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 08/22/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted 8/19/19 through 8/22/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #0TU911.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint survey was conducted on 8/19/19 through 8/22/19. There were a total of 39 allegations investigated and all were unsubstantiated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		9/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2019

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately document code status in both the electronic medical record and paper chart for 2 of 29 residents (Resident #10 and Resident #21) reviewed for advance directives. The findings included: 1) Resident #10 was admitted to the facility on 8/18/16 with diagnoses that included non-Alzheimer ' s dementia. A review of the resident's most recent Minimum Data Set (MDS) was a significant change assessment dated 5/13/19. The MDS revealed Resident #10 had severely impaired cognitive skills for daily decision making. Section J of the MDS assessment reported the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months. Section O of the MDS indicated she was receiving Hospice	F 578	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) The Social Worker(SW) reviewed and updated the advanced directives for Resident #10 on 8/30/19, and a physicians order was written and input into the electronic medical record on 8/30/19. 2) The Social Worker reviewed and updated the advanced directives for Resident #21 on 9/10/10. A physicians order was written and input into the electronic medical record on 9/10/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 578	Continued From page 2 care while a resident at the facility. Review of Resident #10's current care plan in her electronic medical record included an area of focus which indicated the resident was a full code status (which indicated cardiopulmonary resuscitation should be initiated in the event of cardiac or respiratory arrest). The care plan was dated with a review start date of 8/5/19 and target completion date of 8/19/19. A notation dated 5/7/19 on the care plan revealed Resident #10 was under Hospice care. A review of the resident's physician's orders in the electronic medical record included a current order dated 2/24/17 for "Full Code" status. A notation on Resident #10's Homepage in the electronic medical record indicated her code status was "Full Code." A review of Resident #10's paper chart included a form entitled, "Attachment O Resuscitation Designation Order" dated 2/4/19. This form indicated the resident did not desire cardiopulmonary resuscitation to be performed at this facility if she suffered cardiac or respiratory arrest (Do Not Resuscitate or DNR code status). Further review of the resident's paper chart revealed she was admitted to Hospice on 5/3/19. An interview was conducted on 8/21/19 at 1:50 PM with Nurse #1. Nurse #1 was a hall nurse whose usual assignment included caring for Resident #10 on 1st shift. During the interview, Nurse #1 was asked where a resident's advance directives (including code status) were kept. She reported this information was usually kept in both the resident's electronic medical record and in the	F 578	Current facility residents are risk to be affected by the alleged deficient practice of accurately documenting code status in the electronic medical record and paper chart. The Social Worker completed an audit of current facility records on 9/12/19, to validate that residents electronic medical record and paper medical record matched the residents wishes regarding advanced directives. There were 39 discrepancies identified. All discrepancies were corrected by the Social worker and the licensed nurses by 9/12/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Upon admission the Admission Director(AD) or the licensed nurse (LN)will review advanced directives with the resident and/or the Resident representative, to identify the wishes of the resident regarding their advanced directives. The resident or the Resident representative will sign the advanced directive form. The licensed nurse will notify the Physician and receive a physician order to support the resident wishes for advanced directive. The MDS nurse will initiate or update the residents care plan to support their advanced directive choice. The SW and/or the MDS nurses will review advanced directives with the resident and/or the RP quarterly, annually and significant change and update forms, physician orders and care	

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F 578	Continued From page 3 resident's paper chart. Upon review, the nurse confirmed Resident #10 ' s electronic medical record indicated her code status was full code. However, Nurse #1 reported because the resident had stickers on the front of her paper chart to indicate she was a Hospice patient, she "would know" Resident #10 was not a full code. An interview was conducted on 8/21/19 at 3:08 PM with Social Worker (SW) #2. Upon inquiry, the SW stated she was responsible to check to be sure an advanced directive was completed for a new resident at the time she did her initial assessment. SW #2 also reported a change in the advance directive for a current resident would be initiated by a Physician ' s Order and SW #1 would be notified of the change. An interview was conducted on 8/21/19 at 3:53 PM with SW #1. During the interview, SW #1 reported the SW's role was to check residents' advance directives on the chart at the time of quarterly and annual assessments to be sure they matched up with their previous code status. When asked if both the electronic medical records and paper charts were checked, he stated, "Yes ...try to check both of them." An interview was conducted on 8/22/19 at 11:06 AM with the facility's MDS Coordinator. The MDS Coordinator reported she had been in her position approximately 1 and ½ months. Upon review of Resident #10's electronic medical record and care plan, the MDS Coordinator confirmed both records indicated the resident was a full code. When asked, the MDS Coordinator reported she would typically review the Physician ' s Orders and Order Summary (generated from the electronic medical record) to identify a resident's	F 578	plans when changes are made. The Regional Director of Clinical Services, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Workers(SW) completed education on 9/13/19, for the admission staff and licensed nurses regarding process for obtaining advanced directives and initiating orders and care plans. Education will be provided during orientation for newly hired licensed nurses or admission staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON or ADON will audit new admission and readmission resident charts 5 times a week for 4 weeks, then weekly for 2 months, to validate that advanced directives were obtained upon admission or readmission, physician order obtained and input into the electronic medical record, and care plan initiated or updated to reflect the accurate code status. The DON or the ADON will review the audits monthly to identify patterns/trends and will update plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI meeting, and audits will continue at the discretion of the QAPI committee.	

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F 578	Continued From page 4	F 578		

code status on their care plan.

An interview was conducted on 8/22/19 at 11:55 AM with the facility's Administrator. The discrepancies noted between the Resident #10's code status in her electronic medical record and paper chart were discussed during the interview. When asked who was responsible to ensure the code status information from these sources of information were accurate and consistent with one another, he reported it should be a team effort between Nursing and Social Services. The Administrator stated, "I can see the disconnect, and they should match."

2) Resident #21 was admitted to the facility on 12/3/18 with diagnoses that included Alzheimer's dementia.

A review of the resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/24/19. The MDS revealed Resident #10 had severely impaired cognitive skills for daily decision making.

Review of Resident #21's current care plan in her electronic medical record included an area of focus which indicated the resident was a full code status (which indicated cardiopulmonary resuscitation should be initiated in the event of cardiac or respiratory arrest). This area of focus was initiated on 12/4/18 and revised on 6/12/19.

Further review of Resident #21's electronic medical record revealed there wasn't a physician's order to designate the resident's code status.

A review of Resident #21's paper chart included a

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F 578	Continued From page 5	F 578		

form entitled, "Attachment O Resuscitation Designation Order" dated 12/3/18. This form indicated the resident did not desire cardiopulmonary resuscitation to be performed at this facility if she suffered cardiac or respiratory arrest (Do Not Resuscitate or DNR code status).
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An interview was conducted on 8/21/19 at 1:50 PM with Nurse #1. Nurse #1 was a hall nurse whose usual assignment included caring for Resident #21 on 1st shift. During the interview, Nurse #1 was asked where a resident's advance directives (including code status) were kept. She reported this information was usually kept in both the resident's electronic medical record and in the resident's paper chart. Upon request, the nurse reviewed Resident #21's electronic medical record and confirmed no code status was listed in the record. She also confirmed there was not a "goldenrod" (yellow form indicating a resident's code status) or a Medical Orders for Scope of Treatment (MOST) form inside the cover (first page) of Resident #21's paper chart. Nurse #1 reported if she didn't see the goldenrod or MOST form on first page inside a resident's paper chart, she would assume the resident was a full code.

An interview was conducted on 8/21/19 at 3:08 PM with Social Worker (SW) #2. Upon inquiry, the SW stated she was responsible to check to be sure an advanced directive was completed for a new resident at the time she did her initial assessment. SW #2 also reported a change in the advance directive for a current resident would be initiated by a Physician's Order and SW #1 would be notified of the change.

An interview was conducted on 8/21/19 at 3:53

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F 578	Continued From page 6 PM with SW #1. During the interview, SW #1 reported the SW's role was to check residents' advance directives on the chart at the time of quarterly and annual assessments to be sure they matched up with their previous code status. When asked if both the electronic medical records and paper charts were checked, he stated, "Yes ...try to check both of them." An interview was conducted on 8/22/19 at 11:06 AM with the facility ' s MDS Coordinator. The MDS Coordinator reported she had been in her position approximately 1 and ½ months. Upon review of Resident #21's electronic medical record, the MDS Coordinator confirmed that other than the care plan indicating she was a full code, there was no code status reported in the resident's record. The MDS Coordinator stated that in Resident #21's case, she would need to go to the paper chart to confirm her code status, then check with Social Services to determine which code status (full code or DNR) was accurate. An interview was conducted on 8/22/19 at 11:55 AM with the facility's Administrator. The discrepancies noted between the Resident #21's code status in her electronic medical record and paper chart were discussed during the interview. When asked who was responsible to ensure the code status information from these sources of information were accurate and consistent with one another, he reported it should be a team effort between Nursing and Social Services. The Administrator stated, "I can see the disconnect, and they should match."	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		9/16/19

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F 609	Continued From page 7 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a 5-day report to the State Agency of an investigation of a fracture to the left arm which was of unknown origin for 1 of 1 (Resident # 6) residents reviewed for an injury of unknown origin. The findings included:	F 609	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Nursing (DON) initiated and faxed a 24 hour report on 5/16/19 to the State agency for Resident #6,	

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F 609	Continued From page 8 Resident #6 was admitted to the facility on 12/7/15. Her diagnoses included, in part, dementia, cerebrovascular accident, contractures and osteoporosis. A review of a quarterly Minimum Data Set assessment dated 5/9/19 indicated Resident #6 had severe cognitive impairment. She was totally dependent on staff for her activities of daily living. Resident #6 had impairment in range of motion to both upper and both lower extremities. A nurse's note dated 513/19 revealed a skin assessment had been completed for Resident #6. There were no new areas of concern noted. No redness, bruising or rash noted. A nurse's note dated 5/14/19 at 6:00 PM revealed Resident #6 was seen by the nurse practitioner for generalized discomfort. Resident #6 was noted to be grimacing more with care. A nurse's note dated 5/15/19 at 4:40 PM revealed Nurse Aide #1 notified Nurse #5 of some bruising found to Resident #6 's left upper arm. NP #1 was notified, and a new order was received to obtain an x-ray of the left humorous. The mobile x-ray company was notified. Resident #6's family member was called and a message was left for the family member to return the call. A nurse's note dated 5/15/19 at 5:35 PM revealed Resident #6 was given pain medication and the Director of Nursing (DON) was notified. A review of the x-ray results received on 5/16/19 at 1:38 AM revealed proximal left humorous mildly displaced/impacted fracture. Clinical	F 609	regarding a fracture of unknown origin. The 5 day investigation was completed and faxed to the state agency on 5/22/19, but the fax confirmation form was not kept with the report. The DON re sent the 5 day investigation on 9/9/19, to the state agency and a fax confirmation form was obtained and placed in the investigation folder. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing completed a review state reportable incidents on 9/13/19, from May 1, 2019 through August 30, 2019, to validate that each reportable sent had a fax confirmation form, validating that the report and investigation was received by the state agency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Clinical Director provided education for the Administrator and the DON regarding the process for submitting facility reported incidents and maintaining a fax confirmation form to validate that the 24 hour report and investigation was received by the state agency. The investigations along with the fax confirmations will be filed in a folder labeled with the residents name and date of incident in the administrators office.	

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F 609	Continued From page 9 correlation was advised. Clinical or repeat examination follow up was advised. Nurse Practitioner #2 was called and an order was received to have the facility physician check x-ray in the morning. A review of the investigation conducted by the facility revealed the Director of Nursing (DON) was made aware of the incident on 5/16/19 at 4:30 AM. A 24-hour report was faxed to the State Agency on 5/16/19 at 1:43 PM. According to the information provided by the facility, the 5-day investigation was completed on 5/22/19, however, there was no evidence the results of the 5-day investigation were faxed to the State Agency. An interview conducted on 8/22/19 at 8:37 AM with the DON revealed she would have to look for the receipt for the fax of the 5-day report. An interview conducted on 8/22/19 at 2:30 PM with the corporate nurse consultant revealed there was no receipt of the 5-day investigation being faxed to the State Agency. She stated she expected the 24- hour report and the 5-day investigation along with the fax confirmation to the State Agency to be kept in one folder.	F 609	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the DON will keep a log/checklist of all reportable incidents that include date of submission of the 24 hour and 5 day including receipt of fax confirmation. The Administrator and/or the DON will review log 5 times a week to validate that investigations and confirmations are sent/received. This will be an ongoing process.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		9/16/19

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F 756	Continued From page 10 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and consultant pharmacist, Nurse Practitioner and staff interviews, the consultant pharmacist failed to identify and report an extended release medication with instructions "do not crush" from the manufacturer was ordered to be given via a feeding tube for 1 of 6 residents (Resident #109) reviewed for unnecessary medications.	F 756	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #109 has a feeding tube and receives her medication via the feeding tube. The licensed nurse notified the physician on 8/21/19, and obtained an	

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F 756	Continued From page 11 Record review revealed Resident #109 was admitted to the facility on 4/24/19 with diagnoses that included stroke, seizures, and aphasia that required the resident to have a feeding tube. Review of the most recent quarterly Minimum Data Set (MDS) dated 7/30/19 revealed Resident #109 had severe cognitive impairment and required one to two-person extensive to total assistance with activities of daily living. The MDS indicated the resident required a feeding tube and received 51% or more of her total calories via her feeding tube. Review of Resident #109's active Care Plan revealed she required a feeding tube, was to have nothing by mouth (NPO), and medications were to be given as ordered by the physician. Review of Resident #109's Physician Orders revealed an order placed on 6/8/2019 for Divalproex Sodium ER Tablet Extended Release 24 Hour 500 MG 1 tablet to be given via her feeding tube once a day related to Epilepsy (seizures). Review of Resident #109's Medication Administration Record revealed the medication was given daily as ordered. During an observation and interview with Nurse #6 on 8/21/19 at 3:15 PM she stated that all of the medications ordered for Resident #109 were crushed prior to administering them via the resident's feeding tube. She stated the resident does not receive any medications, meals, or fluids by mouth. The medication packet for the ordered Divalproex Sodium ER Tablet Extended Release 24 Hour 500 MG was observed and several tablets were missing from the packet.	F 756	order to change Divalproex ER to delayed release sprinkles. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Facility residents that require medications to be crushed are at risk to be affected by the alleged deficient practice. The Regional Clinical Director provided education for the pharmacist on 8/26/2019 regarding the discrepancy found The Pharmacist completed an audit on 8/27/19, for current facility residents that require medications to be crushed, to identify medications that should not be crushed. There were 54 residents identified that needed medications to be changed to an appropriate medication that can be crushed. The Licensed nurses reviewed the recommendations with the physician and new orders were obtained and completed on 9/12/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The licensed nurses will notify the physician and obtain an order to crush medications and will send order electronically and/or fax to the pharmacy when a resident requires crushed medication. The Pharmacist will review resident medications monthly and will validate for residents that receive crushed medications are not receiving medications that should not be crushed.	

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F 756	Continued From page 12 The instructions "Do Not Crush" were noted on the top left hand corner of the pill package. Review of the Pharmacy Consultant's Notes for Resident #109 from June and July 2019 revealed no recommendations to change the route for Divalproex Sodium ER Tablet Extended Release 24 Hour 500 MG. During an interview with the Pharmacy Consultant on 8/21/19 at 3:36 PM he stated that the Divalproex Sodium ER Tablet Extended Release 24 Hour 500 MG ordered for Resident #109 should not have been crushed and administered via her feeding tube. After he reviewed his notes and the medication information he stated that the first time the medication was delivered to the facility was on 6/7/19, and was ordered this particular route and dosage on a discharge summary from the hospital. The order was placed based on the discharge summary and he stated that he had not caught the error during his medication review. During an interview with the Nurse Practitioner on 8/21/19 at 4:17 PM she stated that there are several other ways that this medication can be given and that crushing an extended release medication was not an acceptable method for administering this type of medication. She stated that she would change the type/route of medication ordered but would continue to prescribe the Divalproex Sodium 500mg for seizures.	F 756	The Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) completed education for the licensed nurses on 9/12/19, regarding notification of physician and pharmacy when a resident requires medications to be crushed and an order will be written to support crushing of medications, and review of medications that should not be crushed such as extended or delayed release medications. Newly hired licensed nurses will receive education during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing, ADON and/or the Unit coordinators will audit physician orders 5 times a week for 4 weeks then weekly for 2 months beginning 9/16/19, to validate that residents who require medications to be crushed are not receiving medications that should not be crushed. The Pharmacist will review residents medications monthly and identify residents that require medications to be crushed and validate that they are not receiving medications that should not be crushed. The pharmacist will provide a report to the DON regarding findings. The DON and/or the Pharmacist will review the audits to identify patterns/trends and will adjust plan as necessary to maintain compliance. Completion date: September 16,2019	

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F 756	Continued From page 13	F 756	The DON or the Pharmacist will review the plan during the monthly QAPI meeting, and audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; September 16, 2019	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		9/16/19

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F 761	Continued From page 14 Based on observations and staff interviews, the facility failed to: 1) Discard expired medication in 1 of 2 medication storage rooms observed (200 Hall Med Room); 2) Label medications with a shortened expiration date on 2 of 3 medication carts observed (300 Hall Med Cart and 200 Hall B-2 Med Cart); 3) Failed to store medications as specified by the manufacturer in 2 of 3 medication carts observed (300 Hall Med Cart and 200 Hall B-2 Med Cart); 4) Failed to dispose of a loose, unidentified pills observed in 2 of 3 medication carts (300 Hall Med Cart and 200 Hall B-1 Med Cart). The findings included: 1) In the presence of Nurse #4, an observation of the 200 Hall Med Room was conducted on 8/20/19 at 11:45 AM. Expired bottles of stock medications were identified to be stored on the shelf in the med room. The expired medications included: --1-unopened bottle containing 12 tablets of 60 milligrams (mg) fexofenadine (an antihistamine). The manufacturer's labeling indicated the medication had an expiration date of February 2019. --1-opened bottle containing approximately 90 tablets of 1 gram sodium chloride tablets (an electrolyte replacement). The bottle was dated as opened on 9/6/18. The manufacturer's labeling indicated the medication had an expiration date of February 2019. An interview was conducted on 8/20/19 at 11:55 AM with Nurse #4. During the interview, the nurse reviewed the labeling on the stock bottles and reported she would need to dispose of the expired medications.	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1)The licensed nurse #4 sent the bottle of fexofenadine and the bottle of sodium chloride tablets, from the 200hall med room, to the pharmacy to be destroyed on 8/20/19. 2a) The licensed nurse #1 discarded the bottle of lidocaine from 300 hall med cart on 8/20/19. 2b) The licensed nurse #3 discarded the bottle of lidocaine from B2 med cart on 8/20/19. 3a) The licensed nurse #1 discarded the opened undated/unlabeled vials of albuterol from 300 hall med cart on 8/20/19. 3b) The licensed nurse #3 discarded the open undated vials of albuterol from med cart B2 on 8/20/19. 4a) The licensed nurse #1 removed and discarded the loose pills from the 300 hall med cart on 8/20/19. 4b) The licensed nurse #2 removed and discarded the loose pills from the 200 hall B1 med cart on 8/20/19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be the alleged deficient practice of failure to date/label medications and proper storage of medications.	

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F 761	Continued From page 15 An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON stated she would have expected expired medications (including expired stock meds) found in the Med Room to have been returned to the pharmacy. 2-a) In the presence of Nurse #1, an observation was conducted of the 300 Hall Med Cart on 8/20/19 at 9:31 AM. The observation revealed an opened, 10 milliliter (ml) multi-dose vial of 1% lidocaine injectable solution (used as a local anesthetic) was stored on the med cart. The opened vial of lidocaine was not dated as to when it had been opened. Multi-dose vials should be discarded 28 days after the first use, unless the manufacturer specifies otherwise. The manufacturer labeling on the lidocaine vial did not specify otherwise. An interview was conducted on 8/20/19 at 9:40 AM with Nurse #1. During the interview, the nurse was shown the opened lidocaine vial and asked what her thoughts were. The nurse stated to her knowledge, the lidocaine had not been used for a while. However, she did not know when it had been opened. The nurse was observed as she discarded the vial of 1% lidocaine. An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON stated she would have expected a multi-dose vial of lidocaine to be dated when opened and used within 30 days. 2-b) In the presence of Nurse #3, an observation was conducted of the 200 Hall B-2 Med Cart on	F 761	The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit coordinators (UC)and licensed nurses (LN) completed an audit of all medication carts and medication rooms on 8/23/19, to identify expired, undated/unlabeled medications and storage of medications. There were no other discrepancies identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and ADON completed education for licensed nurses regarding storage of medications, dating and labeling of medications and monitoring for expiration dates. Newly hired licensed nurses will be educated during new hire orientation. The Licensed nurses will check medication carts and medication rooms nightly to assure medications are stored properly and dated and labeled appropriately, including monitoring medications for expiration dates. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON and/or the UC□s will audit medication carts and medication rooms 5 x week for 2 weeks, then weekly for 2 months to validate that medication carts and medication rooms are free of loose medications, medications are properly stored, dated and labeled, and	

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F 761	Continued From page 16 8/20/19 at 11:33 AM. The observation revealed an opened, 10 milliliter (ml) multi-dose vial of 1% lidocaine injectable solution (used as a local anesthetic) was stored on the med cart. The opened vial of lidocaine was not dated as to when it had been opened. Multi-dose vials should be discarded 28 days after the first use, unless the manufacturer specifies otherwise. The manufacturer labeling on the lidocaine vial did not specify otherwise. An interview was conducted on 8/20/19 at 11:40 AM with Nurse #3. During the interview, the nurse reported the vial should be discarded. She stated normally the vial would be dated when opened and discarded within 1-2 days after its initial use. An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON stated she would have expected a multi-dose vial of lidocaine to be dated when opened and used within 30 days. 3-a) In the presence of Nurse #1, an observation was conducted of the 300 Hall Med Cart on 8/20/19 at 9:31 AM. The observation revealed two vials of 0.63 milligrams (mg)/3 milliliters (ml) albuterol nebulizer solution (a bronchodilator) were stored on the med cart outside of the manufacturer's foil pouch. The manufacturer's storage instructions indicated the vials should be stored in the foil pouch at all times; once removed from the pouch, they should be used within 1 week. The vials were not dated or labeled with the minimum identifying information required (including the resident's name).	F 761	medications are not expired. The DON and/or the ADON will review the audits to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue according to the discretion of the QAPI committee.	

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An interview was conducted on 8/20/19 at 9:40 AM with Nurse #1. During the interview, the nurse indicated the albuterol vials needed to be discarded.

An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON reported she would expect albuterol vials to be stored inside the foil packs, and for the foil packs to be dated when opened.

3-b) In the presence of Nurse #3, an observation was conducted of the 200 Hall B-2 Med Cart on 8/20/19 at 11:33 AM. The observation revealed a box of albuterol 0.63 milligrams (mg)/3 milliliters (ml) nebulizer solution (a bronchodilator) dispensed on 9/14/18 for Resident #4 was stored on the med cart. The box originally containing 5 pouches of 5-3 ml vials was opened and dated 5/22/19. Two vials remained in one opened pouch; 2 vials of solution were stored outside of the foil pouch. Labeling on the manufacturer's box indicated the vials should be stored in the foil pouch at all times; once removed from the pouch, they should be used within 1 week. The vials were not dated.

An interview was conducted on 8/20/19 at 11:40 AM with Nurse #3. During the interview, the nurse stated the albuterol vials stored outside of the foil pouch needed to be discarded. The nurse was observed as she discarded two vials of albuterol.

An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON reported she would expect albuterol vials to be stored inside the foil packs, and for the foil packs to be dated when opened.

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F 761	Continued From page 18	F 761		

4-a) An observation of the 300 Hall Med Cart conducted on 8/20/19 at 9:31 AM revealed 4 loose, unidentified tablets and one loose, unidentified capsule were lying on the bottom of a medication cart drawer.

An interview was conducted on 8/20/19 at 9:40 AM with Nurse #1. Nurse #1 was assigned to the 300 Hall Med Cart. During the interview, the nurse was shown the loose, unidentified tablets and capsule observed on the med cart. The nurse reported the loose pills needed to be discarded.

An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON reported she expected the medication carts to be cleaned by the night shift nurses and free of loose pills.

4-b) An observation of the 200 Hall B-1 Med Cart conducted on 8/20/19 at 11:20 AM revealed there were 3 loose, unidentified tablets lying on the bottom of a medication cart drawer.

An interview was conducted on 8/20/19 at 11:20 AM with Nurse #2. Nurse #2 was assigned to the 200 Hall B-1 Med Cart. During the interview, the nurse was shown the loose, unidentified tablets on the med cart. Nurse #2 reported the loose pills needed to be discarded.

An interview was conducted on 8/21/19 at 2:40 PM with the facility's Director of Nursing (DON). When asked, the DON reported she expected the medication carts to be cleaned by the night shift nurses and free of loose pills.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to provide the resident a written notification for the reason for transfer to the hospital for 1 of 4 residents (Resident #2) reviewed for hospitalization.

Findings included:

Resident #2 was admitted to the facility on 11/2/18 with diagnoses that included, in part, anemia, hypertension and diabetes mellitus. Resident #2 discharged to the hospital on 8/12/19.

A review of the quarterly minimum data set (MDS) assessment dated 8/7/19 revealed Resident #2 was cognitively intact.

A review of the medical record revealed Resident #2 was transferred to the hospital on 8/12/19 due to complaints of stomach pain, nausea and observation by the nurse of "dark brown grainy stains of emesis on a sheet in resident's bed." The resident remained in the hospital during the recertification survey. No written notice of transfer was documented to have been provided to the resident.

Multiple attempts to contact Resident #2 on 8/22/19 were unsuccessful.

On 8/22/19 at 10:32 AM an interview was completed with Nurse #4. She said when a resident was sent to the hospital the paperwork that went with a resident included a form with clinical information about a resident's medical condition, progress notes, a medication list and the facility's bed hold policy. Nurse #4 stated there was no paperwork or transfer/discharge notice sent to the resident or resident's representative when a resident transferred to the hospital.

On 8/22/19 at 10:52 AM an interview was completed with the Business Office Manager. She stated the business office had not sent any transfer/discharge notices when a resident discharged to the hospital.

On 8/22/19 at 10:55 AM an interview was completed with the Director of Nursing (DON). She reported when a resident was transferred to the hospital the nurse sent a facesheet, order for transport, transfer checklist and recent lab work. The DON said the social worker sent the transfer/discharge notice when a

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resident transferred and was admitted to the hospital.

On 8/22/19 at 11:14 AM an interview was completed with Social Worker #2. She said the social worker office typically had not sent transfer/discharge notices when a resident transferred/discharged to the hospital.

On 8/22/19 at 2:35 PM an interview was completed with the Administrator. He said the nursing department should have sent the transfer/discharge notice when a resident was sent to the hospital and was unaware this was not completed by the nursing department. He further stated that sending the transfer/discharge notice when a resident went to the hospital should be a joint effort between the nursing and social work departments.

F 655

Baseline Care Plan
CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345197	A. BUILDING: _____ B. WING _____	8/22/2019

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	Continued From Page 3

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and record review, the facility failed to provide a copy of the baseline care plan to the resident and/or resident representative for 2 of 7 (Resident #59 and Resident #44) residents reviewed with baseline care plans.

Findings included:

1. Resident #59 was admitted to the facility on 7/11/19 with diagnoses that included, in part, atrial fibrillation, hypertension and chronic obstructive pulmonary disease.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/18/19 revealed Resident #59 was cognitively intact.

A review of the medical record revealed a baseline care plan was completed 7/11/19.

A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident or resident representative.

On 8/20/19 at 9:03 AM an interview was completed with Resident #59. She said she had not received a summary of the baseline care plan, did not know anything about her medications and stated staff hadn't talked to her about her care at the facility.

On 8/21/19 at 10:43 AM an interview was completed with Nurse #4. She stated baseline care plans were typically completed within 24 hours of admission. Nurse #4 said she interviewed Resident #59 and completed the baseline care plan when Resident #59 was admitted to the facility. She said within the first week of a resident's stay, the facility held a "Bridge" meeting with the resident or resident representative and reviewed the baseline care plan information at that meeting. Nurse #4 said she had not been instructed to give a copy of the baseline care plan to the resident or resident representative and so typically had not provided the care plan information to the resident or resident representative.

On 8/21/19 at 10:53 AM an interview was completed with MDS Nurse #2. She said she participated in the "Bridge" meetings with the interdisciplinary team and resident or resident representative. MDS Nurse #2 stated the admission nurse reviewed the baseline care plan with the resident upon admission. She further stated a copy of the baseline care plan was not provided to the resident or resident representative during the "Bridge" meeting.

On 8/21/19 at 1:42 PM an interview was completed with Social Worker #1. He stated when the interdisciplinary team met with the resident or resident representative during the "Bridge" meeting a copy of the baseline care plan, dietary orders or medication list was not provided.

On 8/22/19 at 11:07 AM an interview was completed with the Director of Nursing (DON) and Corporate Nurse. The DON said she assumed the MDS Nurse provided a copy of the baseline care plan to the resident

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	Continued From Page 4

or resident representative at the "Bridge" meeting. The Corporate Nurse added there was a signature page on the baseline care plan for the resident or resident representative to sign. She further stated the interdisciplinary team should ask the resident or resident representative if they wanted a copy of the baseline care plan and then document whether the copy was accepted or declined.

2. Resident #44 was admitted to the facility on 1/24/19 with diagnoses that included, in part, chronic kidney disease, urinary tract infection and diabetes.

A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/2/19 revealed Resident #44 had moderately impaired cognition.

A review of the medical record revealed a baseline care plan was completed 1/24/19.

A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident or resident representative.

On 8/21/19 at 10:43 AM an interview was completed with Nurse #4. She stated baseline care plans were typically completed within 24 hours of admission. Nurse #4 said she completed the baseline care plan when Resident #44 was admitted to the facility. She said within the first week of a resident's stay, the facility held a "Bridge" meeting with the resident or resident representative and reviewed the baseline care plan information at that meeting. Nurse #4 said she had not been instructed to give a copy of the baseline care plan to the resident or resident representative and so typically had not provided the care plan information to the resident or resident representative.

On 8/21/19 at 10:53 AM an interview was completed with MDS Nurse #2. She said she participated in the "Bridge" meetings with the interdisciplinary team and resident or resident representative. MDS Nurse #2 stated the admission nurse reviewed the baseline care plan with the resident upon admission. She further stated a copy of the baseline care plan was not provided to the resident or resident representative during the "Bridge" meeting.

On 8/21/19 at 1:42 PM an interview was completed with Social Worker #1. He stated when the interdisciplinary team met with the resident or resident representative during the "Bridge" meeting a copy of the baseline care plan, dietary orders or medication list was not provided.

On 8/22/19 at 11:07 AM an interview was completed with the Director of Nursing (DON) and Corporate Nurse. The DON said she assumed the MDS Nurse provided a copy of the baseline care plan to the resident or resident representative at the "Bridge" meeting. The Corporate Nurse added there was a signature page on the baseline care plan for the resident or resident representative to sign. She further stated the interdisciplinary team should ask the resident or resident representative if they wanted a copy of the baseline care plan and then document whether the copy was accepted or declined.