STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345197	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge Of NC	**237 Tryon Road , Rutherfordton, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/16/26 through 03/19/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1F39C0-H1.	E0000		04/03/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/16/26 through 03/19/26. Event ID: 1F39C0-H1. The following intakes were investigated: 279981, 2795223, 2791169, 2749272, 2743012, 2742148, 2732302, 2704156, 2650482, and 2588533. 1 of the 35 complaint allegations resulted in deficiency.	F0000		04/03/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F0656	Criteria 1: On 4/3/2026 the Minimum Data Set (MDS) nurses corrected residents #10, #12, #101 and #104 care plans to ensure accuracy and appropriateness for social interactions requiring resident consent and boundary reinforcement. Care plans were updated to reflect actual behavior. Criteria 2: All residents that exhibit social interactions requiring resident consent and boundary reinforcement are at risk for this deficient practice. On 4/3/2026 Minimum data Set nurses completed a 100% audit of all care plans for cognitively impaired residents with social interactions requiring resident consent and boundary reinforcement to ensure they are appropriate and reflect social behavior accurately. Any care plan that did not accurately reflect the resident's behavior with another resident was revised to more clearly outline the specific behavior occurring. Revisions were made on or before 4/5/2026 Criteria 3: 4/3/2026 The Administrator educated Unit Managers and MDS nurses on appropriateness of interventions for cognitively impaired residents with social interactions requiring resident consent and boundary reinforcement. They were educated that care plans must be specific in outlining the type of	04/06/2026

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

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

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F0656 SS = E	Continued from page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to develop accurate care plans when the facility wrote care plans for cognitively impaired residents for activity they were unable to consent to and wrote goals and interventions that would not apply to the residents for 4 of 8 residents whose comprehensive care plans were reviewed (Resident #10, Resident #12, Resident #101, and Resident #104). The findings included: a. Resident #10 was initially admitted to the facility on 11/01/24 with a readmission date of 01/14/26. Resident #10’s diagnoses included Alzheimer’s disease and unspecified dementia. Resident #12 resided on the secured memory care unit at the time this care plan was developed. A review of Resident #10’s quarterly Minimum Data Set (MDS) assessment dated 01/19/26 revealed Resident #10 was severely cognitively impaired and had no documented behaviors during the assessment period. A review of Resident #10’s active care plan dated 06/08/25 revealed a focused area which stated in	F0656	Continued from page 1 behavior occurring. Newly hired staff members and those contracted through agencies will be educated by DON/designee upon hire through facility orientation or agency orientation, both of which include review of corrective action and facility initiative prior to accepting a resident assignment. Criteria 4: MDS nurses will audit 5 residents care plans per week for 8 weeks to ensure all interventions are appropriate and behaviors requiring resident consent and boundary reinforcement are reflected accurately. These audits will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly for 2 months and will continue at the discretion of the QAPI committee. Date of Compliance is 4/6/26	04/06/2026

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F0656 SS = E	Continued from page 2 part: “Responsible party gave consent for Resident #10 to have intimate relationship with consenting resident partner”. The stated goal was Resident #10 would have psychosocial needs and sexual choices/preferences met with dignity and privacy. Interventions included the following: nursing staff provided education in safe sex practices, to include sexually transmitted infection prevention & hygiene. Staff would ensure signage on door to private areas used for intimate activity to ensure privacy and dignity were maintained. Staff would provide private areas for consensual intimate activities upon request. b. Resident #12 was admitted to the facility on 12/20/24 with diagnoses which included neurocognitive disorder with Lewy bodies (a progressive dementia characterized by accumulation of protein clumps in the brain resulting in cognitive decline). Resident #12 resided on the secured memory care unit at the time this care plan was developed. A review of Resident #12’s quarterly Minimum Data Set (MDS) assessment dated 04/16/25 revealed Resident #12 was severely cognitively impaired and had verbal aggression and wandering behaviors for 1 to 3 days during assessment period. A review of Resident #12’s active care plan dated 04/08/25 revealed a focused area which stated in part: “Resident #12 wishes to have an intimate relationship with consenting resident partner. Family has given approval for Resident #12 developing an intimate relationship with another resident if both residents consent.” The stated goal was Resident #12 would have psychosocial needs and sexual choices/preferences met with dignity and privacy. Interventions included the following: nursing staff provided education in safe sex practices, to include sexually transmitted infection prevention & hygiene. Staff would ensure signage on door to private areas used for intimate activity while residents used it to ensure privacy and dignity were maintained. Staff would provide private areas for consensual intimate activities upon request. c. Resident #101 was initially admitted to the facility on 12/05/24 with a readmission date of 01/21/26. Resident #101’s diagnoses included Alzheimer’s disease. Resident #101 resided on the secured memory care unit at the time this care plan was developed. A review of Resident #101’s quarterly Minimum Data Set (MDS) assessment dated 04/15/25 revealed	F0656		04/06/2026

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F0656 SS = E	Continued from page 3 Resident #101 was severely cognitively impaired and had verbal aggression, rejection of care, and wandering behaviors 1 to 3 days during assessment period. A review of Resident #101's active care plan initiated 04/08/25 and revised 10/21/25 revealed a focused area which stated in part: "Resident #101 wished to have an intimate relationship with consenting resident partner. Responsible party was aware and consent given". The stated goal was Resident #101 would have psychosocial needs and sexual choices/preferences met with dignity and privacy. Interventions included the following: nursing staff provided education in safe sex practices, to include sexually transmitted infection prevention & hygiene. Staff would ensure signage on door to private areas used for intimate activity to ensure privacy and dignity were maintained. Staff would provide private areas for consensual intimate activities upon request. d. Resident #104 was initially admitted to the facility on 12/11/24 with a readmission date of 04/07/25. Resident #104's diagnoses included unspecified dementia. Resident #104 resided on the secured memory care unit at the time this care plan was developed. A review of Resident #104's quarterly Minimum Data Set (MDS) assessment dated 03/25/25 revealed Resident #104 was severely cognitively impaired and had verbal aggression and wandering behaviors for 1 to 3 days during assessment period. A review of Resident #104's active care plan initiated 04/08/25 and revised 10/13/25 revealed a focused area which stated in part: "Resident #104 wished to have an intimate relationship with consenting resident partner. Responsible party aware and consent given". The stated goal was Resident #104 would have psychosocial needs and sexual choices/preferences met with dignity and privacy. Interventions included the following: nursing staff provided education in safe sex practices, to include sexually transmitted infection prevention & hygiene. Staff would ensure signage on door to private areas used for intimate activity to ensure privacy and dignity were maintained. Staff would provide private areas for consensual intimate activities upon request. An interview with the Memory Care Unit Coordinator was conducted on 03/19/26 at 1:41 PM. The Memory Care Unit Coordinator stated that some residents held hands, hugged, and danced but no residents	F0656		04/06/2026

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F0656 SS = E	Continued from page 4 engaged in sexual contact. The Memory Care Unit Coordinator reported that her understanding was that care plans were in place because the responsible parties gave consent for residents to hold hands, hug, and dance. An interview was conducted with the MDS Nurse on 03/19/26 at 12:12 PM. The MDS Nurse verbalized that she completed resident's care plans with a focused area of intimate relations. The MDS Nurse stated that corporate instructed her to enter the intimate relations care plan for residents but could not recall when or who specifically gave her those instructions. The MDS Nurse verbalized that her understanding was that the residents held hands or danced together but did not engage in sexual behaviors. The MDS Nurse reported that she never questioned if the care plan was appropriate for Resident #10, Resident #12, Resident #101, or Resident #104. An interview was conducted with the Director of Nursing (DON) on 03/19/26 at 3:15 PM. The DON stated that care plans should be individualized and updated. The DON reported Resident #10 had a history of holding hands and walking with a peer who was now deceased. Resident #12 and Resident #101 were known to be together all the time and held hands frequently. Resident #12 also would hold hands with Resident #104 at times. The care plans were in place because consent from the responsible party was obtained for the residents to hold hands, hug, and dance. The DON verbalized that no sexual activity occurred between residents. An interview was conducted with the Administrator on 03/19/26 at 4:35 PM. The Administrator stated the care plans should be accurate, appropriate for each resident, be individualized, and up to date.	F0656		04/06/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F0583	Criteria 1: On 3/17/2026 the Director of Nursing immediately re-educated Nurse #3 and Nurse Aide #1 on knocking, announcing, and waiting for permission prior to entry. Criteria 2: All residents have the potential to be affected by this deficient practice On 3/18/2026, the Director of Nursing (DON) completed a walking round audit to identify any additional examples of staff members not knocking, announcing, and waiting for permission to enter. No new issues were found. Criteria 3: On 4/3/2026 The DON/designee completed an all staff inservice on knocking,	04/06/2026

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F0583 SS = D	Continued from page 5 room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to provide personal privacy to residents when staff did not knock before entering resident rooms. This deficient practice affected 2 of 6 residents reviewed for privacy (Resident #94 and Resident #31). The findings included: a. Resident #94 was admitted on 1/29/26. Resident #94's admission Minimum Data Set (MDS) assessment dated 2/4/26 revealed Resident #94 was cognitively intact. An interview with Resident #94 was conducted on 3/16/26 at 10:19 AM. Resident #94 stated that "staff just barge into my room without knocking." He reported that if staff did knock, it was one single knock as they were already entering the room, and they never announced themselves or waited for him to give permission. He indicated this occurred regardless of whether his door was open or shut. Resident #94 reported that it made him very angry when staff entered without knocking and he had asked staff several times to knock before coming into his room. He stated, "I have just given up on having any privacy and I feel like a prisoner with no	F0583	Continued from page 5 announcing, and waiting for permission prior to entry. Newly hired staff members and those contracted through agencies will be educated by DON/designee upon hire through facility orientation or agency orientation, both of which include review of corrective action and facility initiative prior to accepting a resident assignment. Criteria 4: The DON will observe 5 staff members per week for 8 weeks entering residents rooms to ensure that they are knocking announcing and waiting for permission prior to entry. These audits will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly for 2 months and will continue at the discretion of the QAPI committee. Date of Compliance is 4/6/26	04/06/2026

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F0583 SS = D	Continued from page 6 rights." An observation conducted while sitting with Resident #94 in the resident's room behind a fully closed door on 3/18/26 at 9:35 AM revealed that Nurse #3 opened the door and entered the room without knocking or announcing himself. An interview with Nurse #3 was conducted on 3/18/26 at 10:04 AM. Nurse #3 reported he was not sure why he had walked into Resident #94's room without knocking and that he didn't realize he had even done it. He reported he had received education annually on residents' rights and he knew he was supposed to knock before entering the room for all residents and to wait for permission to enter for residents who were cognitively able to give permission. He reported knocking and waiting for permission was the resident's right to privacy. b. Resident #31 was admitted to the facility on 7/17/23. Resident #31's quarterly MDS assessment dated 12/23/25 revealed he was moderately cognitively intact. An observation while sitting with Resident #31 in the resident's room behind a fully closed door on 3/16/26 at 9:45 AM revealed that Nurse Aide (NA) #1 opened Resident #31's door without knocking and entered the room unannounced. Resident #31 began smacking the mattress of his bed and asked NA #1, "What the hell are you doing?" Resident #31 was then observed pounding his fist on his leg and repeating "knock on the door" several times to NA #1. An interview with Resident #31 was conducted on 3/16/26 at 9:50 AM. Resident #31 reported that staff never knocked on his door before entering his room. He stated he felt like a child and that the staff had no respect for him. Resident #31 stated staff always came into his room without knocking and it made him angry. An interview was conducted with NA #1 on 3/19/26 at 10:00 AM. NA #1 reported that he knew he was supposed to knock before entering a resident's room but stated that when he was in a hurry, he forgot to knock. NA #1 reported that he had received training on residents' rights, and that part of the training was to knock on residents' doors prior to entering and to wait for the resident to grant permission to enter if they were able to do so.	F0583		04/06/2026

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F0583 SS = D	Continued from page 7 An interview with the Director of Nursing (DON) was conducted on 3/19/26 at 11:50 AM. The DON reported that she expected her staff to do the same thing at the facility as they would do at any home, which included knocking on the door before entering. She reported that staff received training on residents' rights upon hire and annually. She explained that she was not sure why any staff would enter a resident's room without knocking and waiting for permission from residents who were cognitively able to give that permission. An interview with the Administrator was conducted on 3/19/26 at 4:11 PM. The Administrator indicated that she expected all staff to knock on the door of a room, announce themselves, and wait for the resident's permission before entering a resident's room. She reported that staff received training on residents' rights and should know they were required to knock and wait for permission before entering a resident's room.	F0583		04/06/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident, staff interviews, and Psychiatric Nurse Practitioner (NP) interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident with a serious mental health diagnosis for 1 of 3 residents reviewed for PASRR (Resident #5).	F0644	Criteria 1: On 3/18/2026 the Administrator re-educated the Social Services Director on referring all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon identification of the disorder or with a significant change in status. On 3/17/2026 The Social Services Director submitted a Level II Pre-Admission Screening and Resident Review (PASRR) screening for resident #5. Criteria :2 All residents with a diagnosis for serious mental illness have the potential to be affected by the deficient practice. On 4/3/26, the Director of Social Services completed an audit of all resident diagnoses to ensure that any resident with an existing or new diagnosis for mental illness has had a PASRR level II screening request made. For any findings, a level II screening request will be made on or before 4/5/26. Criteria 3: On 4/3/2026, the facility administrator educated team members who participate in the PASRR request process for mental health diagnoses: Social Services Director, Social Services Assistant, Minimum Data Set (MDS) nurses, and Director of Nursing (DON). The education advised on the necessity for timely notification to facility Social Services Director of mental health diagnoses and required requests for PASRR reviews upon admission, readmission, or if a new diagnosis is given. Newly hired team members who will	04/06/2026

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F0644 SS = D	Continued from page 8 The findings included: Review of Resident #5's medical record revealed Level I PASRR was completed on 03/25/2019 prior to Resident #5's admission to the facility on 01/30/26 with a recommendation to resubmit paperwork for Level II PASRR if a mental health diagnosis was suspected or if there was a significant change in the resident's condition. There was no expiration date. Review of the hospital discharge summary dated 01/30/26 revealed Resident #5 was discharged from acute care hospital following recent deep vein thrombosis (DVT) left lower leg with ulceration and a fall at home. Discharge diagnoses included bipolar disorder. Resident #5's discharge medications included bupropion XL (an antidepressant extended-release medication) 150 milligrams (mg)/24 hours two tablets daily for mood symptoms of bipolar disorder, duloxetine (an antidepressant medication) 60 mg delayed response capsule 1 capsule daily for mood symptoms of bipolar disorder, rivastigmine (medication used to treat mild to moderate dementia) 1.5 mg oral capsule one (1) capsule twice daily for memory related to dementia and trazodone (an antidepressant medication) 50 mg every night at bedtime for sleep. Resident #5 was admitted to the facility on 01/30/26 with diagnoses which included bipolar disorder, hypertension, heart failure, diabetes mellitus, and dementia. The admission Minimum Data Set (MDS) assessment dated 02/06/26 revealed Resident #5 was cognitively intact, and her current active diagnoses included bipolar disorder. According to the admission MDS assessment the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition and was taking antidepressant medications. A psychiatry visit note documented by the Psychiatric NP and dated 02/05/26 revealed Resident #5 was seen for initial evaluation following recent admission to the facility on 01/30/26 with acute embolism and thrombosis of deep vein of left lower extremity. Her medical history was significant for diabetes mellitus type II, bipolar disorder and dementia. During the evaluation the resident reported sleeping adequately and described her appetite as fair. Resident #5 denied suicidal and homicidal ideation, auditory hallucinations and visual	F0644	Continued from page 8 participate in the PASRR review process will be educated on this process by the Administrator/designee upon hire. Criteria 4: The Social Services Director will audit 5 residents per week for 8 weeks, to ensure requests for PASRR reviews have been submitted based on existing qualifying diagnosis or newly added diagnoses. The facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. These audits will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly for 2 months and will continue at the discretion of the QAPI committee. Date of Compliance is 4/6/26	04/06/2026

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F0644 SS = D	Continued from page 9 hallucinations. Mood was reported by resident as stable with no acute behavioral concerns reported by staff. Current psychiatric medications included duloxetine 60 mg daily, bupropion XL 300 mg daily, rivastigmine 1.5 mg, and trazodone 50 mg at bedtime, all of which have been tolerated without reported adverse effects. The plan was for continued psychiatric oversight in the facility to monitor symptom stability, medication effectiveness, and overall safety. Resident #97's care plan dated 02/16/26 revealed a focus area for the resident being on antidepressant medication related to bipolar disorder and insomnia. The goal was for the resident to be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The interventions included administering antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness every shift, and monitor/document/report as needed adverse reactions to antidepressant therapy. The care plan also revealed a focus area for the resident having a mood problem related to bipolar disorder. The goal was for the resident to have improved mood state through the review date. The interventions included administering medications as ordered and monitoring for side effects and effectiveness, behavioral health consults as needed, monitor/document/report as needed, monitor/document/report as needed any risk for harm to self and monitor/record/report as needed any risk for harming others. Further review of psychiatry visit notes revealed Resident #5 was seen on 02/26/26 and 03/13/26 with noted stability of the resident. Continued psychiatric management remained medically necessary due to chronic psychiatric illness and need for structured monitoring in the facility setting. There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. Further review of Resident #5's medical record revealed a letter dated 03/17/26 that stated the resident already had a Level I PASRR and that could be used until it expired but there was no indicated expiration date on the letter. An interview on 03/18/26 at 10:14 AM with Resident #5 revealed she could not recall when she was first diagnosed with bipolar disorder. She stated her symptoms were off and on and that she often noticed them during the evening when she was tired	F0644		04/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345197	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

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F0644 SS = D	Continued from page 10 she experienced increased frustration and closed her self off from others and didn't want to be around anyone. Resident #5 further stated some days she just sat and cried all day without really knowing why. She indicated she had lupus and some days were worse than others with her lupus and that made her feel down on her bad days. Resident #5 indicated her medication for depression seemed to help and that she was seeing a counselor that helped with her medications. She explained that she felt stable at present but said she did have bad days that made her feel down. An interview on 03/18/26 at 10:40 AM with the Social Work (SW) Director revealed he and the other SW would be responsible for completing Level II PASRR paperwork for residents. The SW Director stated it was his understanding that residents were admitted with a Level I PASRR or Level II PASRR that had been completed prior to admission and said he and the other SW would be responsible for completing and submitting PASRR paperwork when the resident received a temporary Level II that required paperwork be resubmitted after 30, 60, or 90 days or if the resident had received a new mental health diagnosis or had a significant change. The SW Director stated he believed he would be notified during their morning meetings and from the nursing staff of any resident who had received a new mental health diagnosis or had a significant change so the Level II PASRR paperwork could be completed. The SW Director further stated he had submitted paperwork for Resident #5 for a Level I PASRR evaluation but stated he had not included any progress notes from the Psychiatric NP, progress notes from the NP or Medical Director and had not sent in a signed FL2 form (medical document in North Carolina completed by a physician to assess a resident's medical needs, diagnoses, and medications before admission to a facility) because there was nowhere on the system to attach the documents. The facility received a letter back on 03/17/26 that Resident #5 already had an existing Level I PASRR and that number could be used until it expired. There was no expiration date included on the letter. The SW Director stated after reviewing Resident #5's mental health diagnosis, he believed a Level II PASRR evaluation should have been completed. He stated he could not recall if he was aware of the bipolar disorder diagnosis prior to Resident #5's admission to the facility on 01/30/26. An interview on 03/19/26 at 10:59 AM with the Psychiatric NP revealed she was currently seeing Resident #5 for bipolar disorder. She stated she was not aware of the exact date of her bipolar disorder	F0644		04/06/2026

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F0644 SS = D	Continued from page 11 diagnosis but said she was stable at present on her medications. The Psychiatric NP stated that Resident #5 may have needed to be evaluated for a Level II PASRR due to her bipolar diagnosis but said her dementia diagnosis superseded the bipolar diagnosis. During an interview on 03/19/26 at 4:08 PM with the Administrator, she communicated her understanding that Level II PASRR evaluation should be completed in a timely manner upon admission of a resident with a mental health diagnosis and anytime a resident had a change of condition or received a new mental health diagnosis. The Administrator stated that Resident #5 should have had a Level II PASRR evaluation submitted when the diagnosis of bipolar disorder was noted on her diagnoses list. The Administrator further stated that she did not know why the referral for Level II PASRR evaluation was not submitted for Resident #5.	F0644		04/06/2026
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 4 resident reviewed for foot care (Resident #94). The findings included: Resident #94 was admitted to the facility on 1/29/26 with diagnoses which included atrial fibrillation and heart failure. Review of the admission nursing assessment dated 1/30/26 did not reveal any issues with Resident	F0687	Criteria 1: On 3/18/2026 the Unit Manager provided footcare for resident #94 Criteria 2: All residents have the potential to be affected by this deficient practice On 3/26/2026 a100% audit of all residents' toenails was conducted by the Department Managers. All residents with toenails requiring care had toenail care performed by a licensed nurse. Residents in need of podiatry services were placed on the podiatry list. Criteria 3: On 4/3/2026 the Director of Nursing/designee educated all licensed nurses and certified nursing assistants (CNA) on the need to examine toenails for care needs when showering and accurately completing shower sheets, which includes condition of toenails. Education also included the proper chain of command for follow-up on toenail care issues that cannot be managed by the CNA during the shower task. If unable to complete toenail care, the CNA will note care needs on the shower sheet that will be given to the licensed nurse. Licensed nurses were instructed that toenails must be trimmed promptly when the CNA is unable to complete the task and they receive a shower sheet noting the need for additional toenail care. If the licensed nurse is unable to complete the task, they must make a referral to the Social Worker for podiatry. Newly hired staff members and those contracted through agencies will be educated by DON/designee upon hire through facility orientation or agency orientation, both of which include review of corrective action and facility initiative prior to	04/06/2026

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F0687 SS = D	Continued from page 12 #94's toenails. Review of Resident #94's admission Minimum Data Set (MDS) assessment dated 2/4/26 revealed Resident #94 was cognitively intact and required moderate assistance with activities of daily living (ADL) and personal hygiene, and was dependent with bathing and frequently refused care. Review of Resident #94's care plan dated 2/4/26 revealed he had an activity of daily living performance deficit and required staff assistance to complete daily tasks and frequently refused care. An observation and interview were conducted on 3/16/2026 at 10:19 PM. Resident #94's toes revealed long, jagged toenails on both feet. Resident #94's right great toenail had a brownish coloring at the base of the nailbed which had started to extend upward to the middle of the toenail. Resident #94 stated he had asked for his toenails to be trimmed several times and that he had never refused for them to be trimmed. He further reported that he had been told he was going to be seen by the podiatrist but to his knowledge the appointment had not been made. He explained that he had not been able to bend down and take care of his toenails and feet for a long time and that wearing socks was uncomfortable. Review of Resident #94's electronic medical chart (EMR) 94's revealed no documentation of resident being offered or refusing podiatry or toenail care. The EMR did reveal documentation of Resident #94 refusing showers and refusing to have his UNNA boots (compression dressing with zinc oxide paste that treats edema, ulcers and sores). Resident #94's weekly nursing assessments from 1/29/2026 through 3/19/26 revealed no notation that his toenails were long and needed trimmed. Review of the facility's podiatry clinic schedule for February revealed Resident #94 was not seen by the podiatrist and was not on the list to be seen. Resident #94 was not on March's podiatry schedule at the time of review. There were no consultation reports or notations in Resident #94's EMR that he was scheduled to see the podiatrist or that he had been seen by a podiatrist since admission to the facility. An interview was conducted with Nurse Aide (NA) #1 on 03/19/2026 at 9:19 AM who stated that he often provided care for Resident #94. NA #1 stated he had noticed Resident #94's toenails were very long and	F0687	Continued from page 12 accepting a resident assignment. Criteria 4: The Director of Nursing (DON)/designee will audit 5 residents' toenails per week for 8 weeks to ensure they are trimmed. These audits will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly for 2 months and will continue at the discretion of the QAPI committee. Date of Compliance is 4/6/26	04/06/2026

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F0687 SS = D	Continued from page 13 needed to be trimmed. NA #1 stated he didn't remember if he had told anyone about Resident #94's toenails. NA #1 further explained that he usually reported any concerns or issues to the resident's assigned nurse. NA #1 reported Resident #94 did refuse care from time to time but was not sure if he had ever refused to have his toenails trimmed. NA #1 reported he had not asked Resident #1 about getting his toenails trimmed. An interview was conducted on 3/18/26 at 10:04 PM with Nurse #3. He reported he was familiar with Resident #94 and remembered that he came in with discoloration on his toenails, and the toenails were long, especially the one on the right great toe. Nurse #3 reported he was unsure why he did not document this in the EMR or why he didn't let the provider know. He reported he was also unsure why he had never attempted to trim the resident's nails. Nurse #3 stated social work (SW) was responsible for getting residents a podiatry consultation, but the floor nurses would be expected to tell social work if a resident needed a podiatrist consultation. Nurse #3 stated he had not personally told social work that Resident #94 needed foot care, he reported he was unsure why he had not told anyone. An interview was conducted on 3/18/2026 at 10:55 AM with the Social Work Director. He reported he had spoken with the podiatrist office today to get Resident # 94 on the podiatry list for March. He reported the nurse on the hall had asked him to include Resident #94 on the list for podiatry services to get his toenails trimmed. The Social Work Director reported he was unaware of any podiatry needs for Resident #94 prior to this request. An interview was conducted on 3/19/26 at 3:45 PM with Director of Nursing (DON). The DON stated she was aware of Resident #94's toenails but Resident #94 refused care a lot, including toenail care. She reported she could not remember which nurse made her aware of his toenails or when she was made aware. She indicated she thought Resident #94 had been seen by the podiatrist and was not sure why he had not been seen or his toenails addressed unless he refused the care. She reported that if he had refused care, it should be documented in his electronic medical record. An interview was conducted on 3/19/26 at 4:11 PM with the Administrator. She reported she would expect any resident who had concerns with their feet to be referred to podiatrist. She stated all residents should be receiving basic foot care to include toenail care.	F0687		04/06/2026

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F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Registered Dietician (RD), and the Nurse Practitioner, the facility failed to initiate a dietary supplement per the RD's recommendation when the resident experienced a significant weight loss for 1 of 5 residents reviewed for weight loss (Resident #20). The findings included: Resident #20 was admitted to the facility on 4/2/2025 with diagnoses that included Alzheimer's disease. Review of Resident #20's care plan dated 4/3/2025 revealed a potential for nutritional problems related to having a mechanically altered and therapeutic diet, with interventions that included providing and serving the diet as ordered and having the RD evaluate and recommend diet changes as needed. Resident #20 had an admission weight of 206 lbs. on 4/3/2025. The RD note dated 9/24/2025 documented a 7.8% weight loss in 30 days and a BMI of 36.2 (Normal	F0692	Criteria 1: On 3/17/2026 the Director of Nursing (DON) implemented the order for a dietary supplement for resident #20. Criteria 2: All residents in the facility with orders for therapeutic diets for supplemental nutrition have the potential to be affected by the deficient practice. On 4/3/2026 The DON/designee completed a 100% audit of all residents with weight loss in the past 30 days to ensure all dietitian recommendations were implemented and orders were placed. There were no other issues found. Criteria 3: On 4/3/26, the Administrator provided education to the nursing staff members who work with the registered dietician including Unit Managers, Director of Nursing (DON) and Assistant Director of Nursing (ADON) on the requirement to immediately implement orders for the dietitian's recommendations for supplements. The DON will audit weight loss recommendations that are provided by the dietitian weekly in the risk meeting to ensure all orders were placed properly. Newly hired staff members and those contracted through agencies will be educated by the administrator upon hire through facility orientation or agency orientation, both of which include review of corrective action and facility initiative prior to accepting a resident assignment. Criteria 4: DON/designee will audit 5 residents per week for 8 weeks to ensure all dietitians' weight loss recommendations are implemented. These audits will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly for 2 months and will continue at the discretion of the QAPI committee. Date of Compliance is 4/6/26	04/06/2026

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F0692 SS = D	Continued from page 15 BMI range is 18.5 to 24.9) and noted weight loss might be beneficial due to obese Body Mass Index (BMI); the RD recommended fortifying foods. On 9/26/2026 Resident #20 had a documented weight of 185 lbs. On 9/29/2025, the physician ordered a fortified nutritional shake 120 milliliters (ml) twice daily for weight loss. Review of Resident #20's quarterly Minimum Data Set (MDS) dated 10/23/2025 revealed she was moderately cognitively impaired, weighed 180 lbs., had experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months, was not following a physician-prescribed weight-loss regimen, and was on a therapeutic and mechanically altered diet. On 10/23/2025 Resident #20 had a documented weight of 186 lbs. On 10/27/2025 the fortified nutritional shake 120 ml twice daily was discontinued. The RD note dated 10/30/2025 showed weight loss of 10.8% in 90 days and 10.1% in 180 days, a BMI of 35.1, noted weight loss might be beneficial due to obese BMI and that the resident was up 6 lbs. since last review, and recommended discontinuing the fortified nutritional shake due to weight gain. On 11/25/2025 Resident #20 had a documented weight of 171 lbs. The RD note dated 12/1/2025 indicated a 8.1% weight loss in 30 days, 11.2% in 90 days, and 18% in 180 days, with a BMI of 32.3; the RD noted weight loss might be beneficial due to obese BMI, that Resident #20 was down 15 lbs. since last review, and indicated the resident received the fortified nutritional shake 120 ml twice daily; the RD recommended re-weigh and monitoring. Review of the December 2025 Medication Administration Record (MAR) showed no active order for the fortified nutritional shake 120 ml twice daily. On 12/3/2025 Resident #20 had a documented weight of 173.5 lbs. The RD note dated 12/8/2025 noted an 8.1% weight loss in 30 days, 11.2% in 90 days, and 18% in 180 days, with a BMI of 32.3; the RD indicated a supplement of fortified nutritional shake 120 ml twice	F0692		04/06/2026

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F0692 SS = D	Continued from page 16 daily and that Resident #20 was up 3 lbs. since the last review and recommended continuing the plan of care. A progress note dated 12/8/2025 documented discussion in the risk meeting, noted the resident's weight was beginning to level out, and directed continuing the fortified nutritional shake and monitoring. Review of the January 2026 MAR showed no active order for the fortified nutritional shake twice daily. On 1/6/2026 Resident #20 had a documented a weight of 168.5 lbs. The RD annual note dated 1/16/2026 revealed a 9.4% weight loss at 90 days and 19.2% at 180 days, a BMI of 31.8, and indicated Resident #20 received the fortified nutritional shake 120 ml twice daily; the RD noted weight loss might be beneficial due to obese BMI and that Resident #20 was down 3 lbs. since last review, and recommended continuing the plan of care and monitoring. Resident #20's annual MDS dated 1/23/2026 indicated she was moderately cognitively impaired, weighed 169 lbs., had experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months, was not following a physician-prescribed weight-loss regimen, and was on a therapeutic and mechanically altered diet. On 2/3/2026 Resident #20 had a documented a weight of 161.5 lbs. A progress note dated 2/9/2026 documented discussion in the risk meeting of a 22.4% weight loss in 180 days and recommended increasing the fortified nutritional shake to 120 ml three times daily. The RD note dated 2/12/2026 documented a 22.4% weight loss at 180 days and a BMI of 30.5; indicated Resident #20 received a the fortified nutritional shake 120 ml twice daily; noted she was down 7 lbs. since last review; and recommended increasing fortified nutritional shake to 120 ml three times daily. Review of the February 2026 MAR showed no active order for the fortified nutritional shake twice or three times daily. During an interview on 3/17/2026 at 1:35 PM, Nurse #1 stated she was familiar with Resident #20 and was not sure if the resident received a supplement during medication pass. Nurse #1 reviewed active	F0692		04/06/2026

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F0692 SS = D	Continued from page 17 orders and verified there was no active order for the fortified nutritional shake. She stated if a resident had an order for a fortified nutritional shake, it appeared on the MAR and nurses administered it during medication pass. Nurse #1 stated weights were reviewed in the risk meeting and explained the risk meeting was a management meeting (Director of Nursing and Unit Coordinators), not floor nurses. She stated she believed supplement orders were entered by the dietician or unit coordinators present at the risk meeting. During an interview on 3/17/2026 at 3:58 PM, the RD stated she was familiar with Resident #20 and had been monitoring weight loss. The RD stated Resident #20's BMI was in the obese range and due to that weight loss could be beneficial, but she monitored Resident #20 to regulate the rate weight loss. The RD stated Resident #20's fortified nutritional shake should have been restarted in December 2025, and it should have been increased in February 2026 per her recommendations. The RD stated the order should have been entered by the RD or the Director of Nursing (DON) within a couple of days. The RD she stated did not know why the fortified nutritional shake was listed on the RD note for 12/1/2025, but it should have been restarted on 12/8/2025. The RD indicated she did not know why the order for the fortified nutritional shake was not entered on 12/8/2025, and that she should have entered the order. During an interview on 3/18/2026 at 9:55 AM, Nurse #2 stated floor nurses did not normally enter orders for nutritional supplements; those orders were entered by the dietician or unit coordinator. During an interview on 3/18/2025 at 10:07 AM, the Memory Care Unit Coordinator stated she believed the dietician entered supplement orders and normally emailed recommendations to the DON. The Memory Care Unit Coordinator stated it must have been a communication error Resident #20's fortified nutritional shake was not restarted in December. She stated during risk meetings the DON read recommendations aloud and unit coordinators and supervisors present at the meeting typed a progress note but did not verify the order had been entered. During an interview on 3/19/2025 at 10:00 AM, the Nurse Practitioner (NP) stated she expected RD recommendations to be followed and entered as orders. The NP stated she expected supplements to be administered as recommended. The NP stated Resident #20 was noted as weight loss being beneficial, but recommended supplements should	F0692		04/06/2026

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F0692 SS = D	Continued from page 18 have been ordered and administered. The NP stated the resident could have experienced more rapid weight loss without supplements, leading to failure to thrive, but stated Resident #20 was able to walk out of her room when encouraged. During an interview on 3/19/2025 at 10:59 AM, the Nurse Supervisor stated she participated in risk meetings and entered progress notes read from RD recommendations. The Nurse Supervisor verified she had signed the note written for the 2/9/2026 risk meeting but stated she did not verify the orders were active. During an interview on 3/19/2025 at 2:27 PM, the DON stated she had been in the DON role since January 2026 and was formerly the Assistant Director of Nursing. The DON stated when the RD's recommendations were read off during the risk meeting the unit coordinators or nurses present would enter a progress note, and as ADON she entered a note on 12/8/2025 for Resident #20. She stated the management team discussed weight loss with the RD during weekly risk meetings. The DON explained that the RD was present at some meetings and emailed the recommendations when not at the meeting in person. The DON indicated she thought the dietician normally entered orders for her recommendations. She stated staff did not verify orders were active when writing progress notes during the risk meeting and stated missing the order for the fortified nutritional shakes for Resident #20 was an oversight or miscommunication. The DON stated Resident #20 was now able to walk and had not had a negative outcome from the weight loss. She stated she expected RD recommendations to be followed. During an interview on 3/19/2025 at 4:04 PM, the Administrator stated the DON handled risk meetings with the RD. The Administrator stated she expected RD recommendations to be followed and administered as recommended.	F0692		04/06/2026