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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 SS=E	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 provide a dignified dining experience in 1 of 4 dining rooms (the memory care unit) for 3 out of 31 residents in the memory care unit. Staff did not supervise and intervene to prevent residents from sharing food, eating with their fingers and or straws (Residents #56, #51, and #80). The findings included: 1. Resident #56 was admitted to the facility on 10/27/15 with diagnoses including adult failure to thrive and dementia. Her annual Minimum Data Set dated 09/27/16 coded her with long and short memory impairments, moderately impaired decision making skills and being independent with set up only for eating. Resident #56 received a pureed diet. On 11/01/16 beginning at 11:58 AM, the dining room in the memory care unit was observed with 5 large round tables and one small square table which was set up for 2 residents. At 12:13 PM 20 residents were in the room with 4 staff beginning to pass trays, table by table. Resident #56 was seated at a round table with 6 other residents. All residents were served their trays by 12:19 PM. As staff had all moved on and serving trays to the	F 241	This plan of correction is submitted as required under State and Federal law. The Plan of Correction does not constitute an admission on the part of the Facility that the findings are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to Facility policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of December 2, 2016. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	12/2/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 residents at the next table, Resident #56 was observed to reached over and scooped ground meat and ketchup from the plate of Resident #81's plate and ate it. She took another bite of ground meat off Resident #81's plate and ate it at 12:42 PM. Although staff were in the room, this activity went unnoticed. At 12:44 PM, Resident #133 who was on the other side of Resident #56 placed a couple of spoons of her food onto Resident #56's plate which she proceeded to eat. Nurse Aide (NA) #1 then removed Resident #56's plate and subsequently provided her a cup of soup. On 11/02/16 beginning at 12:03 PM, 3 nurse aides, 2 nurses and an activity assistant were observed assisting residents in the room and serving trays. At 12:09 PM, Resident #56 was observed at a round table with 4 other residents. The table was served at 12:28 PM. At 12:31 PM, Resident #56 tried to reach for something on the plate of Resident #103 who sat beside her. Resident #103 proceeded to give Resident #56 a small bowl she had eaten from with left over pureed green vegetables. Resident #56 proceeded to take the used bowl and scoop up tomato soup with it and drink from the used small bowl. She also then took the small bowl and scooped out some ice tea and drank the tea from the used small bowl. Resident #56 the reached over and retrieved a paper wrapper from Resident #103's tray area and dunk the paper into the soup multiple times, sucking the soup juice off the paper. Only one staff member was in the room at this time and she was at the opposite end of the room feeding another resident. Although NA #2 was standing at the table assisting other residents, she did not redirect Resident #56.	F 241	The facility will provide a dignified experience for the residents eating on the memory care unit. Residents 56, 51, and 80 have been reassessed for their dining level of assistance, special needs, and preferences and placed accordingly into the dining room environment using a seating chart. Address how corrective action will be accomplished for those having the potential to be affected by the same deficient practice. The facility will assess the memory care residents for their dining level of assistance, preference, and special needs, creating a seating chart to provide a dignified dining experience. Residents will be placed in the dining room and at the seating area which provides the appropriate assistance and supervision. Assessments and seating will be completed by December 2, 2016. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility provided in-service training by the Western North Carolina Alzheimer's Association for nursing staff on the care of cognitively impaired residents with completion by November 22, 2016. Nursing administrative staff provided in-service training, to nursing staff and staff who assists in the dining room, on a	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 241	Continued From page 2 Nurse Aide (NA) #1 was interviewed on 11/03/16 at 1:00 PM. she stated that she had to watch certain residents because they were known to take food from others' plates. She also stated that residents needed to be watched and redirected when not using utensils. NA #5 stated during interview on 11/04/16 at 8:48 AM that residents are placed or come into the room and sit anywhere. There are certain residents such as Resident #56 that need to be closer monitored during eating as she will grab other residents' foods that are not pureed. The staff in the dining room are responsible for watching, intervening and catching any problems that occur. NA #2 stated during interview on 11/04/16 at 8:49 AM that everyone had to observe and catch problems of residents sharing food, and eating with straws and fingers as able. Interview with the Nurse #3 on 11/04/16 at 9:06 AM revealed the staff try to keep those requiring closer supervision at the same table. She stated there were so many residents that needed supervision and redirection. There were no specific assignments for watching specific residents and generally there were 2 to 3 staff in the dining room. Interview with the Director of Nursing on 11/04/16 at 12:00 PM revealed that there was no system to determine what arrangement worked best in the dining room. She stated some residents did better with their plates on a tray and others did better with their plates on the table in terms of boundaries. She stated that had to be	F 241	dignified dinning experience, with completion by December 2, 2016. Nursing staff will continue to assess residents for dignified dining needs and make adjustments to their dining area, seating, assistive devices, or other specialized needs as indicated. Staff members who do not assist residents in a dignified dining experience will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The dietary manager and nursing administration will audit the dining experience on the memory care unit 5 times per week for 8 weeks, followed by 3 times per week for 4 weeks, then monthly for 3 months. The Director of Nursing will provide the QAPI committee with the results of the audits for review and analysis of patterns and trends. The QAPI committee will make recommendations for education or systematic changes as indicated.	

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F 241	Continued From page 3	F 241		

determined. She stated that staff tried to get all the residents in the dining room for meals and that resulted in the tables being crowed. She further stated that in recent months the census in the memory care unit almost doubled and they are considering 2 dining times. There was planned training related to Alzheimer's disease that may help give direction for the unit. She expected staff to watch residents and intervene.

2. Resident #51 was admitted to the facility on 02/29/16 with diagnoses including Alzheimer's Disease, osteoarthritis and psychosis.

The most recent Minimum Data Set (MDS), a quarterly dated 08/30/16 coded her with long and short term memory impairments, severely impaired decision making skills, being independent with eating with tray set up.

On 11/02/16 at 12:03 PM, Resident #51 was set up at the small square table for two in the dining room. There were 3 nurse aides, and activity staff member and 2 nurses in the room passing trays. At 12:23 PM, she was served her tray and she immediately picked up her spoon and started to feed herself the ice cream from the carton. At 12:35 PM, she left her spoon on the table and began eating the ice cream with her fingers. At 12:49 PM, she was taking her finger and sliding it across the table top, then licking her fingers and repeating this gesture even though she had food on her plate on top of which she put her drink cup. It was not until 12:51 PM before Nurse #2 came and assisted the resident to eat the food under her drink cup.

On 11/03/16 at 12:24 PM, Resident #51 was served her meal tray while sitting with 4 other

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 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 241	Continued From page 4	F 241		

residents at a round table. At 12:29 PM Resident #51 began eating her ice cream from the carton with her fingers. Nurse #1 was observed at the table cutting another resident's meat but did not intervene to redirect Resident #51 to use her spoon. At 12:36 PM she continue to scoop the ice cream from the container into her mouth with her fingers with no staff noticing or intervening. At 12:40 PM, Resident #51 picked up the entire slice of ham and began to feed it to herself. No staff offered to cut it up or encouraged her to use utensils even though Nurse #1 was removing other residents' trays from this same table. At 12:47 PM staff filled the tea of Resident #106 who was sitting at Resident #51's table but offered no assistance or redirection as Resident #51 continued to feed herself the ham with her fingers.

Nurse Aide (NA) #4 stated during interview on 11/03/16 at 4:54 PM that Resident #51 will use utensils when redirected. As staff passed out trays they tried to also keep a watch over people reaching for other's foods, leaving the room and eating with their fingers. Although there was no assigned seating, she tried to put those residents who needed closer supervision at the same table.

NA #1 was interviewed on 11/03/16 at 1:00 PM. She stated that she had to watch residents and redirect them when not using utensils.

Interview with the Nurse #3 on 11/04/16 at 9:06 AM revealed the staff try to keep those requiring closer supervision at the same table. She stated there were so many residents that needed supervision and redirection. There were no specific assignments for watching specific residents and generally there were 2 to 3 staff in

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F 241	Continued From page 5	F 241		

the dining room.

Interview with the Director of Nursing on 11/04/16 at 12:00 PM revealed that there was no system to determine what arrangement worked best in the dining room. She stated some residents did better with their plates on a tray and others did better with their plates on the table in terms of boundaries. She stated that had to be determined. She stated that staff tried to get all the residents in the dining room for meals and that resulted in the tables being crowed. She further stated that in recent months the census in the memory care unit almost doubled and they are considering 2 dining times. There was planned training related to Alzheimer's disease that may help give direction for the unit. She expected staff to watch residents and intervene.

3. Resident #80 was admitted to the facility on 01/28/15 with diagnoses including dementia, adult failure to thrive, anxiety, restlessness and agitation.

The most recent Minimum Data Set, a quarterly dated 09/06/16, revealed she had long and short term memory impairment, severely impaired decision making skills, no behaviors and was independent with set up for eating.

On 11/04/16 at 8:17 AM, Resident #80 was observed sitting at the table with her food in front of her playing with the straw. A staff member was feeding another resident in the room and another activity staff was at the doorway of the dining room watching. At 8:21 AM, Resident #80 was observed scraping her food with her fingers and a straw. Although staff were in the room and assisting other residents, no one approached

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 241	Continued From page 6	F 241		

Resident #80 to redirect or assist her to use her utensils and eat her food. At 8:25 AM, Resident #80 was just chewing on the straw. Nurse Aide (NA) # 2 sat with another resident at the table but did not intervene with Resident #80 until 8:30 AM.

Nurse Aide (NA) #5 stated during interview on 11/04/16 at 8:48 AM that residents are placed or come into the room and sit anywhere. There are certain residents such as Resident #80 that need to be closer monitored during eating and redirected or assisted. The staff in the dining room are responsible for watching intervening and catching any problems that occur.

NA #2 stated during interview on 11/04/16 at 8:49 AM that there was no assigned seating for residents and everyone had to observed and catch problems of residents sharing food, eating with straws and fingers, etc.

Interview with the Nurse #3 on 11/04/16 at 9:06 AM revealed the staff try to keep those requiring closer supervision at the same table. She stated there were so many residents that needed supervision and redirection. There were no specific assignments for watching specific residents and generally there were 2 to 3 staff in the dining room.

Interview with the Director of Nursing on 11/04/16 at 12:00 PM revealed that there was no system to determine what arrangement worked best in the dining room. She stated some residents did better with their plates on a tray and others did better with their plates on the table in terms of boundaries. She stated that had to be determined. She stated that staff tried to get all the residents in the dining room for meals and

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F 241	Continued From page 7 that resulted in the tables being crowed. She further stated that in recent months the census in the memory care unit almost doubled and they are considering 2 dining times. There was planned training related to Alzheimer's disease that may help give direction for the unit. She expected staff to watch residents and intervene.	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, record review, resident interviews and staff interviews, the facility failed to honor the choice to smoke when desired for 2 of 2 sampled residents assessed as being safe to smoke independently (Residents #174 and #86). The findings included: Review of the Resident Smoking Policy dated 10/20/14 included: 4. Smoking is only allowed during designated times in the designated smoking area. The facilities designated smoking times shall be posted in public view. 1. Resident #174 was admitted to the facility on 10/07/16 with diagnoses of congestive heart	F 242	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents 174 and 86 have both been discharged from the facility. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility reassessed the current smokers on 11/29 and found no other current residents with the potential to be a safe, independent smoker. Therefore, no	12/2/16

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F 242	Continued From page 8 failure, chronic kidney disease and chronic obstructive pulmonary disease. On 10/07/16 a Smoking Assessment was completed which stated Resident #174 had no cognitive loss, no visual deficits, no dexterity problems, smoked 5 to 10 cigarettes per day, smoked in the morning, afternoon and evening, and was not interested in smoking cessation options. The form noted that he was able to light his own cigarette, and required no smoking apron, no cigarette holder, and no supervision. A Resident Smoking Behavior Contract was completed and signed on 10/07/16 by both Resident #174 and the responsible party. At the top of this smoking contract was a note that if any listed item was not initialed then the facility would not allow smoking to occur. Both the resident and the responsible party agreed to all the listed items including: *I agree to only smoke in the designated area, at the designated times." The admission Minimum Data Set dated 10/14/16 coded Resident #174 as having intact cognition and being independent with all his activities of daily living skills. On 11/02/2016 at 11:25 AM Resident #174 was interviewed. He stated he was told that the facility had a schedule with specific times smoking was permitted. He stated that he was not told that he could smoke without supervision and if he was at home, he would smoke whenever he wanted. In addition to the designated supervised smoking times, he stated he could smoke at other times only if family or visitors accompanied him to the smoking area.	F 242	other residents were affected by the same deficient practice. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing provided in service training to nursing and social services staff on completion of the Point Click Care smoking assessment. Social Services will review the smoking assessments and place the resident's smoking regimen on the resident's plan of care. Residents seeking admission to the facility will be informed of the facility's tobacco policy, which outlines the smoking safety rules and facility designated areas. Residents will be given the choice to admit to the facility as a smoker or be provided smoking cessation support. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility Administrator or designee will review new admissions to ensure smoking assessments and acknowledgements are complete weekly for 8 weeks, then monthly for 2 months. Facility staff that fails to provide smoking privileges to a resident, as outlined on the care plan, will receive progressive discipline. The administrator will submit the results of the audits to the QAPI committed for review and recommendation of further education	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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

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F 242	Continued From page 9 On 11/03/16 at 10:04 AM, Resident #174 was observed smoking during the supervised smoking time. The Central Supply staff was presiding over the smoking area. She stated that staff was responsible for lighting all the cigarettes and no resident was permitted to smoke independently without supervision of staff. they were to smoke at designated times or with family when they visited. She further stated that residents were allowed to smoke only 2 cigarettes at each designated time. Resident #174 was observed smoking safely and using an ashtray during this time. On 11/03/16 at 3:20 PM the social worker was interviewed regarding smoking. She stated that every resident who wished to smoke had to sign the contract which stated smoking was always supervised and at designated times unless accompanied by family. She stated that she observed each resident smoke for each assessment. If a resident was deemed safe to smoke, such as Resident #174 was, then he was permitted to smoke at the 5 designated smoking times and have 2 cigarettes at each time. She stated the facility did not allow any resident, even if their smoking assessment deemed them safe, to smoke unsupervised. During an interview with the Administrator on 11/03/16 at 5:19 PM he stated that the facility felt it was safer for all residents to have oversight when smoking. The administrator was unable to explain how Resident #174's choice to smoke whenever he wanted had been honored with the smoking policy enforced as it is currently. 2. A form titled "Resident Smoking Behavior Contract" dated 04/19/16 and signed by Resident	F 242	or systematic changes needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 242	Continued From page 10	F 242		

#86 and the Social Worker (SW), listed stipulations of smoking including:
· I acknowledge that smoking is a privilege and not a right and the facility may suspend my privilege at any time.
· I agree to only smoke in the designated area at the designated time.
· I agree that I am not allowed to have in my possession and must turn over all smoking materials.
· I understand in cases of unsafe weather conditions that staff may suspend smoking privileges for all residents.
The form also revealed consequences of violating the smoking privileges up to discharge from the facility.

Resident #86 was readmitted to the facility on 07/13/16 with diagnoses including anxiety disorder, peripheral vascular disease (PVD) and chronic obstructive pulmonary disease (COPD).

Resident #86's Smoking Risk Assessment was completed and dated on 07/13/16 by Nurse #4, who assessed Resident #86 to be a safe smoker.

Review of Resident 86's quarterly Minimum Data Set (MDS) dated 09/06/16 revealed him to be cognitively intact and no limitations in the range of motion of his upper extremities.

On 11/01/16 at 10:09 AM the Activity Director (AD) was supervising six smokers including Resident #86. She stated that the smokers were assessed for safe smoking on admission and quarterly. The AD further stated the residents that were assessed to be safe smokers signed a contract on admission agreeing to the facility's rules on smoking. She stated that Resident #86

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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F 242	Continued From page 11 was assessed to be a safe smoker. On 11/01/16 at 3:04 PM Resident #86 stated he had smoked two packs of cigarettes a day for sixty five years and was use to smoking when he wanted to. On 11/03/16 at 3:28 PM an interview with the Social Worker (SW) revealed that she completed the Smoking Risk Assessment on admission and quarterly. She stated she watched the residents smoke from lighting their cigarettes to putting it out safely in the ashtray without incidences like dropping ashes or burning themselves and if they could do that they are considered a safe smoker. She further stated that she considered Resident #86 to be a safe smoker. Interview on 11/03/16 at 5:19 PM with the Administrator who stated all smokers had to smoke in the designated areas at the designated times due to residents injuring themselves in the past. He further stated he understood the issue of choices for the residents assessed as safe smokers and as far as he knew Resident #86 was deemed as a safe smoker.	F 242		
F 272 SS=E	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		12/2/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 12 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 reviews and staff interview, the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors related to pressure ulcer, activities of daily living, nutrition, psychotropic medication use, urinary incontinence, falls, cognition, vision and behaviors for 14 of 24 residents reviewed for the	F 272	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility update the Care Area Assessments (CAAs) to reflect the underlying causes, contributing factors,	

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 11/04/2016

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

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F 272	Continued From page 13 most comprehensive Minimum Data Set (Residents #6, #18, #29, #51, #56, #58, #100, #106, #112, #146, #162, #173, #174, #175). The findings included: 1. Resident #6 was admitted to the facility on 08/09/16 with diagnoses of peripheral vascular disease (PVD), diabetes and cerebral vascular accident (CVA). Review of the admission Minimum Data Set (MDS) dated 08/16/16 revealed Resident #6 was severely cognitively impaired and had a stage two pressure ulcer to the sacrum on admission to the facility. Review of the Care Area Assessment (CAA) dated 08/19/16 for Pressure Ulcer stated Resident #6 had diagnoses including a history of CVA, with left sided weakness, right above the knee amputation, PVD, diabetes and anxiety and depression. Resident #6 required extensive to total care with activities of daily living and was incontinent of bowel and bladder. Resident #6 had a stage two pressure ulcer to the sacrum that was present on admission. Treatments and tracking were in place. The CAA did not address how the pressure ulcer affected Resident #6's day to day function or activities or if it was being treated effectively.	F 272	risk factors, and how the trigger affected the resident day to day function and activities on residents 6,18,29,51,56,58,100,106,112,146,162,173,174, and 175. The corrected assessments with updated CAAs were transmitted by 12-2-16. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility nursing administration team reviewed the most recent comprehensive assessment on current facility residents, as of 11-23-16, for accuracy and completion of CAAs. with immediate corrections and resubmissions as indicate. The MDS nurses who completed the inaccurate assessments are no longer with the facility. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Interdisciplinary Team received in service training on the completion of CAAs from the regional clinical director, with completion by December 2, 2016. Facility nursing administration will review the CAA summaries for accuracy and completion weekly for 12 weeks. Any staff member noted to have incomplete or inaccurate CAA summaries will receive progressive discipline.	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 14 During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. 2. Resident #100 was admitted to the facility on 08/23/16 with diagnoses of end stage renal disease, diabetes and Alzheimer's disease. Review of the admission Minimum Data Set (MDS) revealed Resident #100 was cognitively intact and was on a mechanically altered diet. Review of the Care Area Assessment (CAA) dated 08/29/16 for Nutrition stated Resident #1 was on a mechanically altered diet related to chewing problems. The CAA did not address how Resident #100's chewing problems affected her day to day function or nutrition.	F 272	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The director of Nursing will submit the results of the audits to the QAPI committee for review and recommendation of further education or systematic changes needed.	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 15	F 272		

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.

3. Resident #112 was admitted to the facility on 08/26/16 with diagnoses of end stage renal disease, diabetes, cerebral vascular accident (CVA), non-Alzheimer's dementia, schizophrenia, bipolar disorder and asthma.

Review of the admission Minimum Data Set (MDS) dated 09/02/16 revealed Resident #112 was cognitively intact and required a therapeutic diet. The MDS further revealed Resident #112 had received antipsychotic medication 5 days and antianxiety medication 7 days out of the 7 day lookback period.

a. Review of the Care Area Assessment (CAA) dated 09/08/16 for Nutrition stated Resident #112 was on a therapeutic diet of regular low concentrated sugar related to diabetes. The CAA

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 16	F 272		

did not address how Resident #112's diet affected her diabetes.

b. Review of the Care Area Assessment (CAA) dated 09/08/16 for Psychotropic Medication Use stated Resident #112 had diagnoses of schizophrenia and bipolar disorder. She was independent with activity of daily living care, and able to feed herself. She has had no adverse reactions to medications at this time. The CAA did not address how her psychotropic medications affected her day to day activities or if the medications were effective.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.

4. Resident #18 was admitted to the facility on 08/11/16 with diagnoses of heart failure, non-Alzheimer's dementia, anxiety, depression and mood disorder.

Review of the admission Minimum Data Set (MDS) dated 09/13/16 revealed Resident #18 was cognitively intact. The MDS further revealed Resident #18 received antianxiety and antidepressant medication 7 days out of the 7 day

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 17	F 272		

lookback period.

Review of the Care Area Assessment (CAA) dated 09/16/16 for Psychotropic Medication Use stated Resident #18 should be monitored for changes and report to Physician as needed. Physician and pharmacy to monitor medications and make changes as needed. The CAA did not address how his psychotropic medications affected his day to day activities or if they were effective.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.

5. Resident #106 was admitted to the facility on 04/27/15 with diagnoses of diabetes, Alzheimer's disease, depression and psychotic disorder.

Review of the annual Minimum Data set (MDS) dated 04/20/16 revealed Resident #106 was cognitively intact. The MDS further revealed Resident #106 received antipsychotic and antianxiety medications 7 days out of the 7 day look back period.

Review of the Care Area Assessment (CAA) dated 04/27/16 for Psychotropic Medication Use

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 18	F 272		

stated Resident #106 was on psychotropic medications related to her active diagnoses of Alzheimer's dementia, psychosis, depression and sleep disorder. She resided on the facilities secured memory unit and needed assistance with her activities of daily living and decision making due to poor safety awareness. No adverse signs and symptoms noted at this time related to her medications. Staff to anticipate her needs and Nursing to monitor for signs and symptoms related to her medications. Physician and Pharmacist to monitor for any medication changes needed. The CAA did not address how her diagnoses and psychotropic medications affected her day to day activities or if they were effective.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.

6. Resident #162 was admitted to the facility on 07/01/16 with diagnoses of Alzheimer's disease and osteoporosis.

Review of the admission Minimum Data Set (MDS) dated 07/08/16 revealed Resident #162 was severely cognitively impaired and was always continent of bowel and bladder.

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 19	F 272		

Review of the Care Area Assessment (CAA) dated 07/13/16 for Urinary Incontinence stated Resident #162 was incontinent of both bowel and bladder. She had advanced organic brain syndrome and needed assistance with activities of daily living. Will develop care plan for staff to assist as needed. Nursing to monitor for changes and report to Physician as needed. Staff to keep resident clean and dry. The CAA did not address Resident #162's strengths and weaknesses or how her urinary incontinence affected her day to day activities.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.

7. Resident #29 was admitted to the facility on 07/07/16 with diagnoses including an artificial hip joint, an artificial eye, major depressive disorder, osteoarthritis, anxiety disorder and Alzheimer's Disease.

The admission Minimum Data Set dated 07/14/16 coded her with severely impaired cognition, impaired vision with corrective lenses, being independent with bed mobility, transfers 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 20	F 272		

walking, needing staff assist to balance when moving on and off the toilet and surface to surface transitions, and having no falls.

Review of the Care Area Assessments (CAA) failed to provide individual information explaining why these areas were a problem for the resident, how the problem impacted their day to day routines, any strengths or weaknesses she had that impacted these areas and an actual analysis of the problem relating to the resident as follows:
*The cognition CAA dated 07/15/16 stated that she had advanced Alzheimer's Disease, impaired cognition and impaired vision or hearing.
*The vision CAA dated 07/15/16 noted she only had one eye, had an artificial left eye, impaired vision, and difficulty seeing television, reading or participating in activities.
*The activity of daily living skills CAA dated 07/18/16 stated Resident #29 could ambulate with pretty good mobility and she needed assistance with personal care and toileting due to her poor cognitive function related to dementia. She resided in the locked unit.
*The fall CAA dated 07/18/16 stated that she was at risk for falls due to her decline in mental status, diagnoses of dementia and wandering in the locked unit.
The CAAs failed to provide an individual analysis of how her cognitive deficits affected her care and abilities, how her vision affected her day to day routine, what she was able to do for herself or how her inabilities to do own adls affected her, or what specific issues caused her to be at risk for falls.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 21	F 272		

the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. She stated she had not been taught to do comprehensive analysis of the problems, thought she was doing what she needed to do and she has been rushed to get the work completed due to staffing.

The Director of Nursing was interviewed at the same time with the MDS nurse on 11/04/16 at 11:08 AM. She stated there had been recent turnover with MDS staff and until the new owners took over in June, the budget did not allow for more than one full time MDS staff and one part time staff. In addition there had been many changes with the new ownership resulting in some upheaval with the MDS department. She confirmed the CAA needed improvement.

On 11/04/16 at 2:31 PM the social worker who completed the cognition and behaviors stated during interview she was not trained on what was required in a CAA. She was never trained to paint a picture of the individual resident relating to those areas. She stated she based her CAAs off the way the previous social worker completed them.

8. Resident #51 was admitted to the facility on 02/29/16 with diagnoses including Alzheimer's Disease, osteoarthritis and psychosis.

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 22	F 272		

The admission Minimum Data Set dated 03/08/16 coded her with severely impaired cognition, being physically abusive daily. being verbally abusive 1-3 days out of 7, rejecting care 4-6 days out of 7, receiving antipsychotic and antianxiety medications, and having had a fall in the previous month, the previous 2 to 6 months, and 1 fall since admission.

Review of the Care Area Assessments (CAA) failed to provide individual information explaining why these areas were a problem for the resident, how the problem impacted their day to day routines, any strengths or weaknesses she had that impacted these areas and an actual analysis of the problem relating to the resident as follows:
*The cognition CAA dated 03/08/16 noted she had Alzheimer's Disease, behavioral symptoms, psychiatric or mood disorders and impaired cognition.
*The behavioral CAA dated 03/08/16 stated the resident was not a threat to herself or others, she had long standing mental health problems related to anxiety, she may not recognize the caregiver or misinterpret the environment or other's actions, she was combative, refused medications and activities of daily living skills and wandered.
*The fall CAA dated 03/10/16 stated she experienced one fall since admission with no injuries. She wandered and fell at home was frequently combative and refused care. Staff anticipated her needs. She was noted to ambulate on the unit without staff assistance.
*The psychotropic medications CAA dated 03/10/16 stated she had advancing Alzheimer's Disease and dementia with behaviors. She was admitted to the memory care unit related to her impaired cognition and poor safety awareness. She currently received Seroquel and Ativan as

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

scheduled. She was noted to be monitored for targeted behaviors and side effects of medication.
The CAAs failed to provide an individual analysis describing how her behaviors and cognition affected her day to day routines and care, what the medications were actually treating and their effectiveness and why had a history of falling if she was independently ambulatory.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. She stated she had not been taught to do comprehensive analysis of the problems, thought she was doing what she needed to do and she has been rushed to get the work completed due to staffing.

The Director of Nursing was interviewed at the same time with the MDS nurse on 11/04/16 at 11:08 AM. She stated there had been recent turnover with MDS staff and until the new owners took over in June, the budget did not allow for more than one full time MDS staff and one part time staff. In addition there had been many changes with the new ownership resulting in some upheaval with the MDS department. She confirmed the CAA needed 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

On 11/04/16 at 2:31 PM the social worker who completed the cognition and behaviors stated during interview she was not trained on what was required in a CAA. She was never trained to paint a picture of the individual resident relating to those areas. She stated she based her CAAs off the way the previous social worker completed them.

9. Resident #56 was admitted to the facility on 10/27/15 with diagnoses including adult failure to thrive, dementia and chronic kidney disease.

The annual Minimum Data Set dated 09/27/16 coded here with long and short term memory impairment, moderately impaired cognition, requiring extensive assistance with most activities of daily living skills, and having no falls since the prior assessment.

Review of the Care Area Assessments (CAA) failed to provide individual information explaining why these areas were a problem for the resident, how the problem impacted their day to day routines, any strengths or weaknesses she had that impacted these areas and an actual analysis of the problem relating to the resident as follows:
*The cognition CAA dated 10/12/16 stated the family was aware of the resident's impaired cognition and the overall objective was for her to remain safe and maintain current level of functioning.
The activities of daily living skills (adls) CAA dated 10/11/16 stated she needed assistance with adls and was on the locked memory unit. She had dementia and needed extensive assistance.
The fall CAA dated 10/11/16 stated she was at risk for falls and staff was to assist with adls 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

observe for changes in condition.
The CAAs failed to provide an individual analysis describing how her cognition affected her day to day routines and care, what her strengths or weaknesses were to improve or maintain her adls abilities and what made her at risk for falls.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. She stated she had not been taught to do comprehensive analysis of the problems, thought she was doing what she needed to do and she has been rushed to get the work completed due to staffing.

The Director of Nursing was interviewed at the same time with the MDS nurse on 11/04/16 at 11:08 AM. She stated there had been recent turnover with MDS staff and until the new owners took over in June, the budget did not allow for more than one full time MDS staff and one part time staff. In addition there had been many changes with the new ownership resulting in some upheaval with the MDS department. She confirmed the CAA needed improvement.

On 11/04/16 at 2:31 PM the social worker who completed the cognition and behaviors stated

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 11/04/2016

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

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F 272	Continued From page 26	F 272		

during interview she was not trained on what was required in a CAA. She was never trained to paint a picture of the individual resident relating to those areas. She stated she based her CAAs off the way the previous social worker completed them.

10. Resident #146 was admitted on 06/17/16 with diagnoses including dementia with behaviors, depression, and hypertension.

The admission Minimum Data Set dated 06/30/16 coded her with severely impaired cognition, having other behaviors 1-3 days out of 7, wandering 1-3 days out of 7, requiring no assistance to extensive assistance with activities of daily living skills, being frequently incontinent of bowel and bladder and having had no falls.

Review of the Care Area Assessments (CAA) failed to provide individual information explaining why these areas were a problem for the resident, how the problem impacted their day to day routines, any strengths or weaknesses she had that impacted these areas and an actual analysis of the problem relating to the resident as follows:
*The cognition CAA dated 07/01/16 stated she had Alzheimer's Disease, behaviors, respiratory problems, impaired cognition and lack of frequent orientation, reassurance and reminders to help make sense of things.
*The behavior CAA dated 07/01/16 stated she was no threat to herself or others, she had wandering exit seeking behaviors, depression and anxiety and may have fear due to not recognizing the environment or misinterpreting the environment or actions of others and fatigue.
*The incontinent CAA dated 07/05/16 stated she was incontinent of urine and bowel occasionally

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

making her at risk for skin breakdown.
*The fall CAA dated 07/05/16 stated she was at risk for falls due to her wandering at times and she had diagnoses of atrial fibrillation and cardiomyopathy with a pacemaker.
The CAAs failed to provide an individual analysis describing how her behaviors and cognition affected her day to day routines and care, what specifically about wandering put her at risk for falls, and why she was incontinent at times.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. She stated she had not been taught to do comprehensive analysis of the problems, thought she was doing what she needed to do and she has been rushed to get the work completed due to staffing.

The Director of Nursing was interviewed at the same time with the MDS nurse on 11/04/16 at 11:08 AM. She stated there had been recent turnover with MDS staff and until the new owners took over in June, the budget did not allow for more than one full time MDS staff and one part time staff. In addition there had been many changes with the new ownership resulting in some upheaval with the MDS department. She

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

confirmed the CAA needed improvement.

On 11/04/16 at 2:31 PM the social worker who completed the cognition and behaviors stated during interview she was not trained on what was required in a CAA. She was never trained to paint a picture of the individual resident relating to those areas. She stated she based her CAAs off the way the previous social worker completed them.

11. Resident #174 was admitted to the facility on 10/07/16 with diagnoses including hypertension, chronic kidney disease, cerebral vascular disease and hemiplegia on the left nondominant side.

The admission Minimum Data Set dated 10/14/16 coded him with intact cognition and being independent with activities of daily living skills (ADLs).

Review of the Care Area Assessments (CAA) failed to provide individual information explaining why the ADL area was a problem for the resident, how the problem impacted his day to day routines, any strengths or weaknesses he had that impacted these areas and an actual analysis of the problem relating to the resident as follows:
*The ADL CAA dated 11/01/16 stated he had the potential to decline in functional level and staff were to assist with care as needed as he was working with therapy.
The CAA failed to describe any abilities or weaknesses he had or why he was admitted to the facility for therapy.

During an interview conducted on 11/04/16 at 11:08 AM the MDS nurse stated she had worked at the facility since 06/2016 and was trained 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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	F 272		

the previous MDS nurse on how to write a CAA summary. She further stated she had also been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them. She stated she had not been taught to do comprehensive analysis of the problems, thought she was doing what she needed to do and she has been rushed to get the work completed due to staffing.

The Director of Nursing was interviewed at the same time with the MDS nurse on 11/04/16 at 11:08 AM. She stated there had been recent turnover with MDS staff and until the new owners took over in June, the budget did not allow for more than one full time MDS staff and one part time staff. In addition there had been many changes with the new ownership resulting in some upheaval with the MDS department. She confirmed the CAA needed improvement.
12. Resident #58 was admitted to the facility on 11/20/2015 with diagnoses of history for cerebral vascular accident (CVA), dementia, osteoporosis, arthritis and depression.

Review of the annual Minimum Data Set (MDS) dated 09/26/2016 revealed Resident #58 was cognitively intact, continent of bowel and bladder but required extensive assistance with toileting, had mood state regarding B 12 injections, potential for falls, potential nutritional issues, and potential for side effects of psychotropic medications.

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 30	F 272		

Review of the Care Area Assessment (CAA) dated 10/05/2016 for Resident #58 revealed they did not provide individual information explaining why these areas were a problem for the resident, how the problems impacted her day to day routine, any strengths or weakness she had that impacted these areas and an actual analysis of the problem relating to the resident.

a. Urinary incontinence CAA for Resident #58 stated " will address interventions on ADL care plan. Resident is continent of both bowel and bladder " .

b. Mood state CAA for Resident #58 stated " resident is thinking that she is not getting her B12 shots on time and when she does get them it is not enough, always thinking that no one cares about her health " .

c. Nutritional CAA for Resident #58 stated " Resident has a BMI of 27 with a height of 62 inches and a weight of 149#. Resident is on a mechanically altered diet of mechanical soft related to chewing problems " .

d. Psychotropic Drug Use CAA for Resident #58 stated " Resident takes antidepressant, antianxiety and hypnotic medications. She is at risk for side effects and falls. Nursing to monitor changes and report to MD. Nursing to give meds as ordered " .

During an interview conducted on 11/04/2016 at 11:08 am the MDS nurse stated that she had worked at the facility since June, 2016 and was

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 31	F 272		

trained by the previous MDS nurse who was no longer at the facility on how to write a CAA summary. She also stated that she had been taking the MDS manual home with her to study. The MDS nurse stated she wrote the CAA summary by reviewing the triggered areas and writing the problem, the plan and reason the area triggered. She stated that she was not aware that she was " supposed to paint a picture of the resident with their individual strengths and weaknesses and how the triggered area affected them " .

During an interview conducted on 11/04/2016 at 11:21 am the Director of Nursing (DON) and the Administrator stated their expectation was the CAA summaries would give a description of the underlying causes, risk factors, and factors to be considered in developing individualized care plan interventions for all residents.

13. Resident #175 was admitted to the facility on 10/12/2016 with diagnoses of stage IV uterine cancer with metastasis to the lung, anxiety, bilateral lower extremity edema, and depression.

Review of the MDS dated 10/19/2016 revealed Resident #175 was cognitively intact, had potential for decline in ADL functional levels, potential for nutritional issues, and actual plan to return to the community.

Review of the CAA dated 10/25/2016 for Resident #175 revealed that they did not provide individual information explaining why these areas were a problem for the resident, how the problems impacted her day to day routine, any strengths or weakness she had that impacted these areas and an actual analysis of the problem relating 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 32	F 272		

resident.

a. ADL functional rehab potential CAA for Resident #175 stated " staff to assist as needed. Nursing to monitor for changes and adjust POC (plan of care) as needed. Make referrals as needed. Therapy to continue to treat as ordered " .

b. Nutritional CAA for Resident #175 stated " Resident has a BMI of 34 with a height of 60 inches and a weight of 175#. Resident is within her IBW (ideal body weight) and no special interventions are needed " .

c. Return to community referral CAA for Resident #175 stated " Resident states she will be returning home when she has completed her therapy and can return home safe. Will discuss services and equipment she will need when her discharge date is closer " .

During an interview conducted on 11/04/2016 at 11:08 am the MDS nurse stated that she had worked at the facility since June, 2016 and was trained by the previous MDS nurse who was no longer at the facility on how to write a CAA summary. She also stated that she had been taking the MDS manual home with her to study. The MDS nurse stated she wrote the CAA summary by reviewing the triggered areas and writing the problem, the plan and reason the area triggered. She stated that she was not aware that she was " supposed to paint a picture of the resident with their individual strengths and weaknesses and how the triggered area affected them " .

During an interview conducted on 11/04/2016 at

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 33	F 272		

11:21 am the Director of Nursing (DON) and the Administrator stated their expectation was the CAA summaries would give a description of the underlying causes, risk factors, and factors to be considered in developing individualized care plan interventions for all residents.

14. Resident #173 was admitted to the facility on 10/12/16 with diagnoses including hypertension (HTN), anxiety disorder and chronic obstructive pulmonary disease (COPD) requiring continuous oxygen.

Review of the admission Minimum Data Set (MDS) dated 10/19/16 revealed Resident #173 was severely cognitively impaired, no short or long term memory recall and required extensive assistance for transfers, walking and toilet use.

Review of the Care Area Assessment (CAA) dated 11/01/16 for Falls stated Resident #173 had diagnoses including cognitive impairment, anxiety disorder, incontinence and infection. Resident #173 required extensive assistance with transfers, walking and toilet use. Resident #173 also received a daily antidepressant medication. The Falls CAA did not address her day to day function or interventions put into place to prevent falls.

During an interview conducted on 11/04/16 at 11:08 AM the MDS Nurse stated she had worked at the facility since 06/2016 and was trained by the previous MDS Nurse on how to write a CAA summary. She further stated she had been taking the MDS manual home to study. The MDS Nurse stated she wrote the CAA summary by reviewing the triggered areas and writing what the problem

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 34 was, what the plan was and the reason the area triggered. She stated she did not know she was supposed to paint a picture of the resident with their strengths and weaknesses and how the triggered area affected them.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		12/2/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 35 by: Based on record review and staff interview the facility failed to accurately code information regarding falls, dental condition, smoking, and continence on the Minimum Data Sets for 6 of 24 sampled residents (Residents #29, #56, #146, #51, #174, and #162). The findings included: 1. Resident #29 was admitted to the facility on 07/07/16 with diagnoses including an artificial hip joint, an artificial eye, major depressive disorder, osteoarthritis, anxiety disorder and Alzheimer's Disease. The admission Minimum Data Set (MDS) dated 07/14/16 coded her with severely impaired cognition, impaired vision with corrective lenses, being independent with bed mobility, transfers and walking, needing staff assist to balance when moving on and off the toilet and surface to surface transitions, and having no falls. Review of the nursing notes, occurrence reports, and investigative notes revealed that Resident #29 had the following falls: *08/03/16 at 9:20 AM when she attempted to sit in a dining room chair and she and the chair tipped over and she landed on the floor; *08/15/16 at 7:50 AM when she slid off the bed trying to ambulate resulting in a skin tear; *08/30/16 at 11:35 AM when she was ambulating down the hallway and she left the walker behind and lost her balance; *09/18/16 at 8:00 PM when she was walking in her room without her walker attempting to get another resident to leave her room; and *10/05/16 at 12:00 PM when she was switching	F 278	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility has corrected the MDS assessments on residents 29,56 146, 51, 174, and 162. The corrected assessments were transmitted by 12/2/16. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility nursing administration team reviewed the most recent comprehensive assessment on current facility residents, as of 11/26/16, for accuracy and completion of sections H, L, and J1800 and J1900, with immediate corrections and resubmissions as indicated. The MDS nurses who completed the inaccurate assessments are no longer with the facility. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility Interdisciplinary Team received in service training on the completion of the MDS with accuracy from the regional clinical director, with completion by December 2, 2016. Facility MDS consultant will review MDS completion for accuracy monthly for 12-months 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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 36 chairs in the dining room and missed the chair when she went to sit down and landed on her buttocks resulting in skin tears. The quarterly MDS dated 10/11/16 coded her as having had no falls since her last assessment which was 07/14/16. None of the 5 falls had been documented on the MDS. Interview with the MDS nurse on 11/04/16 at 11:05 AM revealed she gathered the information for the MDS via the 2 computer systems which housed nursing charting, the paper medical records, and interviews with the resident and staff. She stated each fall was discussed in morning meetings and she was unable to state how these falls were missed being recorded on the MDS. Due to a change in staffing, the MDS nurse could not say who recorded the information on the MDS or why it was not accurate. The Director of Nursing present during he MDS interview on 11/04/16 at 11:05 AM stated there was a lot of changes that had occurred in the MDS office as well as staffing issues. She stated she expected the MDS to be accurate. 2. Resident #146 was admitted on 06/17/16 with diagnoses including dementia with behaviors, depression, and hypertension. The admission Minimum Data Set dated 06/30/16 coded her with severely impaired cognition, having no teeth problems including not being edentulous and having had no falls. The undated admission nursing data collection tool stated she had no teeth, had a full set of upper and lower dentures that did not fit.	F 278	report any comments on discrepancies to the facility Administrator. Assessments noted to be inaccurate will be corrected and resubmitted. Any staff member noted to have incomplete or inaccurate MDS's will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility QAPI committee will review the consultant monthly reports for patterns and trends. The facility QAPI committee will make recommendations for further education or systematic changes as indicated.	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 37	F 278		

Review of the nursing notes and occurrence reports revealed Resident #146 had the following documented falls:
*08/12/16 at 8:00 PM a nurse observed her getting out of her chair and place herself on the floor resulting in a lower arm skin tear;
*08/17/16 at 2:45 AM an aide in the hallway heard a loud noise and found the resident lying on her left side, complaining of head pain and with a purple hematoma on her forehead above her left eye;
*09/06/16 at 6:30 PM she had been eating in her room when staff noticed her on the floor sliding across the floor;
*09/08/16 at 1:40 PM staff witnessed her fall in hallway when trying to transfer her self from a chair; and
*09/12/16 at 3:15 PM when staff witnessed her stand up, loose her balance and fall onto her buttocks.

The quarterly MDS dated 09/20/16 coded her having no falls since the previous assessment which was 06/30/16. None of the 5 falls had been documented on the MDS.

Interview with the MDS nurse on 11/04/16 at 11:05 AM revealed she gathered the information for the MDS via the 2 computer systems which housed nursing charting, the paper medical records, and interviews with the resident and staff. She stated each fall was discussed in morning meetings and she was unable to state how these falls were missed being recorded on the MDS. Due to a change in staffing, the MDS nurse could not say who recorded the information on the MDS or why it was not accurate. In addition she could not say why the edentulous

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 38	F 278		

condition was not captured on the initial MDS.

The Director of Nursing present during he MDS interview on 11/04/16 at 11:05 AM stated there was a lot of changes that had occurred in the MDS office as well as staffing issues. She stated she expected the MDS to be accurate.

3. Resident #51 was admitted to the facility on 02/29/16 with diagnoses including Alzheimer's Disease, osteoarthritis and psychosis.

The admission Minimum Data Set (MDS) dated 03/08/16 coded her with severely impaired cognition and having had a fall in the previous month, the previous 2 to 6 months, and 1 fall since admission.

Review of the nursing notes and occurrence reports revealed Resident #51 experienced the following falls:
*04/23/16 at 4:09 AM she became shaky and was lowered to the floor;
*05/22/16 at 4:30 PM she slid off the chair onto the floor;

The quarterly MDS dated 06/02/16 coded that Resident #51 had no falls since the previous assessment which was 03/08/16. The MDS did not accurately document the 2 falls she had since the previous assessment.

Review of the nursing notes and occurrence reports revealed Resident #51 experienced the additional falls:
*07/09/16 at 11:39 AM she fell out of the chair leaning forward;
*07/14/16 at 10:00 AM she fell out of a chair onto her left side;

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 11/04/2016

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

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F 278	Continued From page 39	F 278		

*08/02/16 at 11:40 AM she fell forward out of a chair onto her left elbow;
*08/04/16 at 9:30 PM she fell onto the floor from a chair when she leaned forward;
*08/08/16 at 10:05 PM she fell to the floor when leaning forward;

The quarterly MDS dated 08/30/16 coded her as having had no falls since the previous assessment which was 06/02/16. The MDS did not accurately document the 5 falls she had since the previous assessment.

Interview with the MDS nurse on 11/04/16 at 11:05 AM revealed she gathered the information for the MDS via the 2 computer systems which housed nursing charting, the paper medical records, and interviews with the resident and staff. She stated each fall was discussed in morning meetings and she was unable to state how these falls were missed being recorded on the MDS. Due to a change in staffing, the MDS nurse could not say who recorded the information on the MDS or why it was not accurate.

The Director of Nursing present during he MDS interview on 11/04/16 at 11:05 AM stated there was a lot of changes that had occurred in the MDS office as well as staffing issues. She stated she expected the MDS to be accurate.

4. Resident #56 was admitted to the facility on 10/27/15 with diagnoses including dementia, chronic kidney disease and adult failure to thrive.

The quarterly Minimum Data Set (MDS) dated 07/19/16 coded her as having severely impaired cognition, requiring extensive assistance with most activities of daily living skills including

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 40	F 278		

ambulation and having had no falls.

Review of nursing notes and occurrence reports revealed Resident #56 had the following falls:
*08/30/16 at 7:05 PM she fell trying to get out of a chair and into another resident's bed;
*09/07/16 at 9:30 PM she fell when staff left the room to obtain supplies; and
*09/15/16 at 4:22 PM she leaned too far out of her chair and fell.

The annual MDS dated 09/27/16 coded her with long and short term memory, moderately impaired decision making skills, requiring extensive assistance with most activities of daily living skills, being nonambulatory and having had no falls since the previous assessment which was 07/19/16. The MDS did not document the 3 falls she experienced during this assessment period.

Interview with the MDS nurse on 11/04/16 at 11:05 AM revealed she gathered the information for the MDS via the 2 computer systems which housed nursing charting, the paper medical records, and interviews with the resident and staff. She stated each fall was discussed in morning meetings and she was unable to state how these falls were missed being recorded on the MDS. Due to a change in staffing, the MDS nurse could not say who recorded the information on the MDS or why it was not accurate.

The Director of Nursing present during he MDS interview on 11/04/16 at 11:05 AM stated there was a lot of changes that had occurred in the MDS office as well as staffing issues. She stated she expected the MDS to be accurate.

5. Resident #174 was admitted to the facility on

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 41	F 278		

10/07/16 with diagnoses of chronic kidney disease, cerebral vascular disease, congestive heart failure, and chronic obstructive pulmonary disease.

A smoking assessment dated 10/07/16 noted that he was assessed as a safe smoker.

The physician's history and physical dated 10/12/16 noted that he was here for exacerbation of CHF and smoked a pack of cigarettes per day.

The admission Minimum Data Set dated 10/14/16 coded him with intact cognition, having no moods, no delirium, no behaviors and being independent with all his activities of daily living skills. He was also coded as not using tobacco.

Interview with the MDS nurse on 11/04/16 at 11:21 AM revealed she gathered the information for the MDS via the 2 computer systems which housed nursing charting, the paper medical records, and interviews with the resident and staff. She stated that she was not sure who actually completed the MDS section on smoking and gave no explanation for the error.

The Director of Nursing present during he MDS interview on 11/04/16 at 11:21 AM stated there was a lot of changes that had occurred in the MDS office as well as staffing issues. She stated she expected the MDS to be accurate.

6. Resident #162 was admitted to the facility on 07/01/16 with diagnoses of osteoporosis and Alzheimer's disease.

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 278	Continued From page 42 Review of the admission Minimum Data Set (MDS) dated 07/08/16 revealed Resident #162 was severely cognitively impaired. The MDS further revealed Resident #162 was always continent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 07/13/16 for Urinary Incontinence stated Resident #162 was incontinent of both bowel and bladder. She had advanced organic brain syndrome and needed assistance with activities of daily living. Will develop care plan for staff to assist as needed. Nursing to monitor for changes and report to Physician as needed. Staff to keep resident clean and dry. Review of the nurse's notes from 07/13/16 to present revealed Resident #162 was always incontinent of bowel and bladder. During an interview conducted on 11/04/16 at 12:12 PM the MDS Nurse stated the admission MDS dated 07/08/16 for Resident #162 should have been coded as always incontinent of bowel and bladder. She stated she did not know why it was coded as always continent of bowel and bladder.	F 278		
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	F 280		11/28/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 43 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 each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to reassess the effectiveness of interventions and review the plan of care for a resident on psychotropic medications for 7 months, a change in continence for 2 of 24 residents (Resident #18, #51). The findings included: 1. Resident #18 was admitted to the facility on 08/11/16 with diagnoses that included cancer, non-Alzheimer's dementia, anxiety, depression and mood disorder. Review of the annual Minimum Data Set (MDS) dated 09/13/16 revealed Resident #18 was cognitively intact. The MDS further revealed Resident #18 received antianxiety and antidepressant medications 7 days during the 7 day look back period. Review of the care plan dated 01/28/16 revealed	F 280	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 18 had his psychotropic medication use care plan updated on 11-28-16 to reflect his current review. Resident 51 had her incontinence care plan updated on 11-28-16 to reflect her current interventions and needs. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility nursing administration team audited current care plans on 11-28-16 for current updates, with immediate updates and corrections as indicated.	

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 11/04/2016

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F 280	Continued From page 44 Resident #18 was at risk for potential adverse medication side effects related psychotropic medication administration as evidenced by behaviors and or side effects in relation to psychotropic medication use. The goal was for Resident #18 to not experience adverse medication side effects from use of psychotropic medications. Goal time: three months and as needed related to changes in resident condition. The care plan's next review date for psychotropic medication administration was 07/25/16 and stated the care plan was reviewed 07/25/16. Continue plan of care through next quarterly review and update. During an interview conducted on 11/04/16 at 3:20 PM the MDS Nurse stated Resident #18's care plan for psychotropic medication use had not been reviewed or updated from 01/28/16 until 07/25/16. She stated when she began working at the facility in June 2016 she was given a stack of care plans that were very behind in being reviewed and updated and she did her best to get them caught up. During an interview conducted on 11/04/16 at 3:30 PM the Director of Nursing stated it was her expectation for all care plans to be reviewed and updated as needed and every 3 months. 2. Resident #51 was admitted to the facility on 02/29/16 with diagnoses of Alzheimer's Disease, psychosis, hypertension, and osteoarthritis. The admission Minimum Data Set (MDS) dated 03/08/16 coded her with severely impaired	F 280	Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. the facility Director of Nursing provided in service training to the Interdisciplinary team on updating care plans timely. The Director of Nursing or designee will perform audits of a random sample of 15 care plans weekly for 4 weeks, then 10 care plans weekly for 4 weeks, then 5 care plans weekly for 4 weeks for timeliness. Staff found not to have completed timely updates to care plans will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility Director of Nursing will submit the results of the audit to the QAPI committee for review and recommendation of further education or systematic changes needed.	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 45	F 280		

cognition, having verbal and physical behaviors, being independent with bed mobility, transfers, ambulation, required limited assistance with toileting and was always continent of bowel and bladder.

The Care Area Assessment for urinary incontinence dated 03/10/16 stated she was continent of bladder and bowel and staff provided assistance with continence care related to her advancing Alzheimer's Disease and behaviors.

The quarterly MDS dated 06/02/16 coded her with long and short term memory impairment and moderately impaired decision making skills, having no behaviors, requiring limited assistance with toileting and being occasionally incontinent of bladder and always being incontinent of bowel.

A care plan was developed on 07/25/16 for potential for alteration in bowel elimination related to need for assistance in activities of daily living care (ADL). The goal was to establish and maintain a regular pattern for bowel care with interventions to give medications as prescribed, provide diet as ordered and observe for bowel movements.

A care plan was developed for self care deficit on 07/28/16 related to a need for assistance with activities of daily living care. The goal was to maintain present level of participation with interventions to assist with ADLs as needed and for nurses to assess her functional level, administer medications and observed for side effects and effectiveness and monitor vital signs.

A care plan was developed 08/08/16 for the problem of potential for impairment of skin

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 46	F 280		

integrity related to any episodes of urine and or bowel incontinence. The goal was "if changes in skin integrity should occur, show signs of improvement". Interventions included staff should assist with hygiene, attempt to keep clean and dry, use incontinence pads as needed, change wet linen as needed and report any changes in skin integrity to nursing.

The quarterly MDS dated 08/30/16 coded her with long and short term memory impairment, severely impaired decision making skills, requiring total assistance with toileting and always being incontinent of bowel and bladder.

No additional interventions or changes were made to the care plans which mentioned Resident #51's continence.

Resident #51 was observed with soaked outer garments across her buttocks on 11/01/16 at 3:10 PM, on 11/03/16 at 9:38 AM and on 11/04/2016 8:59 AM.

Nurse Aide (NA) #3 stated during interview on 11/03/16 at 9:38 AM that Resident #51 stated she had incontinent episodes, resisted requests from staff to use the bathroom but also used the commode when placed on the toilet. The resident was described as combative especially during bathroom and shower times.

On 11/03/16 at 10:38 AM, NA #1 led Resdient #51 from the dining room to the shower/bathroom. The resident's pants were visibly wet across her buttocks. Upon leaving the shower/bathroom at 10:45 AM, NA #1 stated that when she took the resident to the commode a few minutes before she changed her soiled brief

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 47 and she also urinated in the commode. NA #1 stated that she had both continent and incontinent episodes. On 11/03/2016 at 4:45 PM NA #4 was interviewed and stated she has declined and was currently mostly incontinent. She further stated that Resident #51 was incontinent on second shift most of the time. During an interview conducted on 110/04/16 at 11:21 AM, the MDS nurse gave no explanation for the continence care plan to not be revised for the increased incontinence. On 11/04/16 at 3:20 PM the MDS Nurse stated when she began working at the facility in June 2016 she was given a stack of care plans that were very behind in being reviewed and updated and she did her best to get them caught up. The Director of Nursing (DON) stated on 11/04/16 at 11:49 AM that since Resident #51's continence had declined the care plan should have been changed to reflect it. During an interview conducted on 11/04/16 at 3:30 PM the DON stated it was her expectation for all care plans to be reviewed and updated as needed and every 3 months.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to transcribe physician	F 281	Address how corrective action will be accomplished for those residents found to	12/2/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 281	Continued From page 48 order's and properly administer medications for 1 of 1 resident reviewed for dialysis (Resident #112). The findings included: Resident #112 was admitted to the facility on 08/26/16 with diagnoses including coronary artery disease, end stage renal disease and diabetes. Review of the admission Minimum Data Set (MDS) dated 09/02/16 revealed Resident #112 was cognitively intact. The MDS further revealed Resident #112 received dialysis. Review of the Dialysis Physician orders dated 09/14/16 for Resident #112 revealed the following: 1. Discontinue Resident #112's multi-vitamin. 2. Start Daily-vite 800 1 tab after dialysis on dialysis days. 3. Make sure calcium-acetate (a medication used for reducing blood phosphate levels in people with end stage kidney disease on dialysis who have high phosphate levels) 2100 milligrams (mg) was being given while eating, not before or after meals. Review of the September, October and November 2016 Medication Administration Record's (MAR) revealed the order to discontinue the multi-vitamin and start the Daily-vite 800mg after dialysis on dialysis days was never changed or transcribed to the MAR. Review of the November 2016 MAR revealed the order for calcium acetate 2100mg had not been transcribed to the MAR. An observation was made of the November MAR	F 281	have been affected by the deficient practice. Resident 112 recommendations for medication changes from dialysis were reviewed with the physician and updated orders transcribed into the resident's medication administration record (MAR) for administration as ordered, as presented during survey. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility nursing staff conducted a chart to MAR reconciliation of current residents as of November 30, 2016 with immediate transcription corrections or physician notification as indicated. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing provided in service training to facility licensed nursing staff regarding the proper transcription of physician orders. The facility has put into place dialysis communication folders for each resident to improve collaboration and continuity of care with resident dialysis providers and the facility. Order recommendations from the dialysis center will be reviewed with the attending physician for approval and transcription. Any staff member found non-compliant	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 281	Continued From page 49 on 11/03/16 at 3:52 PM with Nurse #1 and she agreed the order for calcium acetate 2100mg and the Daily-vite were not listed on the 11/2016 MAR and were not being administered to Resident #112. She further stated the order for the multi-vitamin was still on the 11/2016 MAR and was being administered to Resident #112. During an interview conducted on 11/03/16 at 3:58 PM the Nurse Manager stated it was the nurse on duty's responsibility to review the dialysis communication sheet and transcribe any new orders when Resident #112 returned from dialysis. An interview was attempted with the nurse that worked on 09/14/16 and received the dialysis communication sheet and orders but she did not return the surveyors calls. During an interview conducted on 11/03/16 at 4:50 PM the Director of Nursing stated it was her expectation for all orders to be transcribed to the MAR correctly. She stated they had recently changed computer systems and that could have contributed to the transcription error but it was still the facility's responsibility to administer medications and transcribe orders correctly. An interview conducted on 11/04/16 at 9:08 AM with Resident #112's Dialysis Physician revealed it was his expectation for the facility to review the dialysis communication forms each time Resident #112 returned from dialysis and carry out orders as he had written them.	F 281	with order transcription accuracy will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility nursing administration team will conduct audits of new physician orders 5 times a week for 4 weeks then 2 times per week for 8 weeks by comparing the new orders report to the resident chart. The results of the audits will be reported to the QAPI committee for review with the committee recommending further education or systematic changes as needed.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		12/2/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 312	Continued From page 50 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to change the urine soaked pants of 1 of 1 resident reviewed for incontinence (Resident #51). The findings included: Resident #51 was admitted to the facility on 02/29/16 with diagnoses of Alzheimer's Disease, psychosis, hypertension, and osteoarthritis. The admission Minimum Data Set (MDS) dated 03/08/16 coded her with severely impaired cognition, having verbal and physical behaviors, being independent with bed mobility, transfers, ambulation, required limited assistance with toileting and was always continent of bowel and bladder. The history and physical completed by the physician on 03/10/16 mentioned Resident #51 had intermittent incontinence of urine. The Care Area Assessment for urinary incontinence dated 03/10/16 stated she was continent of bladder and bowel and staff provided assistance with continence care related to her advancing Alzheimer's Disease and behaviors. The quarterly MDS dated 06/02/16 coded her with	F 312	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility management had the nursing staff change the resident's pants immediately after being notified, as evidenced during survey. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility administrative and nursing staff identified no other residents through rounds during the survey that had soiled clothing from incontinence, as evidenced during survey. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility certified nursing assistants were provided with ADL documentation training for accuracy by the corporate MDS consultant on November 7, 2016	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 312	Continued From page 51 long and short term memory impairment and moderately impaired decision making skills, having no behaviors, requiring limited assistance with toileting and being occasionally incontinent of bladder and always being incontinent of bowel. A care plan was developed 08/08/16 for the problem of potential for impairment of skin integrity related to any episodes of urine and or bowel incontinence. The goal was "if changes in skin integrity should occur, show signs of improvement". Interventions included staff should assist with hygiene, attempt to keep clean and dry, use incontinence pads as needed, change wet linen as needed and report any changes in skin integrity to nursing. The quarterly MDS dated 08/30/16 coded her with long and short term memory impairment, severely impaired decision making skills, requiring total assistance with toileting and always being incontinent of bowel and bladder. No additional interventions or changes were made to the care plans which mentioned Resident #51's continence. On 11/03/16 at 10:37 AM Resident #51 pushed back from the dining room table where she had eaten breakfast and slowly stood up. At 10:38 AM NA #1 came into the dining room and encouraged the resident to follow her into the shower/bathroom. At this time, Resident #51 was observed with visibly wet pants across the buttocks. At 10:45 AM, NA #1 and the resdient came out of the shower/bathroom and NA #1 encouraged her to go back into the dining room. Again the resident was observed wearing the same visibly wet pants. At this time, NA #1 was	F 312	with any staff missing the in-service having a make-up session provided by the Director of Nursing, completed by December 2, 2016. Director of Nursing and Assistant Director of Nursing provided in service training on providing the necessary services to maintain good personal hygiene to facility nursing staff, completed by December 2, 2016. Any staff found not to provided appropriate personal hygiene to facility residents will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility nursing administration team will review resident's personal hygiene can clothing during facility rounds conducted 5 times per week for 12 weeks. results of the audits will be presented by the Director of Nursing to the QAPI committee to review for patterns and trends. The QAPI committee will make recommendations for further education or systematic changes as indicated.	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 312	Continued From page 52 asked about it and she stated she had not noticed her pants were soiled and took the resident back to be changed. During follow up interview with NA #1 on 11/03/16 at 10:54 AM, NA #1 stated that once in the bathroom, the resident's pants were pulled down to her knees and the resdient sat on the commode and urinated. Once she stood up and leaned over, NA #1 stated she provided incontinent care and changed her brief and pulled her pants up. She further explained that although she was facing Resdient #51's back side she did not notice her pants were soiled. Interview with the Director of Nursing on 11/04/16 at 11:05 AM revealed she expected staff to make sure Resident #51's clothes were clean and dry after incontinent care.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to reassess and	F 315	Address how corrective action will be accomplished for those residents found to	12/2/16

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 53 implement measures to determine the causes of increased incontinence for 1 of 1 sampled resident reviewed for incontinence (Resident #51). The findings included: Resident #51 was admitted to the facility on 02/29/16 with diagnoses of Alzheimer's Disease, psychosis, hypertension, and osteoarthritis. The admission Minimum Data Set (MDS) dated 03/08/16 coded her with severely impaired cognition, having verbal and physical behaviors, being independent with bed mobility, transfers, ambulation, required limited assistance with toileting and was always continent of bowel and bladder. The history and physical completed by the physician on 03/10/16 mentioned Resident #51 had intermittent incontinence of urine. The Care Area Assessment for urinary incontinence dated 03/10/16 stated she was continent of bladder and bowel and staff provided assistance with continence care related to her advancing Alzheimer's Disease and behaviors. The quarterly MDS dated 06/02/16 coded her with long and short term memory impairment and moderately impaired decision making skills, having no behaviors, requiring limited assistance with toileting and being occasionally incontinent of bladder and always being incontinent of bowel. A care plan was developed on 07/25/16 for potential for alteration in bowel elimination related to need for assistance in activities of daily living	F 315	have been affected by the deficient practice. Resident 51 was assessed by Occupational Therapy on 11/22/16 for recommendations to improve continence. Resident 51 was also started on a toileting program on 11/28/16. Resident 51's care plan was updated on 11/28/16. The nursing assistant who failed to change resident 51's clothing was counseled. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility reevaluated residents with a decline in bladder function for interventions to improve continence and toileting programs. Resident care plans were updated as indicated. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing provided in service training to facility nursing staff regarding using the Stop and Watch process to report a change in condition, such as continence; completed by December 2, 2016. the Director of Nursing provided in service training to facility nursing staff on bowel and bladder, and toileting programs; completed December 2, 2016. Facility nursing administration team will review 24 hour	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 315	Continued From page 54 care (ADL). The goal was to establish and maintain a regular pattern for bowel care with interventions to give medications as prescribed, provide diet as ordered and observe for bowel movements. A care plan was developed for self care deficit on 07/28/16 related to a need for assistance with activities of daily living care. The goal was to maintain present level of participation with interventions to assist with ADLs as needed and for nurses to assess her functional level, administer medications and observed for side effects and effectiveness and monitor vital signs. A care plan was developed 08/08/16 for the problem of potential for impairment of skin integrity related to any episodes of urine and or bowel incontinence. The goal was "if changes in skin integrity should occur, show signs of improvement". Interventions included staff should assist with hygiene, attempt to keep clean and dry, use incontinence pads as needed, change wet linen as needed and report any changes in skin integrity to nursing. The quarterly MDS dated 08/30/16 coded her with long and short term memory impairment, severely impaired decision making skills, requiring total assistance with toileting and always being incontinent of bowel and bladder. No additional interventions or changes were made to the care plans which mentioned Resident #51's continence. Resident #51 was observed with soaked outer garments across her buttocks on 11/01/16 at 3:10 PM.	F 315	reports and Stop and Watch reports in the daily clinical meeting to identify resident with a change in bladder function. Residents with a change in bladder function will be evaluated for interventions to improve continence and for toileting programs. Care plans will be updated with new interventions as appropriate for each resident. Staff who fail to report change in resident condition will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility MDS staff will report any residents that trigger on the assessment as occasionally or frequently incontinent without a toileting program to the Director of Nursing on a weekly basis for 12 weeks. The Director of Nursing will review the resident that triggered for interventions to improve continence or toileting programs as appropriate. The QAPI committee will review the trigger reports and follow up for patterns and trends. The QAPI committee will make recommendations for further staff education or systematic changes to improve facility resident's continence.	

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 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 315	Continued From page 55	F 315		

On 11/02/2016 3:20 PM one nurse aide was heard telling another nurse aide that she was not to wake Resdient #51 up to go to the bathroom as she would not go until she got up. Continued observations revealed NA #4 woke her on 11/02/16 at 3:53 PM and offered to take her to the bathroom several times but she refused. Another offer to assist her to the bathroom was made at 4:23 PM and the resident again declined.

Nurse Aide (NA) #3 stated during interview on 11/03/16 at 9:38 AM that Resident #51 stated she had incontinent episodes, resisted requests from staff to use the bathroom but also used the commode when placed on the toilet. NA #3 stated that Resdient #51 will do for herself when she makes her mind up to do something. She further stated that if Resident #51 was told that her mama wants her to go she will go to the bathroom. She stated Resident #51 was very slow to respond.

Observations were made on 11/03/2016 from 8:58 AM until 10:37 AM of Resident #51 sitting at the same table which she ate breakfast. At 10:38 AM Resident #51 scooted back in her chair, pushed up on the arms of the chair and stood. she is scooting chair back and looks like trying to stand pushing up on hand rails. Once she stood she pulled at the back of her pants. At this time NA #1 entered and encouraged the resident to leave the dining room. as the resident left the dining room, her pants were visibly wet across the buttocks. NA #1 guided her to the shower/bathroom. She then came out of the shower/bathroom at 10:45 AM and the NA proceeded to encourage her and guide her back into the dining room. NA #1 stated Resident #51

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 11/04/2016

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

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F 315	Continued From page 56	F 315		

was wet with urine, sat on the commode and urinated. NA #1 stated that once she is on the commode, Resident #51 usually will urinate. NA #1 stated she had continent and incontinent episodes.

On 11/03/2016 at 4:45 PM NA #4 was interviewed and stated she had declined and was currently mostly incontinent. She further stated that Resident #51 was incontinent on second shift most of the time but she did not recall Resident #51 wetting so much urine soaked her outer garments.

On 11/04/16 at 8:56 AM, Resident #51 was observed sitting at the dining room table from breakfast. At 8:59 AM, NA #1 encouraged her to leave the dining room so it could be cleaned. NA #1 proceeded to encouraged her to walk with her to the shower/bathroom. At this time, Resident #51 was observed to have visibly wet pants across the buttocks.

On 11/04/16 at 10:26 AM, NA #3 was interviewed. NA #3 stated she was usually responsible for Resident #51 full time. When asked about toileting practices, NA #3 stated that normally resident #51 was already up, dressed and in the dining room when she arrived for her shift at 7:00 AM. She stated that she did not offer to take Resdient #51 to the bathroom in the mornings before breakfast because she was busy getting other resident's up.

During an interview conducted on 11/04/16 at 11:42 AM, the MDS nurse gave no explanation for Resident #51's change in continence and stated that this was a significant change for the resident. No explanation was provided for the lack 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 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 315	Continued From page 57 further assessment and intervention. Interview with the Director of Nursing on 11/04/16 at 11:05 AM revealed she expected staff to make sure Resident #51 was taken to the bathroom prior to breakfast. The Director of Nursing (DON) stated on 11/04/16 at 11:49 AM that since Resident #51's continence had declined, the resident should have been re-evaluated and a new plan implemented related to incontinence. She further stated there were many changes that had occurred in the MDS office which caused the MDS nurse to be overwhelmed.	F 315		
F 323 SS=E	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 analyze the root cause for repeated falls and implement changes to the care plan to prevent further falls for 1 of 5 sampled residents reviewed for falls. Resident #51 fell 8 out of 9 times from a sitting position in a chair and no changes were made to address her falling alseep or poor seating position to prevent further falls. The findings included:	F 323	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. resident 51 fall interventions were reviewed and the care plan and care guide were updated with current interventions to reduce the risk of falls with injuries.	12/2/16

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 11/04/2016

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

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F 323	Continued From page 58 Resident #51 was admitted to the facility on 02/29/16. Her diagnoses included Alzheimer's Disease, psychosis, osteoarthritis and degenerative joint disease. Review of nursing notes and occurrence reports revealed that on 03/07/16 at 2:30 PM Resident #51 was sitting in a chair at the nursing station leaning forward and sleeping. She came out of the chair and fell onto her knees. A new intervention was to offer to assist her to bed when sleepy. The admission Minimum Data Set (MDS) dated 03/08/16 coded her with having severely impaired cognition, being independent with bed mobility, transfers, and walking, receiving antipsychotic and antianxiety medications. She was coded with no range of motion impairment and steady with transitions at all times. She was coded has having fallen in the last month, in the last 2 to 6 months and once since her admission. The Care Area Assessment (CAA) for falls completed 03/10/16 stated Resident #51 had one fall since admission with no injuries. She was noted to be wandering and falling at home and family opted for memory care unit. She was frequently combative with staff and refused care. Staff were to anticipate all needs due to her impaired cognition. She was able to ambulate in the memory care unit without staff assistance. Nursing was to monitor for further decline in resident's safety awareness. A care plan for falls was developed for falls on 03/07/16 with the goal for her to have no injury. The interventions included for nurses to observe,	F 323	Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility reviewed for resident fall care plans of current residents with a fall occurring in the facility in the last six months as of November 28, 2016. The Interdisciplinary Team reviewed current interventions for effectiveness and recommended to discontinue or initiate interventions as appropriate. Care plans and care guides were updated on residents whose interventions changed. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility Director of Nursing in-serviced facility staff on resident fall prevention techniques, completed by December 2, 2016. The facility moved the care guides into the resident rooms for easier access by the direct care staff at the point of care. Nursing administration will immediately update care plans and care guides to reflect changes in interventions during the clinical meeting's review of falls. Staff found not to be implementing fall mitigation interventions will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 59 record, and report all unsafe conditions and situations, encourage her to ask for assistance, instruct her in use of adaptive equipment and instruct on safety. Nursing was also supposed to encourage to assist her to bed when sleepy and encourage her to ask for assistance, assist her in use of eyeglasses, dentures, hearing aids (none of which she had) and keep telephone and call light in reach and anticipate her needs. On 03/08/16 the care plan intervention of encouraging her to bed when sleepy was added. Review of the nursing notes, occurrence reports and investigations revealed the following falls and interventions for Resident #51: *On 04/23/16 at 4:09 AM she was standing at the nursing station shaky when she began to fall and was lowered to the floor by an aide. The intervention was for the physician to assess her and review laboratory results and medications. The physician saw her on 05/19/16 regarding ear pain and the psychiatrist saw her on 05/30/16 and increased her antipsychotic medication due to combativeness and psychosis. Neither note mentioned Resident #51's fall. *On 05/22/16 at 4:30 PM she was sitting on the edge of a dining room chair and slid to the floor onto her buttocks. On 05/23/16 the care plan intervention of offering to assist her with sitting all the way back in a dining room chair when in the dining room was added to the care plan. The quarterly MDS dated 06/02/16 coded her as being rarely understood or understanding, having long and short term memory impairment and moderately impaired cognition, being independent with bed mobility, transfers and ambulation and incorrectly having no falls since previous admission. She was coded with no range of	F 323	The facility Director of Nursing or designee will review a random sample of 10% of residents for fall interventions use as indicated on the care guided for 3 times per week for 4 weeks then 1 time per week for 8 weeks. Results of the audits and the fall incident log will be submitted to the QAPI committee for discussion of patterns and trends. The QAPI committee will make recommendations for further staff education or facility systemic changes as indicated.	

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 60	F 323		

motion impairment and steady with transitions at all times.

Falls continued per nursing notes, occurrence reports as follows:
*On 07/09/16 at 11:39 AM she was sitting in a chair at the nursing station leaning forward as she did daily and with frequent attempts did not sit back and she fell out of her chair onto her buttocks. This was witnessed by staff and the intervention was to increase visual checks.
*On 07/14/16 at 10 AM, she was sitting at the nursing station in a chair and she leaned over and fell out of the chair onto her left side. The intervention was to offer to assist her to bed after breakfast.
*On 08/02/16 at 11:40 AM, she was sitting in a chair at the nursing station and fell forward landing on her left elbow. Notes revealed that staff repositioned her several times throughout the morning. The new intervention was to offer diversional activities when leaning in a chair.

On 08/03/16 a therapy screen for Resident #51 due to falling stated she sat and leaned excessively forward in a chair requiring frequent repositioning. She was also noted to slide out of the chair onto the floor. There were no injuries and therapy did not feel an evaluation was indicated.

*On 08/04/16 at 9:30 PM she was sleeping in a chair in front of the nursing station while leaning forward and fell head first onto the floor. Staff could not get to her in time when they saw her falling. She sustained a hematoma. The intervention was a therapy referral, which was done on 08/03/16.
*On 08/06/16 at 10:05 PM Resident #51 was

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 61	F 323		

sitting in a by the nursing station leaning over. She had been repositioned several times and fell out of the chair and landed on the floor on her left side. Nursing staff was in the process of going to reposition her again but could not get to her before she fell to the floor. She sustained a small abrasion to her left knee. The intervention was for the physician to review her medications. The physician noted he saw her on 09/27/16 at which time he noted her blood pressure was normotensive and her medications were to continue. The physician did not mention her falls in his note. The psychiatrist saw her on 09/12/16 and talked about her psychosis but never mentioned her falling.

The quarterly MDS dated 08/30/16 coded her with long and short term memory impairments, having severely impaired decision making skills, requiring extensive assistance with bed mobility and transfers and being independent with ambulation. She was incorrectly coded as having had no falls since previous assessment. She was coded with no range of motion impairment and steady with transitions at all times.

The next fall Resident #51 had was on 10/01/16 at 2:20 PM when she was sitting in a chair in the dining room. She had refused to attend activities on the outside patio and while staff were cleaning the dining room, Resident #51 slid off the dining room chair onto the floor after falling asleep in the chair. The intervention was for staff to attempt to redirect the resident when leaning forward.

The care guide for nurse aides to follow for Resident #51 was found in a book at the nursing station. The care guide was undated and included the need to offer to lay her down after

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 11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	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 62	F 323		

breakfast, encourage her to go to bed when sleepy and to provide diversional activities. There was nothing about positioning when she was seated in a chair.

Observations were made of Resident #51 having poor seating positions as follows:
*On 11/01/16 at 9:24 AM and 10:17 AM Resident #51 was seated in a chair opposite the nursing station, bent over with her head in her lap. She independently could sit up straight.
*On 11/01/16 at 12:04 PM and 4:17 PM she was in the dining room with her head bent to her lap.
*On 11/02/16 at 11:35 AM sitting in the dining room with her head bent over onto her lap. She was pushed up closer tot he table so her head rested on the table at 11:40 AM.
*On 11/02/16, she was observed at a dining room table with her head resting on the table at 3:12 PM, at 3:20 PM, at 3:28 PM, at 3:47 PM, at 3:52 PM, and at 3:53 PM. Although staff would occasional speak to her she would immediately lay her head back on the table often snoring. At 3:53 PM Nurse Aide (NA) #4 stated she had narcolepsy and slept all the time. She further stated they tried to keep her at a table to support her head. Resident #51 remained with her head on the table during observations on 11/02/16 at 4:23 PM and 4:31 PM.
*On 11/03/16 Resident #51 was observed in the dining room seated in a chair leaning forward onto the table at 8:58 AM, at 9:30 AM, and at 9:38 AM. Interview with NA #3 on 11/03/16 at 9:38 AM revealed Resident #51 leaned forward all the time unless she was eating then she would immediately lean forward again. NA #3 stated the resident never wanted to lay down. When asked what was planned to keep her from falling, NA #3 stated nothing other than to consider a helmet to

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 11/04/2016

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

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F 323	Continued From page 63	F 323		

protect her head.
*On 11/03/16 at 10:55 AM, Resident #51 was seated at the side of a round table, not facing the round table in the dining room, with her head bent forward at arm chair level. Activity staff was observed not to intervene and taking residents to the courtyard. At 11:01 AM NA #5 aroused her and encouraged and took her to the courtyard as the resident walked bent over following the NA.
*On 11/03/16 at 4:13 PM Resident #51 was seated beside the round table in the dining room, not facing toward the dining room with her head on her lap snoring. At 4:45 PM NA #4 was observed seated next to her trying to wake her up. NA #4 stated staff often turn her toward the table in the dining room for support but she turns herself away at times.
*On 11/04/16 at 8:56 AM, she was observed sitting at the dining room table a few feet from the table leaned over, fiddling with her clothing.

During an interview with Nurse #3 on 11/04/16 at 9:08 AM, the nurse was asked what was in place to prevent Resident #51 from falling. She stated staff try to keep her in eyesight most of the time and we will redirect her to sit up and get someone to sit next to her.

An interview with NA #3 who took care of her most of the time was conducted on 11/04/16 at 10:26 AM. NA #3 stated she was not sure why Resident #51 continued to fall. She further stated that she recently returned from a leave of absence for 4 months and was unaware of the resident falling before or after her return.

Resident #51 was observed opposite the nursing station on 11/04/16 at 2:45 PM leaning over with her head in her lap. Staff were standing around

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F 323	Continued From page 64 the nursing station. On 11/04/2016 at 2:55 PM Resident #51's falls and interventions were discussed with the Assistant Director of Nursing (ADON) who was responsible for tracking and trending falls and involved in care plan interventions. She related that every work day she obtained the reports form nursing related to resident falls. She obtained the incident reports and witness statements. Each fall was also discussed at morning meetings. Within 24 hours the ADON followed up on every fall to make sure that she had a clear idea of what happened and that follow up was in place and appropriate. After reviewing each fall and intervention, ADON stated at 3:43 PM that many of the falls were due to the way Resident #51 sat on the edge of the chair and she instructed staff to make her sit back. She revealed that some staff are afraid of her due to combative behaviors. She also stated that the physicians should mention in their notes that they reviewed her medications specifically due to her frequent falling. She stated notes were left in the physician's book to review the medications when that was the planned intervention following the fall. ADON stated she expected staff to engage the use of a table for support and encourage activities to keep her busy. She also stated that there was a planned inservice specific to Alzheimer's for staff education. She was not able to describe how Resident #51's continued falling from a chair was being addressed.	F 323		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		12/2/16

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 333	Continued From page 65	F 333		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility failed to transcribe physician order's and properly administer medications for 1 of 1 resident reviewed for dialysis (Resident #112).
The findings included:
Resident #112 was admitted to the facility on 08/26/16 with diagnoses including coronary artery disease, end stage renal disease and diabetes.
Review of the admission Minimum Data Set (MDS) dated 09/02/16 revealed Resident #112 was cognitively intact. The MDS further revealed Resident #112 received dialysis.
Review of the Dialysis Physician orders dated 09/14/16 for Resident #112 revealed the following:
1. Make sure calcium-acetate (a medication used for reducing blood phosphate levels in people with end stage kidney disease on dialysis who have high phosphate levels) 2100 milligrams (mg) was being given while eating, not before or after meals.
Review of the November 2016 MAR revealed the order for calcium acetate 2100 mg had not been transcribed to the MAR.
An observation was made of the November MAR on 11/03/16 at 3:52 PM with Nurse #1 and she agreed the order for calcium acetate 2100 mg was not listed on the 11/2016 MAR and was not being administered to Resident #112.
During an interview conducted on 11/03/16 at 3:58 PM the Nurse Manager stated it was the nurse on duty ' s responsibility to review the dialysis communication sheet and transcribe any new orders when Resident #112 returned from

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident 112 recommendations for medication changes from dialysis were reviewed with the physician and updated orders transcribed into the resident's medication administration record (MAR) for administration as ordered, as presented during survey.

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.

The facility nursing staff conducted a chart to MAR reconciliation of current residents as of November 30, 2016 with immediate transcription corrections or physician notification as indicated.

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur.

The Director of Nursing provided in service training to facility licensed nursing staff regarding the proper transcription of physician orders. The facility has put into place dialysis communication folders for each resident to improve collaboration

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 333	Continued From page 66 dialysis. An interview was attempted with the nurse that worked on 09/14/16 and received the dialysis communication sheet and orders but she did not return the surveyors calls. During an interview conducted on 11/03/16 at 4:50 PM the Director of Nursing stated it was her expectation for all orders to be transcribed to the MAR correctly. She stated they had recently changed computer systems and that could have contributed to the transcription error but it was still the facility's responsibility to administer medications and transcribe orders correctly. An interview conducted on 11/04/16 at 9:08 AM with Resident #112's Dialysis Physician revealed it was his expectation for the facility to review the dialysis communication forms each time Resident #112 returned from dialysis and carry out orders as he had written them.	F 333	and continuity of care with resident dialysis providers and the facility. Order recommendations from the dialysis center will be reviewed with the attending physician for approval and transcription. Any staff member found non-compliant with order transcription accuracy will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility nursing administration team will conduct audits of new physician orders 5 times a week for 4 weeks then 2 times per week for 8 weeks by comparing the new orders report to the resident chart. The results of the audits will be reported to the QAPI committee for review with the committee recommending further education or systematic changes as needed.	
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	F 371		11/28/16

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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F 371	Continued From page 67 by: Based on observations and interviews, the facility failed to date stored food and discard expired food in 1 of 3 nourishment rooms and 1 of 2 freezers in the kitchen. The findings included: 1. On 10/31/16 at 2:50 PM a tour of the kitchen was conducted with the Cook on duty. Observations noted a stand up freezer had a clear plastic box that was not the manufacturer's container with a lid that had several layers of uncooked sausage in it. The box was undated as to when the uncooked sausage was opened and stored in the freezer. There was also an undated gallon storage bag that was sealed with four pieces of factory cooked chicken in it. On 11/04/16 at 8:29 AM, the Dietary Manager said the clear box that contained the uncooked sausage in the kitchen freezer had a sticker that dissolved on it and the date could not be read. She stated she did not know how long the cooked chicken was in the freezer. 2. On 11/01/16 at 2:19 PM a tour of the nourishment rooms was made with the Charge Nurse. Found in the refrigerator in nourishment room C were two peanut butter and jelly sandwiches in sandwich bags dated 10/28/16, one pimento cheese sandwich in a sandwich bag dated 10/26/16, one sandwich that could not be determined what it was in a sandwich bag dated 10/25/16, ½ of a peanut butter and jelly sandwich in a sandwich bag dated 10/23/16, one frozen Activia yogurt with the factory printed date of 10/16/16 and one undated small bowl of frozen applesauce that had no lid on it.	F 371	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. the facility discarded all items that were unmarked or outdated in facility kitchen and pantries during the survey. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility administration team found no other outdated or unmarked foods throughout the survey after the discarding on November 1, 2016; as evidenced during survey. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. Dietary staff were in serviced by the dietary manager during survey on food storage policies. The facility dietary staff was also provided an in service by the dietician on food storage, including labeling and when to discard. the facility implemented a food storage policy with guidelines, as presented during survey. Staff was informed of the polity guidelines and any staff found to be non-compliant will received progressive discipline. The facility dietary manager will audit food storage areas in the kitchen and pantries	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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

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F 371	Continued From page 68 On 11/04/16 at 8:29 AM, the Dietary Manager (DM) stated that it was housekeeping's responsibility to clean the refrigerators in the nourishment rooms and dietary was supposed to supply them with juice, milk and snacks. She stated that dietary made a variety of sandwiches every day and took them to the nourishment rooms for the staff to offer the residents at night. If the sandwiches are not used they are put in the refrigerators and should not be kept longer than three days. She further added it was housekeeping's responsibility to discard the expired food. During an interview with the Administrator on 11/04/16 at 4:00 PM he stated the facility did not have a specific policy on food in the refrigerators, freezers or the nourishment refrigerators. He further stated that it was unacceptable for old food and undated food to be in the refrigerators.	F 371	5 times a week for 4 weeks then weekly for 8 weeks for proper storage and labeling. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility dietician will conduct monthly sanitation audits, including food storage, monthly and give the results to the facility administrator. The results of the dietary manager audits and the dietician audits will be presented to the QAPI committee for review. The QAPI committee will make recommendations for further education or systemic changes as indicated.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to keep the area around 3 of 3 the dumpsters clean and free of potential hazards. The Findings Included: Observations on 11/03/16 at 10:30 AM of the dumpster area with the Dietary Manager (DM) revealed three pieces of broken white glass, two	F 372	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility dumpster areas were cleaned immediately as evidenced during survey. Address how corrective action will be	11/28/16

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 372	Continued From page 69 nails each with a black ring attached to them that enabled them to stick straight up on the ground. The trash on the ground around all three dumpsters consisted of gloves, papers, torn briefs and pieces of wet cardboard. The lids of two of the dumpsters were not able to be closed because of the overflow of trash bags. During the tour of the dumpster area the DM stated she did not know whose responsibility it is to keep the dumpster area clean. Interview with the Maintenance Director (MD) on 11/03/16 at 10:40 AM the MD stated there was no specific department responsible to clean up the dumpster area. Interview with the Regional Director of Operations on 11/03/16 at 10:53 AM revealed she was aware of the condition of the dumpster area and stated she had asked the Administrator to check on it 11/02/16. She also stated she expected the dumpster area to be cleaned daily by the Maintenance department.	F 372	accomplished for those residents having the potential to be affected by the same deficient practice. The facility dumpster area showed no further issues with refuse on the ground, as evidenced during survey. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility staff was in serviced by the Administrator on the expected condition of the dumpster area are the requirements to clean up any loose trash on the ground. The Maintenance Director was notified of his responsibility to maintain cleanliness in the dumpster area throughout the day. the administrator will monitor the cleanliness of the dumpster area by doing rounds twice a day 5 times per week for 4 weeks then once a day 5 times per week for 4 weeks then weekly for 4 weeks. Staff found to be non-compliant with maintaining cleanliness in the dumpster area will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility Administrator will review the results of the audits with the Maintenance Director immediately as issues are noted. The facility Administrator will submit the results of the audits to the QAPI committee for patterns and trends. the	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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F 372	Continued From page 70	F 372	QAPI committee will make recommendations for further education or systemic changes as indicated.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document an acute episode of coughing in the resident's medical record for 1 of 24 residents (Resident #156). The findings included: Resident #156 was admitted on 05/18/16 with diagnoses including Alzheimer's disease, coronary artery disease, anxiety disorder and thyroid disorder. Review of Resident #156's quarterly Minimum Data Set (MDS) dated 08/23/16 revealed he had severely impaired cognitive skills, required set up	F 514	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility nurse documented a late entry on the acute episode of coughing in resident 156's medical record on 11/4/16 as presented during survey. The nurse who failed to document the acute episode was counseled. Address how corrective action will be accomplished for those residents having the potential to be affected by the same	12/2/16

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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

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F 514	Continued From page 71 only for eating and received a mechanically altered diet. Care Plan dated 05/23/16 stated Resident #156 required a mechanically altered diet related to chewing and swallowing problems. The goal stated Resident would comply with diet restriction and verbalize understanding of need for diet ordered. The interventions were to monitor food intake, report rejection to the dietary manager, provide ordered diet, offer replacement food and determine food likes. On 09/06/16 an evaluation of the care plan stated the goal was met and was ongoing as well as no change in plan of care was needed at that time. Observations on 11/02/16 at 12:22 PM revealed Resident #156 received a lunch diet of stew beef, rice, green peas, peaches and roll. After Resident fed himself a few bites of stew beef he began to cough continuously while continuing to feed himself. Staff removed Resident #156's tray and requested a puree diet from dietary. Resident received a puree diet of chopped stew over rice, mashed potatoes and puree peaches. Resident #156 fed himself the puree diet and the coughing subsided. Review of Resident #156's chart on 11/03/16 at 12:16 revealed the Resident was screened by the Speech Therapist who noted the report of coughing and choking while eating from nursing. The note also stated Resident became the services of Hospice on 11/02/16 and permission would be requested of Hospice to evaluate Resident. In the meantime Resident #156 would receive a puree diet for safe eating. On 11/04/16 at 2:10 PM a review of Resident	F 514	deficient practice. On November 28, 2016, the facility nursing administration team reviewed facility shift change reports for November 1 to November 27 for documentation on acute episodes, with immediate corrections as indicated. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing in serviced facility nursing staff on the Interact Program including the use of the SBAR and Stop and Watch forms; completed by 12/2/16.the Director of Nursing in serviced facility licensed nursing staff on the follow up of acute resident changes; completed by 12/2/16. Facility nursing administration team will review 24 hour reports and Stop and Watch reports in the daily clinical meeting for 12 weeks to identify residents with a change in condition. Residents with a change in condition will be evaluated for interventions and nursing documentation. Staff who fail to report or to document a change in resident condition will receive progressive discipline. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will provide the QAPI committee with the results of the audits for review and analysis of patterns	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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

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F 514	Continued From page 72 #156's chart revealed there was no documentation in the Nurses notes of the incident on 11/02/16 of Resident coughing and was given an alternate diet. Therefore no follow up documentation as to how Resident #156 was tolerating the puree diet. Interview with the Director of Nursing on 11/04/16 at 2:13 PM revealed she expected the nurses to document on acute episodes every shift until the situation subsides. On 11/04 16 at 3:20 PM interview with Nurse #1, stated she should have documented the coughing episode on Resident #156 on 11/02/16 when it occurred but she forgot.	F 514	and trends. The QAPI committee will make recommendations for further staff education or systemic changes.	
F 520 SS=E	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	F 520		12/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 520	Continued From page 73 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: The facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2015. This was for one recited deficiency which was originally cited in October of 2015 on a recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of accurate transcription of orders and proper administration of medication. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to F 281: Based on observations, record review and staff interviews the facility failed to transcribe physician orders and properly administer medications for 1 of 1 resident reviewed for dialysis (Resident #112). The facility was recited for F 281 for failing to accurately transcribe physician orders and properly administer medication. F 281 Accurate Transcription of Orders and Proper Administration of Medication was originally cited during the	F 520	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility has developed and implemented a Performance Improvement Plan to address the deficient practice in the area of medication transcription. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility conducted a chart to MAR reconciliation of current residents as of November 30, 2016 with immediate transcription corrections or physician notification as indicated. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The facility will identify potential transcription errors by routinely conducting monthly chart to MAR	

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	345197	A. BUILDING _____ B. WING _____	C 11/04/2016

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F 520	Continued From page 74 October 1, 2015 recertification survey for failing to accurately transcribe and properly administer medications for 2 of 6 residents (Resident #50 and Resident #44). During the recertification survey of October 31, 2016 the facility was cited again for failure to accurately transcribe and properly administer medication to a resident. During an interview on 11/4/2016 at 5:37 PM the facility Administrator explained they monitored quality assurance activities in monthly and quarterly meetings. He stated they followed the plan of correction from the previous survey and they monitored the deficiencies from previous citations. He explained it was an on-going process and they tried to audit the things they had failed at in the past but it was difficult to monitor and keep everything in compliance with staff changes and because there was so much to monitor in the facility.	F 520	reconciliation reviews for 6 months. The Director of Nursing will also review monthly pharmacy consultant reports to identify potential transcription errors. Staff found to have deficient transcription practices will receive progressive discipline. Any patterns or trends of deficient practice will initiate an updated Performance Improvement Plan submitted by the Director of nursing to the Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility results of the monthly audits and any resultant Performance Improvement Plans will be submitted to the QAPI committee for review. The QAPI committee will meet monthly for 6 months and make recommendations for further education or systemic changes based on review of the monthly audits. The QAPI committee will provide oversight for the execution of the Performance Improvement Plan. the audits and QAPI committee notes will be reviewed by the Regional Clinical Director to assure issues have been identified and corrective measures have been put into place.	