Staff Development Coordinator in serviced the Licensed Nurses on medication errors including following Physician orders, manufacturers specifications and accepted professional standards. **Measures that will be put into place to ensure that this deficiency does not recur:** The Nurse Management Team will reconcile the monthly recertification physician orders. This will begin in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 333	Continued From page 65 discontinue on 09/04/14. Resident #159 received a daily dose of 5 milligrams of Lexapro from 08/22/14-09/04/14 and then it was discontinued. On 09/23/14 at 3:45 PM the physician of Resident #159 reviewed his 08/22/14 progress note and physician order and stated he made several medication changes that day for Resident #159 to prevent further falls. The physician stated he wrote the order for a tapered discontinuation of the Lexapro (a change from 5 milligrams every day to 5 milligrams every other day for 2 weeks and then discontinue) to lessen the unpleasant side effects of coming off an anti- depressant. The physician stated his writing is not the best so he usually has a nurse work with him to ensure his orders are understood. On 09/23/14 at 4:20 PM Nurse #2 stated she worked with the physician of Resident #159 on 08/22/14. Nurse #2 reviewed the physician orders written for Resident #159 on 08/22/14. The 08/22/14 order included the physician's handwriting as well as a printed clarification in parentheses beside each order. Nurse #2 stated she wrote the clarification in parentheses because the physician's handwriting wasn't always legible. Nurse #2 noted what she wrote in parentheses on the 08/22/14 order regarding the Lexapro was, "Discontinue 5 milligrams of Lexapro every day. Lexapro 5 milligrams every day X 2 weeks then discontinue." Nurse #2 looked at the physician's handwritten order and stated, "I wrote it wrong", indicating it should have been every other day. As a result, Nurse #2 stated she entered the order in error in the electronic MAR for Resident #159 which was why it was given every day, instead of every other day from 08/22/14-09/04/14. Nurse #2 stated third	F 333	October 2014 and will be completed every month. The Director of Nursing, or the Assistant Director of Nursing, or a Nurse Manager or Unit Coordinator will review a medication pass each week, times four weeks, and then monthly thereafter for three months observing change in medication orders. The change in medication observation will be compared to the medical records to ensure there are no identified transcription errors. The Director of Nursing, or the Assistant Director of Nursing, or a Nurse Manager or Unit Coordinator will audit five medication changes every week, times four weeks, and then monthly thereafter for at least 3 months to ensure all residents have medications transcribed and administered as ordered by the attending physician. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Director of Nursing. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 333	Continued From page 66 shift nurses were supposed to check all physician orders and initial verification of the order. Nurse #2 stated she did not see an initial from third shift nurse to verify the order. On 09/24/14 at 4:00 PM the concern involving the 08/22/14 order for Lexapro for Resident #159 was reviewed with the Director of Nursing (DON). The DON stated third shift nursing staff were supposed to review all orders and initial the original order to verify accuracy. The DON could not explain why this was not done on 08/22/14. The DON stated because the facility utilized electronic MARs there was not a monthly reconciliation but instead they relied on the two step check (the nurse that takes the order and third shift to verify the order) to ensure orders were implemented as ordered by the physician.	F 333	If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the dish machine log the facility failed to 1) ensure the dish machine final rinse temperature reached a minimum of 180 degrees	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 67 Fahrenheit 2) failed to ensure a wall mounted fan was free from excess debris 3) failed to ensure 1 of 2 ice machines used by residents, staff and families was clean and 4) failed to store 2 of 2 ice scoops in a sanitary manner. . The findings included: 1. On 09/19/14 between 9:30 AM and 10:15 AM observations were made in the facility kitchen of three dietary aides working in the area of the dish machine to process dishware from the breakfast meal. Continuous observations were made of racks of dishware going through the wash and final rinse cycle from 9:30 AM to 9:50 AM with the final rinse temperature not reaching the minimum of 180 degrees Fahrenheit (F) throughout the final rinse cycle. These observations included the following: rack of bowls with the highest temperature during the final rinse cycle of 175 F rack of cups with the highest temperature during the final rinse cycle of 175 F rack of bowls with the highest temperature during the final rinse cycle of 175 F rack of plates with the highest temperature during the final rinse cycle of 175 F rack of bowls with the highest temperature during the final rinse cycle of 175 F rack of trays with the highest temperature during the final rinse cycle of 175 F rack containing a beverage container with the highest temperature during the final rinse cycle of 175 F rack of trays with the highest temperature during the final rinse cycle of 172 F rack of plate covers with the highest temperature during the final rinse cycle of 172 F rack of plate covers with the highest temperature	F 371	**F 371** **Corrective action for residents found to have been affected by this deficiency:** No specific residents were affected. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. 1. The dish machine will maintain a final rinse temperature of 180 degree Fahrenheit. 2. The fan was removed while the survey was still in progress. 3. The ice machines were cleaned while the survey was still in progress and will be cleaned weekly. 4. The ice scoops will be stored in sanitary manner. A system of routine sanitation checks will be conducted to identify sanitation and outstanding maintenance issues. **Measures that will be put into place to ensure that this deficiency does not recur:** The Dietary Manager and/or the Assistant Dietary Manager will conduct weekly sanitation checks including dish machine temperatures, dusty fans, ice machine cleanliness and ice scoop storage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 68 during the final rinse cycle of 170 F The dietary aide positioned at the clean side of the dish machine was observed removing the dishware and placing it in storage for future use. At 9:50 AM this dietary aide was asked about the final rinse temperature and she reported she had not checked the temperature gauge since the dish machine had been in use. The dietary aide stated the final rinse temperature was typically noted at the beginning and end of use but again stated she had not yet checked the final rinse temperature of the machine. After the interview staff continued to utilize the dishwasher to process dishes with the following noted: rack of cups with the highest temperature during the final rinse cycle of 170 degrees F. rack of cups with the highest temperature during the final rinse cycle of 170 degrees F. On 09/19/14 at 9:55 AM the Food Service Director (FSD) was asked if she had checked the dish machine since it was put in service that morning. The FSD stated she had not and was not aware of any concerns. The dish machine log book was reviewed and noted the last recorded temperature was from the supper meal on 09/18/14. The FSD stated the final rinse temperature was supposed to be checked at some point during use but there had never been a designated time to check the final rinse temperature of the dish machine. On 09/19/14 at 9:57 AM the FSD observed the dish machine in use with the highest temperature of the final rinse cycle reaching 170 degrees F during the processing of two separate racks of	F 371	On 9/22/14, the Dietary Manager held an in service with the Dietary staff regarding dish machine temperatures, dusty fans, ice machine cleaning and ice scoop handling. The Administrator will complete a weekly audit of the kitchen ice machine, Ice Scoops, Dusty fans B-Hall Ice Machine, and Dishwasher temperatures, times 4 weeks and monthly thereafter for at least three months to ensure sanitation and maintenance issues are maintained. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Dietary Manager. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 69 plate covers. The FSD left the vicinity of the dish machine and went to call the company that services the dish machine. The dietary aides continued to utilize the dish machine to process dishware with a rack of plates processed with the highest temperature during the final rinse cycle reaching 170 degrees F. At 9:58 AM the FSD directed the dietary aides to stop washing dishes until she could troubleshoot the problem with the final rinse temperature. At 10:00 AM a facility maintenance worker came to the kitchen and reported when he had checked the dish machine earlier that morning he thought it reached 180 degrees during the final rinse cycle. The maintenance director looked at the booster heater and noted the switch had been turned off. The booster heater was reset and, after several racks were sent through the dish machine, the final rinse temperature reached and maintained 180 degrees F. Dietary staff reported not being aware the booster heater switch had been turned off. 2. During the initial tour of the facility kitchen on 09/15/14 at 10:30 AM a wall mounted fan positioned in the area of the dish machine was noted with a thick coating of dust and debris covering the majority of the surface area of the front and back grills and the blades. On 09/17/14 between 4:30-5:00 PM this same fan was noted in use with air flow directed toward the area of the dish machine. Dust and debris could be seen on the front and back grill of the machine with dust extending via the air flow from the front grill. On 09/19/14 at 10:15 AM the wall mounted fan was noted with a thick coating of dust and debris covering the majority of the surface area of the front and back grills and blades. The FSD was present at the time of the observation and	F 371	The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 70 reported that maintenance was supposed to clean the fan. The FSD stated a request had been made for the fan to be taken down since renovations were made to air circulation in the area of the dish machine. On 09/19/14 at 10:30 AM the FSD presented a copy of a "Departmental Safety Survey" dated 08/28/14 which was presented at the last safety committee meeting. The FSD had checked "needs improvement, fan dirty" under the column labeled "are electric motors clean, lint free, well ventilated". The FSD stated the concerns are presented at the meeting with the intent any areas would be addressed. On 09/22/14 at 6:10 PM the maintenance director stated he attends safety committee meetings and receives the Departmental Safety Survey from each manager. The maintenance director stated the need to clean the fan had "slipped by the cracks" but that the fan was now permanently removed from the kitchen. On 09/24/14 at 4:00 PM the administrator stated she expected any items identified as concerns by department managers during the safety committee meetings would be addressed in a timely manner. 3. On 09/17/14 at 5:00 PM the ice machine in the vending area of the facility was observed. The vending room was located on a nursing unit and was accessible to residents, families and staff. The ice machine had a dispensing chute in the front portion of the machine that dispensed ice when a container was placed under the chute. The interior portion of the dispensing chute (where the ice passed through) was observed with a significant amount of black, red, yellow and tan wet foreign matter encompassing a majority of the surface area. Two ice chests on rolling carts were stored in this room, beside the ice	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 71	F 371		

machine. In an earlier conversation on 09/17/14 at 2:25 PM, NA #2 reported the ice chests were filled with ice from the machine and used by staff to fill residents personal water pitchers in their rooms.

On 09/17/14 at 5:05 PM the housekeeping director reported his staff wipes down any visible area on the exterior surface of this ice machine. The housekeeping director stated his department would not clean the interior portion of the ice chute but noted the condition of the interior of the ice chute and indicated it was not good.

On 09/17/14 at 5:10 PM the maintenance director stated he cleaned the interior of the ice machine every quarter and thought it had last been cleaned in August. The maintenance director then demonstrated what he did when he cleaned the interior portion of this ice machine. An upper stainless steel panel was removed (above the dispensing chute) which exposed the inside area where water flowed and ice was made. Pink and black matter was noted on the ice shield as well as on plastic sides on the interior of the machine. The interior of the dispensing chute was not accessible from this panel. The maintenance director stated he pours the manufacturer cleaning solution into the machine and it goes through the dispensing chute and out the drain. When the maintenance director saw the condition of the inside of the machine as well as the inside of the dispensing chute he commented he was surprised to see it because he had just cleaned the machine in August. The maintenance director stated he did not have the manufacturer literature to know if the dispensing chute was accessible for detailed cleaning and, other than pouring the manufacturer solution through the machine, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 72 dispensing chute did not get cleaned. On at 09/17/14 at 5:50 PM the administrator noted the condition of the interior of the dispensing chute on this ice machine and stated she was not aware the machine was "in that condition." The administrator stated she did not know how to access the interior portion of the ice chute for cleaning. At the time of the interview a paper towel was gently wiped across the interior portion of the ice chute and the foreign matter was easily removed. The ice machine was immediately shut down for detailed cleaning. On 09/18/14 at 9:20 AM the administrator reported they learned the cover over the dispensing chute was removable which allowed for detailed cleaning of the dispensing ice chute. The administrator stated the machine was detailed the prior evening as well as ice chests used to pass ice to residents, residents water pitchers and ice scoops. On 09/18/14 at 2:00 PM this ice machine was observed and noted to be free from the foreign matter observed the prior day. 4. On 09/15/14 at 11:58 AM, an ice chest was observed in the vending area. The ice scoop was located on a table, uncovered, exposed, and not in a holder. The ice chest was observed in the vending area on 09/16/14 at 8:54 AM. The large scoop was observed inside laying sideways with the handle touching the ice inside the ice chest. At this time Nurse Aide (NA) #5 stated that the ice was obtained from the ice maker and placed in the ice chest where it was passed at least 3 times per day.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 371	Continued From page 73 On 09/17/14 at 3:15 PM the ice chest was observed on the hall. The large scoop was observed left laying on a towel off to the side of the cart uncovered, even though there was a built in swinging tray designed as a scoop holder. At this time NA #1 stated that the ice chest was filled from the ice machine and then passed out. She stated sometimes there was a large ice scoop and sometimes a smaller ice scoop. On 09/17/14 at 5:14 PM observation of the ice chest in the vending area was observed with the large scoop uncovered next to the ice chest on a towel. There were some dark brown spots located inside the scoop. Observation on A hall at this time revealed an ice chest on the hall and a small scoop uncovered and leaning against the ice chest on a towel. On 09/18/14 at 2:25 PM NA #2 stated that she will find the ice scoops wrapped in towels or unwrapped and left laying exposed. She further stated that she personally washed the scoops prior to use. On 09/19/14 at 4:09 PM, NA #1 was observed passing ice with the ice scoop in a plastic baggy. She stated that today the ice scoops were handed out in a baggy. She further stated that sometimes the scoops are bagged and sometimes just laid to the side of the ice chest on top of a towel. On 09/23/14 at 12:42 PM the Director of Nursing stated she expected ice scoops to be in a drawer attached to the ice chest carts or in a plastic bag. She further stated the ice scoops should not be left inside the ice chest or left out unprotected.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to obtain dental services for 2 of 3 residents sampled for dental needs. (Residents #26 and #84). The findings included: 1. Resident #26 was admitted to the facility on 01/14/14 with diagnoses including a history of cerebral vascular accident and hypertension. The admission Minimum Data Set (MDS) dated 01/22/14 coded her as being cognitively intact, having no behaviors, being nonambulatory, and requiring extensive assistance with most activities of daily living skills (ADLs). The MDS section under dental failed to check the section that Resident #26 was edentulous (having no natural teeth). Because she was inaccurately checked as having no natural teeth, the area of dental did not trigger for a comprehensive assessment. The nutrition Care Area Assessment dated	F 412	**F 412** **Corrective action for residents found to have been affected by this deficiency:** Resident #26 is no longer a resident at this facility. Resident #84 has a dentist appointment on 10/30/14. **Corrective action for residents that may be affected by this deficiency:** All resident have the potential to be affected by these identified concerns. On 10/13/14, the Staff Development Coordinator in serviced the Licensed nurses, the Social Workers and the Medical Record nurse on routine dental services, emergency dental services, how to arrange and transportation to and from the dentist. **Measures that will be put into place to ensure that this deficiency does not recur:** The Medical Record LPN did a 100% resident dental evaluations on 10/13/14 and 10/14/14. On 10/23/14, the Director of Nursing and the Administrator, using the new Quality Assurance process, identified that the review was done incorrectly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412	Continued From page 75 01/27/14 noted the resident was on a mechanical soft diet due to having a partial denture plate. On 04/15/14 a care plan identified the problem of Resident #26 having a chewing problem with a goal for Resident #26 to comply with her mechanically altered diet. During interview on 09/16/14 at 1:53 PM, Resident #26 stated she had chewing problems because she did not have any teeth. She further stated her dentures did not fit. She was observed at this time without any natural teeth or dentures in place. Resident #26 was observed feeding herself a pureed diet on 09/17/14 at 1:04 PM. Interview with the medical records clerk on 09/17/14 at 3:30 PM, revealed she was in charge of ensuring dental care was provided for all residents. She stated that the dentist came to the facility every 6 months and assessed every resident, except those who refused. If a resident needed dentures, there was a special fund that a resident could access to pay for the necessary dentures. The medical record clerk stated she sent the dental office a list of residents who needed to be seen at the next visit, including all new admissions. After his visit, the dentist left copies of each resident's exam for each resident's medical record . The medical record clerk stated she then filed the examination reports in each resident's medical record. At this time she confirmed that Resident #26 was admitted on 01/14/14 and the dentist last came to the facility in April 2014. Follow up interview with the medical record clerk	F 412	On 10/23/14, the Director of Nursing and the Administrator commissioned a second dental review on 100% of all residents for accurate dental evaluations. On 10/23/14, 100% RAI notes were reviewed and updated if indicated with the corrected dental information for all residents on 10/23/14. The Administrator, or the Director of Nursing, or a facility Department Head will complete an audit, monthly, times three months to ensure residents are being seen by the dentist as needed. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Administrator. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412	Continued From page 76 on 09/17/14 at 4:38 PM revealed Resident #26 was just missed at the dentist's last visit and would be seen at his next visit. She further stated that she did not go with the dentist when he came to the facility and had no system in place to ensure each resident was seen. The medical records clerk stated that Resident #26 did have dentures but they needed to be realigned by the dentist in order to fit properly. On 09/18/14 at 2:00 PM, observation revealed Resident #26 had a full set of dentures in a cup at bedside. She again stated that she did not wear her dentures because they did not fit. On 09/18/14 at 5:03 PM, Nurse Aide (NA) #8 stated Resident #26 never wore dentures. NA #8 stated she had not offered to put her dentures in as Resident #26 "does her own thing." NA #8 stated she assumed the resident did not need them as she ate a pureed diet. On 09/19/14 at 10:38 AM a telephone interview with NA #9 was conducted. NA #9 stated she was unsure if Resident #26 had dentures to wear. Interview on 09/19/14 at 12:13 PM with the dentist office staff revealed the facility faxed a list of residents to be seen to the dental office on 03/24/14. The dentist last went to the facility on 04/08/14. The office staff stated the dentist would only see the residents that were on the list sent by the facility on 03/24/14. Resident #26 was not on that list. Interview with the Director of Nursing on 09/22/14 at 10:17 AM revealed Resident #26 should have been seen by the dentist and it appeared she fell through the cracks. If needed, the facility had an	F 412	The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412	Continued From page 77 emergency dental service available to residents. 2. Resident #84 was admitted to the facility on 03/11/14 with diagnoses including cerebral atherosclerosis, obstructive sleep apnea, diabetes, and chronic airway obstruction. The admission Minimum Data Set (MDS) dated 03/19/14 coded her with having intact cognition, receiving a mechanically altered diet and having no natural teeth. The Care Area Assessment (CAA) dated 03/21/14 for nutrition indicated a mechanical soft , no added salt and low concentrated sweet diet was ordered due to diabetes and chewing problems. The CAA for dental dated 03/24/14 indicated she needed assistance for set up and oral care. The CAA indicated no dental care plan would be developed as staff assisted the resident. On 09/15/14 at 5:08, Resident #84 stated during interview that she did not have any teeth and would like dentures. She was observed at this time with no natural teeth or dentures in place. On 09/17/14 at 1:06 PM Resident #84 was observed eating her meal. She was picking out the carrots and peppers from the macaroni salad and was not eating the cabbage. She stated these items were too hard to chew without teeth. She further stated that if she had dentures, she could eat everything on her tray. Interview with the medical records clerk on 09/17/14 at 3:30 PM, revealed she was in charge of ensuring dental care was provided for all residents. She stated that the dentist came to the	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412	Continued From page 78	F 412		

facility every 6 months and assessed every resident, except those who refused. If a resident needed dentures, there was a special fund that a resident could access to pay for the necessary dentures. The medical record clerk stated she sent the dental office a list of residents who needed to be seen at the next visit, including all new admissions. After his visit, the dentist left copies of each resident's exam for each resident's medical record . The medical record clerk stated she then filed the examination reports in each resident's medical record. At this time she confirmed that Resident #84 was admitted on 03/11/14 and the dentist last came to the facility in April 2014.

Follow up interview with the medical record clerk on 09/17/14 at 4:38 PM revealed she did not go with the dentist when he came to the facility and had no system in place to ensure each resident was seen.

Another interview with the medical record clerk on 09/18/14 at 10:36 AM revealed Resident #84 was not seen by the dentist at his last visit in April 2014 because the dentist did not go by the list she provided.

Interview on 09/19/14 at 12:13 PM with the dentist office staff revealed the facility faxed a list of residents to be seen to the dental office on 03/24/14. The dentist last went to the facility on 04/08/14. The office staff stated the dentist would only see the residents that were on the list sent by the facility on 03/24/14. Resident #84 was not on that list.

Interview with the Director of Nursing on 09/22/14 at 10:17 AM revealed Resident #84 should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 412	Continued From page 79 been seen by the dentist and it appeared she fell through the cracks. If needed, the facility had an emergency dental service available to residents.	F 412	**F 520** **Corrective action for residents found to have been affected by this deficiency:** No specific residents were affected.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to address assessment issues for care	F 520	**Corrective action for residents That may be affected by this deficiency:** All residents have the potential to be affected. On 10/8/14, the Director of Quality Assurance and Compliance Officer In serviced the Administrator and Director of Nursing and on 10/16/14 the Director of Quality Assurance and Compliance Officer completed an in-service with the facility Quality Assurance Committee regarding an effective Quality Assurance Committee and Process which included but was not limited to a QAPI Overview, Perceptions of Quality, Six Step Process, Data Collection, Root Cause Analysis, Outcomes, Leadership Oversight, Quality Assessment and Assurance Committee (Purpose, Membership, Roles, Expectations of the Committee, communication, Confidentiality of the Committee, Conducting a Meeting, Monthly Meeting, QAA Committee Meeting Minutes, QAA Subcommittee, Subcommittee Planning and Development, QAA AD HOC Committee, Celebrate Success,) Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 520	Continued From page 80 areas that the committee had put into place in June 2013. This was for the recited assessment deficiency which was cited in June, 2013 and on a current recertification and complaint survey. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective quality assurance program. Findings included: This tag is cross referenced to: F272 : Resident assessment: Based on record review, observations, resident interview, and staff interview, the facility failed to comprehensively assess 5 of 26 sampled residents identifying how the condition affected each resident's function and quality of life. This included assessing psychotropic medications for Resident #19, #26 and #44; dental for Resident #84; and catheter for Resident #10. During a recertification survey dated June 2013 the facility was cited for F272 for failing to accurately code and comprehensively assess incontinence. On the current recertification and complaint survey the facility was again cited for failing to code and comprehensively assess residents for psychotropic meds, dental concerns, and a catheter. During an interview on 09/24/14 at 6:29 PM the Administrator, Director of Nursing (DON) and the Director of Clinical Services stated the quality Assessment and Assurance Committee have hired a Minimum Data Assessment (MDS) Coordinator with the ability to write action plans and implement monitoring tools to address other	F 520	QAPI Annual Reporting Schedule, Quality Assurance Performance Improvement Action Plan, Quality Assurance Summary Report and Federal Regulatory Groups for Long Term Care Facilities. **Measures that will be put into place to ensure that this deficiency does not recur:** The QA Program guidelines will be followed to address identified facility issues. The entire Quality Assurance Process was changed and a new system was put into place that includes: New policy, new Forms, new Reporting Schedule. The Administrator and/or Director of QA/Compliance will monitor the implementation of the revised QA Program Plan and the QA Committee's performance in identifying and addressing compliance issues monthly for at least three months. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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) COMPLETION DATE
F 520	Continued From page 81 care areas. The previous recertification survey in June, 2013 had not implemented monitoring tools for the assessment of incontinence. The Administrator and DON explained there had been a turnover of the Administrator and MDS Coordinator in the last couple of months that had made it difficult to implement action plans and monitoring of potential problems related to the assessment citation found during the current recertification and complaint survey.	F 520	From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NC0590	A. BUILDING: _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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
L 006	.2104(C) REQUIREMENTS FOR LICENSE RENEWAL/CHANGE 10A-13D.2104 (c) The facility shall notify the Licensure and Certification Section of the Division of Facility Services within one working day following the occurrence of: (1) change in administration; (2) change in the director of nursing; (3) change in facility mailing address or telephone number; (4) changes in magnitude or scope of services; or (5) emergencies or situations requiring relocation of patients to a temporary location away from the facility. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to notify the North Carolina Division of Health Service Regulation (N.C. DHSR) of a change in the Director of Nursing (DON) within one working day of the change. The findings included: At the beginning of the survey on 09/15/14 the nurse introduced as the DON did not correspond to the name of the DON listed on our federal computer system. An interview with the Administrator on 09/18/14 at 10:30 AM revealed the current DON was hired by the previous Administrator and she did not know if N.C. DHSR was notified of the change. During a second interview with the Administrator on 09/18/14 at 10:40 AM, the Administrator stated she was unable to locate documentation in the former Administrator's files that N.C. DHSR had	L 006	**L 006** **Corrective action for residents found to have been affected by this deficiency:** No specific residents were affected. **Corrective action for residents that may be affected by this deficiency:** All residents have the potential to be affected. The Administrator informed the North Carolina Division of Health Services of the change in the Director of Nursing while the survey was still in progress. The completed form was reviewed, transmitted and accepted on 9/18/14. On 9/18/14, the Human Resource Manager was in-serviced by the Administrator on the one day rule for change in Director of Nursing and/or Administrator, how to find the website, how to fill out the form and how to transmit the information. **Measures that will be put into place to ensure that this deficiency does not recur:** The Administrator will audit and ensure the North Carolina Division of Health Services is informed any time there is a change in the Director of Nursing and/or Administrator within one working day of the change.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne Washburn — TITLE: Administrator — (X6) DATE: 10/28/14

DHSR NH L&C Black Mountain RRO Received OCT 28 2014 by: SKH

Original Signature Date: 10-17-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NC0590	A. BUILDING: _____ B. WING _____	C 09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(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
L 006	Continued From page 1 been notified of the change in DON, which occurred 04/14/14. The Administrator provided documentation that she had sent notification to N.C. DHSR on 09/18/14. In an interview on 09/24/14 at 3:35 PM the Administrator acknowledged that she was aware of the requirement to notify N.C. DHSR within 24 hours of a change in the facility's Administrator or DON. She stated she would expect the notification to be made.	L 006	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** Any discrepancies identified in the audits will be documented, investigated and corrected immediately by Administrator. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur. Facility alleges compliance with this deficiency on 10/27/14.	10/27/14