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 02/04/2025

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 and complaint investigation survey was conducted on 01/27/25 through 01/31/25. The survey team returned onsite to validate the corrective action plan, therefore, the exit date was changed to 02/04/24. The facility was found in compliance wtih the requirement CFR 483.73, Emergency Preparedness. Event ID# QGS311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 01/27/25 through 01/31/25. The survey team returned onsite to validate the corrective action plan on 02/04/25; therefore, the exit date was changed to 02/04/25. Event ID# QGS311. The following intakes were investigated NC00226210, NC00226127, NC00226048, NC00225835, NC00225656, NC00225432, NC00225374, NC00222868, NC00222742, NC00220887, NC00220702, NC00220651, NC00220239, NC00220174, NC00219963, NC00219908, NC00219005, NC00217933, NC00216159, NC00215807, and NC00214708. 6 of 38 complaint allegations resulted in deficiency. Intake NC00225656 and NC00225374 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity of (J). The tag F600 constituted Substandard Quality of Care.	F 000	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/01/2025

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		
	An extended survey was conducted.			
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests	F 551		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 551	Continued From page 2 of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review, and Legal Guardian and staff interviews, the facility failed to communicate with the Resident's Legal Guardian and obtain authorization from the Legal Guardian prior to the Resident being transferred across state lines to a hospital in South Carolina (SC) for 1 of 3 residents reviewed for discharge (Resident #366). The findings included: Resident #366 was admitted to the facility on 4/14/23.	F 551	Criteria 1: Resident #366□s guardian was made aware of the transfer on 12/20/24 by the Administrator. Criteria 2: All residents transferring to the hospital have the potential to be affected by the deficient practice. On 2/20/25, an audit was completed by the Administrator of all facility transfers to the hospital from 2/6/25 - 2/20/25 to ensure that verbal notification of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 551	Continued From page 3 Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian. Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment. Review of Resident #366's discharge Minimum Data Set (MDS) dated 12/21/24 revealed the discharge was coded as an unplanned discharge to hospital with return anticipated. Review of Resident #366's electronic medical record revealed no written notification to Resident #366's Legal Guardian of his transfer to the hospital in SC. A telephone interview was conducted with Resident #366's Legal Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's legal guardian through the Department of Social Services. She stated she received a telephone call on 12/20/24 from the Administrator at the facility stating Resident #366 would be moving to another skilled nursing facility within the day. Resident #366's Legal Guardian stated she informed the Administrator that Resident #366 could not be moved so quickly without her speaking with and touring the other facility. Resident #366's Legal Guardian revealed a few hours later on 12/20/24, she received a telephone call from the Administrator stating Resident #366 had been taken to a hospital in SC for an in-patient psychiatric hold and evaluation. She stated she did not receive any notification in	F 551	transfer had been provided to the resident or responsible party and was indicated in the medical record. There were no negative findings. Criteria 3: On 2/20/25, education was provided by the Director of Nursing (DON)/designee to all nurses of the requirement to notify the resident/resident's representative(s) of the transfer or discharge to the hospital and the reasons for the move prior to the transfer. This notification will be evident in the medical record through the completion of the E-interact Transfer documentation. Newly hired or agency staff will be trained prior to working a shift in the facility. Criteria 4: The Director of Nursing/designee will monitor this process by auditing all facility transfers to the hospital to ensure that verbal notification of the transfer has been provided to the resident or responsible party and is evident through the E-Interact Transfer documentation. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The DON is responsible for the plan of corrections. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 551	Continued From page 4 writing or verbal notification prior to Resident #366 being transferred to the hospital in SC. Resident #366's Legal Guardian revealed she would like to have been notified prior to Resident #366 being transferred to the hospital but especially to a hospital across state lines when there was a local hospital a few minutes away that was equipped to treat him. The Administrator was interviewed on 1/30/25 at 5:30 PM. The Administrator reported on 12/20/24 that the facility felt it would be best for Resident #366's safety due to his wandering and sexualized behavior to be sent out to the hospital for an in-patient psychiatric evaluation and treatment. She stated the facility transported Resident #366 to the hospital in SC because they have a geriatric psych unit, and their local hospital did not have a psychiatric unit and would only have provided him with a tele psychiatric visit and sent him back to the facility. The Administrator revealed she did not notify Resident #366's legal guardian prior to his transfer to the hospital in SC but did notify the Legal Guardian by telephone after Resident #366 had left the facility.	F 551		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility	F 558	Criteria 1:	2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 5 failed to ensure residents could access their light switch located behind the bed for 3 of the 3 residents reviewed for accommodation of needs (Resident #76, Resident #364, and Resident #54). The findings included: a. Resident #76 was admitted to the facility on 11/13/24. The admission Minimum Data Set (MDS) assessment dated 11/18/24 coded Resident #76 with intact cognition and indicated walking between locations inside the room for more than 10 feet was not attempted during the assessment period due to medical condition or safety concerns. During an observation conducted on 01/27/25 at 11:45 AM, the switch for the light fixture behind Resident #76's bed was attached with a broken cord 10 inches in length. It was 5 feet from the floor and 6 feet from Resident #76's bed. Resident #76 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #76 on 01/27/25 at 11:48 AM. He could not recall how long the switch cord had been broken. He stated he wanted to switch on the light fixture behind his bed at times, but he could not reach the switch cord. It was very inconvenient for him, and he wanted the switch cord to be fixed immediately. Subsequent observation conducted on 01/28/25 at 10:46 AM revealed the switch cord for the light fixture behind Resident #76's bed remained inaccessible.	F 558	On 1/29/25, overbed lighting cords for residents #54, #76, and #364 were replaced by the Maintenance Director when the facility was made aware of the issue. Criteria 2: All residents have the potential to be affected by the deficient practice. On 1/29/25, an audit of all overbed lights was completed by the Maintenance Director to ensure that all light pull cords were intact and could be reached by the resident. All cords identified in the audit were repaired the same day. Criteria 3: Beginning on 2/19/25, all maintenance and nursing staff will receive training on the requirement for a resident to access the overbed light and that the pull cord must be long enough to reach from the resident's light to the bed. Also included in the education was the need to ensure that maintenance requests such as broken overbed light cords are communicated to maintenance by placing the request in the maintenance communication binder located at the nurse station. This training will be completed by the Administrator/designee. Newly hired or agency staff will be trained prior to working a shift in the facility.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 6 During joint observation and subsequent interview with Nurse Aide #4 (NA #4) and Nurse #1 on 01/28/25 at 2:33 PM, both nursing staff stated they provided care for Resident #76 frequently in the past few weeks, but they did not notice the switch cord was broken and inaccessible for Resident #76. Both nursing staff acknowledged that it needed to be fixed as soon as possible. b. Resident #364 was admitted to the facility on 01/23/25. The Admission MDS assessment dated 01/27/25 coded Resident #364 with intact cognition and impairment on one side of her lower extremity. The MDS indicated Resident #364 required supervision or touching assistance to walk for more than 10 feet between locations inside the room. During an observation conducted on 01/27/25 at 11:55 AM, the switch for the light fixture behind Resident #364's bed was attached with a broken cord 3 inches in length. It was 5 feet from the floor and 4 feet from the bed. Resident #364 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #364 on 01/27/25 at 11:58 AM. Resident #364 stated when she wanted to switch on the light fixture behind her bed at times, she could not stand up to reach the switch cord as she had knee surgery recently. It was very frustrating and inconvenient for her as she had to depend on the staff to switch it on each time. She hoped it could be fixed as soon as possible.	F 558	Criteria 4: The Maintenance Director/designee will audit 5 resident rooms per week for 8 weeks to ensure overbed lighting cords are intact and a reasonable length to accommodate the resident. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of corrections. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 7	F 558		

Subsequent observation conducted on 01/28/25 at 10:49 AM revealed the switch cord for the light fixture behind Resident #364's bed remained inaccessible.

During joint observation and subsequent interview with NA #4 and Nurse #1 on 01/28/25 at 2:33 PM, both nursing staff stated they provided care for Resident #364 frequently in the past few days and added they did not notice the switch cord was broken and inaccessible for Resident #364. Both nursing staff acknowledged that it needed to be fixed as soon as possible.

c. Resident #54 was admitted to the facility on 03/31/21.

The quarterly MDS assessment dated 12/05/24 coded Resident #54 with moderately impaired cognition. The MDS indicated she could walk in between locations in the corridor up to 150 feet independently.

During an observation conducted on 01/27/25 at 3:30 PM, the switch for the light fixture behind Resident #54's bed was attached with a broken cord 10 inches in length. It was 5 feet from the floor and 4 feet from Resident # 54's bed. Resident #54 was unable to reach the switch cord from the bed if needed.

An interview was conducted with Resident #54 on 01/27/25 at 3:31 PM. She did not know how long the switch cord had been broken. She could not reach the cord when she was lying in her bed, and it was very inconvenient to her.

Subsequent observation conducted on 01/28/25 at 10:51 AM revealed the switch cord for the light

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 8	F 558		

fixture behind Resident #54's bed remained inaccessible.

During joint observation and subsequent interview with NA #5 and Nurse #5 on 01/28/25 at 2:45 PM, both nursing staff stated they provided care for Resident #54 frequently in the past few weeks. NA #5 stated she did not notice the switch cord was broken and unreachable for Resident #54. Nurse #5 stated she noticed the switch cord was unreachable for Resident #54 on 01/28/25 in the morning and had notified the maintenance staff verbally. She did not know why the issue was not being addressed. Both nursing staff stated the cord needed to be fixed to ensure full accessibility for Resident #54.

An interview was conducted with the Maintenance Director on 01/29/25 at 9:43 AM. He stated he walked through the facility at least once daily to identify repair needs. He also depended on nursing staff to report repair needs either verbally or via facility website electronically. He could not recall if he had fixed Resident #54's switch cord on 01/28/25 in the morning. He explained some of the switch cords could be broken again after he had fixed them. He acknowledged that all the broken cords needed to be fixed immediately to accommodate residents' needs.

During an interview conducted on 01/29/25 at 1:25 PM, the Administrator expected the staff to be more attentive to residents' living environment and reported repair needs in a timely manner to accommodate residents' needs and ensure full accessibility to their light fixture.

An interview was conducted with the Director of Nursing on 01/29/25 at 1:33 PM. She stated it

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 9 was her expectation for all the residents to have full accessibility to their light fixture all the time to accommodate their needs.	F 558		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with residents, facility staff, the Medical Director, the Lieutenant from the Police Department, resident's family friend, and the resident's responsible person (RP), the facility failed to protect the resident's right to be free from resident-to-resident abuse for 2 of 3 residents reviewed for abuse (Resident #15 and Resident #57). On 4/12/24 while completing morning rounds, Nurse Aide (NA) #6 found Resident #366 in Resident #15's room, lying on top Resident #15 while she was asleep in her bed, with his brief pulled down and his penis exposed. Resident #15's brief appeared to be sideways, undone on the left side, but was in place between her legs.	F 600	Past noncompliance: no plan of correction required.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

Resident #366 was placed on one-to-one supervision at this time due to wandering and sexualized behaviors. Both residents were severely cognitively impaired. On 12/18/24 Resident #57 and Resident #36 (Resident #57's roommate) had their call light on and motioned for NA #1 to come into the room. Resident #36 spoke first and reported to NA #1 that Resident #366 came into the room took his pants off and got on top of Resident #57 and raped her. Resident #57 nodded her head in agreement and stated she told them to "get off of her" and "get out of her room" and they left. Both residents were assessed as cognitively intact. Resident #366 was supposed to be under one-to-one supervision at the time of the incident on 12/18/24 due to his continued wandering and sexualized behaviors and NA #2 left him unattended. A reasonable person would expect to be free from abuse in their own home and could experience altered mental condition, fear, anxiety, and depressed mood.

The findings included:

A. Resident #15 was admitted to the facility on 11/03/17. Diagnosis included Alzheimer's disease, dementia, and muscle weakness.

Review of the annual Minimum Data Set (MDS) dated 3/07/24 revealed Resident #15 was severely cognitively impaired and required substantial assistance for mobility and dependent on staff for transfers and toileting due to being incontinent of bladder and bowel. Resident #15 was also coded for having adequate hearing and vision, usually able to make herself understood, and usually able to understand others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

Resident #366 was a 49-year-old male admitted to the facility on 4/14/23. Diagnosis included a traumatic brain injury (TBI), altered mental status, and cognitive communication deficit.

Review of Resident #366's facility face sheet dated 4/14/23 revealed Cleveland County Department of Social Services as his responsible person and guardian.

Review of quarterly MDS dated 3/08/24 revealed Resident #366 was severely cognitively impaired, independent for mobility, supervision for transfers, partial assistance with toileting as he was always continent for bowels with frequent urinary incontinence. Resident #366 was also ambulatory, utilized a wheelchair for long distances, able to make himself understood, able to understand others, adequate vision, and no hearing deficits. Resident #366 was not coded for any wandering or behaviors.

A telephone interview with NA #6 on 1/30/25 at 8:30 AM revealed she typically worked 11:00 PM to 7:00 AM on the locked memory care unit and was familiar with Resident #15 and the incident regarding Resident #366. She stated in April 2024 she worked in the locked memory care unit and while completing her morning rounds, she had entered Resident #15's room and saw Resident #366 on top of Resident #15 who was sleeping in her bed. NA #6 revealed Resident #366's pants and brief were pulled down with his penis exposed and Resident #15's brief was sideways, undone on the left side but still in place between her legs, her gown was pulled down, and her breasts were covered. NA #6 stated she immediately removed Resident #366 from Resident #15's bed, called for Nurse #6 to come

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

to Resident #15's room, explained to Nurse #6 what happened and was then instructed for Resident #366 to be placed on one-to-one supervision. NA #6 revealed she assisted Resident #366 back to his room and stayed with him while Nurse #6 assessed Resident #15 and notified the Administrator. NA #6 stated after the incident, Resident #366 was moved from the memory care unit to a room on the regular hall and to her knowledge remained on one-to-one supervision. NA #6 revealed that prior to the incident with Resident #15, she was not aware of Resident #366 having any type of behavior and had never witnessed him display those types of sexualized behaviors.

Attempted to contact Nurse #6 who was unable to be reached.

Review of interdisciplinary team (IDT) progress note dated 4/12/24 revealed on the morning of 4/12/24 staff found Resident #366 in a severely cognitively impaired female resident's room (Resident #15). Resident #366 was observed lying on top of Resident #15 with his brief pulled halfway down and his penis exposed. Resident #15 was asleep at the time, but her brief was noted to be sideways, undone on the left side, but still in place between her legs. Resident #366 was immediately placed on one-to-one supervision which required him to always be in the staff's line of sight due to the sexualized and wandering behaviors. Resident #366 was also moved off the locked memory care unit to room 300 on B hall and one-to-one supervision to remain on-going.

Review of the Medical Director progress noted dated 4/12/24 for Resident #15 revealed the following: Examination of Resident #15 due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

history of a male resident [Resident #366] being on top of Resident #15 while she was in her bed. The Medical Director noted apparently around 6:30 AM a male resident [Resident #366] was found on top of Resident #15; his penis was out and Resident #15's brief was pulled to the side. According to the nursing staff, Resident #15 was asleep when they found her, was asleep when Medical Director went to see her, and remained asleep during Medical Director exam. Resident #15 had severe dementia. The Medical Director revealed to the best of his knowledge it did not seem that Resident #15 was penetrated at all, there were no scratch marks or other marks visible on Resident #15's hands, body, or in her vaginal area.

Review of the Medical Director progress note dated 4/12/24 for Resident #366 revealed the following: Around 6:30 AM, Resident #366 was found on top of a female resident [Resident #15] with his penis exposed and Resident #15's diaper was also possibly pulled to the side. Resident #366 was pulled off Resident #15 immediately and apparently placed on one-to-one. This had never happened with Resident #366 before; he did not seem agitated at the time, and there had been no knowledge of any behaviors leading up to this problem. Resident #366 did have a long mental health history he was being treated for with no recent changes to his medications. Hospital evaluation recommended by psychiatric (psych) services. Resident #366 returned from his evaluation from the local hospital and per their report, Resident #366's computed tomography (CT) scan and bloodwork showed no evidence of any acute abnormalities, and his urinalysis was negative. The Medical Director noted Resident #366 exposed himself on the way back from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

hospital which was totally abnormal behavior. Resident #366 presently has one-to-one supervision for safety risks for both residents and staff. The Medical Director revealed he spoke with the psych provider who recommended new medications and agreed with Resident #366's one-to-one supervision for his and other residents' safety.

Review of facility 5-day investigation report completed by the previous Administrator dated 4/18/24 revealed their investigative findings included the following: On the morning of 4/12/24 while NA #6 was making her rounds on the locked memory care unit when she entered Resident #15's room and found Resident #366 on top of Resident #15 who was sleeping, with his pants and brief pulled halfway down exposing his penis. Resident #15's gown was on, her breasts were covered, and her brief was sideways, appeared to be undone on the left side, but still in place between her legs. NA #6 notified Nurse #6 and Resident #366 was removed from Resident #15's room, taken back to his room, and immediately placed on one-to-one supervision. Resident #15 was assessed by Nurse #6 with no findings and continued sleeping. Law enforcement, Department of Social Services, State, Medical Director, and Resident #15's RP was notified of the incident. The facility Medical Director completed a physical examination of Resident #15 that included thorough examination of the vaginal and peri areas and found no indication that any sexual contact had occurred. Resident #15's RP declined the facilities offer to send her out to the hospital for any further evaluations. Both Resident #15 and Resident #366 were severely cognitively impaired and resided in the facility locked memory care unit.

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

Resident #366 was not admitted with this type of behavior and prior to this incident had not displayed any types of behaviors that would cause staff to be aware of the potential for this type of behavior. Resident #366 was sent out to the hospital emergency department for evaluation and returned with no issues noted. Resident #366 was removed from the locked memory care unit into a room on a regular hall, remained on one-to-one supervision, monitored by the Medical Director, and was being evaluated and treated by psych services. Resident #15 was monitored for any psychosocial changes, mental anguish, change in her demeanor, or alterations in her daily activities and no issues were noted and Resident #15 remained pleasant and cooperative and appeared to have no negative impact. All facility staff were educated on abuse and neglect policies and procedures, wandering residents, new behaviors, and one-to-one supervision process. The facility was not able to substantiate abuse or neglect against any residents, and the residents involved remained without any physical injury, mental harm, pain, or anguish.

Review of Resident #366's care plan initiated on 4/12/24 revealed Resident #366 had exhibited inappropriate sexualized behaviors and was noted to continue sexualized behaviors such as masturbating while in bed with a goal to not exhibit any of these sexual behaviors any further through the next review. Interventions for Resident #366 included allowing privacy for masturbation in his room, new medications ordered for sexual behaviors and send out to emergency room for medical and psych clearance. Resident #366 also had a care plan approach for being an elopement risk and wanderer with goals of not leaving the facility

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

unattended and maintaining his safety through the next review. Interventions for Resident #366 included one-to-one observation, monitoring locations, and documenting wandering behaviors.

Attempted to contact the previous Administrator who was unable to be reached.

B. Resident #36 was admitted to the facility on 2/08/24. Diagnosis included chronic pulmonary obstructive disease (COPD) and muscle weakness.

Review of quarterly MDS dated 9/26/24 revealed Resident #36 was cognitively intact with adequate vision and hearing, able to make herself understood, and able to understand others.

Resident #57 was admitted to the facility on 10/31/24. Diagnoses included mild dementia, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness.

Review of admission Minimum Data Set MDS dated 11/05/24 revealed Resident #57 was cognitively intact and required partial assistance with mobility, substantial assistance with transfers, and substantial assistance with toileting as she was always incontinent for both bladder and bowel. Resident #57 was also coded for oxygen use and utilized a wheelchair for mobility, adequate vision and hearing, able to make herself understood, and able to understand others.

Resident #102 was admitted to the facility on 12/13/24. Diagnosis included COPD and type 2 diabetes.

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

Review of admission MDS dated 12/18/24 revealed Resident #102 was cognitively intact with adequate vision and hearing, able to make herself understood, and able to understand others.

Resident #366 was a 49-year-old male admitted to the facility on 4/14/23. Diagnosis included a traumatic brain injury (TBI), altered mental status, and cognitive communication deficit.

Review of Resident #366's facility face sheet dated 4/14/23 revealed Cleveland County Department of Social Services as his responsible person and guardian.

Review of Resident #366's care plan revised on 6/11/24 revealed Resident #366 had exhibited inappropriate sexualized behaviors and was noted to continue sexualized behaviors such as masturbating while in bed with a goal to not exhibit any of these sexual behaviors any further through the next review. Interventions for Resident #366 included allowing privacy for masturbation in his room, new medications ordered for sexual behaviors and send out to emergency room for medical and psych clearance. Resident #366 also had a care plan approach for being an elopement risk and wanderer with goals of not leaving the facility unattended and maintaining his safety through the next review. Interventions for Resident #366 included one-to-one observation, monitoring locations, and documenting wandering behaviors.

Review of quarterly MDS dated 10/23/24 revealed Resident #366 was severely cognitively impaired, independent for mobility, supervision for

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

transfers, partial assist with toileting as he was always continent for bowels with frequent urinary incontinence. Resident #366 was also ambulatory, utilized a wheelchair for long distances, able to make himself understood, able to understand others, adequate vision, and no hearing deficits. Resident #366 was also coded for wandering and for physical and verbal behaviors towards others such as scratching, grabbing, threatening, screaming, cursing, or abusing others sexually.

Review of facility incident report completed by the Administrator revealed on 12/19/24 at 1:30 AM the following information was reported: "[Resident #36] rang her call bell to alert staff that someone had wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] had a BIMS (brief interview for mental status) of 15 and stated no inappropriate touching had taken place. Investigation was underway. [Resident #57] was being placed on one-on-one temporarily. Nursing Home Administrator (NHA) and the Director of Nursing (DON) were in the facility to conduct full investigation and ensure resident's safety. [Resident #57] stated that she felt safe at the facility." The incident report also revealed law enforcement had been contacted on 12/19/24 at 3:00 AM.

An interview with Resident #57 on 01/30/2025 at 4:09 PM revealed one night a black woman [Resident #366] had come into Resident #57's room, got on top of her, and tried to feel of her. When Resident #57 told the black woman [Resident #366] to get off and "get the hell out of her room" initially she would not get off her so Resident #57 used her hands fight to get her off

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

and to leave. Resident #57 stated on that night she was wearing her gown but could not remember if her gown was pulled up or was down and Resident #57 did not recall if she was wearing a brief or not.

A telephone interview was conducted with Nursing Aide (NA) #1 on 1/30/25 at 8:49 AM and revealed she was familiar with Resident #57 and the alleged incident regarding Resident #366. She stated on the evening of 12/18/24 she was scheduled to work 11:00 PM to 7:00 AM and was assigned to the A hall which included Resident #57's room. She revealed while reviewing her room assignments at the A hall nurse desk she observed Resident #366 sitting in his wheelchair at the desk with his assigned one on one (NA #3). NA #1 stated when she went down the A hall, she saw that three resident call lights were on including Resident #57's room. She revealed after answering the first two call lights, she went in to answer Resident #57's call light around 11:17 PM and upon entering the doorway to the room she observed both Resident #57 and her roommate Resident #36 to be alert and awake and were motioning for her to come into their room. She stated when she entered the room, she noticed there was a brief lying on the floor near the trash can and a brief lying at the end of Resident #57's bed and she asked both residents "what was going on in there". NA #1 revealed Resident #36 then informed her that she saw Resident #366 come into their room, took off his pants, got on top of Resident #57 and "raped" her and that Resident #57 told Resident #366 to "get off of her" and "get the hell out of their room", so he got up and left. She stated Resident #57 was shaking her head in agreement with what her roommate Resident #36 was saying and then

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

stated, "I told them to get off of me and get the hell out of the room" and they left. NA #1 revealed she pulled back Resident #57's comforter and observed Resident #57 was not wearing a brief, so she immediately stopped and began yelling out for assistance from the other nursing staff to stay with the residents while she went to inform the nurse what was just reported to her. She stated she was not able to get any other staff to come into the room at that time, so she called the Director of Nursing (DON), which she believed to be around 11:30 PM to let her know what had been reported to her by both residents and that Resident #57 was not wearing a brief. She stated while on the telephone with the DON, she informed her that she was on her way and for NA #1 to stay with the residents, not to leave the room, not to touch anything in the room, and not to provide any type of personal care or incontinence care to Resident #57. She revealed the DON also inquired where Resident #366 was, and she informed her the last time she had seen Resident #366 he was sitting in his wheelchair at the nurse's desk with his assigned one to one. NA #1 stated she stayed in the resident's room until the DON and Administrator arrived and they asked her to step out of the room while they spoke with both residents privately. She revealed as she was leaving the resident's room, Resident #366's roommate (Resident #102) whose room was located directly across from Resident #57 room, motioned for her to come into their room. She stated Resident #102 informed her that earlier in the evening his roommate Resident #366's one on one had left the room and Resident #366 had gotten up out of his bed and attempted to get into bed with him. NA #1 revealed Resident #102 stated he asked Resident #366 what he was doing which seemed

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

to startle Resident #366 and he got up from Resident #102's bed and watched him walk across the hall to Resident #57's room. She stated Resident #102 revealed he saw Resident #366 bend down, remove his pajama pants, get on top of Resident #57 and was moving around. She revealed Resident #102 stated he then heard Resident #57 yell "get off of me" and to "get out of her room" and saw Resident #366 get off the bed, put his pajama pants back on, leave Resident #57's room and walk down the hall. NA #1 stated after speaking with Resident #102 she finished her rounds with her other residents, went to the nurse station and notified NA #3 what Resident #57, Resident #36, and Resident #102 had reported and NA #3 informed her that when she had come back from her break a little before 11:00 PM, she had observed Resident #366 walking down the hallway unattended without his one to one. She revealed while at the nurse's station she began writing her handwritten statement about what had been reported to her by the residents and what she had observed, when she was asked to go back into Resident #57 room to sit with her. She revealed when she arrived back at the room, Resident #57 was still not wearing her brief, had used the bathroom on herself and was complaining about feeling wet and her gown and bedding being wet. NA #1 stated she then contacted the DON who was still in the building and asked if she could provide Resident #57 incontinence care and the DON and the Administrator came back into Resident #57 room. She revealed she was asked to step out of the room again but assumed the DON had cleaned and provided Resident #57 incontinence care, because when she returned to Resident #57 room afterwards, she was wearing a clean brief, and her gown and bedding had been

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

changed.

Attempted to contact NA #2 by telephone and was unable to be reached.

A telephone interview was conducted with NA #3 on 1/30/25 at 9:23 AM revealed she was familiar with Resident #57 and the alleged incident regarding Resident #366. On 12/18/24, NA #3 was scheduled to work 7:00 PM to 7:00 AM on the A hall and her shift assignment was to provide one-to-one supervision for Resident #366. NA #3 revealed resident one-to-one supervision included being within arm's reach while the resident was up or ambulating around the facility and while the resident was in their room or sleeping the one-to-one was to sit outside the room and maintain line of sight. NA #3 stated on the evening of 12/18/24 she had assisted Resident #366 with turning on his TV and getting ready for bed and then asked NA #2 who was agency staff but had worked at the facility for several months and was aware of the one-to-one supervision protocol to come down and relieve her for her break which NA #2 agreed. NA #3 revealed that as she was leaving to go to break at 10:27 PM according to her watch and the time clock she notified the A hall nurse who was sitting at the nurse's desk that she was going on break and NA #2 was covering Resident #366's one-to-one supervision. NA #3 stated when she returned from her break at 10:51 PM and rounded the corner to A hall she observed Resident #366 three doors down from his room, walking the hallway unattended, wearing his pajama pants and a t-shirt. NA #3 revealed she did not see NA #2 anywhere in sight, so she assisted Resident #366 back to his room where she noticed he was not wearing a brief which was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

not uncommon because he would take them on and off, got him into his wheelchair and took him to sit with her at the A hall nurse's desk. NA #3 stated right after the 11:00 PM shift change while she and Resident #366 were sitting at the nurse's desk, NA #2 came up to the desk and she informed NA #2 that upon her return from break she had found Resident #366 walking around the A hall unattended and NA #2 apologized stating that she had gone to answer another resident's call light and had left Resident #366 unattended. NA #3 revealed that sometime around midnight while she and Resident #366 continued to sit at the nurse's desk, the Administrator and DON came in and went down the A hall and a few minutes later NA #1 came up to her and told her that Resident #36 had reported to her that Resident #366 had come into her and Resident #57's room, removed his pajama pants, got on top of Resident #57 while she was lying in her bed and "raped" her, Resident #57 yelled at Resident #366 to "get off her" and to "get out of her room" and Resident #366 left the room and walked down the hall. NA #3 stated NA #1 reported that Resident #57 had agreed with everything her roommate, Resident #36, was saying. NA #3 reported that as NA #1 was leaving Resident #36 and Resident #57's room, was when Resident #366's roommate (Resident #102) had motioned for NA #1 to come into his room. Resident #102 then reported to NA #1 that when Resident #366's one-on-one left the room, Resident #366 attempted to get into his bed and when he asked him what he was doing he got up and left. Resident #102 stated he saw Resident #366 walk across the hall into Resident #57's room, remove his pants, get on top of Resident #57 who was lying in her bed, move around on top of Resident #57, and when he heard Resident

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

#57 yell at Resident #366 to "get off of her" and to "get out of her room", Resident #102 saw Resident #366 get off Resident #57, put his pants back on, leave the room, and walk down the hall. NA #3 revealed she then informed NA #1 that when she had returned from her break earlier that evening, she had witnessed Resident #366 walking around the A hall unattended 3 doors down from his room. NA #3 also informed NA #1 that NA #2 was supposed to be covering her break and providing one-to-one supervision for Resident #366 but had left him attended while she went to answer a call light. NA #3 recalled a few minutes later after speaking with NA #1, was when NA #1 was asked to go back into Resident #57's room. NA #3 revealed while the Administrator and DON were walking back up the hallway from Resident #57's room was when she informed both about when she had returned from her break, she found Resident #366 walking around the A hall three doors down from his room, he was unattended wearing only his pajama pants, t-shirt, and no brief. NA #3 also reported to the Administrator and the DON that NA #2 was supposed to be covering her break and providing one-to-one supervision to Resident #366, and while providing Resident #366's one-to-one supervision NA #2 went to answer a call light and left Resident #366 unattended. NA #3 stated that after she was informed what Resident #57 had reported, she asked Resident #366 what had happened while he had been walking around the hall, and he stated that he had gone in to get into bed with his wife and he was touching and kissing on her but she didn't like it and told him to get out, so he left.

An interview with Resident #36 who on 1/29/25 at 12:40 PM revealed she recalled being roommates

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

with Resident #57. When asked if anything had ever happened while she and Resident #57 had been roommates, she stated "she did remember this one time where a black man had come into their room, got on top of Resident #57, she told them to get out and they left". She stated after that she believed Resident #57 moved rooms and nothing ever happened again. Resident #36 could not recall who she had spoken with on the night of the incident or any further details about the incident.

A telephone interview with Resident #102 on 1/30/25 at 3:08 PM revealed on the evening of 12/18/24 he was lying in his bed, and his roommate Resident #366 was lying in his bed, when Resident #366's one-to-one staff left the room, Resident #366 got up out of his bed and tried to get into bed with him. Resident #102 stated it seemed to startle Resident #366 when he asked him what he was doing, and that was when Resident #366 got up from Resident #102's bed, left their room, walked across the hall, and into Resident #57's room. Resident #102 stated Resident #57's room was dark, but he was still able to see into the room with the hallway lights. Resident #102 revealed he saw Resident #366 remove his pants, get on top of Resident #57 while she was lying in her bed, and witnessed Resident #366 moving around on top of Resident #57. Resident #102 reported he could not tell if Resident #366 was wearing his brief or not while on top of Resident #57. Resident #102 stated he then heard Resident #57 tell Resident #366 to "get off of her" and "get the hell out of her room" and he saw Resident #366 exit off the left side of Resident #57's bed, walk around the end of the bed, put his pants back on, exit Resident #57's room, and walk down the hall. Resident #102

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

stated he would have used his call light to let staff know what had happened, but his call light had gotten tangled up and he couldn't find it. Resident #102 reported a few minutes later Resident #366's one-to-one came back into their room to get Resident #366's wheelchair, and appeared frazzled, so he did not tell her about what he had witnessed either. Resident #102 revealed a few minutes after Resident #366 one-to-one had come into his room, he saw NA #1 go into Resident #57's room and when he saw her leaving Resident #57 room was when he motioned for NA #1 to come into his room, and he told NA #1 what he had witnessed between Resident #366 and Resident #57, and then repeated this same information to the Administrator, and law enforcement.

A telephone interview with Resident #57's friend on 01/30/2025 at 3:50 PM revealed she had been Resident #57 previous caretaker prior to her coming to the facility and continued to visit with her often. She stated on 12/26/24 she was visiting with Resident #57 when she suddenly became quiet, looked at her and said, "I have something to tell you." Resident #57's friend stated she asked Resident #57 what she needed to tell her, and she said, "I was raped." When asked what she was talking about, Resident #57 stated "I was raped by a black woman [Resident #366], she got on top of me, and I had to tell her to get off me and out of my room." Resident #57's friend then asked if anyone had come into her room when this was going on and she said "no." When she asked Resident #57 if she was ok and felt safe at the facility she said "yes." Resident #57's friend stated she did not ask any further questions about the incident and Resident #57 had seemed fine, but it bothered her to think

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27	F 600		

Resident #57 had gone through something like this.

Review of physician progress note written by the Medical Director on 12/20/24 indicated he was asked to see Resident #57 for questions about an incident that happened the night before and was unclear whether Resident #366 had assaulted her. While the Medical Director was talking with Resident #57, she stated that nothing happened, but someone did come into her room. It was really unclear to the Medical Director whether she knew exactly what happened, but the incident was being investigated. Resident #57 did not seem to be more anxious now or change in her mental status from previous. In speaking with Resident #57 today, it did not appear like there had been any trauma that he could think of but obviously the whole incident had to be anxiety provoking, however, he could not get a real history of what happened. Again, there were no signs of believed trauma but certainly wanted her seen by mental health provider and discussed all of this with Resident #57's RP.

During an interview with the Medical Director on 1/28/25 at 11:09 AM he stated that he was aware of the alleged "incident" with Resident #57 and Resident #366. He stated the date of his progress note 12/20/24 was when he was notified, and he assumed the incident had occurred the night before on 12/19/24 and was not made aware the incident had occurred on the evening of 12/18/24. He revealed he did speak with Resident #57's RP on 12/19/24 regarding a sleep medication the RP wanted stopped, but he could not recall if she had mentioned anything to him about the incident, he only recalled that he discontinued Resident #57's sleep medication as requested. The Medical

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

Director stated he was asked on 12/20/24 regarding an incident where Resident #366 had come into Resident #57's room and gotten onto her bed, she asked him to leave her room and he did, and it was unclear if any type of assault had occurred. He revealed that when he saw Resident #57 on 12/20/24 he only attempted to speak with her about the incident, but did not complete any type of physical exam. He stated Resident #57 would not really give him any details about the incident, only that someone had come into her room, but he did not feel that she was showing any signs or symptoms that any type of trauma or injuries had occurred. The Medical Director revealed to his knowledge Resident #57 had never showed any signs of increased anxiety or changes to her mental status and she was followed by psych services, and he was not aware of them noting any issues or concerns stemming from the incident. He stated Resident #366 was supposed to always be on one-to-one supervision due to sexualized behaviors, wandering, and an incident that occurred with another female resident earlier in the year. He revealed it appeared the one-on-one process failed allowing Resident #366 the opportunity to go into Resident #57's room which should have never been allowed to happen, Resident #366 was not suitable for skilled nursing level and not matter how much his medications were increased he would continue to require one-on-one supervision as long as he was at the facility because his sexualized behaviors specifically were unable to be controlled.

A telephone interview was conducted with Resident #57's RP on 1/30/25 at 10:31 AM revealed she received a telephone call from the Administrator and the DON on 12/19/24 at 7:55

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

AM letting her know about an incident that occurred the night before, where another resident had come into Resident #57's room and she yelled for them to get out and they left. She stated they told her that Resident #57 was fine, but they were going to be moving her this morning to another room closer to the nurse station for her safety. She revealed when she arrived at the facility around 9:00 AM, they were moving Resident #57's room, she was sitting in her wheelchair out in the hallway waiting for her new room to be cleaned. The RP stated while she was waiting in the hallway with Resident #57, she asked her how she was doing and then she said, "I heard you had an interesting night" and Resident #57 turned her head towards her and said "yep, I was raped." She revealed she did not ask Resident #57 any further questions, stopped the first staff she could find and asked them to call the Administrator and the DON that she needed to speak with them immediately. She stated while waiting on the Administrator and DON to come back to the facility to speak with her, she spoke with the Medical Director, informed him they had a safety issue regarding Resident #57 and that she had stated she was "raped", and she would like for one of her sleep medications to be discontinued. The RP revealed the Medical Director never addressed with her about any safety issues with Resident #57 or the fact that she had mentioned "rape", just stated that he wasn't the one who prescribed the sleep medication but that he would discontinue it and then left. She stated the Administrator and the DON arrived and she told them what Resident #57 had said and they denied the word "rape" ever being mentioned by Resident #57, other residents, or their staff, they went on explain what had been reported to them, results of their skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

assessment, their report to law enforcement, and they offered to send Resident #57 for a rape kit but after consulting with other medical professionals she and the family declined. The RP revealed Resident #366 was supposed to always have one-on-one supervision and didn't, but the facility had notified her that he had been sent to the hospital for a psych evaluation and would not be returning. She stated she felt like if Resident #366 had been supervised like he was supposed to be then none of this would have happened in the first place.

An interview was conducted with the Lieutenant at the Police Department on 1/30/25 at 3:30 PM revealed he interviewed the residents involved, Resident #57 would not really speak with him about the matter, but the other two residents' [Resident #36 and Resident #102] stories remained the same, he also attempted to contact the staff that were working that night but none of them would return his call. The Lieutenant revealed initially when the incident was reported they did not have a name for Resident #366 but then once they identified him as the resident who entered the room, they remembered that he had been involved in a similar situation earlier that year. He stated they would more than likely close the case on their end because Resident #366 was severely cognitively impaired and even if they were able to prove he assaulted or violated Resident #57 they would not be able to charge him due to his cognition and medical issues.

An interview conducted with the Director of Nursing (DON) on 1/30/25 at 4:03 PM revealed she was familiar with Resident #57 and the incident involving Resident #366. On the evening of 12/18/24 around 11:30 PM, the DON stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

she received a telephone call from NA #1 who sounded anxious and panicked and reported that she had gone into Resident #57 and Resident #36's room to answer a call light and Resident #36 had informed her that a black male with hairy back legs had come into their room, sat down on Resident #57 bed and Resident #57 told them to "get the hell out of her room" and they left and NA #1 had no further information. She stated she informed NA #1 to stay with residents, not to leave their room, not to touch anything, and that she was on her way. She revealed she also asked NA #1 where Resident #366 was and was told that he was sitting at the A hall nurse's desk with his one-on-one. The DON stated she immediately called the Administrator and informed her of what had been reported to her and then both she and the Administrator arrived around 12:30 PM at the facility. She revealed she and the Administrator went down to Resident #57 and Resident #36's room, asked NA #1 to leave the room while they interviewed both residents. She stated they interviewed Resident #57 and asked her if she was okay and she stated yes and then they asked her what happened and Resident #57 told them "a black female had come into their room, climbed onto the end of her bed, said something to her about changing her, she told them to "get the hell out of her room" and she left." The DON revealed the Administrator asked Resident #57 if the person had touched her or done anything to her and Resident #57 said yes, and when asked where they touched her, she pointed out to the shoulder and collar bone area and stated again that when she told them to get out, they left. She stated they also interviewed Resident #36 who stated a black male had come into their room with no pants on and sat down on Resident #57 bed and Resident

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32	F 600		

#57 told them to get out of the room and they left, when Resident #36 was asked how she knew the male was not wearing pants she stated that she could see the hair on the back on his legs. The DON revealed that she did see a brief laying on the floor of the room near the trash can and tabs appeared to be stretched out, a brief at the end of Resident #57 bed, and Resident #57 was not wearing a brief, but she was not aware of why Resident #57 was not wearing a brief. She stated when she and the Administrator arrived at the facility Resident #366 was sitting in his wheelchair at the nurse's desk with his one-on-one, and they were not made aware until later that Resident #366 had been left unattended while his scheduled one-on-one had gone to break, and his relief one-on-one had gone to answer resident call lights. She revealed she believed the Administrator interviewed Resident #366 roommate (Resident #102) who reported Resident #366 had tried to get into his bed and when he asked him what he was doing, Resident #366 got out of his bed, walked out of their room and saw him in Resident #57's room with his pants down, on top of her bed, Resident #57 yelled for him to "get out of her room" and Resident #366 pulled his pants back up, left Resident #57's room and walked down the hall. She stated she and the Administrator interviewed Resident #57, Resident #36, and Resident #102 three separate times and their stories never changed. The DON revealed during this time NA #1 who was with Resident #57 had contacted her about providing Resident #57 incontinence care due to her being wet, so she and the Administrator went back down to Resident #57 room, asked NA #1 to leave the room again so they could ask Resident #57 one more time if she was sure nothing had happened, she stated no,

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 33	F 600		

and they asked for her to show them again where she was touched and she pointed out to the shoulder and collarbone area. The DON stated that she completed Resident #57 skin assessment and did not note any new skin issues, no bruises or scratches, she also cleaned up and provided incontinence care, changed Resident #57 gown and bed sheets due to being soaked from not having on a brief. She revealed Resident #57 appeared to be fine during all of this and never showed to her any signs of having increased anxiety, changes in her mental condition, or feeling scared or afraid. She stated they did contact Resident #57's RP and told her exactly what had been reported by Resident #57 and her RP stated she would swing by shortly, so she and the Administrator left because they had been there all night. The DON revealed not long after she had arrived home probably around 9:00 AM, she received a telephone call from the facility stating that Resident #57's RP wanted to speak with her and the Administrator, that Resident #57 had told her that she had been raped. She stated when she and the Administrator arrived back at the facility, they spoke with Resident #57's RP who stated that when she came in to see Resident #57, she said to her "I heard you had an interesting night" and that Resident #57 turned to her and said, "I was raped." She revealed they explained to Resident #57's RP this was the first time they had heard the word "rape" and went into detail about what had been reported to them night before, what they had done as part of their investigation, they had completed a skin assessment which showed no signs of any new skin issues, they had reported everything to law enforcement, and they did offer to send Resident #57 to the hospital for a rape kit but the family declined.

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 34	F 600		

Review of Resident #57 skin assessment completed on 12/19/24 by the DON revealed no new skin abnormalities noted.

Review of facility 5-day investigation report completed by the Administrator dated 12/26/24 revealed their investigative findings included the following facts: Resident #102 witnessed the entire incident citing Resident #366's confusion and wandering behaviors, no willful intent on behalf of Resident #366 as evidenced by the fact that he also attempted to get into his roommates bed just prior to the incident, no evidence of sexual intercourse during thorough skin assessment or per resident reports, and there were no reports that indicate abuse from the two resident eyewitnesses, staff interviews, or other resident interviews. Based on their comprehensive investigation and the findings listed above, the facility did not substantiate abuse, and Resident #57 remained without any physical injury, mental harm, pain, or anguish. Education was provided to all staff regarding one-on-one supervision, abuse and neglect policy, reporting abuse and neglect, dementia and sexualized behaviors, and reasons why someone would be placed on one-on-one supervision.

An interview conducted with the Administrator on 1/30/25 at 5:34 PM revealed she was also familiar with Resident #57 and the incident involving Resident #366. On the evening of 12/18/24 at around 11:45 PM, she received a telephone call from the DON stating Resident #36 had reported to NA #1 that a "black man had come into their room there and got on Resident #57's bed and she heard her say "get out of here"

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 35	F 600		

and the man left" and that she knew it was a black man due to seeing the back of his hairy legs. She stated when she and the DON arrived at the facility, they went to interview Resident #57 and she stated a "black lady came into her room and was touching her, she told them to get out of here and they left", when Resident #57 was asked where she was touched, she pointed out to the shoulder and collarbone area. She revealed they also interviewed Resident #36 during this time, and she told them the same story that had originally been reported to the DON. The Administrator stated after leaving Resident #57's room they were informed by NA #3 who was scheduled as Resident #366's one-on-one that when she returned from her break, she saw Resident #366 walking around in the hallway unattended. The Administrator revealed she went and interviewed Resident #366's roommate (Resident #102) and he stated that "[Resident #366] got out of bed, tried to get into bed with him, he asked him what he was doing, [Resident #366] became startled and got up from his bed. [Resident #366] left their room, walked across the hall to [Resident #57's] room, saw him take off his pajama pants and get onto [Resident #57's] bed. He heard her tell [Resident #366] get out and he left." She stated she asked Resident #102 if he could tell if Resident #366 had on his brief and he stated that he couldn't really tell, he never saw his "butt cheeks" or anything. She revealed they interviewed Resident #57, Resident #36, and Resident #102 three different times that night and their stories never changed, and no one mentioned the word "rape" to them including staff. She stated the DON completed Resident #57's skin assessment that night and there were no new issues noted and no signs of any bruises or scratches, the DON also provided Resident #57

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 36	F 600		

incontinence care, changed her gown and bed sheets due to her being soaked from not having on brief. She was not aware of why Resident #57 did not have a brief on and did not recall any briefs lying on the floor and thought the brief laying at the end of Resident #57's bed was a clean brief. She stated the following morning on 12/19/24 she notified Resident #57's RP of the incident that occurred, RP came to the facility later that morning, and when she asked Resident #57 about the night before and supposedly Resident #57 told her that she was "raped." She revealed they explained to Resident #57's RP about the incident, results from the skin assessment, offered to send Resident #57 out for a rape kit which the RP declined, reported the incident to law enforcement, and was moving her room for safety. The Administrator stated they unsubstantiated the incident due to no evidence of "rape" or any kind of assault, they did find that Resident #366 had been without his one-on-one supervision for a period of time and they re-educated staff on the one-on-one process, behaviors, and their abuse and neglect policy, Resident #366 was also sent out to the hospital on 12/20/24 for a psych evaluation and returned on 1/22/25 and he is back on the locked unit with one-on-one supervision.

The facility was notified of immediate jeopardy on 1/31/25 at 1:50 PM.

The facility provided and implemented the following corrective action plan:

On 4/12/24, Resident #366 was found in bed with a female resident on the locked dementia unit while she remained asleep. Female resident gown and brief were intact, and her breasts were

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 37	F 600		

covered. M.D. completed full physical assessment on female resident including a thorough examination of the genitalia that revealed no indication that sexual contact had occurred. RP for female resident was notified and offered resident to be sent to hospital for further evaluation. This offer was declined.
On 4/12/24, Resident #366 was placed on 1:1 supervision and sent to ER for evaluation and treatment as this was a new behavior. All labs were negative. Resident #366 was seen by psyche services with medication changes. Resident returned to the community the same day and remained on 1:1 supervision.
On 4/12/24, Education was completed by the LNHA/Designee working on the dementia unit regarding wandering residents, new behaviors and the 1:1 supervision for Resident #366. All staff received education on Abuse and Neglect.
On 12/18/2024, the facility failed to protect a female resident (Resident #57) from sexual advances from a cognitively impaired male (Resident #366). Resident #366 required 1:1 level of supervision and Nurse Aide (NA) #2, who was assigned to provide the 1:1 level of supervision did not keep Resident #366 in line of sight. This failure allowed Resident #366 to wander into Resident #57's room, remove his pants, and climb onto her bed, resulting in sexual abuse.
On 12/18/2024, when Nurse Aide #3 returned from her break and found Resident #366 walking in the hallway unattended by a staff member. She assisted Resident #366 into his wheelchair and provided 1:1 supervision. Resident #366 remained on 1:1 supervision for the duration of his time in the facility.
On 12/18/24 the Director of Nursing (DON) was contacted by phone at 11:34 pm by NA #1.
On 12/19/24, the Administrator and DON reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 38	F 600		

to the facility immediately after being notified about the incident.
On 12/19/24, staff and resident interviews were completed by the Administrator, DON, and Assistant Director of Nursing (ADON). These interviews discovered that Resident #366 had wandered into Resident #57's room, removed his pants, and climbed onto the bed. Resident #57 yelled for Resident #366 to get out, at which time he got out of the bed, put his pants back on, and wandered back out of the room.
On 12/19/2024, Resident #57 was assessed by DON and ADON with no injuries, mental anguish or other concerns noted. Resident #57 was also interviewed by the DON, ADON, and Administrator. Resident #57's initial statement conveyed that a female entered her room and stated that she was going to change her. She then proceeded to explain that a black female got onto her bed and started touching her body. She stated she yelled for this person to get out, and at that time, the female exited the room. When asked where this person touched her, she pointed to her shoulder and collar bone area. Resident #57 was interviewed again by the DON, ADON, and Administrator approximately one hour later, and she repeated the same information. Resident #57 was interviewed for a third time by the DON, ADON, and Administrator, and on this occasion, the Administrator pointed to various body parts, including breasts, genitals, and buttocks to ask if she was touched in any of these areas. Resident #57 maintained the same response, stating that she was touched only on her shoulder and collar bone area. She further explained that the other resident did not touch her under her gown or get under her covers.
On 12/19/2024, Resident #57 was monitored via one-on-one staff supervision when notification to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 39	F 600		

DON occurred. 1:1 supervision remained in place until a full body examination occurred by DON and ADON and then every fifteen minutes for seventy-two hours by facility staff to ensure no injuries or psychosocial effects are identified. A psychiatric referral was also made for Resident #57.

On 12/19/24, Resident #57's care plan was updated by a licensed nurse for increased monitoring to ensure psychosocial well-being.

On 12/19/2024 immediately following the incident, Resident #366 was assessed by a licensed nurse for behavior after he displayed sexually aggressive behaviors. It was determined by the assessment that the current intervention of 1:1 supervision and activities for distraction remained appropriate. Resident #366 was also interviewed on 12/19/2024 at approximately 12:15am following the incident by DON, ADON, and Administrator, and he stated that he wanted to be near his wife and was trying to give her a back massage. He was asked to show them where he massaged her, and he pointed to his shoulder area. Resident #366's care plan was not updated as it already reflected the need for 1:1 supervision and activities for distraction.

On 12/19/2024, residents' responsible parties were notified of the incident by licensed nurse.

On 12/19/2024, the Medical Director was notified of the incident by a licensed nurse with no new orders given.

On 12/19/2024, all residents were audited by the DON to ensure that they were in the correct bed with no additional residents noted to be in wrong bed.

Resident #366 was seen by psychiatric services on 12/20/2024. There were no medication changes from this visit, and recommendations were for follow-up in a week.

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 40	F 600		

How will the facility identify other residents having the potential to be affected by the same deficient practice:
All residents are at risk of being affected.
On 4/12/24, An audit was conducted by the Administrator/designee for all residents with a BIMS 10 or greater. This was an interview that asked residents if they felt safe at the facility and if there had ever been any sexual advances or inappropriate touching. There were no new findings
On 4/12/24, skin assessments were completed by a licensed nurse for residents with a BIMS of 9 or less to ensure that there was no evidence of abuse. There were no new findings.
On 12/19/2024, an audit was completed by the Administrator/designee for Residents with a BIMS of 10 or greater to ensure that no abuse had occurred. This audit consisted of interviews that asked residents if they had ever experienced any inappropriate touching and if they felt safe at the facility. There were no new findings.
On 12/19/2024, skin assessments were completed by licensed nurses for residents with a BIMS of 9 or less to ensure there was no evidence of abuse. There were no new findings.
On 12/19/2024, interviews with staff, including agency and contracted staff, were conducted in person or via phone by the Administrator/designee to ensure there were no additional findings of resident abuse. There were no new findings.
On 12/19/2024, ADON completed an audit for sexually aggressive behaviors over the last 24 hours by reviewing the Behavior Summary report for any documentation of sexually aggressive behaviors, and she also completed a walking round to ensure that no resident was visibly expressing sexually aggressive behaviors. Any

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 41	F 600		

other resident with a known history of sexually aggressive behavior would be identified so that staff could be made aware of the need for increased monitoring. There are no other residents with sexually aggressive behaviors that required 1:1 supervision.
What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:
On 12/19/2024, all staff in all departments, including contract and agency staff, were educated in person or via phone to abuse policy by the Administrator/designee including types of abuse, reporting, response, and prohibition. Education included strategies to manage a resident's sexually aggressive behaviors such as redirection, distraction, communicating clearly and respectfully with the patient, and involving family members in the care plan. Additionally, staff were made aware of indicators for potentially sexually aggressive patients that include making inappropriate sexual comments or advances, attempts to touch others sexually, and exhibiting unusually aggressive or disinhibited sexual behavior. All staff in all departments, including contract and agency staff, were also educated in person or via phone by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to the plan of care requiring Resident #366's need for one-on-one supervision and the one-on-one supervision process. Education included that the resident who requires one-on-one must remain in line of sight. At no time should the individual take a break, answer a call light, or deviate from this one-on-one level of supervision without ensuring that the other employee assigned to one-on-one is present in line of sight of the resident and attentive to the resident. Newly hired, contract and agency staff, as needed staff, and staff on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 42	F 600		

leave will be educated prior to accepting a resident assignment. DON and ADON are responsible for tracking education completion.
How will the facility monitor its corrective actions to ensure that the deficient practice will not recur:
On 12/19/24 during an ad hoc Quality Assurance Process Improvement (QAPI) meeting, a root cause analysis was completed. It was identified through this analysis that the root cause for this failure was a need for additional staff education on the facility abuse policy, including types of abuse, reporting, response, and prohibition. In addition, education should include the 1:1 process and that the resident who requires one-on-one must remain in line of sight. At no time should the individual take a break, answer a call light, or deviate from this one-on-one level of supervision without ensuring that the other employee assigned to one-on-one is present in line of sight of the resident and attentive to the resident. Included in the meeting were the Administrator, DON, and ADON.
DON/designee will randomly audit 5 residents per week for 8 weeks via interview or skin assessment to ensure that no abuse has occurred and that the resident feels safe in the facility.
DON/designee will randomly audit 5 staff members per week for 8 weeks to ensure that they are not aware of any abuse in the facility.
DON/designee will audit residents that require one on one supervision 5 times weekly for 8 weeks to ensure that one on one being completed per protocol and one on one employee breaks are listed on assignment sheet.
The Facility Administrator will review the audits to identify patterns/trends and will adjust the plan to maintain compliance.
The Facility Administrator will present the audits

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 43	F 600		

during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. The QAPI Committee includes the Administrator, DON, ADON, Medical Director, Business Office Manager, Activity Director, Medical Records Coordinator, Maintenance Director, Rehab Director, Minimum Data Set (MDS) Nurse, Admissions and Marketing Director, and Human Resource Manager
Alleged Date of Immediate Jeopardy Removal: 12/20/24
Alleged Date of Compliance: 12/20/24

The facility's corrective action plan was validated on 2/04/25 by the following: Interviews with all facility staff revealed they had received education on abuse and neglect and reporting abuse and neglect where they went through different scenarios of what would be abuse and what would be neglect, if abuse or neglect had been suspected or reported they do not leave residents alone, make sure they are safe, and use resident's call light or yell if needed to get assistance from other staff. Observation of Resident #366 sitting in his wheelchair inside of his room with his one-to-one staff sitting beside him within arm's reach. Resident #366's one-to-one staff were able to verbalize the education they had received regarding abuse and neglect, reporting of abuse and neglect, one-to-one supervision protocols, and where to find the name of staff who was scheduled to relieve them for their breaks. Resident #366's one-to-one staff was also able to show the documentation used for one-to-one supervision where they sign and document Resident #366's mood and behaviors during their shifts. Resident #366 was also observed ambulating his wheelchair up and down the hallway with his

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 44	F 600		

one-to-one staff walking behind him or to the side of him with no issued noted. They were educated about sexual abuse and discussed if they ever observed themselves or it was reported to them that another resident was on top of another resident, how they should proceed and again making sure both residents were safe. They also received education on one-to-one supervision, making sure the resident was within their line of sight at all times, protocol for switching out for any breaks and the name of both the staff scheduled as the one-to-one and the staff responsible for relief was located on the staff assignment sheets, why residents would require on one-to-one supervision and how to document the one-to one supervision. The facility staff were also asked to demonstrate the education they had received by taking a quiz regarding abuse, neglect, and one-to one supervision. Review of facility orientation education for new hires and contract staff included education on the facility abuse and neglect policy, the one-on-one supervision policy and procedures, reporting abuse and neglect, documentation for one-on-one supervision, how to handle resident behaviors to include sexualized behaviors. Review of staff assignment sheets for shift also revealed the name of the staff person who was assigned to any resident for one-on-one and included the name of the staff person who was scheduled to provide their break relief. Reviewed the audit and monitoring tools with no issues noted. Interviews with the Administrator and the DON revealed they had received training from their corporate regarding abuse and neglect, sexual behaviors and diversions, protocols for abuse and neglect, one-to-one supervision policy. They were also responsible for providing the same education to all the facility staff, those

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 45 training sessions were held both in person and via telephone, and all of the staff were able to demonstrate their understanding of the education they had received by completing quizzes related to the education they had received. The facility's immediate jeopardy removal date was validated as 12/20/24 and compliance date was validated as 12/20/24.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §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	F 609		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 46 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 provide report an allegation of resident to resident abuse to the State Agency, law enforcement, and Adult Protective Services (APS) within the required timeframe and to ensure the report to all agencies included accurate information. The facility learned of an allegation of rape on 12/19/24, did not provide the information to law enforcement, and did not report the information to the State Agency until the investigation report was submitted on 12/26/24. This deficient practice affected 1 of 3 residents reviewed for abuse (Residents #57). Findings included: A review of the facility's abuse policy entitled Abuse, Neglect, Exploitation, and Misappropriation, last revised 6/13/21 revealed if an incident of suspected abuse occurs, the facility shall report immediately, but not later than 2 hours after forming the suspicion, if the events that caused the suspicion resulted in bodily harm, and no later than 24 hours if the events that caused the suspicion did not result in bodily harm to designated state agencies. Review of facility initial report completed by the Administrator indicated the incident date was 12/19/24 and the facility became aware of the incident on 12/19/24 at 1:30 AM. The fax date and time revealed the report was submitted on 12/19/24 at 3:24 AM. The initial report revealed the following information: "[Resident #36] rang her call bell to alert staff that someone had	F 609	Criteria 1: The police were notified on 12/19/25 of the rape allegation from resident #57 after being contacted by resident #57's family member. Adult Protective Services (APS) was notified of the allegation on 12/26/25. Criteria 2: All residents reporting incidents have the potential to be affected by the deficient practice. On 2/20/25, the Administrator completed an audit of reportable incidents for 2/1/25 - 2/20/25 to ensure that no new allegations were made that were not reported in the initial report and that all state agencies were notified timely. There were no negative findings. Criteria 3: On 2/20/25, the Regional Director of Operations educated the Administrator and Director of Nursing (DON) that all new allegations of abuse must be reported to the state agency, law enforcement, and APS in the appropriate timeframe - within 2 hours when the events that cause the allegation involve abuse or result in serious bodily injury, and not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 47 wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] has a BIMS [brief interview for mental status] of 15 and states no inappropriate touching took place. Investigation underway. [Resident #57] is being placed on [one-on-one] temporarily. [The Administrator] and [the Director of Nursing] were in facility to conduct full investigation and ensure resident's [safety]." The report indicated Resident #57 stated that she felt safe at the facility and that law enforcement had been contacted on 12/19/24 at 3:00 AM. It did not indicate if APS had been contacted. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 4:03 PM. She indicated she received a telephone call from nursing staff around 11:34 PM on 12/18/24 stating Resident #57 and her roommate (Resident #36) had alleged a Resident #366 came into their room, sat down on Resident #57 bed, and when Resident #57 asked him to get out of the room he (Resident #366) left. She stated she immediately notified the Administrator and they both agreed to come into the facility to start their investigation and begin interviewing both residents and staff. The DON revealed she and the Administrator arrived at the facility sometime between 12:30 AM and 1:00 AM on 12/19/24 and immediately began interviewing residents so they could determine what type of incident had occurred and to begin their investigation. Review of the Police Department report dated 12/24/24 revealed on 12/22/24 detectives responded to the facility in reference to a past tense assault. Upon arrival they spoke with the	F 609	injury. Criteria 4: The Regional Director of Operations will monitor this process by auditing all facility reportable incidents monthly for 2 months to ensure that the state agency, law enforcement, and APS are notified within 2 hours when the events that cause the allegation involve abuse or result in serious bodily injury, and not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of corrections. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 48	F 609		

Administrator who advised they had an incident that occurred on 12/19/24 around 3:00 AM and they had contacted the police department and spoke with a patrolman regarding the incident of a male resident entering the room of a female resident, sitting on the female resident's bed, and then leaving the room. The Administrator advised there was no nudity and no contact between the male (Resident #366) and female (Resident #57) resident. The Administrator stated the female resident had instructed the male resident to leave when he entered the room, and he left. As the detectives continued to receive the story of the incident from the rest of the staff there, as well as speaking with the patrolman about what was initially reported to him, it was concluded the male resident had crawled into bed with the female resident prior to getting him out of her room. This was information the Administrator did not mention to law enforcement during the initial interview about the situation.

An interview conducted with the Lieutenant at the Police Department on 1/30/25 at 3:30 PM revealed on 12/19/24 at 3:00 AM they received a report from the Administrator at the facility regarding resident-to-resident abuse. The Administrator reported Resident #366 had walked into Resident #57's room, sat down on the bed, and then left the room. The Lieutenant revealed he was later notified on 12/22/24 by Resident #57's responsible person that Resident #57 had alleged she was "raped." He stated he then went to the facility to take the report regarding Resident #57's allegation of "rape." The Lieutenant revealed he interviewed the Administrator, and she stated on the evening on 12/18/24, Resident #366 had entered Resident

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 49	F 609		

#57's room, removed his pants, and got on top of Resident #57 while she was lying asleep in her bed. The Administrator revealed Resident #57 told Resident #366 to "get off of her" and to "get out of her room", Resident #366 put his pants back on and left the room. The Lieutenant revealed this was a different story than what was initially reported on 12/19/24. He stated he attempted to interview Resident #57, but she would not really speak with him about the matter, and he also attempted to contact the staff that were working that night but none of them would return his call. He revealed the Administrator denied Resident #57 reporting to her that she was "raped" and the first time she had heard that word was when Resident #57's responsible person had mentioned it.

Review of facility 5-day investigation report completed by the Administrator dated 12/26/24 revealed their investigative findings included the following information: Resident #102 witnessed the entire incident citing Resident #366's confusion and wandering behaviors. There was no willful intent noted on behalf of Resident #366 as evidenced by the fact that he also attempted to get into his roommate's bed just prior to the incident. There was no evidence of sexual intercourse observed during completed skin assessment and per resident reports. Resident #57's responsible person (RP) alleged Resident #57 had stated to her (the RP) that she (Resident #57) was "raped." The Administrator and law enforcement attempted to interview Resident #57 about the allegation of "rape", but she was not able to provide any further information. There were no reports that indicate abuse from staff interviews, or other resident interviews. The facility did not substantiate abuse, and Resident

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 50	F 609		

#57 remained without any physical injury, mental harm, pain, or anguish.

Review of an intake letter from Adult Protective Services (APS) dated 12/31/24 revealed they had received the facility's 5-day investigation report on 12/26/24 related to the incident involving Resident #57 and Resident #366. The letter also revealed APS would not be following up on the intake report and were sending the report to the state for further review.

An interview conducted with the Administrator on 1/30/25 at 5:34 PM revealed she had completed the initial and 5-day investigation reports regarding the incident between Resident #57 and Resident #366. She stated she was contacted by the DON around midnight on 12/18/24 informing her of an alleged incident that occurred regarding Resident #57 and a male resident, who was later identified as Resident #366, coming into the room, sitting on Resident #57's bed, and then leaving the room. The Administrator revealed she and the DON arrived at the facility she believed between 12:30 AM and 1:00 AM on 12/19/24 to begin interviewing the residents. She stated that was why the initial report had was dated for 12/19/24 at 1:30 AM because that was when she was able to arrive at the facility, begin interviewing the residents, and receive the information needed for the report. The Administrator revealed based on the initial information that was provided to her by Resident #57 she did not have reason to believe anything further had happened than Resident #366 coming into Resident #57's room, getting on top of her bed, touching her shoulder area, Resident #57 telling him (Resident #366) to get out, and him leaving. She revealed the information that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 51 initially provided to law enforcement on 12/19/24 was the information she had received after interviewing Resident #57 and the staff who were working that night. The Administrator stated it was not until later into the day on 12/19/24, after the incident had occurred on 12/18/24, that Resident #57's RP notified her that Resident #57 had said she was "raped." The Administrator revealed Resident #57's RP did not provide her with any further information and when she attempted to interview Resident #57 again, she would not give her any further information. She revealed she addressed the "rape" allegation in the 5-day report and was not aware that she should have sent in a new report regarding that information and was also not aware that she should have contacted APS prior to the 5-day investigation since they had no information to show any alleged abuse had taken place.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 52 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 complete a thorough investigation of an allegation of resident-to-resident abuse for 1 of 3 residents reviewed for abuse (Residents #57). Findings included: The facility's "Abuse Investigation and Reporting" policy revised 6/13/21 indicated: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The role of the investigator included: - Review the completed documentation forms. - Resident the residents medical record to determine events leading up to the incident. - Interview the person reporting the incident. - Interview any witnesses to the incident. - Interview the resident. - Interview the residents Attending Physician as needed to determine the resident's current level of cognitive function. - Interview the resident's roommate, family members and visitors. - Interview other residents to whom the accused employee provided care or services. - Review all events leading up to the alleged incident.	F 610	Criteria 1: Resident #57 and her family refused for her to be sent to hospital for further testing and assessment on 12/19/25. Additionally, they did not wish for the facility to conduct any additional interviews or bodily assessment; therefore, no additional assessments were completed after the skin assessment on 12/19/25. No assessment was completed for resident #366 after the incident occurred. Criteria 2: All residents involved in reportable incidents have the potential to be affected by the deficient practice. On 2/20/25, an audit was conducted by the Administrator of all state reported incidents from 2/1/25 - 2/20/25 to ensure that thorough assessments and interviews were completed post incident for all involved residents. There were no negative findings. Criteria 3: On 2/20/25, the Regional Director of Operations educated the Administrator and Director of Nursing (DON) that thorough assessments and interviews must be completed post incident for all involved residents in order to complete a	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 53 The following guidelines will be used when conducting interviews: - Each interview will be conducted separately in a private location. - Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. Resident #57 was admitted to the facility on 10/31/2024. Resident #57's admission Minimum Data Set (MDS) assessment dated 11/05/24 revealed she was cognitively intact. Resident #366 was admitted to the facility on 4/14/23. Resident #366's quarterly MDS assessment dated 10/23/24 revealed he was severely cognitively impaired. Resident #36 was admitted to the facility on 2/08/24. Resident #36's quarterly MDS assessment dated 9/26/24 revealed she was cognitively intact. Review of Nurse Aide (NA) #1's signed statement typed by the Administrator dated 12/18/24 revealed NA #1 answered call light from Resident #36's room, she (Resident #36) called her to her bedside and stated she had seen someone come into the room and get on her roommates Resident #57's bed. Resident #36 stated it had been a black person that looked like a man.	F 610	full investigation. Criteria 4: The Regional Director of Operation will monitor this process by auditing all facility reportable incidents monthly for 2 months to ensure that thorough assessments and interviews occurred for all involved residents during the investigation of the incident. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of correction. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 54	F 610		

Review of NA #2's verbal statement via telephone and typed by the Administrator dated 12/18/24 revealed NA #3 asked me to watch Resident #366 while she went on break. NA #2 was sitting at the nurse's station so she could see the hall, she did however answer a few call lights while NA #3 was on break.

Review of NA #3's signed statement typed by the Administrator dated 12/19/24 revealed NA #3 went to break around 10:25 PM (12/18/24) and asked NA #2 to take over one-to-one with Resident #366. When NA #3 returned she saw Resident #366 walking down the hallway near the A station dining room.

Review of facility initial report completed by the Administrator indicated the incident date was 12/19/24 and the facility became aware of the incident on 12/19/24 at 1:30 AM. The fax date and time revealed the report was submitted on 12/19/24 at 3:24 AM. The initial report revealed the following information: "[Resident #36] rang her call bell to alert staff that someone had wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] has a BIMS [brief interview for mental status] of 15 and states no inappropriate touching took place. Investigation underway. [Resident #57] is being placed on [one-on-one] temporarily. [The Administrator] and [the Director of Nursing] were in facility to conduct full investigation and ensure resident's [safety]."

Review of facility 5-day investigation report completed by the Administrator dated 12/26/24 revealed their investigative findings indicated Resident #102 witnessed the entire incident citing Resident #366's confusion and wandering

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 55	F 610		

behaviors. There was no willful intent noted on behalf of Resident #366 as evidenced by the fact that he also attempted to get into his roommate's bed just prior to the incident. There was no evidence of sexual intercourse during thorough skin assessment or per resident reports, and there were no reports that indicate abuse from the two resident eyewitnesses, staff interviews, or other resident interviews. Typed statements for Resident #57 and her roommate, Resident #36, were included in the investigation.

The investigation did not include a resident statement from Resident #366 and no assessments were documented for either Resident #57 or Resident #366.

On 1/30/25 at 4:03 PM an interview was conducted with the Director of Nursing (DON). The DON stated she assisted the Administrator with the investigation regarding the incident that occurred on 12/18/24 between Resident #57 and Resident #366. She stated she did not have anything to do with collecting the nursing staff's witness statements. She explained that the Administrator handled those statements. She stated she believed the Administrator had stated that due to the staff's written statements being hard to read, the Administrator had re-typed the staff statements and had staff to sign them. The DON revealed she had no knowledge of Resident #366 being interviewed and she was never asked to assess Resident #366. She stated she had completed a skin assessment on Resident #57 and was not aware that she needed to complete and document a more thorough physical assessment.

A review of the facility investigation file and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 56 interview with the Administrator were conducted on 1/30/25 at 5:35 PM. The Administrator stated she was aware of and had completed the incident and 5-day investigation reports regarding the incident that occurred on 12/18/24 between Resident #57 and Resident #366. She revealed that two of the three nursing staff from that night provided her with their handwritten statements. She indicated after reviewing those statements, she explained to staff that some of the statements were not legible, had too much detail, only needed to include the facts, and did not need to include any resident interviews. She explained she then took the nursing staff's hand-written statements and typed up new statements and then had the staff to sign them. She stated she did offer the staff to come into her office with her while she typed up the statements and they declined. The Administrator revealed she did not keep the staff's original handwritten statements. The Administrator further revealed Resident #366 was not assessed, but she did speak with him about the incident with Resident #57, and he told her that "he was going to see his wife to give her a back massage." She stated she was not aware that she needed to type up an interview statement for Resident #366 or that he should have been assessed. She revealed the DON assessed Resident #57 and completed a skin assessment, but she was not aware the DON needed to complete and document a more thorough physical assessment.	F 610		
F 623 SS=D	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-	F 623		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 57	F 623		

(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

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 58	F 623		

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 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

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 59 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(k). This REQUIREMENT is not met as evidenced by: Based on record review, legal guardian, and staff interviews, the facility failed to notify the Resident's legal guardian in writing of a transfer to the hospital in South Carolina for 1 of 3 residents reviewed for discharge (Resident #366). The findings included: Resident #366 was admitted to the facility on 4/14/23. Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian. Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment. Review of Resident #366's discharge Minimum Data Set (MDS) dated 12/21/24 revealed the discharge was coded as an unplanned discharge to hospital with return anticipated.	F 623	Criteria 1: On 2/20/25, written confirmation of the transfer that occurred on 12/20/25, was provided to resident #366's guardian by the Administrator. Criteria 2: Any resident transferring to the hospital has the potential to be affected by the deficient practice On 2/20/25, an audit was completed by the Administrator of all facility transfers to the hospital from 2/6/25 - 2/20/25 to ensure that written confirmation of the transfer had been provided to the resident or responsible party. There were no negative findings. Criteria 3: On 2/20/25, education was provided to facility social services department	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 60 Review of Resident #366's electronic medical record revealed no written notification to Resident #366's Guardian of his transfer to the hospital in SC. A telephone interview was conducted with Resident #366's Legal Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's legal guardian through the Department of Social Services. She stated she received a telephone call on 12/20/24 from the Administrator stating Resident #366 had been taken to the hospital in SC for an in-patient psychiatric hold and evaluation. She stated she did not receive any notification in writing prior to Resident #366 being transferred to the hospital in SC. The Administrator was interviewed on 1/30/25 at 5:30 PM. The Administrator reported on 12/202/4 the facility felt it would be best for Resident #366's safety due to his wandering and sexualized behavior to be sent out to the hospital for an in-patient psychiatric evaluation and treatment. She stated she did not send Resident #366's legal guardian notification in writing regarding Resident #366's transfer to the hospital in SC but did notify her by telephone.	F 623	members of the requirement to 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 the Long-Term Care Ombudsman. Newly hired staff will be trained prior to working a shift in the facility. Criteria 4: The Administrator/designee will monitor this process by auditing all facility transfers to the hospital to ensure that written confirmation of the transfer has been provided to the resident or responsible party. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of corrections. Date of compliance is 2/21/25.	
F 626 SS=G	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 626		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 61 following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director, Hospital Case Manager, Resident's Legal Guardian, and staff interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric evaluation. The resident remained in the hospital for over a month despite being cleared to return to the nursing home after	F 626	Criteria 1: On 1/22/2025, resident #366 returned to the facility. Criteria 2: All residents who transfer out of the facility	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 62 3 days. A reasonable person would expect once they were medically cleared from the hospital to be allowed back into their home and not being allowed back into their home could cause them to experience altered mental condition, fear, anxiety, and depressed mood. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #366). Findings included: Resident #366 was admitted to the facility on 4/14/23 with diagnoses including traumatic brain injury (TBI), altered mental status, and cognitive communication deficit. Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian. Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment. Review of discharge Minimum Data Set (MDS) dated 12/21/24 revealed Resident #366 was severely cognitively impaired with wandering, verbal, and physical behaviors towards others. Resident #366's discharge was coded as an unplanned discharge with return anticipated. Review of hospital case manager notes for Resident #366 dated 12/20/24 through 1/22/25 revealed the following: 12/20/24- Resident #366 was brought to the hospital Emergency Room in SC by his current facility located in North Carolina (NC) for a	F 626	have the potential to be affected by the deficient practice. On 2/20/2025, an audit was completed by the Administrator of all transfers out to the hospital over the last 14 days to ensure that all residents had the opportunity to return when they were medically ready to return. There were no findings of additional residents who had not returned when medically ready. Criteria 3: On 2/20/2025, the Administrator and Marketing Director were educated by the Regional Director of Operations that a resident must be permitted to return to an available bed in the location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed. Criteria 4: The Administrator/designee will audit all transfers to hospital for 8 weeks to ensure that the resident was permitted to return when medically ready. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 63 psychiatric (psych) evaluation regarding his hypersexualized behavior and a complaint from another resident. Resident #366 who had a history of TBI had gotten into bed with another resident thinking she was his wife. 12/21/24- Tele psych consult completed, and initial recommendation was for involuntary commitment (IVC) and psych placement in behavioral unit. 12/23/24- Follow up psych note documented, "Psych inpatient facility considered and currently NOT indicated" cleared psychiatrically and medically. 12/24/24 - Hospital psych liaison, contacted the Director of Nursing (DON) at Resident #366's current facility of him being cleared by psych and inquired what time for the hospital to bring him back to the facility. The DON referred to the facility Administrator. The hospital psych liaison informed the Administrator Resident #366 was ready to return to the facility, the Administrator stated Resident #366 had been immediately discharged from their facility and was accepted to another facility in NC. 12/26/24 - Hospital case manager spoke with Admissions at the other facility who stated were unable to offer Resident #366 a bed and they had notified his current facility of this fact. 1/7/25 - Resident #366 was transferred from their hospital behavioral unit to a regular hall on their main campus until placement could be found. 1/9/25 - Hospital case manager spoke with Resident #366's guardian who communicated that his current facility was refusing to accept him back and she was working on a new placement in North Carolina. 1/10/25 - Resident #366 was agitated and wandering into other patient rooms; transferred to their only secured unit in the hospital, the	F 626	The Administrator is responsible for the plan of corrections. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 64	F 626		

Intensive Care Unit (ICU).
1/10/25 - Following transfer to the ICU, the hospital case manager questioned why the nursing home brought Resident #366 across state lines to their hospital in SC. The hospital case manager contacted the hospital in NC to inquire if they offer psych services. The facility Administrator then explained they did not send Resident #366 to their local hospital because they knew he would be evaluated and sent right back to their facility. The hospital case manager explained and advocated Resident #366's needs to return to their facility, but the Administrator continued to refuse to accept him back.
1/13/25- The hospital case manager spoke with Resident #366's guardian and stated Resident #366 current facility transported him across the state lines to their hospital for a psych evaluation which Resident #366's guardian agreed was inappropriate and stated she had filed a report with the State Agency regarding this and the facility's refusal to readmit the resident.
1/17/25- The hospital case manager noted the facility was still unwilling to accept Resident #366 back and the hospital was currently awaiting placement.
1/20/25- Resident #366 was medically stable, ready for discharge, and awaiting placement.

A telephone interview with Resident #366's Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's Guardian through the Department of Social Services. She stated Resident #366 had a history of wandering and sexual behaviors over the past year while at his current facility and some incidents of going into other female resident's rooms and getting into their beds which had required him to be on one-to-one supervision. She revealed after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 65	F 626		

last incident on 12/18/24 of Resident #366 wandering into a female resident's room and getting into her bed, she received a telephone call on 12/20/24 from the Administrator at the facility stating Resident #366 would be moving to another skilled nursing facility within the day. Resident #366's Guardian stated she informed the Administrator that Resident #366 could not be moved so quickly without her speaking with and touring the other facility. She revealed she contacted the other facility and after discussing Resident #366 with them, the other facility refused to take him on that day and stated they would need to come and assess Resident #366 in person the following week. Resident #366's Guardian stated she contacted the Administrator at Resident #366's current facility and let her know the other facility would not be able to take Resident #366 on 12/20/24 but would be able to assess him in person the following week, and the Administrator stated Resident #366 would not be at their facility next week he would be leaving that day. Resident #366's Guardian revealed a few hours later on 12/20/24, she received a telephone call from the Administrator stating Resident #366 had been taken to the hospital in SC for an in-patient psychiatric hold and evaluation. She stated after that she began communicating with the hospital, Resident #366 was evaluated and on 12/23/24 was psychiatrically and medically cleared and recommended for discharge back to his current facility but the Administrator refused to take him back. Resident #366's guardian revealed both she and the hospital spoke with the Administrator at the facility on numerous occasions begging for them to take Resident #366 back until they could find a more appropriate placement for him and the Guardian offered that the Department of Social Services

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 66	F 626		

would pay for a private one-to-one for the resident and the Administrator continued to refuse to take him back. She stated during Resident #366's hospital stay, the hospital had to place him in the intensive care unit because it was the only locked unit in the hospital, and he was trying to wander in and out of patient rooms. Resident #366's Guardian revealed she contacted the State Agency for help with placement for Resident #366 and believed the state must have contacted the Administrator at the facility because a few days after she had spoken with the State Agency, she received a telephone call from the facility stating they would be readmitting Resident #366 to the facility.

A telephone interview with the hospital case manager on 1/31/25 at 4:00 PM revealed she was familiar with Resident #366. She stated Resident #366's current facility brought him to their hospital Emergency Room in SC on 12/20/24 requesting an in-patient psych evaluation. She revealed Resident #366 was admitted to their behavioral unit on 12/21/24 for completion of a psych evaluation. The hospital case manager stated the follow-up recommendations from the behavioral unit on 12/23/24 revealed in-patient psych placement had been considered for Resident #366 and was not indicated. Resident #366 was psychiatrically and medically cleared for discharge. She revealed the hospital contacted Resident #366's current facility and spoke with the Administrator and advised that Resident #366 had been cleared and was ready for discharge and the hospital needed to know when they could schedule transport back to the facility. She stated the Administrator informed the hospital Resident #366 would not be returning to their facility that he had been discharged from

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 67	F 626		

their facility and had been accepted to another skilled nursing facility. The hospital case manager revealed the hospital contacted the other skilled nursing facility about Resident #366 and were informed that they had notified Resident #366's current facility they were unable to offer him a bed and would not be admitting him. She stated the hospital also spoke with Resident #366's guardian who informed her Resident #366's current facility was refusing to take him back. The hospital case manager revealed that during Resident #366's hospital stay she contacted Resident #366's current facility numerous times and spoke with the Administrator about Resident #366 needing to return to their facility, and the Administrator continued to refuse to allow Resident #366 to come back to their facility. The hospital case manager stated on 1/20/25 the hospital received a call from Resident #366's current facility stating they would be coming to assess Resident #366 to see if they would be able to accept him back to their facility. She revealed to the Administrator, and the Admissions Director came to the hospital to speak with Resident #366 and then agreed he could come back, and he was discharged back on 1/22/25 after being left at the hospital for over a month.

An interview conducted with the Director of Nursing (DON) on 1/30/25 at 4:03 PM revealed she was familiar with Resident #366 and that he required one-to-one supervision due to his wandering and sexual behaviors. She stated there had been an incident on 12/18/24 where Resident #366's one-to-one supervision had left him unattended and he wandered into another female's residents' room, got into her bed.The DON revealed on 12/20/24, Resident #366 was supposed to be transferred to another skilled

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 68	F 626		

nursing facility, but that placement apparently fell through. The DON stated that she and the Administrator notified the facility Medical Director about Resident #366's placement to the other facility had fallen through and discussed with the Medical Director about Resident #366 being sent out to the hospital for a psych evaluation. She revealed the Medical Director agreed for Resident #366 to be sent out to the hospital in SC due to the local hospital not having a psych unit. The DON stated that she only spoke with the hospital in SC once which she believed was on 12/21/24, when the doctor from the hospital was requesting information on Resident #366 and stated they would be admitting him for a psych evaluation. The DON revealed she was not aware of the hospital staff or the guardian calling the facility multiple times to notify them Resident #366 was ready to return to the facility and she was not aware of the facility ever refusing to take him back. She stated she believed the facility did receive a telephone call from the State Agency regarding Resident #366's discharge and return to the facility, but to her knowledge the plan had been for him to return to their facility once they were able to assess him and make sure his psych evaluation and recommendations had been completed. She revealed that the facility had been trying to find a more appropriate placement for Resident #366 since last year due to his TBI and his behaviors.

An interview was conducted with the Administrator on 1/30/25 at 5:34 PM revealed she was familiar with Resident #366. She stated Resident #366 had a history of wandering and sexual behaviors and had been on one-to-one supervision for safety. She also stated that on 12/18/24, Resident #366's one-to-one supervision

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 69	F 626		

had left him unattended, and he wandered into a female resident's room, got into her bed. The Administrator revealed on 12/20/24 Resident #366 was scheduled to transfer to another skilled nursing facility, but that placement fell through, and in the meantime the other facility residents had heard about the incident on 12/18/24 and had started calling Resident #366 a "rapist". The Administrator revealed she and the DON had discussed their fears for Resident #366 safety and felt it might be best for him to be sent out to the hospital for a psych consultation due to his wandering and sexual behaviors. She stated she and the DON spoke with the facility Medical Director, they notified him that the other skilled nursing placement for Resident #366 had fallen through and discussed sending Resident #366 out to the hospital for a psych evaluation due to his behavior and for his safety. She revealed the Medical Director agreed for Resident #366 to be sent out to the hospital for an in-patient psych evaluation based on his sexual behaviors and for his own safety. The Administrator stated the facility transported Resident #366 to the hospital in SC because they have a geriatric psych unit, and their local hospital did not have a psych unit and would only provide him with a tele psych visit and send him back to the facility. She revealed while Resident #366 was at the hospital in SC she did speak with the hospital over the telephone and provided them with some diversion activities she thought would help with his behaviors and informed them the facility would assist them with finding other placement. She denied ever refusing to take Resident #366 back and did not have an explanation as to why the hospital had documented the facility's refusals to take him back. The Administrator stated she did receive a telephone call from the State Agency

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 70	F 626		

she believed on 1/17/24 advising her of the facility's responsibility to readmit Resident #366. She revealed prior to the State Agency calling the facility, she had already planned to go to the hospital and assess Resident #366 for him to return and was just waiting to make sure his recommended treatment from his psych evaluation had been completed.

An interview was conducted with the facility Director of Marketing and Admissions on 1/29/25 at 11:07 AM revealed he was familiar with Resident #366. He stated he was not involved with Resident #366 discharge to the hospital and never spoke with anyone at the hospital regarding Resident #366 not being allowed to return. He revealed on 1/20/25 he was notified by the Administrator to contact the hospital in SC to let them know they would be coming to the hospital to assess Resident #366 to see if they would be able to allow him to return. The Director of Marketing and Admissions stated he accompanied the Administrator to the hospital on 1/20/25 where they assessed Resident #366 and agreed for him to return to the facility, and he assisted with scheduling Resident #366's admission and transport back to the facility on 1/22/25.

An interview was conducted with the Medical Director on 1/28/25 at 11:09 AM revealed he was familiar with Resident #366. He stated Resident #366 had a history of wandering and sexual behaviors and required one-to-one staff supervision for his safety. He revealed on 12/20/24, Resident #366 was supposed to be transferred to another skilled nursing facility, but that placement fell through. The Medical Director stated after Resident #366's placement fell

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 71 through; the Administrator and DON spoke with him about concerns for Resident #366's safety facility along with the safety of the other's residents given his sexual behaviors and asked if he could be sent out to the hospital for a psychiatric evaluation. He revealed he agreed with the Administrator and the DON for Resident #366 to be sent out for an evaluation to the hospital in SC. The Medical Director stated that because their local hospital would more than likely have briefly evaluated Resident #366 and sent him back to the facility, he felt the behavioral unit at the hospital in SC would be able to evaluate and assist with locating a more appropriate placement for Resident #366. The Medical Director stated he did not feel Resident #366's current placement was the most appropriate for him given his age, TBI, and his behaviors and was told when he was sent out that he would not be returning to his current facility. He revealed he did speak with the hospital in SC on 12/21/24 to give some medical and background information on Resident #366 but was not aware of any further details of his stay at the hospital. He stated as far as Resident #366 being readmitted to the facility; it was his understanding the facility had received a call from the State Agency saying the facility had to allow him to return until they found him a more appropriate placement.	F 626		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 72	F 636		

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 73 chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessment Summary (CAAS) of the Minimum Data Set (MDS) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 6 sampled residents reviewed for unnecessary medications (Residents #48 and Resident #82). The findings included: a. Resident #48 was admitted to the facility on 05/09/23 with diagnoses including dementia, anxiety disorder, and depression. The MDS assessment dated 05/16/24 coded Resident #48 with moderately impaired cognition. A review of the CAAS revealed 8 care areas were triggered for Resident #48. Other than listing medications received by Resident #48, the facility did not provide any information in analysis of findings for 6 of the 8 triggered areas to describe the nature of Resident 48's problems, possible	F 636	Criteria 1: Updated Care Area Assessment Summaries (CAAS) were completed by licensed nurse on 1/30/2025 for resident #48's cognitive loss, activities of daily living, falls, dental care, pressure ulcer injury, and psychotropic drug use and on 1/30/2025 for resident #82's activities of daily living, falls, nutritional status, pressure ulcer injury, and psychotropic drug use. Criteria 2: All residents have the potential to be affected by the deficient practice. All Minimum Data Sets (MDS) transmitted 1/31/25 - 2/6/25 were audited by a licensed nurse to ensure the CAAS comprehensively address underlying causes and contributing factors of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 74 causes, contributing factors, risk factors related to the care areas, and reasons to proceed with care planning for the following triggered care areas: 1. Cognitive loss/dementia 2. Activities of daily livings functional/Rehabilitation potential 3. Falls 4. Dental care 5. Pressure ulcer/injury 6. Psychotropic drug usage b. Resident # 82 was admitted to the facility on 05/09/23 with diagnoses including Alzheimer's disease, bipolar disorder, and chronic pain. The quarterly MDS assessment dated 10/24/24 coded Resident #82 with intact cognition. A review of the CAAS of the annual MDS assessment date 03/29/24 revealed 5 care areas were triggered for Resident #82. Other than listing medications received by Resident #82, the facility did not provide any information in analysis of findings for all 5 triggered areas to describe the nature of Resident 82's problems, possible causes, contributing factors, risk factors related to the care areas, and reasons to proceed with care planning for the following triggered care areas: 1. Activities of daily livings functional/Rehabilitation potential 2. Falls 3. Nutritional status 4. Pressure ulcer/injury 5. Psychotropic drug use During an interview conducted on 01/29/25 at 1:19 PM, MDS Coordinator #2 confirmed 6 of the 8 triggered care areas for Resident #48's MDS	F 636	triggered areas for that resident. No additional issues were identified. Criteria 3: On 1/31/25, all licensed nurses responsible for completing CAAS were educated by the Administrator that CAAS must comprehensively address underlying causes and contributing factors of a triggered areas for each resident. Newly hired or agency staff will be trained prior to completing an MDS in the facility. Criteria 4: A licensed nurse will audit 3 MDSs a week for 8 weeks to ensure that the CAAS comprehensively address underlying causes and contributing factors of the triggered areas for that resident. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of correction. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 75 dated 05/16/24 and all 5 triggered care areas for Resident #82's MDS dated 03/29/24 were submitted without providing pertinent information in the analysis of findings in the CAAS. She explained she started to work as the MDS Coordinator last July and both MDS assessments were submitted by the former MDS Coordinator. She did not know how both incidents occurred and acknowledged that it was an error to submit an annual MDS without completing analysis of findings for all the triggered areas comprehensively. An interview was conducted with the Administrator on 01/29/25 at 1:25 PM. She stated it was her expectation for all the CAAS to be completed comprehensively to include at least the underlying causes, contributing factors, and reasons to proceed with care planning. On 01/29/25 at 1:33 PM an interview was conducted with the Director of Nursing. She stated all the CAAS must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in the CAAS before submission.	F 636		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 76 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post daily nurse staffing in a prominent location that was readily accessible to residents on 4 of 5 days during the survey (01/27/2025, 01/28/2025, 01/29/2025, and 01/30/2025). The findings included:	F 732	Criteria 1: On 1/30/25, the daily staffing schedule posting was relocated to an area accessible to residents by the Administrator. Criteria 2:	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 77 An observation on 01/27/2025 at 9:00 AM revealed the daily nurse staff posting was located on the wall in the front lobby. The daily nurse staffing sheet was a white, 8 by 10-inch piece of paper enclosed in a hard plastic display holder. The lobby was only accessible to the residents by entering through a closed door which had a keypad access. The facility staff had the access code for the keypad. The daily nurse staff posting was not readily visible or accessible for the residents to view. Additional observations on 01/28/2025 at 8:15 AM, 01/29/2025 at 8:15 AM, and 01/30/2025 at 7:45 AM of the facility's daily nurse staff posting revealed it was located on the wall in the front lobby and was not readily visible or accessible for residents to view. An interview was conducted with the Scheduler on 01/30/2025 at 11:34 AM. The Scheduler revealed that she had worked in her current role for 12 years and she was responsible for posting the daily nurse staffing. The Scheduler also stated the daily staff posting had been located in the lobby for quite a long while. An interview was conducted with the Director of Nursing (DON) on 01/30/2025 at 12:30 PM. The DON revealed that the residents could view the daily staff posting if they entered the lobby. She further stated the residents had to ask a staff member to enter the keypad code to unlock the door for the residents to enter the lobby and view the daily staff posting. An interview was conducted with the Administrator on 01/30/2025 at 1:40 PM. The Administrator revealed the facility's daily staff	F 732	All residents have the potential to be affected by the deficient practice. On 1/31/25, an audit was completed by the Administrator to ensure that the daily staffing schedule was posted in the new area that is accessible to residents. The schedule was posted in the new location. Criteria 3: On 1/30/25, the Administrator educated the scheduler that the daily staffing schedule must be posted in a designated area where it is accessible to residents. Criteria 4: The Administrator will audit the daily staffing posting 5 x week for 8 weeks to ensure that it is located in the newly designated location that is accessible to residents. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The Administrator is responsible for the plan of corrections. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 78 posting should be placed in an area that was readily accessible and visible for residents to view. She also stated the daily staff posting had been displayed in this area since she had been with the facility and was not readily accessible to residents.	F 732		
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. §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.	F 756		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 79 §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 review, and interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities related to the use of as needed (PRN) psychotropic drug (drug that affects mental state) and provide recommendations for 1 of 7 residents reviewed for unnecessary medications (Residents #25). The findings included: Resident #25 was admitted to the facility on 12/12/2023 with diagnoses that included anxiety disorder. The quarterly Minimum Data Set (MDS) dated 11/14/24 assessed Resident #25 with moderately impaired cognition and indicated she had received antianxiety medications in the 7-day assessment periods. A physician's order dated 11/26/24 indicated- 1 tablet of Ativan 0.5 milligrams (mg) by mouth every twelve hours as needed for anxiety was ordered for Resident #25. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found in Resident #25's medical records.	F 756	Criteria 1: On 1/28/2025, a stop date was added by the Medical Director to the pro re nata(PRN) psychotropic medication for resident #25. Criteria 2: All residents receiving PRN psychotropic medications have the potential to be affected by the deficient practice. On 2/19/25, an audit was completed by the Director of Nursing (DON) for all other PRN psychotropic medications that were prescribed in the last 30 days to ensure stop dates or provider evaluation and documentation of need for the PRN psychotropic medication beyond 14 days were present for each PRN psychotropic medication. No new issues were identified. Criteria 3: On 2/19/25, the consultant pharmacist and all prescribing medical providers were educated by the Administrator that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 80 A review of the medication administration record (MAR) revealed Resident #25 had received 4 doses of PRN Ativan in January 2025. A review of medical records revealed the Consultant Pharmacist had conducted a medication regimen review (MRR) for Resident #25 on 11/18/24 and 12/30/24. She did not identify any drug irregularities. The only recommendation from 12/30/24 MRR was to discontinue PRN meds due to non-use which included Ativan, Senna, Preparation H, and albuterol. During a phone interview conducted on 01/28/25 at 4:08 PM, the Consultant Pharmacist confirmed she had completed MRRs for Resident #25 on 11/18/24 and 12/30/24. She stated she did not notice the drug irregularities related to the PRN Ativan order without a stop date and attributed the error to her oversight. During an interview conducted on 01/28/24 at 11:50 AM, the Medical Director was familiar with Resident #25 but did not remember the specifics of the exact order. The Medical Director stated he did not write stop dates on his orders, and stated he wrote his orders with no refills then reviewed the medication when a refill was requested before a new order was given. He stated he wrote his orders that way they would not last more than 30 days. He stated he was bad at writing stop dates. He stated he was not aware of a 14-day duration for PRN psychotropic medication. An interview was conducted with the Director of Nursing (DON) on 01/29/25 at 2:16 PM. She expected the Consultant Pharmacist to identify the drug irregularities and report the findings to	F 756	facility must 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, including adding stop dates or documenting a rationale to continue a PRN psychotropic medication beyond 14 days. Criteria 4: The DON will monitor this process by auditing the Point Click Care (PCC) dashboard for psychotropic medications 5 x weekly for 8 weeks to ensure that no PRN psychotropics are missing a stop date or that they have a documented rationale to continue beyond 14 days. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The DON is responsible for the plan of correction. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 81 the facility and provider in a timely manner. During an interview conducted on 01/29/25 at 2:37 PM, the Administrator stated it was her expectation for the Consultant Pharmacist to identify the drug irregularities and report it in a timely manner.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 82 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, and the Medical Director (MD), the facility failed to ensure physician's orders for as needed (PRN) psychotropic drug (drug that affects mental state) was time limited in duration and provided rationales for therapy exceeding 14 days for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #25). The findings included: Resident #25 was admitted to the facility on 12/12/2023 with diagnoses that included anxiety disorder. The quarterly Minimum Data Set (MDS) dated 11/14/24 assessed Resident #25 with moderately impaired cognition and indicated she had received antianxiety in the 7-day assessment	F 758	Criteria 1: On 1/28/2025, a stop date was added by the Medical Director to the pro re nata (PRN) psychotropic medication for resident #25. Criteria 2: All residents receiving PRN psychotropic medications have the potential to be affected by the deficient practice. On 2/19/25, an audit was completed by the Director of Nursing (DON) for all other PRN psychotropic medications that were prescribed in the last 30 days to ensure stop dates or provider evaluation and documentation of need for the PRN	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 83 periods. A physician's order dated 11/26/24 indicated 1 tablet of Ativan 0.5 milligrams (mg) by mouth every twelve hours as needed for anxiety was ordered for Resident #25. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found in Resident #25's medical records. Attempts to interview Nurse #4 who confirmed the order on 11/26/2024 were unsuccessful. A review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed Resident #25 had received 4 doses of PRN Ativan in January 2025. 1/11/25 - 2 doses 1/14/25- 1 dose 1/17/25- 1 dose On 01/27/25 02:24 PM an attempt to interview Resident #25 was unsuccessful. She was unable to engage in the interview. During an interview on 01/29/25 at 12:17 PM Nurse #1 stated PRN orders for psychotropic medications were to be written for 14 days. Nurse #1 stated she would ask the Doctor for clarification if PRN psychotropic medications were written without a stop date. An interview was conducted with the Director of Nursing (DON) on 01/29/25 at 2:16 PM. The DON stated she expected orders for PRN psychotropic medications to be written per the facilities policy. The DON expected the orders to be reviewed by 3rd shift nurses for accuracy. The DON also	F 758	psychotropic medication beyond 14 days were present for each PRN psychotropic medication. No new issues were identified. Criteria 3: On 2/19/25, the Medical Director, all other facility prescribing medical providers, an all nurses were educated by the DON that PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Newly hired or agency staff will be trained prior to working a shift in the facility. Criteria 4: The DON will monitor this process by auditing the Point Click Care (PCC) dashboard for psychotropic medications 5 x weekly for 8 weeks to ensure that no PRN psychotropics are missing a stop date or that they have a documented rationale to continue beyond 14 days. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The DON is responsible for the plan of correction. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 84 stated during morning management meetings all orders were reviewed by being read off and double checked. The DON was unsure how the order for a PRN psychotropic with no stop date was not caught during the review process. During a telephone interview on 01/30/25 at 09:20 AM Nurse #2, who worked 3rd shift after the order on 11/26/2024 was written, stated she did know she was supposed to, and had never reviewed the orders for accuracy while working third shift at the facility. During a telephone interview on 01/30/25 at 09:43 AM Nurse #3, who worked 3rd shift after the order on 11/26/2024 was written, stated she had never reviewed orders for accuracy while working third shift, and stated she did not know that was expected. During an interview conducted on 01/29/25 at 2:37 PM, the Administrator stated she expected orders for PRN psychotropic meds to be written per the facilities policy. During an interview conducted on 01/28/24 at 11:50 AM, the Medical Director was familiar with Resident #25 but did not remember the specifics of the exact order. The Medical Director stated he did not write stop dates on his orders, and stated he wrote his orders with no refills then reviewed the med when a refill was requested before a new order was given. He stated he wrote his orders so they would not last more than 30 days. He stated he was bad at writing stop dates. He stated he was not aware of a 14 day duration for PRN psychotropic medication.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		2/21/25

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 85 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: Based on observation, record review, and staff interviews, the facility failed to secure an opened tube of topical paste for 1 of 1 Resident reviewed for medication storage. (Resident #99). The findings included: Resident #99 was admitted to the facility on 12/20/24.	F 761	Criteria 1: On 1/27/25, the tube of zinc oxide paste that was found in resident #99's room was removed by the Director of Nursing (DON). Criteria 2: All residents have the potential to be	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 86 The admission Minimum Data Set (MDS) assessment dated 01/10/25 coded Resident #99 with severely impaired cognition. During an observation conducted on 01/27/25 at 12:32 PM, one opened tube of zinc oxide paste (a topical paste for treating or preventing skin irritation) with the concentration of 15% was left unattended on top of the left bedside table in Resident #99's room. It contained approximately 75 grams of zinc oxide and was ready to be used. An interview was conducted with Resident #99 on 01/27/25 at 12:35 PM. She did not know how long the tube of zinc oxide paste had been left unattended in her room. She could not provide any additional information related to the zinc oxide paste. During an interview conducted on 01/27/25 at 12:39 PM, Nurse #5 stated the zinc oxide paste should be kept in the medication cart instead of leaving unattended in Resident #99's room. She did not notice the tube of zinc oxide paste was in Resident #99's room when she did medication pass on 01/27/25 in the morning. An interview was conducted with Nurse Aide #4 on 01/27/25 at 12:41 PM. She stated she had provided care for Resident #99 frequently in the past few weeks. She did not notice the tube of zinc oxide was left unattended on Resident #99's bedside table when she rounded her on 01/27/25 in the morning. During an interview conducted with the Director of Nursing (DON) on 01/27/25 at 12:55 PM, she stated Resident #99's daughter could have brought the zinc oxide paste to the facility for	F 761	affected by the eficient practice. On 1/27/25, a walking round audit was completed by the DON of all resident rooms to ensure no additional zinc oxide paste was present at bedside. No other issues were identified. Criteria 3: Beginning on 1/27/25, education was completed with nursing staff that the facility must store all drugs and biologicals in locked compartments including zinc oxide. Medications such as zinc oxide must be removed from bedside after use and returned to the locked treatment or medication cart. Newly hired or agency staff will be trained prior to working a shift in the facility. Criteria 4: The DON will monitor this process by auditing 10 resident rooms 5 x week for 8 weeks to ensure that no medications, including zinc oxide, are left at bedside. The results of these audits will be presented to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee. The DON is responsible for the plan of correction. Date of compliance is 2/21/25.	

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 02/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 87 Resident #99. She stated zinc oxide paste should be kept in the medication cart. It was her expectation for all the nursing staff to be more attentive to residents' room when providing care to ensure none of the medications were left unattended in the facility. An interview was conducted with the Administrator on 01/27/25 at 4:02 PM. She expected nursing staff to pay attention to residents' room when providing care. It was her expectation for the facility to remain free of unattended medications at all time.	F 761		