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	11/03/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observations, record review and resident and staff interviews, the facility allowed a resident that had been assessed as unable to self-administer medications to self-administer medications via a gastrostomy tube (G-tube). This occurred for 1 out of 1 resident reviewed for medication administration (Resident #227). The findings included: Resident #227 was admitted to the facility on [DATE] with diagnoses which included malnutrition. Resident #227's physician orders since her admission on 8/23/23 were reviewed and did not reveal an order to self-administer medication. Resident #227's entry Minimum Data Set (MDS) dated [DATE] revealed she was moderately cognitively impaired requiring supervision of one staff member for most activities of daily living (ADL). A self- medication assessment dated [DATE] revealed Resident #227 was assessed as being unable to administer her own medication. On 11/01/23 at 10:40 AM an observation was conducted of Nurse #2 removing Resident #227's medication from the medication cart, crushing, and placing the pills into a cup. Nurse #2 handed the cup of crushed pills to Resident #227 and left the room. Resident #227 was then observed picking up a large syringe and placing it into her G-tube. She proceeded to pour a nutritional supplement in a cup and mix the crushed medication while Nurse #2 remained out of sight. Resident #227 began to pour the nutritional supplement and medication down the large syringe into her G-tube. Once the cup was empty, Resident #227 began to pour a 240 milliliter (ml) cup of water into her G-tube. Nurse #2 never re-entered the room. An interview was conducted on 11/1/23 at 10:47 AM with Resident #227. During the interview she stated most of the nurses would administer the medication themselves however Nurse #2 would usually just let her do her own medication. Resident #227 stated, I don't know how much water I am supposed to pour into the tube I just keep pouring until it is clear. The interview revealed she had never had any issues with her G-tube in the past. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on11/1/23 at 10:55 AM with Unit B Coordinator. During the interview she stated no residents in the building have an order to self-administer their own medication. She stated Resident #227 was unable to self-administer her medication and had been assessed for it. An interview was conducted on 11/1/23 at 11:10 AM with the Director of Nursing (DON). She stated no residents in the facility had orders to self-administer their medication. She stated she expected nurses to administer the resident's medication and remain in the room with the resident until they took all of the medication that was ordered. The DON stated if a resident were to request to self-administer their medication, they would need to sign a form prior to doing so and be assessed as safe to self-administer their medication. An interview was conducted on 11/1/23 at 2:47 PM with Nurse #2. She stated she had worked in the building for 2 months and thought Resident #227 could self-administer her medication. The interview revealed Resident #227 had told her she could administer her medication herself. Nurse #2 stated she had provided Resident #227 a cup of water that was 240ml, she stated she didn't know the order for the resident's flush was 60 ml before and after the administration of the medication. She stated she just made a mistake.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on resident, staff, responsible party, and family interviews, and record reviews the facility failed to notify the Responsible Party of a new wound (Resident #17) and the Power of Attorney (POA) or family of a fall and being sent out to the hospital for evaluation (Resident #95) for 2 of 2 sampled residents reviewed for notification of changes. The findings included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses including dementia, high blood pressure, congestive heart failure (CHF), atrial fibrillation, pulmonary embolism, and embolism of left lower extremity with long term anticoagulant use. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #17 had severely impaired cognition and required total dependence for all activities of daily living (ADLs). She was incontinent of bowel and bladder and was identified as being high risk for pressure ulcer development. Review of Resident #17's care plan dated 8/24/2023 revealed Resident #17 was at high risk for skin breakdown; a revision to her care plan dated 10/31/2023 reveal Resident #17 had an open wound to her right heel with interventions to encourage intake, monitor wound and provide wound care as ordered by physician. A review of the wound assessment report dated 10/18/2023 completed by the wound treatment nurse revealed Resident #17 was assessed to have a new wound during nursing rounds and the wound care provider was notified. A right heel intact blister which measured 10.0 centimeters in length and 11.2 centimeters in width was identified. Treatment was initiated with daily liquid dressing application. The wound assessment report did not indicate the responsible party was notified of the new wound. During an interview with the responsible party (RP) on 11/01/2023, the RP revealed the facility did not notify her of the right heel wound. During an interview with the wound care treatment nurse on 11/2/2023 at 3:46 PM, the wound treatment nurse stated the wound was identified by the nursing staff on 10/18/2023 and was reported to her on 10/18/2023. She initiated treatment and notified the wound care provider on 10/18/2023. She further stated she did not contact Resident #17's responsible party to notify them of the new wound. Wound care provider evaluated Resident #17's right heel wound on 10/20/2023 with no necrotic tissue observed. Wound care provider continued daily liquid dressings (a dressing which forms a film on the skin to help reduce friction) to right heel. An interview was conducted with the Director of Nursing (DON) on 11/3/2023 at 11:50 AM. The DON indicated all families should be notified anytime there was a change in a resident's condition. An interview was conducted with the Administrator on 11/3/2023 at 11:50AM. The administrator indicated her expectation was for all responsible parties to be updated on all clinical changes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13811 2) Resident #95 was admitted to the facility on [DATE] from the hospital after an aortic heart valve replacement and to continue intravenous (IV) antibiotic infusion in the facility. Record review of the SBAR (Situation, Background, Assessment, and Recommendation) report dated 10/2/23 at 11:30 PM revealed that Resident #95 fell on [DATE] at 11:20 PM. The recommendation of the Primary Care Provider (PCP) was to send Resident #95 to the emergency room (ER) for evaluation. Nurse #5 completed the SBAR report. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #95 was moderately cognitively impaired. The nursing progress note dated 10/3/23 at 1:40 PM written by the Unit B Coordinator revealed Resident #95 was sent to the ER after the fall for evaluation due to being on blood thinner medication. The note revealed Resident #95 came back to the facility via the facility van on 10/3/23. Interview with Resident #95 and the family member who was in the room was conducted on 10/30/23 at 11:20 AM. The family member stated that Resident #95 was sent to the hospital after he fell on [DATE] and that the family and the POA (Power of Attorney) were not notified of the fall. Resident #95 stated he called his family from ER. Attempts to interview Resident #95's POA were not successful. Interview with the Unit B Coordinator was conducted on 11/2/23 at 10:58 AM. She stated that she closed the incomplete SBAR documentation that was left open by Nurse #5. Unit B Coordinator stated that she could not find documentation that Nurse #5 notified the POA or the family member. Nurse #5 was called via phone several times and did not return the call for an interview. Interview with the interim Director of Nursing (DON) was conducted on 11/3/23 at 11:53 AM. She stated the nurse should have notified Resident #95's POA and family just after the time of the fall and being sent to the hospital. An interview with the Administrator on 11/3/23 at 12:17 PM was conducted. She stated that the POA and the family should have been notified of the fall.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on observations, resident interviews, staff interviews and record reviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of oral and dental status (Resident #97) for 1 of 2 sampled residents. The findings included: Resident #97 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #97 had intact cognition and was independent with activities of daily living (ADL's). The MDS also indicated Resident #97 had no dental issues. An observation and interview was conducted with Resident #97 on 10/30/2023 at 1:30 PM. Resident #97 stated he had no upper or lower teeth, and he has been waiting to see the dentist since he was admitted . He also indicated he had a dental appointment in July but was sick and could not go. He stated he was frustrated with waiting so long to see a dentist and does not understand what is taking so long. An interview was conducted with both MDS Coordinators on 10/31/2023 at 4:45 PM. The MDS Coordinators stated the MDS was coded incorrectly and should have indicated Resident #97 had no teeth. The MDS Coordinators also stated an assessment of the resident's mouth is completed to determine dental status and the MDS Coordinators were aware Resident # 97 had no teeth. An interview was conducted with the Administrator on 11/2/2023 at 4:45 PM. The administrator indicated her expectation was for the MDS to be completed accurately.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on observation, record review, staff and physician assistant interviews, the facility failed to safely assist a resident without causing injury to 1 of 5 residents (Resident #86) reviewed for accidents. Resident #86 was left standing without assistance in her room and fell . Resident #86 sustained a laceration to the head and a right fractured hip. The findings included: Resident #86 was admitted to the facility on [DATE] with diagnoses that included Alzheimer ' s, hypertension, anxiety, age related osteoporosis, muscle weakness, and adult failure to thrive. Resident #86 resided in the facility ' s memory care unit. Review of Resident #86's care plan revised on 02/21/23 revealed the resident was at increased risk for falls due to deconditioning, poor communication, psychoactive drug use, and unaware of safety needs. The goal was for Resident #86 to not sustain serious injury through the review date. Interventions included anticipate and meet the resident's needs, ensure that the resident is wearing appropriate footwear when ambulating, and follow facility fall protocol. Review of Resident #86's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #86 was severely cognitively impaired and required extensive assistance with one person assist for bed transfers, walk in corridor, and walk in room. The MDS further revealed that under balance during transitions and walking Resident #86 was coded for not being steady but able to stabilize without staff assistance. Review of Resident #86's undated Kardex (a written plan of care for staff to know the needs of a resident). revealed Resident #86 was extensive assistance with one person assist for transfer and mobility. Review of incident report completed by Nurse #3 dated 10/25/23 revealed NA #3 ambulated Resident #86 to her room when NA #3 turned to shut the door and Resident #86 lost balance and fell on her right side. The report further revealed Resident #86 sustained a cut above right eyebrow measuring approximately 3 centimeters (CM) by 1/2 CM. The cut had a small amount of bleeding with light purple bruising and was cleaned and strips were applied. The report indicated Resident #86 remained at her baseline neurological status and unable to voice pain due to cognition during assessment. The note revealed Resident #86 was assessed and assisted to bed and neurological checks were initiated. The responsible party and Assistant Director of Nursing (ADON) were notified, and the resident was placed in the book to be followed up by the provider the next day. The report revealed immediate action taken was Resident #86 was assessed for injuries, wound care applied to laceration above right eye, and neurological check initiated. Predisposing physiological factors indicated Resident #86 was confused and had impaired memory. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of progress note completed by Nurse #3 dated 10/25/23 revealed Nurse Aide #3 ambulated Resident #86 to her room when NA #3 turned to shut the door and Resident #86 lost balance and fell on her right side. The note further revealed Resident #86 sustained a cut above right eyebrow measuring approximately 3 centimeters (CM) by 1/2 CM. The cut had a small amount of bleeding with light purple bruising and was cleaned and strips were applied. The note indicated Resident #86 remained at her baseline neurological status and unable to voice pain due to cognition during assessment. The note revealed resident #86 was assessed and assisted to bed and neurological checks were initiated. The RP, on call provider, and Assistant Director of Nursing (ADON) were notified. The indicated Resident #86 was not sent out but was placed in the book to be followed up by the provider the next day. Review of progress note completed by the ADON dated 10/26/23 revealed Resident #86 was assessed by the provider and was ordered an x-ray of right arm and shoulder and was sent to the hospital. The note further revealed IDT recommended educating staff about safe transfers. Review of the x-ray results completed at the hospital on 10/27/23 revealed Resident #96 sustained a transverse fracture at the right femoral neck seen at its base with slight angulation and displacement. The note further revealed osteopenia is noted, bony pelvic structures appear intact, and left hip appeared to be normal. Review of hospital progress note dated 10/27/23 revealed Resident #86 was admitted to the hospital and was diagnosed with a right femur fracture and laceration above the right eye. The note further revealed Resident #86 ' s resident representative (RR) indicated Resident #86 was not ambulatory before the fall. Review of progress note dated 10/27/23 revealed Resident #86 was transferred back to the facility from the hospital and the resident sustained a hip fracture and urinary tract infection (UTI). The note further revealed Resident #86 is in bed and had a follow up appointment in 4 to 6 weeks with orthopedic. Review of progress note dated 10/29/23 revealed Resident #86 was admitted to hospice. Review of progress note completed by the Medical Director (MD) on 10/30/23 revealed Resident #86 was transported to the hospital for a fall. The note further revealed the resident was found to have a right sided hip fracture and would not be managed operatively and would return to the facility. The note indicated Resident #86 would be followed by hospice and all medicines had been discontinued other than comfort measures. An observation was conducted on 10/30/23 at 11:00 AM revealed Resident #86 was in bed with with her eyes closed. Observation further revealed laceration over the resident ' s right eyebrow to have green and purple bruising with three steri strips on it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with NA #3 on 11/02/23 at 3:50 PM revealed on 10/25/23 she had assisted Resident #86 back to her room to put her in the bed. NA #3 further revealed Resident #86 had a good day and was walking with little assistance. NA #3 was an extensive assistance with one person support which meant to have hands on the resident assisting them. NA #3 indicated she walked Resident #86 into her room and stopped at the sink and left Resident #86 unattended to close the bedroom door because the resident had a good day and seemed stable to stand alone. NA #3 indicated she does not recall why she did not assist Resident #86 to the bed before shutting the bedroom door. NA #3 stated as she closed the door Resident #86 lost balance and fell to the ground on her right side. NA #3 revealed Nurse #3 assessed Resident #86 and the resident showed no signs of pain or injury other than the laceration above the right eye. NA #3 on 10/26/23 Resident #86 was assessed by the provider in the facility and Resident #86 started to show signs of discomfort and was sent to the hospital to be further assessed. An interview conducted with Nurse #3 on 11/01/23 at 11:10 AM revealed Resident #86 was an extensive assist with one person for ambulating. Nurse #3 indicated Resident #86 ' s health and memory had declined in the last couple months. Nurse #3 further revealed on 10/25/23 NA #3 had assisted resident #86 to her room and left Resident #86 unassisted standing when shutting the resident's door. Nurse #3 indicated at that time Resident #86 fell to the floor on her right side. Nurse #3 revealed she was called to Resident #86's room and observed Resident #86 on her right side near the bathroom door. Nurse #3 revealed she assessed Resident #86, and the resident sustained a laceration above the right eyebrow but did not show indications of pain or other injuries. Nurse #3 indicated Resident #86 was assisted back to bed and the Medical Director (MD), RR, and ADON were notified. Nurse #3 stated Resident #86 did not complain of pain and neurological assessments were completed. An interview conducted with the ADON on 11/01/23 at 11:10 AM revealed she was not present at the time of the incident. The ADON further revealed Resident #86 was extensive assistance with one person assist for ambulating and transfers. The ADON stated NA#3 should have not left the resident unattended in her room. The ADON indicated prior to the incident on 10/25/23 Resident #85's health was declining and had become weaker. An interview conducted with the Director of Nursing (DON) on 11/01/23 at 1:45 PM revealed Resident #86 was unstable and required extensive assistance with one person for ambulation and transfers. The DON further revealed NA #3 should have not left Resident #86 unassisted while closing the bedroom door. An interview conducted with the Physician Assistant (PA) on 11/03/23 at 12:25 PM revealed Resident #86 ' s health had declined rapidly since the residents fall on 10/25/23. The PA further revealed Resident #86 had been admitted to hospice before and could not state the fall had caused the resident ' s rapid health decline. The PA indicated Residents #86's weakness and dementia had progressed prior to the incident on 10/25/23. An interview conducted with the Administrator on 11/03/23 at 12:25 PM revealed if Resident #86 was coded and documented for extensive with one person assist then NA #3 should not have left the resident unattended. The Administrator indicated she expected nursing staff to follow the Kardex and what each Resident was coded for.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 13811 Based on observations, record review, and staff interviews, the facility failed to store medications according to manufacturer's guidelines on acceptable temperature range for 2 of 3 medication refrigerators (Unit A Station Medication Room), failed to date an opened Tuberculin Purified Protein Derivative (PPD) for 1 of 3 medication refrigerators (Unit A Station Medication Room) and failed to store unopened insulin in the medication refrigerator as specified by manufacturer's guidelines for 1 of 6 medication carts (Unit C Station Medication Cart #2) reviewed for medication storage. Findings included: Review of the facility policy for medication storage dated April 2019 handed by the Assistant Director of Nursing (ADON) read in part, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. Review of the manufacturer's package insert indicated the Alteplase and insulin lispro should be stored between 36*F to 46*F. Review of the manufacturer's package insert indicated the flu vaccines should be stored between 35*F to 46*F. Review of the manufacturer package insert for Tuberculin Purified Protein Derivative (PPD) indicated to store in refrigerator at 35*F to 46*F. Do not freeze and discard product if exposed to freezing. Protect from light and a vial of PPD which has been entered and in use for 30 days should be discarded. Review of manufacturer package insert for insulin glargine injection indicated unopened pen should be stored in refrigerator at 36*F to 46*F until expiration and kept away from direct heat and light. Once the insulin was opened, it could be stored at room temperature below 86*F or under refrigeration for under 28 days. 1) An observation of the Unit A medication room on 11/3/23 at 8:58 AM with the presence of the Unit B Coordinator revealed there were two refrigerators to store vaccines and insulins. The refrigerator/freezer temperature log sheet where they documented the temperature readings daily indicated clearly on the top that the temperature should be 36*F to 45*F. The following were observed from the temperature log in front of the refrigerator. a. The gray refrigerator with the thermometer inside showed 38*F. It contained Alteplase (use to dissolve blood clots that have formed in the blood vessel) and insulin lispro was seen with the temperature log that was below 36*F. The temperature log was in front door of the refrigerator. For the month of September 2023 log, there was one day with 32*F recorded (9/18/23) and for the month of October 2023 log, there were 17 days of 32*F to 34*F recorded (10/1, 10/13, 10/14, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/27, 10/28, 10/29, 10/30, 10/31). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The black refrigerator with the thermometer inside showed 32*F. It contained flu vaccines and glargine insulin was seen with the temperature log that was below 35*F. The temperature log was in front door of the refrigerator. For the month of September 2023 log, there were 12 days of temperature of 32*F (9/5, 9/7, 9/8, 9/9, 9/10, 9/11, 9/12, 9/13, 9/15, 9/16, 9/17, 9/19). For the month of October 2023 log, there were 13 days of temperature between 32*F to 34*F (9/15, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/26, 9/27, 9/28, 9/29, 9/30, 9/31). And for the first week of November 2023 log, there was 1 day of 34*F (11/1). Interview with the Unit A coordinator was conducted on 11/3/23 at 9:10 AM. The Unit A Coordinator stated that she checked the refrigerator every day at around 7:45 AM and just recorded the temperature without paying attention to the reading. She stated that she did not ask for the maintenance to fix the issue. 2) An observation on the Unit A station medication room refrigerator with the presence of the Unit A Coordinator revealed a Tuberculin PPD with the expiration date of June 2024 was open with no date when opened. The Unit A Coordinator stated that the ADON was the one giving the PPD and would have the information when it was opened. 3) An observation on Unit C medication cart #2 on 11/3/23 at 9:50 AM with the presence of Medication Aide #1 revealed an unopened insulin glargine injection delivered by the pharmacy on 11/1/23 was in the medication cart. Interview with the Medication Aide (MA) #1 on 11/3/23 at 9:54 stated that the insulin glargine injection should be stored in the refrigerator when not opened for use. Interview with the Assistant Director of Nursing (ADON) on 11/3/23 at 09:56 AM was conducted. The ADON stated that the refrigerator temperature should follow the manufacturer's recommendations. The ADON stated that she opened the PPD but forgot to write the date of opening in the PPD bottle. She was supposed to date it before storing it back in the refrigerator. Interview with Director of Nursing (DON) on 11/3/23 at 10:01 AM was conducted. The DON stated that the medication in the storage should be checked daily by the nurses and the unit coordinator. She stated that the refrigerator temperature should be within 36*F to 46*F as specified on the refrigerator log sheet. The DON said that she was not made aware of temperature issues and if she had known about it, she would have asked the maintenance to fix it. The DON also stated that unopened insulin should be stored in the refrigerator. Interview with the Administrator on 11/3/23 at 12:04 PM was conducted. She stated that the medication refrigerator's temperature should be within the acceptable range of temperature.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on observations, resident interviews, staff interviews and record reviews the facility failed to provide dental services for a resident who desired dentures. This was evident for 1 of 2 residents reviewed for dental services (Resident #97). The findings included: Resident #97 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM), diabetic neuropathy, chronic obstructive pulmonary disease (COPD), high blood pressure, and post-traumatic stress disorder (PTSD). The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #97 had intact cognition and was independent with activities of daily living (ADL's). The MDS also indicated Resident #97 had no dental issues. Review of Resident #79's current care plan revealed no care plan for addressing dental concerns. A review of the facility's dental schedules showed Resident #97 was scheduled for a dental visit on 07/11/2023. Resident #97 was unable to go to the dental appointment on 07/11/2023. There were no other dental appointments scheduled for Resident #97 from his admitted [DATE] to 10/31/2023. A review of Resident #97's admission information revealed he was his own responsible party. A review of Resident #97's weight revealed no weight loss since admission. An observation and interview was conducted with Resident #97 on 10/30/2023 at 1:30 PM. Resident #97 stated he had no upper or lower teeth and he had been waiting to see the dentist since he was admitted . He also revealed he had no upper or lower teeth when he was admitted to the facility. He also indicated he had a dental appointment in July but was sick and could not go. He stated he was frustrated with waiting so long to see a dentist and does not understand what is taking so long. He further stated he was on a regular diet and had not experienced any weight loss. An interview with the Business Office Manager on 11/1/2023 at 10:45 AM revealed Resident #97 had qualified for Medicaid eligible services. An interview with the Social Worker (SW) was conducted on 11/1/2023 at 11:03 AM. The SW stated she did not have Resident #97 on the list to see the dentist and she was not aware he needed fitting for dentures. An interview was conducted with the Administrator on 11/2/2023 at 4:45 PM. The administrator indicated her expectation was for all residents to receive dental services timely and appropriately.

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	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge of NC	237 Tryon Road Rutherfordton, NC 28139

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43643 Based on observations and staff interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observations. This practice had the potential to affect food served to residents. The findings included: An observation and interview conducted on 11/01/23 at 5:15 PM revealed dietary aide #1 had a beard and did not have a facial covering on. The Dietary Aide was observed pouring and handling tea and drinks. The dietary aide stated he was not aware he had to wear a facial covering. An observation and interview conducted on 11/01/23 at 5:20 PM revealed dietary aide #2 had a beard and did not have a facial covering on. The Dietary Aide was observed prepping food on the meal line. The dietary aide stated he was not aware he had to wear a facial covering. An interview with the Dietary Manager (DM) on 11/01/23 and 5:25 PM revealed she was used to dietary staff wearing masks during covid and had not thought to have the dietary aides wear facial coverings that have facial hair. The DM further revealed she had not educated the dietary aides. An interview conducted with the Administrator on 11/03/23 at 3:30 PM revealed all kitchen staff were expected to wear hair coverings and facial coverings if needed. The Administrator further revealed she was not aware dietary aides were not wearing facial coverings but expected them to be for sanitary reasons.

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	11/03/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation surveys that occurred on [DATE] and [DATE]. This failure was for three deficiencies cited in the areas of Free of Accidents/Hazards, Labeling and Storing of Drugs and Biologicals, and Food Procurement and Storage which were subsequently recited on the current recertification and complaint investigation survey of [DATE]. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: 1. F689: Based on observation, record review, staff and physician assistant interviews, the facility failed to safely assist a resident without causing injury to 1 of 5 residents (Resident #86) reviewed for accidents. Resident #86 was left standing without assistance in her room and fell . Resident #86 sustained a laceration to the head and a right fractured hip. During the recertification and complaint investigation survey conducted on [DATE], the facility failed to secure smoking materials, provide a smoking apron, and supervise 1 of 2 residents reviewed for smoking. During an interview on [DATE] at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing agency personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, but obviously they needed a more extensive PIP to educate Nurse Aides and Nurses on properly assisting residents according to their documented need for assistance. 2. F761: Based on observations, record review, and staff interviews, the facility failed to store medications according to manufacturer's guidelines on acceptable temperature range for 2 of 3 medication refrigerators (Unit A Station Medication Room), failed to date an opened Tuberculin Purified Protein Derivative (PPD) for 1 of 3 medication refrigerators (Unit A Station Medication Room) and failed to store unopened insulin in the medication refrigerator as specified by manufacturer's guidelines for 1 of 6 medication carts (Unit C Station Medication Cart #2) reviewed for medication storage. During the recertification and complaint investigation survey conducted on [DATE], the facility failed to date opened breathing treatment foiled pouches on 2 of 5 med carts (B-2 hall and 300 hall) and failed to remove loose pills from 1 of 5 med carts (300 hall). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the recertification and complaint investigation survey conducted on [DATE], the facility failed to discard expired medication from 5 of 5 med carts (C hall, A1 hall, A1B hall, B1 hall and B2 hall) and 2 of 3 medication rooms (Med room A and Med room C) and failed to properly discard controlled medications from 2 of 5 med carts (B1 hall and B2 hall). During an interview on [DATE] at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing agency personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, abuse, medication administration, and fire and safety for employees and residents. She further stated the PIPs were ongoing and they would be adding another PIP on labeling and storing medications and it would be monitored extensively to ensure future compliance. 3. F812: Based on observations and staff interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observations. This practice had the potential to affect food served to residents. During the recertification and complaint investigation survey conducted on [DATE], the facility failed to remove unlabeled and undated foods in the nourishment room refrigerators in 2 of 3 nourishment rooms (B and C station) and failed to clean and remove rust from inside a microwave oven in a nourishment room (A station) for 3 or 3 nourishment rooms reviewed. During an interview on [DATE] at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing agency personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, abuse, medication administration, and fire and safety for employees and residents. She further stated the PIPs were ongoing and they would be adding another PIP on proper use of personal protective equipment (PPE) in the kitchen to ensure the kitchen staff abide by wearing hair nets to cover all head and facial hair while providing meal service to residents. .