DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/24/2012 FORM APPROVED

CENTE	<u>RS FOR MEDICARE 8</u>	R MEDICAID SERVICES				OMB I	NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ultipli Loxng	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B. WING			C 02/10/2012	
NAME OF P	PROVIDER OR SUPPLIER	<u></u>			47 1000000 0001 07175 710 0005		10/2012
					ET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD		
WILLOW	RIDGE OF NC LLC				ITHERFORDTON, NC 28139		
	CHAIRDA	TAYGURA OF PERIOR 1970		, '\ <u>'</u>		***	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8F.	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	s	F	000	Preparation and execution of plan does not constitute admi		1
	Immediate iegoardy	began on 1/29/2012 when			or agreement by the provider		•
	staff became aware				the truth of facts alleged or		•
		ning Resident #8. The			conclusion set forth on the		!
		olified of the Immediate			statement of deficiencies. Th	e nlan	•
	igeopardy on 02/8/20	12 at 9:50 AM. Immediate			is prepared and executed sole		
		ed on 02/10/2012 when the			because it is required by	ı, y	
		implemented an acceptable			provisions of the State and F	adarai	
	credible allegation of		=		•	cuciai	
	483.13(b), 483.13(b)		F	223	Law.		
SS=J	ABUSE/INVOLUNTA	ARY SECLUSION			F 223		3/2/12
	The recident has the	right to be free from verbal,				~ E i 4 ~	
		s ngnt to be free from verbal, I mental abuse, corporal			The facility does protect all		
	punishment, and inv			:	residents from Abuse, prop	erly	
		ordinary oboligation,		=	investigate, screen and		
	The facility must not	use verbal, mental, sexual,			coordinate with law enforce	amant	
	or physical abuse, co	orporal punishment, or			•	ement	•
	involuntary seclusion).			officials		
	This REQUIREMEN	T is not met as evidenced		:	RESIDENT IDENTIFIED		-
	by:				On 2/3/12 at 11:00 pm, res	ident	
		rlews and record review, the			#2 was assigned a staff me	mber	
	sampled coonitively i	e that four (4) of five (5) mpaired female residents			to be with him at all times.		
		that was free from sexual			intervention continued unt		
		ed not consistently identified			resident was discharged fro		
		conducted investigations and			-	All the	
	-	effective preventative			facility on 2/8/12.		
		the female residents from					
	had knowledge of the	sexual abuse. Facility staff e inappropriate sexual			IDENTIFYING OTHER RESID	ENTS	
	behaviors of one mal	e resident (Resident #2)			AT RISK		
	toward four (4) samp				1. On 2/6/2012 complete b	ody	
	(Residents #1, 8, 9, a					•	
					audits done by the Unit Ch	arge	
,	Immediate jeopardy b	egan on 1/29/2012 when			Nurses to assess any obvio	us	
BCRATORYD	RECTOR'S OR PROMOER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	······································	(X6) DATE

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deliciency statement ending with an asterisk (*) denotes a deliciency which unproviding it is determined that 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.

FORM CMS-2587(02-99) Previous Versions Obsolete

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If continuation sheet Page 1 of 47

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE 8	MEDICAID SERVICES				0	<u>MB NO. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION		ATE SURVEY OMPLETED	
							С	
		345197	B. WI	√ G		- [02/10/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
WILLOW	RIDGE OF NC LLC			237 1	RYON ROAD			
			RUTHERFORDTON, NC 28139					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC	iΧ	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPINATE	(X5) COMPLETION DATE	
F 223	Continued From page 1 staff became aware of Resident #2 inappropriately touching Resident #8. The			physical injury,		y, on reside	ent	
			F	223	#1, #8, #9 and #10,	who were		
					touched by resident	t #2. Result	rs.	
	administrator was notified of the immediate jeopardy on 02/8/2012 at 9:50 AM. Immediate jeopardy was removed on 02/10/2012 when the facility provided and implemented an acceptable				of this audit reveale			
					bruising or signs of physical			
						hiideicai		
	credible allegation of compliance. The facility will				trauma.			
	remain out of compliance at a scope and severity				2. On 2/6/2012, res	sidonts # 1		
		rm with potential for more						
	then minimal harm to				#8, #9, and #10 's fa		e	
		le employee education and ystems put in place are			contacted by the Di	rector of		
	effective.	ystems put in place are			Nursing to notify th	em of their		
					family member beir	ng		
	The findings are: Resident #2 was admitted on 09/02/11 with				inappropriately tou	=		
					were asked by the [
		Coronary Artery disease,			•			
		and above the left knee			Nursing if they were		any	
	amputation. Review	of the most recent Minimum		:	other instances of r	esid ent		
		essment dated 12/04/2011			inappropriate beha	vlor. No		
		t was identified as cognitively	; , [additional concerns	were	:	
		stand and make himself behaviors identified. The		•	ldentifled.			
		the resident as once assisted			identifica:			
	into his wheelchair b	eing able to move about the			3. 2/7/12 and 2/8/3	12 The		
		/. Review of current care			Nursing staff were i			
		cember 2011 revealed no			-			
	care plans related to	resident behaviors.			observe resident's f	ғт, нв, нэ а	na	
:	Resident #2 was obs	erved exhibiting			#10, for and signs, s	such as crying.		
	inappropriate sexual behaviors towards female residents on the following dates:			•	increased anxiety, r	-		
					behaviors, physical		ch	
	A Sunday 01/20/12:				• • •	•	CII	
	A. Sunday 01/29/12: Review of nursing notes on 01/29/12 at 3:49 PM				as bruising, etc., Ob			
					will be on-going. No	changes		
		revealed Licensed Nurse (LN) #1 documented			have been noted in	theses	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						c	
	 ,	345197	B. WIN	G		02/10/2012	
	ROVIDER OR SUPPLIER			237 T	ADDRESS, CITY, STATE, ZIP CODE RYON ROAD HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION	
	,		•	•	resident's behaviors or		
F 223	Continued From page 2 Resident #2 was observed by Activity Assistant		F 223		demeanor.		
(AA) #1 touching a fe		female resident's breast. The avior was documented in the			4. 2/9/12- Twenty- Nine		
	Physician's commu	nication book.			Resident families were o		
	Review of the Phys			by the DON, MDS nurse			
	revealed an entry b			Worker, to determine if	they		
	time) which stated s touching Resident f		,	were aware of any inapp	propriate		
		ros bieast.		:	resident to resident		
	_	otes on 01/29/12 at 11:12			contact/abuse and educ	ated to	
	PM, LN #2 docume		:	immediately report any	concerns.		
		eidents on their upper arms heir hands. One resident		<u>:</u>	Messages were left with	11	
		im not to touch her and he let			additional families. No f		
		nded him it was inappropriate ents without their consent.			contacted reported any	•	
:		ager's on Duty" report dated	· :		5. On 2/8/12 the Social	Worker	
		n part: LN #2 reported und in Resident #8's room		:	completed interviews, w	vith thirty	
	holding her hand.	moon 8 64 medicent main			four (34) alert and inter	viewable	
:	-		•		residents, to ascertain if	•	
		ws with staff concerning			were any other incident		
-	these incidents reve	ealeo:		:	inappropriate resident t		
-	An interview was co	inducted with activity assistant			resident contact noted.		
		2 at 10:00 AM. AA #1 stated				•	
		lent #2 touch Resident #8's			were asked if they felt s		
		hing around lunch time on ther stated that she			anyone had made them		
		d the incident to Licensed		•	uncomfortable. No addi	tional	
	Nurse (LN) #1 who was Resident #2's and				concerns were identified	d.	
		ed nurse on this shift. The eated the nursing assistants					
•		interview further revealed the nursing assistants (NAs) stated they were not aware of Resident #2			6. 2/8/12 and 2/9/12 –	Ninety-	
	inappropriately touching other residents prior to				two employees were		
	01/29/12.				interviewed by departm	ent	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					(M APPROVED 10. 0938-0391
STATEMENT	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		346197				02/	C 10/2012
NAME OF PA	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WILLOW	RIDGE OF NC LLC				TRYON ROAD "HERFORDTON, NC 28139		
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				: (X5) COMPLETION DATE
F 223	with LN #1 revealed to observed Resident #2 over her clothing arou LN #1 recalled Reside the hall near the nurs bed by a nursing assidocumented the incid communication book, passed the informatio (3:00 PM to 11:00 PM interventions were purposed at the Activity Director (Aresident #2 was touc #2 revealed the AD to the DON and Administrations with the province of the province with the province wit with the province with the province with the province with the	on 02/07/12 at 11:00 AM hat AA #1 told her that she touch Resident #8's breast and lunch time on 01/29/12. ent #2 was removed from e's station and assisted to stant. LN #1 stated she ent in the Physician's her nurse's note, and in on to the second shift I) nurse (LN #2). No other t into place. terview on 02/06/12 at 5:35 in 01/29/12 she reported to AD) (manager on duty), that hing female residents. LN eld her that she would inform strator. AM the Activity Director	F	223	heads, and asked if they observed any inappropriatesident to resident cont staff members who were available for interview were removed from the sched such interview is completed the department head. No additional concerns were identified. PROCESS IMPLEMENT PREVENT FURTHER OCCURRENCES 1. On 2/7 and 2/8/12 a persons employed by the observed and asked in the process of the proces	ate act. All not ill be ule until ted by ED TO	
	(AD) confirmed she was the Manager on Duty on 01/29/12. The AD revealed LN #2 reported Resident #2 was holding female residents' hands and staff was having a hard time keeping him out of female residents' rooms. The AD stated she did not address Resident #2's behavior herself on 01/29/12 but made sure it was discussed during the facility's morning meeting on 01/30/12. The AD stated the conclusion at the 01/30/12 morning meeting was staff would monitor Resident #2 for inappropriate behaviors. B. Monday 01/30/12:			Service services	were in-serviced. All de heads were inserviced Regional Vice President Operations. Staff Deve Coordinator, Nurse Ma inserviced the nurses. A staff was in-serviced by department managers. services contained the	epartment by the t of elopment nagers , All other their	
				•	100% completed on 2/	•	

: Nursing notes dated 01/30/12 at 11:32 AM revealed LN #4 documented Resident #2 had

OLIVILI	TO TOIS WILDIOANE &	MEDICAID SEKVICES				Olvin I	<u>10. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B. WIN	c			C
NAME OF 2	ROVIDER OR SUPPLIER	1 340107			· · · · · · · · · · · · · · · · · · ·	02	/10/2012
				ı	T ADDRESS, CITY, STATE, ZIP CODE		
WILLOW RIDGE OF NC LLC				,	TRYON ROAD THERFORDTON, NC 28139		
04410	: SIBILIADA CA	ATEMENT OF DEFICIENCIES		_ '(0'		- ATION	
(X4) ID PREFIX TAG	EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	: (X5) : COMPLETION DATE
F 223	∵ - Continued From page	e 4	·	223	a. The facilitles Abuse po	olicy and	
•		several female residents	•		procedure states that ab	use can	
	this morning and tried				be considered physical to	ouching	
	: Review of the physici	an verbal orders dated			that is inappropriate, if it	: is	
	01/30/12 revealed an		•	uninvited by the person	being		
	every day for depress	ion. Review of Medication		•	touched.	=	
	Administration Record	ds (MAR) revealed Resident			touchou.		
	 #2 received the Celex 01/31/12 and 02/01/1 	ta at 9:00 AM starting on 2.			b. Immediately protect	all	
				:	residents when inapprop	oriate	
	Subsequent interviews with staff concerning this				resident to resident conf		
	incident revealed:						
	During interview on 0	2/06/12 at 12:46 PM, LN #4			identified, by staying wit		
	revealed Resident #2	s behaviors started on		÷	resident to protect them		
		ed on 01/30/12, but she		:	must immediately notify	the	÷
	could not recall who F				administrator.		
	approaching those da	ys.		:	c. Immediately report a	ll events	;
	During interview on 02	2/06/12 at 1:20 PM, the		-	of inappropriate resider	it to	
		ON) stated she was aware		:	resident contact to the		
	Resident #2 was "hav	ing behaviors" on 01/30/12		ĺ	Administrator, if the		
		vorker to "look into it." She not follow up on the report		:	Administrator is not ava	ilablo	-
,	about Resident #2's b	ehaviors.		i		•	
;				1	the employee reporting		;
	C. Wednesday 02/01	/12:			alleged abuse should re	-	
:	Review of the nursing	notes revealed the only		:	his/her supervisor who	contacts	
		ident #2's behaviors was		÷	the Administrator or Dir	ector of	
	documented by LN #5	focumented by LN #6 on 02/01/12 at 10:15 PM.			Nursing.		
	LN #5 documented Re	sident #2 was observed			U .		
		ering the halls grabbing female residents' ts and groins. Resident #2 was redirected			d. 2/8/12 Abuse policy	revised to	
:	several times and curr	sed at staff. Resident #2			state nurses are to imm		
		gned a Nursing Assistant (NA) for			fill out an incident repor	•	
	observation when he t	hreatened to punch staff in			<u>-</u>		
	the head and told and	her recident that he was			submit it to the DON; ca	ii the	

CLIVILIV	O TON MEDICARE &	MEDICAID SEKVICES		,		CINID M	J. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
			B. WNG				
		345197				02/1	0/2012
	ROMDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD		
WILLOW RIDGE OF NC LLC					JTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 223	Continued From page	. 5	F	223	physician; notify		,,
		e Director of Nursing (DON)	•	220	family/responsible party	at the	
	was notified.				time of the occurrence.	In-service	
	· Facility record review	revealed no documentation			was conducted by the U	nit	•
		supervision provided on			Managers, DON, depart	ment	
	02/01/11 and no incid		:	heads on 2/8/12. The N	urse's		
	Subsequent interview	s with staff concerning this		:	Responsibilities when a	leged	
	incident revealed:				abuse is suspected and	the	:
	During an interview of	n 02/06/12 at 12:05 PM,			facility's Policy and Proc	edure on:	:
	nursing assistant (NA) #1 revealed, that on				Abuse was placed at ea	ch Nurses	
		ng on the first shift she had his wheelchair away from		:	station.		
:	Resident #8 four time	s. NA #1 stated she	=	1			
		at Resident #2 had been		1	e. All staff should repor		
:		sident #8 up to her groin. d later that day the Director	•	•	immediate supervisor a		
Ī	of Nursing (DON) can	ne to the nursing station.			feedback from that sup	ervisor	
-		N of what happened. NA #1		i	that an investigation ha	s been	_
		DON to "keep an eye" on et him around the female			initiated, if feedback no	it	
	residents.		-		provided, staff should o	ontact	:
; ;	I N #4 stated on 02/04	6/12 at 3:25 PM that on			Administrator directly.	The	•
3	02/01/12 the NAs (she				Administrators contact		
:	reported to her they h	ad observed Resident #2			information is posted a	t every	
	inappropriately touching	ng female residents, and Resident #8. LN #4		:	Nurses station and in e	very	
	•	onsidered Resident #2's			ancillary department.	,	
1	behaviors as sexual a	buse, so on 02/01/12 she		:	ationial Jacks direct		
		per facility policy. The		:	f. Any staff member th	at is	•
-	behaviors in the resident	Resident #2's actions under ent's medical record.		-	unable to attend the Al	ouse in-	
				:	service will not be allow	ved to	
	An interview on 02/06			work until they receive	this in-		
	revealed Resident #2 during the 3:00 PM to			•			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		346197	B. WNG		C 02/10/2012	
	ROVIDER OR SUPPLIER		237	T ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 223 Continued From page 6 female residents' (Resident #1 and Resident #8) breasts and groins over their clothing. LN #5 stated Resident #2 was redirected, the DON was notified and a NA was assigned to sit with Resident #2. LN #5 was not aware of how long the one to one supervision continued after she left that evening. LN #5 further stated she asked the DON if she needed to fill out an incident report and was instructed only to document her findings in the behavior section of the medical record. D. Thursday 02/02/12:		F 223	service by the Unit Mana Department Head or Sta Development Nurse. 100 completed on 2/10/12. g. The Administrator or immediately report any allegations of abuse to the Regional Vice President Operations or Chief Clini officer for proper guidan	ff 0% DON will he of cal		
:	PM revealed LN #4 defrequently touched fer inappropriately this shaper of physician vertical and a new order (antidepressant) 5mg (female hormone) 1m sexual behaviors."	erbal order dated 02/02/12 for Lexapro every day and Estrace g every day, both "for		Effective 2/9/2012,the Down of Nursing and Unit Mar and Weekend Superviso review the 24 hour nurs	I changes and 24 hours. Director nagers r will es report	
	received the Lexapro and Estrace on 02/03/12 at 8:00 AM in addition to the daily dose of Celexa. Review of Resident #2's Social Service Notes, a late entry dated 02/03/12 revealed on 02/02/12 the social worker spoke directly with Resident #2 regarding "his sexually inappropriate touching of staff, as well as residents." The note stated Resident #2 verbally agreed to not touch residents in a sexual manner. Review of nursing notes dated 02/02/12 at 11:13			daily to note any instance behavior changes and/o occurrences of inapprop resident to resident con 2/9/12 nurses were in-s on including more informations. Any Allegations that are ider be immediately reporter	r vriate tact. On erviced mation on viified will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	ED
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l IR WANG	c
346197 02/1	0/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139	
	,
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223 Continued From page 7 F 223 Administrator. These will be	
PM revealed LN #2 documented staff had discussed in the morning	
attempted to constantly watch Resident #2 due to meeting. him touching female residents inappropriately.	
The nurse aides observed him rubbing on a 3. On 2/9/12 a Quality Assurance	
female resident's shoulder in the main dining room during supper and redirected Resident #2 Tool was started. This tool will	
away from her. In addition, another female have department heads make	
resident had to be moved out into the hall due to Resident #2's numerous attempts to touch her rounds 5 times per week,	
Resident #2's numerous attempts to touch her. The social worker was in this evening to talk to monitoring for inappropriate	
him about his inappropriate fouching of female behaviors, interviews with staff	
residents. Review of the 24 hour shift report for	
02/02/12 revealed during the first shift Resident and residents related to this	
#2 continued "to touch" female residents; during topic, until Substantial the second shift Resident #2 required constant	
watching to keep him from touching female Compliance is obtained. After	
residents; and during third shift Resident #2 that, should no further instances	:
continued "to touch" female residents. of non-compliance be identified,	
Subsequent interviews with staff concerning rounds will be completed weekly	
these incidents revealed: by the managers thereafter. This	:
An interview with Licensed Nurse Unit Manager Information will be monitored by	:
(LNUM) #2 on 02/07/12 at 11:20 AM revealed the Quality Assurance Committee	
that Liv #4 informed her on UZ/UZ/1/2 that	
Resident #2 was behaving inappropriately and monthly and any necessary trying to touch other residents. She further stated actions taken. The Quality	
she did not ask for specific details reparding	
Resident #2's behaviors at that time. LNUM #2 Assurance Tool Instructs the staff	
also stated she did not notify the Director of member to observe, and	
Nursing or the Administrator because she did not guestion residents and staff to	
know the extent of his behaviors. She further stated she did not follow up with staff regarding see if there was any	
Resident #2's behavior. Inappropriate resident to	
During an interview on 02/07/12 at 4:30 PM the resident contact; heard any	
Social Worker (SW) stated Resident #2 grabbed resident/family complaints;	
at staff members and was combative with care observe or receive a report of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES						OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
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NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE				
WILLOW	RIDGE OF NC LLC			237	TRYON ROAD				
***************************************				RU	THERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OVLO BE	(X5) COMPLETION DATE		
F 223	Continued From page	8	F	223	Inappropriate resident	to			
	when he was first admitted to the facility. The SW further stated Resident #2's behaviors were discussed during the facility's morning meeting on		•	:	resident contact. They				
			:		•	employees the first thing they are			
		ninistrator asked her to meet			to do when they obser	ve or hear			
	with Resident #2 and				of inappropriate reside	ent to			
		or. SW further stated she			resident contact, ask e				
	met with Resident #2 02/02/12.			to whom they should a					
	E. Friday 02/03/12:			:	This will be conducted	•			
				:	shifts. The Quality Ass				
	Nursing notes dated (1	Tool will gather the rel					
	revealed LN #3 docui								
	continued to touch fer	nale residents	information, which will be taken						
		atched for the nurse to go		7	to the morning meetin	g, where it			
;		noved closer to the female It was kept in sight of the			will be discussed and a	ny			
	nurse since he got up				negative responses wil	l be			
					handled immediately b	y the			
	Nursing notes on 02/0	03/12 at 3:04 PM revealed esident #2 continued to			administrator or his/he	≥r			
		residents inappropriately			designee.	•			
;	frequently during this				acoi8iice.		-		
	Museum and a detail of	20/00/40 -1 4 40 014			4. Beginning on 2/9/12	any			
	Nursing notes dated (revealed I N #2 documents	nented Activities Assistant		1	residents displaying	•			
		e nurse Resident #2 was			inappropriate behavior	's wore			
	seen by a visitor touch	ning Resident #10's breasts.			assessed and their care				
	•	ident #10 and Resident #2.				· •			
		d she notified the social DON of this incident and			were reviewed and upo				
		hall to monitor Resident #2		:	appropriate actions. To				
	and know where he was.			:	completed by the MDS	completed by the MDS nurses.			
	Review of nursing not	ng notes dated 02/03/12 at 11:48			5. On 2/17/12 all Nurse	3			
		ocumented AA #2 reported			Managers were in-serv				
		esident #2 in Resident #9's	•		the Chief Clinical Officer on;				
room with his hand on the resident's groin. AA #2				the Chief Chilical Office	a on,				

PRINTED: 02/24/2012 FORM APPROVED OMB NO. 0938-0391

CENTER	(S FOR MEDICARE &	MEDICAID SERVICES					OWE	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTI G	ON	(X3) DATE SURVEY COMPLETED	
		346197	6. WING					C 02/10/2012
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	1	Ter	DEET ADDRESS (TY, STATE, ZIP CODE	<u> </u>	JE/ 10/2012
					237 TRYON ROF	TI, SINIE, ZII GODE		
WILLOW	RIDGE OF NC LLC				RUTHERFOR	N, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	(cī/ CR	7 9'S PLAN OF CORRECT ECT & ACTIO SHO ENCED TO THE APPROPRIED CY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From page	0.0		222	a. The	facility's Skin tear/i	oruise	
1 220	attempted to remove Resident #2 from the room		r	223	>. ∷ Policy ai	nd Procedure.		
		mesident #2 from the room ame combative and tried to			, 0,10, 0,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		was removed from the room			b. Pro	perly investigating S	Skin	
		se's desk. LN #2 contacted			-	nd Bruises to rule or		
		r (NP) about Resident #2's			. Abuse.			
		quently called the DON. /2 back and was told to have			Abase.			
		#2 at all times. Resident			с Ном	v to properly invest	igate	
		called at 10:30 PM. LN #2						
explained Resident's #2's behavior had escalated					•	causative factors t		
	·=·	asked for the DON's phone			may hav	e contributed to th	ie skin	
	with new orders for a	led LN #2 back at 10:50 PM			tear or i	bruise such as; Resi	dent	
		n. Also the MD stated the			and stat	ff statements,		
		in the morning (02/04/12)	medications, behaviors, medical conditions and environmental					
	to arrange for Reside	nt #2's transfer to a hospital.						
	: Desdess of the universal	الملاحة الماد ماد ماد ماد ماد					itui	
		an verbal orders dated xapro was discontinued and	•		factors.			
		ased to 20mg every day. In			d Tha	facility's Quality		
		notic medication, Haldol 1mg				facility's Quality	1.6.	
		as ordered now, then 1mg				ice Investigational t	ool for	
		every 8 hours on schedule.	:		Skin Tea	ars and Bruises.		
	ordered now and ever	ation, Ativan 0.5 mg was						:
3	Oldered How and ever	y o nours as needed.			e. The	requirement that t	hese	-
	Review of facility doc	umentation revealed one on			be revie	ewed dally as they o	occur,	
:	•	started on 02/03/12 at 11:00			orders o	obtained as needed		
		til 02/08/12 at 12:05 PM			•	ntions implemented		
•	when Resident #2 wa	s transferred to the hospital.				riate, care plans up		•
	Subsequent interview	s with staff concerning				•		
	these incidents reveal					ised as necessary a		
					Suspicio	ous skin tears/bruis	es that	•
į		terview on 02/07/12 at 2:55			a plausi	ble causative factor	r could	
PM, LN #3 stated at approximately 6:00 AM on 02/03/12, she observed Resident #2 with his			not be derived from a					

i hand on Resident #9's stomach. LN #3 further

investigation be reported as and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345197	B. WING		C 02/10/2012			
	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
sta an no inf Du So ma fact diss Du sta Re over din Re inc Du the anc bet DO corrings sup Dur MD con eve inag he o	d kept Resident #8 I fill out an inciden ormation to the on uring an interview of cial Worker (SW) beting with Resider clitity's 02/03/12 inci- ing interview on 0 ing a telephone in ing a telephone in ing a telephone in ing a telephone in ing the should in ing Resident #1 DON if she should in interview of corevealed the cial tacted by the nurs ing the interview of revealed the facil tacted him at hom ning about Reside propriate sexual in inci- called the DON on	Resident #2 to his room with her. She stated she did report but did report this coming nurse (LN #4). In 02/07/12 at 4:30 PM the explained she shared her at #2 on 02/02/12 during the rning meeting and staff or a family meeting. 2/07/12 at 10:00 AM, AA #1 32 a visitor reported ching Resident #10's breast e they were seated in the stated that she moved her table and reported the terview on 02/06/12 at 5:35 t on 02/03/12 she told the s observed inappropriately 0's breasts. LN #2 asked if ill out an incident report to document Resident #2's . She further stated the r 9:00 PM, after being e practitioner (NP), and Resident #2 on one on one In 02/06/12 at 12:50 PM, the ty physician on call e on Friday (02/03/12)	F 223	treated as a possible Abuse scenario. If Abuse can not be ruled out, these events will reported and investigated as Alleged Abuse cases. 6. The 7 types of abuse was posted in numerous visual a in the facility on 2/14/12. 7. The contact phone numb for the Administrator, Direct Nursing, Social Service Direct and the Corporate Compliant Hotline was posted in numerous visual areas in the facility on 2/13/12. This will allow sfamilies and outside vendor immediately contact Key fastaff if they have concerns. 8. On 2/10/12 the facility implemented a weekly Rescouncil meeting. This meet will allow the residents to vany concerns that they may of concerns are identified, they will be immediately reported the Administrator per the grievance policy.	reas reas ers tor of ctor nce erous taff, rs to cllity ident ling /olce y have. hese			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		3461 9 7	B. WNG	· 	C 02/10/2012	
	ROVIDER OR SUPPLIER		237	ET ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139	V 10/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	
F 223	: Continued From page	e 11	F 223	9. On 2/17/12 a all sta	iff Directed	
		ation. During continued		in-service was conduc		
	interview the MD note	ed he had ordered		representative of The		
		ext morning when Resident	-	Protective Services De		
	#2 could be sent to th	e hospital.		This In-service include		
		2/06/12 at 1:20 PM, she and ided to place the resident on	:	a. Signs and symptom	s of abuse.	
	(02/03/12).	л ол глау підпі	· · · · · · · · · · · · · · · · · · ·	b. Types of abuse.	:	
	H. Saturday 02/04/12	: :	-	c. Preventing abuse.		
	#2 was administered	2 MAR revealed Resident Haldol 1 mg IM at 11:00 PM		d. Protection against a	abuse.	
		mouth at 11:00 PM. There		e. Protection of reside	ents when	
	as needed medication	behaviors for which these ns were administered.	: :	abuse is suspected.		
:	: Subsequent interview : Incident revealed:	s with staff concerning this		f. Immediately report	ing abuse.	
;	:			MONITORING		
	PM, the MD revealed	rview on 02/06/12 at 1:20 he called the facility on the		1. The DON and Unit I	Managers	
:		to see if Resident #2 had ospital and was told by		will continue review t	he facility's	
-		DON was "working on it."		24 hour report to for	anv	
•				documented instance	•	
	I. Sunday 02/05/12:		•			
, -		es dated 02/05/12 at 5:53	•	inappropriate residen		
7	AM revealed Residen			resident contact or an	•	
	and threatened to hit:	ed to be agitated, cursing,		allegations of abuse. F	urther	
				Education and possibl	e	
-	Review of the MAR for		,	disciplinary action will	occur as	
Resident #2 received Ativan at 1:30 AM, 1:0 and 6:17 PM in addition to his regularly schemedications.			·	needed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & N		MEDICAID SERVICES				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345197	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		etocet	ADDRESS, CITY, STATE, ZIP CODE		0/2012
WILLOW RIDGE OF NC LLC				237 T	RYON ROAD HERFORDTON, NC 28139		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORREC	TION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	Continued From page	⊋ 12	· F	223	2. The Department hea	ds will	
	Review of the physician communication book				continue to complete th	ne daily	
	revealed an entry on		:	Quality Assurance round	ds for		
	Resident #2 was still		:	abuse until substantial			
	behaviors."			compliance is obtained,	At that		
	Review of nursing no	les dated 02/05/12 at 9:21		:	time the Quality Assura		
	PM revealed Residen	t #2 was trying to approach			committee will review t		
	Resident #10. The ne #2 was redirected, wa	ursing note stated Resident		:	process and these round		
	supervision and recei	ved as needed medication.		-	conducted weekly there		
	J. Monday 02/06/12:				each Department Head.	-	:
;				:			
		w of the Social Service Notes dated /12 revealed the Administrator requested a r meeting to be scheduled immediately due		:	All allegations of Ab		
	family meeting to be s				be immediately reporte		
	to Resident #2's ongo	ing sexually inappropriate	•	:	Administrator. The alleg	ations	1
	behavior.		•	:	will be fully investigated	and	:
	Subsequent interview	ent interviews with staff concerning this			reported per regulations	s. The	
	incident revealed:	· ······ ottai ootiootijiilig tillo	-	:	Administrator will notify	the	:
	During an interview a	- 00/00/40 -1 0 50 014 1/			Regional Vice President	and/or	
		n 02/06/12 at 3:50 PM, the ad prior to 02/03/12 at 10:30			the Chief Clinical Officer	for	
•	PM, her understandin	g was Resident #2 had			guidance and to ensure	that the	1
	been holding hands a				facility's policy has been		
	not usually review the	dministrator stated she did 24 hour reports, nursing		:	followed.		
	notes or Physician cor	mmunication book but		:	ronowed.		
	expected her clinical s	taff to inform her of any		:	4. The Regional Vice Pres	sident	
•	changes in resident's	condition.		:	and/or the Chief Clinical		
		notified of the immediate		٠	will provide guidance an		
	jeopardy on 02/8/12 a	t 9:50 AM. The facility		:	support to the facility on		
7	02/10/12 at 4:24 PM.	egation of compliance on The following interventions the facility to remove the		•	reported Abuse scenario		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		346197	8 MNG			C 02/10/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139		TRYON ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 223	Continued From page	∍ 13	· F	223	5. The weekly Resident Co	uncil		
	Immediate Jeopardy:	,		Meeting will continue until				
	, ,		ī		-	1		
	Credible Allegation of	f Compliance:			Substantial Compliance is			
	02/02/42 of 44:00 pm			obtained. At that time the	;			
	02/03/12 at 11:00 pm a staff member to be		i	Resident Council will vote	on			
	Intervention continue		:	whether to continue this				
		ransferred from the facility to the hospital on			practice.			
	02/08/12 at 12:05 p.n		:	•	*			
	02/08/12 Administra	tor called the County			6. The results of the Quali	•		
		ort a possible crime, related			Assurance monitoring tool	, 24		
	to the inappropriate b	ehavior of resident #2.			hour report, and investigate	tions of		
		TIFY OTHER RESIDENTS			any inappropriate resident	t i		
;	AT RISK	the Cariel Minutes			contact will be reviewed a			
:	1. 2/6/12 and 2/8/12	the Social vvorker , with thirty four (34) atert		:	analyzed in the monthly Q			
		idents, to ascertain if there			•	· · · · · · · · · · · · · · · · · · ·		
		nts of inappropriate resident	•		Assurance Committee me	- :		
:	to resident contact no	ted. They were asked if they		:	for three months and qua	rterly		
:	felt safe or if anyone i				thereafter until deemed re	esolved		
i :	uncomfortable. No ed identified.	ditional concerns were		:	by the committee.			
1		lete body audits done by the			2) the sommer.			
-	Unit Charge Nurses to	assess any obvious			7. Monthly in-services will	be		
	physical injury, on res	idents #1, #8, #9 and #10,			provided to all facility staf			
,		s being inappropriately			•	1 101		
		2. Results of this audit			the next 3 months, then			
:	revealed no visible bratrauma.	uising or signs of physical			quarterly there after. The	se in-		
-		ents # 1, #8, #9, and #10 '			services will review the Fa	Facility's		
	s families/responsible	parties were contacted by			Abuse Policy and Procedu	re. The		
	the Director of Nursing	g to notify them of their			facility will attempt to arra			
		inappropriately touched.			·			
	They were asked by the they were aware of an			Outside speakers with Ab				
				Prevention knowledge to	to provide			
	resident inappropriate behavior. No additional concerns were identified.				these in-services.			

OF-141	CO. OIL MEDIOVICE OF	MICDIONID OLIVACES			 		MD NO. 0336-0391	
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WNG			C		
		345197	H.WN	νG .			02/10/2012	
	ROVIDER OR SUPPLIER RIDGE OF NC LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD					
	·			1	RUTHERFORDTON, NC 28139		· , _ , _ , _ , _ , _ , _ , _ , _ , _ , 	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 223	Continued From page	e 14	F 223		23 8. The Medical Direct	or was		
		The Nursing staff were						
		ctor of Nursing to observe			consulted on these a	-	"	
	resident 's #1, #8, #9	and #10, for and signs,			the facilities processo	es,		
		ased anxiety, new behaviors,			interventions implen	rented,	•	
	physical injuries, such Observations will be a	n as bruising, etc., on-going. No changes have			suggestions and/or g	uidance.	The	
	been noted in theses	resident 's behaviors or			facility will continue	to involve	!	
i	demeanor.			the Medical Director	in the			
:	5. 2/9/12- Twenty- N	nne (29) Resident Parties were selected at			Quality Assurance pr	ocess and	1 :	
		d by the DON, MDS nurse			seek guidance, suppo			
-		letermine if they were aware					:	
	of any inappropriate r				further educational r	ieeas.		
		ucated to immediately						
;		Messages were left with 11			9. The Administrator	IS	:	
	, additional tamilles. No ∈any concerns.	family contacted reported			responsible for comp	llance.	:	
	•	- Ninety-two employees						
		lepartment heads, and					Į.	
		served any inappropriate					:	
	-	ontact. All staff members						
:	who were not available	e for interview will be					:	
		edule until such interview is						
:		artment head. No additional						
-	concerns were identifi							
		MENTED TO PREVENT					\$ -	
	FURTHER OCCURR							
	1. On 2/7 and 2/8/12 employed by this facil	ity were in-serviced. All					•	
:	department heads we							
:		ent of Operations. Staff					-	
		ator, Nurse Managers,						
	in-service the nurses.							
	in-serviced by their de	partment managers.						
	In-services contained	the following:						
		se policy and procedure						
		be considered physical opriate, if it is uninvited by						

NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A BUILE	NIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC WILLOW RIDGE OF NC LLC 237 TRYON ROAD RUTHERFORDTON, NC 28139 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			345197	B. WING		O	C 2/10/2012
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE					237 TRYON ROAD	CODE	
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
free person being touched. b. Immediately protect all residents when inappropriate resident to resident contact is identified, by staying with the resident to protect them. You must immediately notify the administrator. c. Immediately report all events of inappropriate resident to resident to resident to resident contact to the Administrator. If the Administrator is not available, the employee reporting the alleged abuse should report it to his/her supervisor who contacts the Administrator or Director of Nursing. d. 2/8/12 Abuse policy revised to state nurses are to immediately ill out an incident report and submit it to the DON; call the physician; notify family/responsible party and the administrator at the time of the occurrence. In-service was conducted by the Unit Managers, DON, department heads on 2/8/12. e. All staff should report to their immediate supervisor and expect feedback from that supervisor that an investigation has been initiated. If feedback not provided, staff should contact Administrator directly. The Administrators contact information is posted at every Nurses station and in every ancillary department. f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until they receive this in-service by the Unit Manager or Department Head or Staff Development Nurse. g. The Administrator or DON will immediately report any allegations of abuse to the Regional Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator of Cornect or Operations or Chief Clinical officer for proper guidance. The Administrator of cornects. h. The 24 hour report is a reflection of any		the person being touch. Immediately proteinappropriate resident identified, by staying a them. You must immediately report resident to reporting the alleged his/her supervisor whor Director of Nursing d. 2/8/12 Abuse policy to immediately fill out submit it to the DON; family/responsible part the time of the occurre conducted by the Unit department heads on e. All staff should report supervisor and expect supervisor that an invinitiated, if feedback in contact Administrator contact information is station and in every at f. Any staff member the Abuse in-service will report any allegations Vice President of Ope officer for proper guida Director of Nursing will authorities within 2 hooccurs, or within 24 hooccurs, or wit	thed. ct all residents when ct to resident contact is with the resident to protect ediately notify the all events of inappropriate ontact to the Administrator. not available, the employee abuse should report it to o contacts the Administrator revised to state nurses are an incident report and call the physician; notify ty and the administrator at ence. In-service was Managers, DON, 2/8/12. or to their immediate feedback from that estigation has been of provided, staff should directly. The Administrators posted at every Nurses notllary department. nat is unable to attend the not be allowed to work until rvice by the Unit Manager or Staff Development Nurse. or DON will immediately of abuse to the Regional rations or Chief Clinical ance. The Administrator of I report to the proper urs if serious bodily injury ours of a suspicion of crime.	F 2	23		

OLIVILI	NOT ON MEDICANE &	MILDICAID SERVICES				- OWIE	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WAN	G			С
		345197				02	//10/2012
	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD		
				RUT	HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(XS) COMPLETION DATE
F 223	Continued From page	- 16		223			:
			F	223			
	behaviors in the last 2	esident 's conditions and					:
	2/9/2012,the Director						
		end Supervisor will review					•
	the 24 hour nurses re			:			*
	instances of behavior			:			:
		ropriate resident to resident					:
		urses were in serviced on		:			Ē .
		nation on resident behaviors.					1
		use that are on the 24 hour		1			1
		e immediately reported to		÷			1
	the Administrator.	o miniculatory reported to					:
		y Assurance Tool will be		:			
		have department heads					•
	- E	per week, monitoring for					
	•	ors, interviews with staff and		Ī			
		is topic, for the next 3		i			
		ould no occurrences of			•		•
		unds will be made weekly.		į			:
		e monitored by the Quality					•
	Assurance Committee			1			-
		en. The Quality Assurance]			
		f member to observe, and	•	į			•
	question residents an	d staff to see if there was		1			:
		dent to resident contact;		Į			
		nily complaints; observe or		1			-
	receive a report of ina	ppropriate resident to					
	resident contact. They	/ will ask 2 employees the					
	first thing they are to d	to when they observe or		:			
	hear of inappropriate	resident to resident contact,					
	ask employee to whor	n they should report this.					
		on all shifts. The Quality		:			
	Assurance Tool will ga			:			
		be taken to the morning		:			
	meeting, where it will i			_			•
		ill be handled immediately					
	by the administrator o						
	 Beginning on 2/9/12 	2 any residents displaying					

		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B, WING		C 02/10/2012	
	OVIDER OR SUPPLIER		237 T	ADDRESS, CITY, STATE, ZIP CODE RYON ROAD HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 223	Continued From page		F 223			
:	have their care plans appropriate actions w		:			
:		ons or additions will be mpleted by the MDS nurses.			; ; ;	
	review the facility 's 2	Managers will continue 24 hour report to for any as Of inappropriate resident	:		· :	
	to resident contact or	any allegations of abuse. d possible disciplinary action				
; ; ;	abuse until substantla	rality Assurance rounds for all compliance is obtained.			:	
	review this process at	ly Assurance committee will nd these rounds will ncy that rounds are to				
:	continue to be comple process.	oted as a Quality Assurance buse will be immediately				
:	reported to the Admin Be fully investigated a The Administrator will	istrator. The allegations will and reported per regulations. I notify the Regional Vice				
:		Chief Clinical Officer for re that the facility 's policy			:	
: : :	monitoring tool, 24 ho of any inappropriate r reviewed and analyze	ur report, and investigations esident contact will be d in the monthly Quality	:			
<u>.</u>	Assurance Committee and quarterly thereaft the committee. The immediate jeopar	e meeting for three months er until deemed resolved by	:		:	
	02/10/12 at 5:15 PM f administrative, license	ollowing interviews with od and direct care staff on to mandatory education on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		c	
		346197	B. WNG		02/10/2012	
	ROVIDER OR SUPPLIER		237	ET ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 226 SS=J	families; review of insof staff on abuse; review of the 24 hours and review of the quaplace. 483.13(c) DEVELOP/ABUSE/NEGLECT, EThe facility must dever policies and procedur mistreatment, neglect and misappropriation This REQUIREMENT by: Based on observation record review the faciliabuse policies and protection, preventiand reporting for four impaired residents. (Fill #10) Immediate jeopardy by staff became aware of inappropriately touching administrator was not jeopardy on 02/8/2012 jeopardy was removed facility provided and incredible allegation of cremain out of compliant level D (no actual harm than minimal harm than jeopardy) to complete	a residents; interviews with service rosters on education ew of revised abuse policy; a communication sheets; lity assurance tool put into IMPLMENT TC POLICIES Iop and implement written es that prohibit, and abuse of residents of resident property. Is not met as evidenced as, staff interviews, and ity failed to implement occdures related to on, protection, investigation (4) of five (5) cognitively Resident #1, #8, #9, and egan on 1/29/2012 when a Resident #2 as Resident #8. The fied of the immediate at 9:50 AM. Immediate at 9:50 AM. Immediate at 9:50 AM. Immediate an acceptable compliance. The facility will not at a scope and severity in with potential for more t is not immediate employee education and	F 226	Preparation and execution of plan does not constitute adror agreement by the provide the truth of facts alleged or conclusion set forth on the statement of deficiencies. To is prepared and executed so because it is required by provisions of the State and Law. F 226 The facility does protect all residents from Abuse, propinvestigate, screen and coordinate with law enforce officials RESIDENT IDENTIFIED On 2/3/12 at 11:00 pm, resident was assigned a staff me to be with him at all times. Intervention continued untresident was discharged from a	mission er of The plan plely Federal 3/2/12 of its erly ement sident mber This til om the DENTS body harge pus	
	staff became aware of inappropriately touchir administrator was notificated and increased and incredible allegation of cremain out of compilar level D (no actual harm than minimal harm than	Resident #2 ng Resident #8. The fied of the immediate 2 at 9:50 AM. Immediate 3 on 02/10/2012 when the aplemented an acceptable compliance. The facility will not at a scope and severity n with potential for more t is not immediate employee education and		resident was discharged from facility on 2/8/12. IDENTIFYING OTHER RESIDENT AT RISK 1. On 2/6/2012 complete facility done by the Unit Characteristics.	om the DENTS body narge ous	

CENTER	O LOW MICHIONLE OF	MEDICAID SERVICES				OND NO. 0830-0381		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С		
		345197	B. WIN	·	····	02/10/2012		
NAME OF PR	ROVIDER OR SUPPLIER	·			T ADDRESS, CITY, STATE, ZIP CODE			
WILLOW I	RIDGE OF NC LLC				TRYON ROAD			
	.			RU'	THERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRÉCEDEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION		
F 226	Continued From page	÷ 19	F.	 226	#1, #8, #9 and #10, who w			
	effective.	9 - ·-			touched by resident #2. Results			
					of this audit revealed no v			
	Findings include:			1	bruising or signs of physic			
÷	The facility abuse pol part:	icy dated 7/27/11 reads in		÷	trauma.			
	DALIAV 671			;	2. On 2/6/2012, resident	s # 1,		
	POLICY STATEMEN The Facility and its st	T taff are committed to		:	#8, #9, and #10 's families			
	-	d abuse-free environment	:	:	contacted by the Director			
	for all residents.		-	-	Nursing to notify them of			
	DENTIFICATION			!	family member being			
-	IDENTIFICATION During orientation and	d throughout the year, staff				They		
		bservation and reporting	•	-	inappropriately touched . They			
	Important information	about resident care,		1	were asked by the Director of			
:		Staff and vendors are	:	Nursing if they were aware of any				
	mandated to report, ir which abuse and neg	ntervene in situations in lect has occurred or		other instances of resident				
;		ce. Staff is to immediately		:	Inappropriate behavior.	No		
	report allegations and	or observations of abuse	_	1	additional concerns were			
i		trative and supervisory staff	:		identified.	3 1 1		
:	will supervise staff to behaviors.	шенину шарргорласе	•		испинси.	•		
:	:		:	:	3. 2/7/12 and 2/8/12 Th	ie ·		
1	PREVENTION			:	Nursing staff were instru			
:	Provide staff informati	tion on how and to whom			observe resident's #1, #8			
:	they may report conce							
		e fear of retribution; and			#10, for and signs, such a	is cryilig,		
	provide feedback rega	arding the concerns that		:	Increased anxiety, new			
		. The facility will review			behaviors, physical injuri			
	-	neglect and incidents in an s/patterns and to maintain a			as bruising, etc., Observa	as bruising, etc., Observations		
	safe environment for			:	will be on-going. No changes			
	DD AMM AM A				have been noted in these			
1	PROTECTION The facility will immed	flately protect the resident,						

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OL. TIL	TO I OIT MEDIONILE OF	MICDIONID OFICEIONS			ONID NO. 0936-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345197	B. WNG_		02/10/2012			
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE				
WILLOW	RIDGE OF NC LLC			237 TRYON ROAD				
				RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION			
E 228	Continued France	- 00		resident's behaviors or				
r 220	Continued From page		F 226	6 demeanor.				
	 identify_the perpetrate the resident care are: 	or, remove the resident from		demedia				
		ector of Nurses. Other		4. 2/9/12-Twenty- Nine (29)			
	residents who may ha	ave potentially been affected		Resident familles were con				
		ified and a plan of care will		by the DON, MDS nurse or				
	their safety.	sed as appropriate to ensure		Worker, to determine if th				
	NU COTIONTION			were aware of any inappro				
	INVESTIGATION			resident to resident	•			
		and actual or suspicious		contact/abuse and educat	ed to			
	crimes will be reporte	d and investigated.		immediately report any co				
	REPORTING		÷	Messages were left with 1				
:				;				
		use violations and all		additional families. No fan				
		ls to the State Agency and		contacted reported any co	ncerns.			
		gencies as required, and rective actions depending						
		rective actions depending rective actions depending rective actions depending		5. On 2/8/12 the Social W				
1		al law enforcement agency		completed interviews, wit	h thirty			
	any suspicion of a crit			four (34) alert and intervi	ewable			
	1 Resident #1 was a	dmitted to the facility with		residents, to ascertain if th	nere			
;	diagnoses including s	enile dementia, anxiety and		were any other incidents	of			
	osteoporosis.	, ,		inappropriate resident to				
	Davidson af the Letter LA			resident contact noted. Ti	nev			
	MDS) dated 11/07/11	nnual Minimum Data Set I revealed Resident #1 was			•			
		tally dependent on staff for		were asked if they felt safe or if				
:		ities of Daily Living (ADL).		anyone had made them for				
•	In addition the MDS re	evealed Resident #1 had		uncomfortable. No addition	onal			
		tions and was impaired er and lower extremities.		concerns were identified.				
:		the MDS with severely						
	impaired cognition.	,		6. 2/8/12 and 2/9/12 - N	inety-			
	Dovinu of the austin	Manager and a fire		two employees were				
	Review of the nursing	progress notes for		the state of the s				

interviewed by department

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				ONID INC	ONID NO. 0936-039 I	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MC A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLET		
			B. WNG		<u> </u>	C	
		345197		,	02/1	0/2012	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
WILLOW	RIDGE OF NC LLC			237 TRYON ROAD RUTHERFORDTON, NC 2	3843Q		
	CIGHIADVOY	AYENGIN OF BESIGNINGS					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATE EFICIENCY)	(X6) COMPLETION DATE	
F 226	Continued From page	o 21		heads, and as	ked if they have		
. 220	: Resident #1 revealed		1.	observed any	observed any inappropriate		
	documentation:	-		resident to re	esident contact. All		
	02/06/12 at 10:51 PM			staff member	rs who were not		
	Inappropriately touch (Resident #2) as a lat	eo by male resident, le entry for: 02/01/12 at 9:30		available for	Interview will be		
	PM Resident #1 was	sitting in the hallway in her		removed from	m the schedule until		
		occurrence happened. Also vas notified on 02/02/12,		such intervie	w is completed by		
	-	ied in AM on 02/07/12,		the departme	ent head. No		
	02/08/12 at 2:42PM fa	amily RP notified at 9:00		additional co	ncerns were		
	: AM. :			identified.			
	An interview on 02/06	3/12 at 3:20 PM with LN #5		PROCESS IMPLE	MENTED TO		
		was observed on 02/01/12		PREVENT FURTH		:	
		o 11:00 PM shift grabbing sident #1 and Resident #8)					
	breasts and groins ov	er their clothing. LN #5		OCCURRENCES		:	
		as redirected, the DON was	:	1 On 2/7 and 2/	/8/12 all available	•	
	notified and a NA was Resident #2. LN #5 v	s assigned to sit with vas not aware of how long		· ·	1. On 2/7 and 2/8/12 all available persons employed by this facility were in-serviced. All department heads were inserviced by the		
		rision continued after she		•			
	_	#5 further stated she asked					
		d to fill out an incident cted only to document her					
		or section of the medical		Regional Vice Pr			
	record.			Operations. Sta	•		
	LN #4 stated on 02/06	8/12 at 3:25 PM that on		Coordinator, Nu			
	02/01/12 the NAs (she	e did not recall whom)		inserviced the n	urses. All other		
		ad observed Resident #2		staff was in-serv	riced by their		
	inappropriately touchincluding Resident #1	ng temale residents. and Resident #8. LN #4		department ma	nagers. In-		
-	further revealed she o	onsidered Resident #2's		services contained the following:			
		buse, so on 02/01/12 she		100% completed on 2/12/12.			
		per facility policy. The Resident #2's actions under					
	behaviors in the reside				Abuse policy and		
				procedure state	s that abuse can	-	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					<u> </u>	С	
		345197	8. WN	G		02/10/2012	
	ROVIDER OR SUPPLIER			23	EET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD JTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
5.00 0			,	•	be considered physical tou	ching	
F 226	Continued From page	: 22 abuse investigations since	F	226	that is inappropriate, if it is		
		ed no abuse investigations			uninvited by the person be		
		nce involving Resident #1.		:	touched. This in-service als		
	PM. During the interviknew of Resident #2's had the SW look in to the behaviors. The D Administrator decided to address the situation #2 was on one on one noted Resident #2 has supervision over the pwas now trying to get evaluation. The DON yet started her investignappropriate behaviored Resident #2 has supervision over the pwas now trying to get evaluation. The DON yet started her investignappropriate behaviored.	ast weekend and the MD a referral for a psychiatric further stated she had not gation of Resident #2's rs. The DON confirmed		to the see to be the present of the section of the	included; 1. Identification: - Staff and vendors are mandated to report, interv situations in which abuse a neglect—based on facility reporting policy, - Staff is to immediately report allegations and/or	e rene in	
	that neither she nor the the facility during the value of through 02/05/12.	e Administrator came by veekend of 02/04/12	:		observations of abuse and neglect based on facility		
	Administrator stated fifrom the DON at 10:30 not understand Reside sexually inappropriate stated when abuse is the resident(s) to be p to be filed, a full invest	The Administrator further dentified she would expect rotected, an incident report igation to be completed, be contacted, resident(s) inge in behaviors or		angumani termi de empere de la compansión de la compansió	reporting policy, - The facility will facilitate assessment, care planning, a monitoring of residents with needs and behaviors which lead to conflict or neglect be on individualized assessment. 2. Prevention:	and n might ased	
:	twenty-four (24) hour i Carolina Health Care I	ocuments revealed the nitial report to the North Personnel Registry was :46 PM by the DON and	•	:	- Provide resident, familie and staff information on ho - Provide resident, familie - Provide resident r		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345197	B. WING		C 02/10/2012	
	ROVIDER OR SUPPLIER		237	T ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
F 226	2. Resident #8 wa	-	F 226	to whom they may report concerns, incidents, and grievances without fear of retribution; and provide for regarding the concerns the been expressed.	f eedback	
	dated 12/21/11 rev ambulatory and rec Activities of Daily L In addition the MDS impaired bilaterally	t Minimum Data Set (MDS) ealed Resident #8 was not quired extensive assistance for iving (ADL). S revealed Resident #8 was on lower extremitles. She te MDS with severely impaired		- The facility will review reports of abuse and negon injury of unknown origin incidents in an effort to it trends/patterns and to make a safe environment for mand staff. Analysis and	lect, s, dentify naintain	
	Resident #8 reveal documentation: 02/06/12 at 10:47 F Inappropriately tour (Resident #2) as a	PM Occurrence type: ched by male resident, late entry for: 02/01/12 at 9:30	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	corrective/responsible a plans will be coordinated the Quality Assurance Committee.		
	wheelchair when the noted the Physician family RP notified of 02/06/12 at 10:48 Finappropriately tout (Resident #2) as a PM Resident #8 we the occurrence hap "physician notified properties."	as sitting in the hallway in her be occurrence happened. Also have notified on 02/02/12, an 2/6/12 at 9:10 PM. PM Occurrence type: ched by male resident, late entry for: 01/29/12 at 3:49 as sitting in the hallway when pened. Also noted: but on MD book for review on the protified on 2/6/12 at 9:10		3. Protection - When abuse or a conviction witnessed the 1 ST that had one is to protect the read all other residents further abuse or crimes once you as the emposuspect abuse or a crimes	as to be esident from :. ployee	
<u>į</u> :		ician's communication book y LN #1 dated 01/29/12 (no		must stay with the residence situation to protect then	ent in the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С	
		345197	B. WNG		02/	10/2012	
NAME OF PR	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	RIDGE OF NC LLC			37 TRYON ROAD UTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULO BE	(X6) COMPLETION DATE	
F 226	Continued From page	o 24	F 226	- You then must then cor	ntact		
	time) which stated sta		:	help to report "who" the al	eged		
	touching Resident #8's breast.			perpetrator is.			
	Review of the "Manag	ger's on Duty" report dated		- This can be reported to	а		
		d in Resident #8's room		charge nurse or departmen			
	holding her hand.			head.			
	During an interview of	n 02/06/12 at 12:05 PM,	:	ileau.			
	=	A) #1 revealed, that on	:	- You must not leave the			
		ng on the first shift she had		resident while the reportin	g		
	pulled Resident #2 in Resident #8 four time	his wheelchair away from	1 1		U		
		s. NA #1 stated she It Resident #2 had been		occurs.			
:	rubbing the leg of Res	sident #8 up to her groin.	,	- Once the Nurse or			
-		d later that day the Director		Department head arrives, I	eport		
· :		ne to the nursing station. N of what happened. NA #1	:	what you observed and wh			
1		DON to "keep an eye" on	:	•	10 13		
1	Resident #2 and not le	et him around the female		the alleged perpetrator.			
	residents.		:	- The Nurse/Departmen	t Head		
į		/12 at 3:20 PM with LN #5		must then immediately loo	ate		
		was observed on 02/01/12 11:00 PM shift grabbing		the perpetrator and imme	diately		
		sident #1 and Resident #8)		remove them from area of			
	breasts and groins over	er their clothing. LN #5		residents.			
		as redirected, the DON was		residents.			
	notified and a NA was Resident #2. LN #5 w	assigned to sit with as not aware of how long		- You must not leave the	е		
		ision continued after she		abused perpetrator alone.			
		5 further stated she asked		and and beat beat and			
		d to fill out an incident ited only to document her		- You must then immed	iately		
		red only to document her or section of the medical		notify the Administrator o	f the		
	record.			situation.			

LN #4 stated on 02/06/12 at 3:25 PM that on

CENTER	O FUN MEDICARE &	MEDICAID SERVICES	. ,-			OMB I	NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WAN	1G			С
		345197				02	2/10/2012
	ROVIDER OR SUPPLIER RIDGE OF NC LLC				ET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD		
********				RL	JTHERFORDTON, NC 28139		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION CAYE
F 226	Continued From page	295	E	226	- From this point you fo	ollow	
		e did not recall whom)	Г	220	the direction of the		
	•	ad observed Resident #2			Administrator.		
	including Resident #1	and Resident #8. LN #4 considered Resident #2's		:	4. Investigate:		
	reported it to the DON	buse, so on 02/01/12 she I per facility policy. The			- The Administrator or	Director	
DON told her to chart Resident #2's action							
	behaviors in the resid	ent's medical record.			the investigative process	to	•
	: : Subsequent interview	s with staff concerning			include:		:
	these incidents revealed:			:	- Interview the resider	nts	
	An interview was con-	ducted with activity assistant		1	involved		
		at 10:00 AM. AA #1 stated					:
,		nt #2 touch Resident #8's			 Interview of staff that 	st had	÷ :
:	breast over her clothin	ng around lunch time on			contact with the residents		± :
	01/29/12. AA #1 furth				involved in the allegation of	f	
!		the incident to Licensed	-			1	
	Nurse (LN) #1 who wa Resident #8's licensed				abuse		:
;	Treatdent no a nochaot	a noise on this sint.					
	A telephone interview	on 02/07/12 at 11:00 AM			- Interview other aler		:
		nat AA #1 told her that she			oriented residents who had	l the	
		touch Resident #8's breast			opportunity to observe the		
	•	nd lunch time on 01/29/12.			alleged abuse.		
;		ont #2 was removed from b's station and assisted to			anegea abase.		
		stant. LN #1 stated she			- Interview any kno	wn	
	documented the incide				•	1114	<u> </u>
	communication book,				witness.		
	•	on to the second shift				9	
:) nurse (LN #2). No other			- assess all involved		
	interventions were put	into place.	residents for signs and				
•	the last survey revealed	abuse investigations since ad no abuse investigations nce involving Resident #8.			symptoms of abuse	ì .	

DEPARTMENT OF HEALTH AND MUMAN SERVICES

PRINTED: 02/24/2012

DEFAIL	LIMITAL OF BEALLINA	NU NUMAN SERVICES				FORM APPROVED)	
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED		
			B. WA	IG	·	С		
		346197				02/10/2012	_	
NAME OF P	ROVIDER OR SUPPLIER			ſ	T ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	RIDGE OF NC LLC			l	TRYON ROAD			
		· · · · · · · · · · · · · · · · · · ·		RU'	THERFORDTON, NC 28139			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID oper	IV	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI			
TAG			PREFIX TAG		CROSS-REFERENCED TO THE APPR			
					DEFICIENCY)		_	
F 000			•	•	E Donorting			
F 226	Continued From page	e 26	F	226	5. Reporting			
	The DON was intervi-	ewed on 2/6/2012 at 1:20		į	- The Administrator or			
	PM. During the interv	iew the DON reveated she		1	Director of Nursing will be			
		s behaviors on 1/30/12 and it but did not follow up on			responsible for reporting th	ne		
		ON stated she and the	abuse allegation to all State and					
	Administrator decided on Friday (02/03/12) night				-			
		on on 2/6/2012 as Resident			Local Authorities per requir			
	#2 was on one on on	e supervision. The DON			time frames as mandated t	ру		
	•	d been on one on one			regulation.			
		past weekend and the MD a referral for a psychiatric			_			
		I further stated she had not			b. Immediately protect all			
		gation of Resident #2's	residents when inapprop			ate		
	•	ors. The DON confirmed			resident to resident contac	et is		
	that neither she nor the	ne Administrator came by weekend of 02/04/12			identified, by staying with	the		
	through 02/05/12.	HOOKONG OF OPTO-17 TE	-		resident to protect them.			
				,	must immediately notify th			
		n 02/06/12 at 3:50 PM the			•	ic.		
:		hat prior to the phone call 0 PM on 02/03/12 she did			administrator.			
:	not understand Resid							
		e. The Administrator further			c. Immediately report all e	events		
<u>.</u>		identified she would expect			of inappropriate resident t	0		
	the resident(s) to be p	protected, an incident report			resident contact to the			
:		tigation to be completed,			Administrator. If the			
	to be observed for cha	o be contacted, resident(s)			Administrator is not availa	hle		
:	demeanor and interve							
		pus and place.			 the employee reporting th 	e		

Review of the facility documents revealed the

twenty-four (24) hour initial report to the North

Carolina Health Care Personnel Registry was faxed on 02/06/12 at 9:46 PM by the DON and

the Sheriff's office was notified by the

Administrator on 02/08/12 at 10:45 AM.

Nursing.

alleged abuse should report it to

his/her supervisor who contacts

the Administrator or Director of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	IS FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	Oivio	NO. 0938-039 I	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345197	B. WA	1G		0	C 2/10/2012	
NAME OF PE	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>	<u></u>	
WILLOW	RIDGE OF NC LLC			1	7 TRYON ROAD			
				RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	: (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX :	POMOER'S PLAN OF CORRE (F. ARRECTIVE ACTION SHOOL OF THE APPLICATION	IOULD BE	(X5) COMPLETION DAYE	
F 226	: : : Continued From page	e 27	F	226	d 3/9/13 Abusa nalisy ray	rised to		
		admitted to the facility with	;		•	d. 2/8/12 Abuse policy revised to		
		dementia and anxiety.	-		state nurses are to immed			
	Davis version of the second	ALLEGO CONTRACTOR OF THE STATE			fill out an incident report a			
		rly Minimum Data Set (MDS) ed Resident #9 was non		:	submit it to the DON; call	the		
		red extensive assistance for		:	physician; notify			
	activities of Daily Livi	ng (ADL). She was			family/responsible party a	it the		
		with severely impaired			time of the occurrence. In	-service		
<u>.</u>	cognition.			į	was conducted by the Uni			
	Review of the nursing	progress notes for		1	Managers, DON, departm			
	Resident #9 revealed the following			-	-			
	documentation:			i	heads on 2/8/12. The Nur			
į	02/06/12 at 10:55 PM Inappropriately touch			1	Responsibilities when alle			
1		e entry for: 02/03/12 at 8:21		i i	abuse is suspected and th	e		
1		sitting in the hallway when		1	facility's Policy and Procee	dure on		
:	the occurrence happe			į	Abuse was placed at each	Nurses		
	notified on 02/06/12 a	on 02/02/12, family RP			station.			
			:					
-		les dated 02/03/12 at 11:48	•		e. All staff should report	to their		
		ocumented AA #2 reported Resident #2 in Resident #9's			Immediate supervisor and	dexpect		
:		the resident's groin. AA #2			feedback from that super	visor		
	attempted to remove	Resident #2 from the room		:	that an investigation has	been		
		ame combative and tried to was removed from the room			initiated, if feedback not			
:		se's desk. LN #2 contacted			provided, staff should con	ntact		
	-	(NP) about Resident #2's			Administrator directly. Th			
		quently called the DON.			•	ic		
		2 back and was told to have #2 at all times. Resident			Administrators contact			
					information is posted at e			
		hysician (MD) called at 10:30 PM. LN #2 ned Resident's #2's behavior had escalated			Nurses station and in eve	ry		
	on 02/03/12. The MD asked for the DON's phone				ancillary department.			
	number. The MD call with new orders for ar	ed LN #2 back at 10:50 PM antipsychotic and						

· · · · · · · · · · · · · · · · · · ·		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345197	B. WIN	G	·		C)2/10/2012	
NAME OF PROVIDER OR SUPP WILLOW RIDGE OF NC L		· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CO 237 TRYON ROAD RUTHERFORDTON, NC 28139		<u> </u>		
PREFIX (EACH I	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
DON would be to arrange for Subsequent in these incider. During a tele PM, LN #3 sto O2/03/12, she hand on Resistated she reand kept Resonot fill out an information to Review of the last surveron file for this. The DON was PM. During the knew of Resist had the SW letter behaviors Administrator to address the #2 was on on noted Reside supervision of was now trying evaluation. The yet started he inappropriate that neither sides.	nedication be calling an Reside interview has reveal the phone interview dent #9 incident #9 incident #9 incident #9 incident #9 ook in too. The Down interview dent #2 ha ver the pag to get the DON or investibehavious control to the nor the proper investibehavious control to the nor the proper investibehavious control to the proper investible proper inves	n. Also the MD stated the g in the morning (02/04/12) nt #2's transfer to a hospital.	: :	226	f. Any staff member the unable to attend the Aservice will not be allowed work until they receive service by the Unit Made Department Head or Some Development Nurse. It completed on 2/12/12 g. The Administrator or immediately report any allegations of abuse to the Regional Vice President Operations or Chief Clin officer for proper guidar Administrator or Director Nursing will report to the authorities within 2 house serious bodily injury occur there is a reasonable succrime. 2. The 24 hour report reflection of any unusuin resident's conditions	buse in- wed to e this in- mager or taff 00% DON will he of ical mce. The or of me proper ars if curs, or if aspicion of		

OF 151 F1	CO TOTALLEDIONINE OF	MILDIONID OLIVIOLO				OND 10. 0330-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING	ß		C
		345197				02/10/2012
	ROVIDER OR SUPPLIER			237	IT ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
F 226	Administrator stated of from the DON at 10:3 not understand Residually inappropriate stated when abuse is the resident(s) to be it to be filed, a full investamily and physician to be observed for chedemeanor and intervence Review of the facility twenty-four (24) hour Carolina Health Care	n 02/06/12 at 3:50 PM the hat prior to the phone call 0 PM on 02/03/12 she did lent 2 's behaviors as e. The Administrator further identified she would expect protected, an incident report stigation to be completed, to be contacted, resident(s) ange in behaviors or entions put into place. documents revealed the initial report to the North Personnel Registry was 9:46 PM by the DON and s notified by the	F:	226	and Weekend Supervisor we review the 24 hour nurses of daily to note any instances behavior changes and/or occurrences of inappropriate resident to resident contact 2/9/12 nurses were in-served on including more Informative resident behaviors. Any Allegations that are identified immediately reported to Administrator. These will be discussed in the morning meeting.	report of te t. On lced tion on ied will o the
	4. Resident #10 was diagnoses including A depressive disorder. Review of the Annual dated 12/7/11 reveale ambulatory and requiactivities of Daily Livin identified on the MDS cognition. Review of the nursing Resident #10 reveale documentation: 02/06/12 at 10:54 PM Inappropriately touched.	admitted to the facility with alzheimer's disease and Minimum Data Set (MDS) and Resident #10 was not red extensive assistance for any (ADL). She was with severely impaired progress notes for dithe following Occurrence type:		to come content of the content of th	3. On 2/9/12 a Quality Ass Tool was started. This tool have department heads m rounds 5 times per week, monitoring for inappropria behaviors, interviews with and residents related to the topic, until Substantial Compliance is obtained. As that, should no further ins of non-compliance be idear rounds will be completed	will ake ste staff nis fter tances ntified, weekly
٠	Inappropriately touched by male resident, (Resident #2) as a late entry for: 02/03/12 at 2:45 PM Resident #10 was sitting in the dining room when the occurrence happened. Also noted the				by the managers thereafte information will be monito	

OLLIN I C	COT ON MEDIONICE G	MICOSONID OF MAIOEO			OND NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WNG		С	
	·	345197			02/10/2012	
	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD		
WILLOW	RIDGE OF NC LLC			RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 226	Continued From page	30	F 22	the Quality Assurance Co	ommittee	
	•	d on 02/03/12, family RP	1 22	monthly and any necessary		
	notified on 02/06/12 a			actions taken. The Quali	ty	
	. Nursing notes dated (02/03/12 at 4:48 PM		Assurance Tool instructs	the staff	
	revealed LN #2 docur	mented Activities Assistant		member to observe, an	į.	
-		ne nurse Resident #2 was		question residents and		
		hing Resident #10's breasts. ident #10 and Resident #2.		see if there was any	1	
:		ed she notified the social	;	inappropriate resident	:0	
worker (SW) and the DON of this incident and				resident contact; heard		
	assigned all staff on A hall to monitor Resident #2			resident/family compla		
-		40.		observe or receive a re		
		s with staff concerning				
	these incidents reveal	led:		inappropriate resident		
	During interview on 03	2/07/12 at 10:00 AM, AA #1		resident contact. They		
	stated that on 02/03/1		:	employees the first thi		
1 2 2		hing Resident #10's breast		to do when they obser		
	dining room. AA #1 s	e they were seated in the tated that she moved	:	of inappropriate reside	nt to	
ì	Resident #10 to anoth	ner table and reported the	1	resident contact, ask e	mployee	
:	incident to LN #2.		-	to whom they should r	eport this.	
į	During a telephone int	terview on 02/06/12 at 5:35		This will be conducted		
1		on 02/03/12 she told the		shifts. The Quality Ass		
		s observed inappropriately		Tool will gather the re		
		D's breasts. LN #2 asked I fill out an incident report		information, which wi		
		to document Resident #2's				
		She further stated the		to the morning meeting		
	DON called back after			will be discussed and		
		e practitioner (NP), and Resident #2 on one on one		negative responses w		
	Instructed staff to put Resident #2 on one on one supervision.			handled immediately		
:	Davidson of a 1			administrator or his/h	er	
1	Review or nursing note PM revealed Resident	es dated 02/05/12 at 9:21 t#2 was trying to approach		designee.		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
	345197	B. WING		02/10/2012	
NAME OF PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE		
WILLOW RIDGE OF NC LLC		1	RYON ROAD HERFORDTON, NC 28139		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION	
F 226 Continued From p	age 31	F 226	4. Beginning on 2/9/3	L2 any	
1	nursing note stated Resident	:	residents displaying		
	was on one on one		inappropriate behavi	ore ware	
	ceived as needed medication.		•••		
		-	assessed and their ca	=	
	ity abuse investigations since	:	were reviewed and u		
	ealed no abuse investigations rrence involving Resident #10.	· I	appropriate actions.	This was	
ON THE TOT THIS OCCU	atonos atyviving Nosidolit #10.		completed by the MD		
The DON was inte	rviewed on 2/6/2012 at 1:20				
PM. During the inte	erview the DON revealed she	1	5. On 2/17/12 all Nur	se	
	#2's behaviors on 1/30/12 and		Managers were in-se		
	to it but did not follow up on		•		
	DON stated she and the		the Chief Clinical Offi	cer on;	
	ded on Friday (02/03/12) night			. :	
	ation on 2/6/2012 as Resident one supervision. The DON	:	a. The facility's Skin	tear/bruise	
	had been on one on one		Policy and Procedure	·.	
	e past weekend and the MD		Toney una Troopin t	•	
	get a referral for a psychiatric		b. Properly investig	ating Skin	
	ON further stated she had not	. :			
	estigation of Resident #2's		Tears and Bruises to	rule out	
=	viors. The DON confirmed		Abuse.		
that neither she no	r the Administrator came by				
	ne weekend of 02/04/12	1	c. How to properly	investigate	
through 02/05/12.			possible causative fa		
During on interview	00/00/40 -+ 0.50 DM +b-		•		
-	v on 02/06/12 at 3:50 PM the		may have contribute		
	d that prior to the phone call 0:30 PM on 02/03/12 she did	•	tear or bruise such a	s; Resident	
	sident 2's behaviors as	:	and staff statements	·	
	ate. The Administrator further		medications, behavi		
	is identified she would expect				
the resident(s) to b	e protected, an incident report	<u> </u>	conditions and envir	onmental	
	estigation to be completed,	1	factors.		
	in to be contacted, resident(s)	1			
	change in behaviors or		d. The facility's Qua	alitv	
demeanor and inte	rventions put into place.				
1			Assurance Investiga		
2010 010 000700 001 0	.		 Skin Tears and Bruis 	es.	
RM CMS-2567(02-99) Previous Versions	Obsofele Event ID: 71 Of	511 Facility	•	Dana 32	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245407	B. WING		C			
NAME OF B	ROVIDER OR SUPPLIER	346197			02/10/2012			
	RIDGE OF NC LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139					
(X4)1D PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION			
F 226	Continued From page	∋ 32	F 226	e. The requirement th	at these			
	Review of the facility	documents revealed the		be reviewed daily as the	ey occur,			
		initial report to the North		orders obtained as nee	ded,			
		Personnel Registry was 9:46 PM by the DON and		interventions implemen	nted as			
	the Sheriff's office wa	s notified by the	٠	appropriate, care plans	updated			
	Administrator on 02/0	98/12 at 10:45 AM.		and revised as necessar	•			
	The administrator wa	s notified of the immediate		Suspicious skin tears/br	•			
	jeopardy on 02/8/12 at 9:50 AM. The facility			a plausible causative fa				
		llegation of compliance on		not be derived from a				
		2/10/12 at 4:24 PM. The following interventions ere put into place by the facility to remove the		investigation be reporte	ed as a			
	Immediate Jeopardy:			treated as a possible Ak				
	Credible Allegation of	Compliance:	:	scenario. If Abuse can n	:			
	·	ompliano.	•					
		Resident #2 was assigned	ruled out, these events will be reported and investigated as					
		with him at all times. The d until resident #2 was						
		acility to the hospital on	Alleged Abuse cases. 6. The 7 types of abuse was posted in numerous visual areas					
	02/08/12 at 12:05 p.n	1.						
	: 02/08/12 Administra	tor called the County		In the facility on 2/14/12				
	Sheriffs Office to repo	ort a possible crime, related	-	In the facility on 2/14/12				
		ehavior of resident #2. TIFY OTHER RESIDENTS		7. The contact phone num	bers			
	AT RISK	III I OTTIEN NEGIDEIYIO		for the Administrator, Dire	ector of			
	1. 2/6/12 and 2/8/12			Nursing, Social Service Dir	ector			
		, with thirty four (34) alert idents, to ascertain if there		and the Corporate Compli	ance			
		nts of inappropriate resident		Hotline was posted in nun				
		ted. They were asked if they		visual areas in the facility				
	felt safe or if anyone is uncomfortable. No ac	nad made them teet ditional concerns were	2/13/12. This will allow staff,					
	identifled.		families and outside vendors to					
:	2. On 2/6/2012 comp Unit Charge Nurses to	lete body audits done by the		immediately contact Key f				
		idents #1, #8, #9 and #10,		staff if they have concerns				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				OWR VC	<u>). 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345197	B. WN	IG		4	0/2040	
		340167	ŀ	Т		02/1	0/2012	
	ROVIDER OR SUPPLIER			1	ET ADDRESS, CITY, STATE, ZIP CODE ' TRYON ROAD			
WILLOW	RIDGE OF NC LLC			RU	THERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
F 226	Continued From pag	ue 33	F	226	8. On 2/10/12 the facilit	:у		
	· -	as being inappropriately	•	1	implemented a weekly I	Resident		
	touched by resident #2. Results of this audit revealed no visible bruising or signs of physical trauma.			:	Council meeting. This m	eeting		
				1	will allow the residents	to voice	Ī	
	3. On 2/6/2012, resi	idents # 1, #8, #9, and #10's		ļ	any concerns that they	may have.		
		parties were contacted by ng to notify them of their			If concerns are identifie	d, these		
:	•	inappropriately touched.			will be immediately rep	orted to		
		the Director of Nursing if			the Administrator per t	he	:	
:		any other instances of le behavior. No additional ified		1	grievance policy.			
	,	The Nursing staff were		:	9. On 2/17/12 the Adm	inistrator		
	•	ector of Nursing to observe			and Director of Nursing	were		
		9 and #10, for and signs, ased anxiety, new behaviors,	:		placed on a mentorship	program.		
; 1 :	physical injuries, suc	ch as bruising, etc.,		1	This mentorship will be			
:		on-going. No changes have	•	:	by the Regional Vice Pr		•	
; :	been noted in theses demeanor.	s resident's behaviors or		:	and the Chief Clinical O		:	
	5. 2/9/12- Twenty-	Nine (29) Resident		:	mentorship will be con			
		parties were selected at			weekly for 4 weeks. At			
		ed by the DON, MDS nurse determine if they were aware			•			
	of any inappropriate	resident to resident	•		an evaluation of progre		:	
		ducated to immediately			completed for the goal		:	
		Messages were left with 11 lo family contacted reported			After the 4 weeks the (-		
:	any concerns.	o laminy demanded reported			Executive Staff will rev			
: !		- Ninety-two employees	•	:	plan and at that time n	nake the		
1		department heads, and		;	necessary revisions to	ensure		
	asked if they have observed any inappropriate resident to resident contact. All staff members		that the residents of the facility					
	who were not availab	ole for interview will be	are properly cared for. This					
:		hedute until such interview is partment head, No additional		-	program will;			
		NEWTER TO DREVENT					:	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, 1	LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245407	B. WI	1G			C
		345197	L				10/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
	41414407.07	ATCHENT OF OFFICIALISTS		٠.	PROVIDER'S PLAN OF CORR	ECTION	:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF OEFICIENCY)	10ULD BE	(X6) COMPLETION DATE
F 226	Continued From page	ued From page 34 F 226 a. Identify strengths		a. Identify strengths		;	
	FURTHER OCCURR	ENCES	•	1	1. Identify arous that r	aad	
		all available persons		:	b. Identify areas that r	ieeu	:
		lity were In-serviced. All		:	improvement.		:
	department heads we						
	1	ent of Operations. Staff			c. Provide Corporate d	lirection	
		nator, Nurse Managers,		:	and guidance.		
	in-service the nurses.				una garasiros		
	in-serviced by their department managers. In-services contained the following: a. The facility's Abuse policy and procedure states that abuse can be considered physical			:	d. Direction on State/	Federal	
					and corporate expecta	tions.	
	touching that is inapp	ropriate, if it is uninvited by			t		
	the person being touc			-	e. Provide realistic go	ais.	•
	 b. Immediately prote 			•			į
		t to resident contact is		•	f. Provide weekly		
		with the resident to protect			documentation and fed	edback	:
	them. You must imme administrator.	ediately flothly the		:	towards the achievement		
		all events of inappropriate	1			cite of the	
		ontact to the Administrator.			goals.		
		not available, the employee					-
		abuse should report it to	:	:	10. On 2/17/12 a all st		-
	his/her supervisor wh	o contacts the Administrator		1	Directed in-service wa	ıs	
1	or Director of Nursing			1	conducted by a repres	entative of	-
-	-	y revised to state nurses are		-	The Adult Protective S		
:		an incident report and		-	Department. This In-se		
;		call the physician; notify			•		
		rty and the administrator at			included:		
	the time of the occurre				a. Signs and symptoms	s of abuse.	
:	conducted by the Unit department heads on			į	a. Signs and symptom		:
:	e. All staff should repo			:	b. Types of abuse.		
1	supervisor and expect				D. Types of abuse.		
	supervisor that an inve		c. Preventing abuse.				
		ot provided, staff should	c, Preventing abuse.				
:		directly. The Administrators			d. Protection against a	abuse.	:
	contact information is station and in every a	posted at every Nurses ncillary department.			a. i forcotion against		:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SUI COMPLET	
		345197	B. WNG			ļ.	C 0/2012
NAME OF PE	ROVIDER OR SUPPLIER			STREET AL	DDRESS, CITY, STATE, ZIP CODE	·	
WILLOW	RIDGE OF NC LLC				ON ROAD		;
WILLOW	MIDOL OF NO ELO			RUTHE	RFORDTON, NC 28139		
(X4) ID PREFIX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.O BE	(X5) COMPLETION DATE
F 226	! Continued From page	. QK	F 2	26 	e. Protection of resident	s when	•
			l' 2.	20	abuse is suspected.		
	f. Any staff member that is unable to attend the Abuse in-service will not be allowed to work until						-
		rvice by the Unit Manager		-	f. Immediately reporting	abuse.	
		or Staff Development Nurse.					
		or DON will immediately			MONIT <u>ORING</u>		
		of abuse to the Regional		:	<u> </u>		
	Vice President of Ope	erations or Chief Clinical			1. The DON and Unit Ma	nagers	į
		ance. The Administrator of			will continue review the	_	1
	Director of Nursing wi			i			ē
		urs if serious bodily injury			24 hour report to for an	У	-
		ours of a suspicion of crime.		:	documented instances of	of	•
	h. The 24 hour report	esident 's conditions and			inappropriate resident t	0	
	behaviors in the last 2					_	
	2/9/2012,the Director				resident contact or any		į
		and Supervisor will review	:	;	allegations of abuse. Ful	rther	
į	the 24 hour nurses re		:		Education and possible		
	instances of behavior	changes and/or	•	1			-
!		opriate resident to resident		:	disciplinary action will oc	cur as	•
		rses were in serviced on			needed.		;
		ation on resident behaviors.			110000		
!		use that are on the 24 hour		1	2. The Department head	ls will	
	the Administrator.	immediately reported to			continue to complete the		
2		y Assurance Tool will be	•				-
:		nave department heads			Quality Assurance round	s tor	
		per week, monitoring for			abuse until substantial		
:		rs, interviews with staff and			compliance is obtained.	At that	
	residents related to th				•		
	weeks. After that, sho			:	time the Quality Assurar		
		unds will be made weekly.		:	committee will review th	nis	
		e monitored by the Quality			process and these round	is will	-
	Assurance Committee necessary actions take	omonthly and any on. The Quality Assurance		:	conducted weekly there		;
	•	member to observe, and		į	•		
		d staff to see if there was			each Department Head.		•
		dent to resident contact;					
		nily complaints; observe or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B. WIN	ß	·	C 02/10/2012	
NAME OF PE	ROVIDER OR SUPPLIER			0700	ET ADORESS, CITY, STATE, ZIP CODE	V211	0/2012
	RIDGE OF NC LLC		237 TRYON ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	: ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	Л.D BE	: (X6) COMPLETION DATE
	resident contact. They first thing they are to a hear of inappropriate ask employee to who. This will be conducted Assurance Tool will g information, which will meeting, where it will negative responses who the administrator of 3. Beginning on 2/9/11 inappropriate behavior have their care plans appropriate actions who occurrence. Correction made. This will be contact or MONITORING 1. The DON and Unit review the facility's 24 documented instances to resident contact or Further Education and will occur as needed. 2. The Department had complete the daily Quabuse until substantia At that time the Qualit review this process are determine the frequent continue to be completed to the Admin Be fully investigated a	ppropriate resident to y wilf ask 2 employees the do when they observe or resident to resident contact, in they should report this. If on all shifts. The Quality either the relevant I be taken to the morning be discussed and any will be handled immediately or Director of Nursing. I any residents displaying or will be assessed and reviewed and updated for or ithin 24 hours of one or additions will be impleted by the MDS nurses. Managers will continue or hour report to for any or of inappropriate resident any allegations of abuse, of possible disciplinary action and will continue to ality Assurance rounds for or compliance is obtained, or y Assurance committee will or these rounds will or that rounds are to ted as a Quality Assurance buse will be immediately istrator. The allegations will or reported per regulations.		226	3. All allegations of Abube immediately reported Administrator. The allegations will be fully investigated reported per regulations. Administrator will notify Regional Vice President the Chief Clinical Officer guidance and to ensure a facility's policy has been followed. 4. The Regional Vice President will provide guidance and support to the facility or reported Abuse scenarion. 5. The weekly Resident of Meeting will continue under Substantial Compliance obtained. At that time the Resident Council will vow whether to continue this practice. 6. The results of the Quidance of the Quidance of the Current of the Cu	to the ations and . The the and/or for that the officer ad neach o. Council ntil is he te on s	
:	President And/or the	notify the Regional Vice Chief Clinical Officer for that the facility's policy			Assurance monitoring to hour report, and investi		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	· · · · · · · · · · · · · · · · · · ·	345197	B. WNG		C 02/10/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
F 490 SS=J	of any inappropriate of reviewed and analyzed Assurance Committee and quarterly thereaft the committee. The immediate jeopar 02/10/12 at 5:15 PM f administrative, license all three shifts related abuse; interviews with families; review of insof staff on abuse; review of the 24 hours and review of the quaplace. 483.75 EFFECTIVE ADMINISTRATION/R A facility must be admenables it to use its reefficiently to attain or repracticable physical, nowell-being of each resulting of each resulting an environment that an environment that the victims, had not could not implemented an environment of the could be a sure of the process of the could be admenables. The facility had the victims, had not could not implemented an environment of the could be a sure of th	Quality Assurance our report, and investigations esident contact will be ad in the monthly Quality emeeting for three months er until deemed resolved by and was removed on following interviews with ed and direct care staff on to mandatory education on a residents; interviews with service rosters on education ew of revised abuse policy; as communication sheets; lity assurance tool put into the service in a manner that isources effectively and maintain the highest mental, and psychosocial ident. Is not met as evidenced ews and record review, the that four (4) of five (5) inpaired female residents not consistently identified anducted investigations and	F 490	any inappropriate reside contact will be reviewed analyzed in the month! Assurance Committee of three months and quarterity the after of the next 3 months, the quarterity there after. The services will review the Abuse Policy and Process facility will attempt to Outside speakers with Prevention knowledge these in-services. 8. The Medical Director consulted on these allest the facilities processes interventions implement suggestions and/or guifacility will continue to the Medical Director in Quality Assurance proseek guidance, support	d and y Quality meeting quarterly d resolved will be staff for n chese in- e Facility's edure. The arrange Abuse to provide r was egations, inted, idance. The o involve n the cess and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	<u>KS FOR MEDICARE & </u>	MEDICAID SERVICES				OWR V	<u>0. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345197	8. WN	G		1	C 10/2012
MANE OF D	ROVIDER OR SUPPLIER	040107		<u></u>			10/2012
TOTAL OF TH	NOVIDEN ON BOFFEIER			I	T ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD		
WILLOW	RIDGE OF NC LLC		RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Continued From page	e 38	F	490	further educational needs	,	
	actual and potential sexual abuse. In addition, the				9. The Regional Vice Presi	dont	
		failed to implement their ify, prevent, protect and		;	and/or the Chief Clinical or		
	investigate an allegal	tion of abuse. Facility staff		:	•		
		e inappropriate sexual le resident (Resident #2)		:	will provide weekly onsite guidance for the next 30 d		
	· toward four (4) samp		:	•	ays.		
- :	(Residents #1, 8, 9, a				After 30 days a Corporate Executive Meeting will occ		
	: Immediate jeopardy t			-			
	staff became aware of				review the facility's progre		:
		ing Resident #8. The			obtaining substantial com	piiance.	
		tified of the immediate 2 at 9:50 AM. Immediate		1	After 30 days a Corporate		
	jeopardy was remove	ed on 02/10/2012 when the	:		Executive Meeting will occ	ur to	
		implemented an acceptable compliance. The facility will		1	review the facility's progre		
	remain out of complia	ance at a scope and severity			obtaining substantial com		; ;
	than minimal harm th	at is not immediate			Executive Meeting will o	ccur to	
		e employee education and stems put in place are			review the facility's prog		
	effective.	stems put in place are			obtaining substantial co		
	The findings are:				10. On 2/17/12 the Adm	inistrator	:
	Cross Reference i	F223 Rased on staff		:	and Director of Nursing		
:		review, the facility failed to			placed on a mentorship		
:		gnitively impaired residents		:	This mentorship will be	-	
	(Residents #1, 8, 9, 10) were protected an allegation of abuse. Facility staff it			:	by the Regional Vice Pre	-	
:	knowledge of the inar	ppropriate sexual behaviors			and the Chief Clinical Of		•
		(Resident #2) toward four			mentorship will be cond		
:	(4) sampled female residents (Residents #1, 8, 9, and 10).			1	weekly for 4 weeks. At t		
					an evaluation of progres		•
	Cross Reference I interviews and record	F226. Based on staff I review, the facility failed to			completed for the goals		
	"" " I LOUIS BING 160010	conon, mo monty lanca to			combiered for rue Rogiz	361 101 1111	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII	DING			l c	
		345197	B. WIN	G		02	10/2012	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET	FADDRESS, CITY, STATE, ZIP CODE			
WILLOW	RIDGE OF NC LLC			237 T	TRYON ROAD			
IIILLOII	MODE OF NO LEG		RUTHERFORDTON, NC 28139			i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
E 400	Continued From soc	- 20		400	After the 4 weeks the Co	orporate	:	
1 430	Continued From page		F	490	Executive Staff will revie	ew this		
		icies and procedures for four rely impaired residents.			plan and at that time m	ake the		
	(Resident #1, #8, #9,			1	necessary revisions to e		÷	
	resident's condition.			1	that the residents of the			
	: The administrator wa	s notified of the immediate			are properly cared for.			
jeopardy on 02/8/12 at		at 9:50 AM. The facility		:	are property carea for		:	
	provided a credible allegation of compliance on 02/10/12 at 4:24 PM. The following interventions were put into place by the facility to remove the		11. The Administ		11. The Administrator is	3	:	
				:	responsible for complia	nce.		
	Immediate Jeopardy:		=	:			1	
	Credible Allegation of	f Comptiance:						
	staff member to be w intervention continued transferred from the f 2/8/12 at 12:05 p.m. 2/8/12 Administrator Office to report a pos inappropriate behavior B. For residents#1, # On 2/6/2012 complet Unit Charge Nurses to physical injury, on resident #2. On 2/6/2012, resident familles were contact to notify them of their	#8, #9, and #10: the body audits done by the to assess any obvious sident #1, #8, #9 and #10, to being improperly touched ts # 1, #8, #9, and #10's to be the Director of Nursing family member being		to a state and an entry or against a seem coronal to the state to the same to make the same of the sam			months are and the second are also are	
	inappropriately touched. They were asked by the Director of Nursing if they were aware of any other instances of resident inappropriate behavior. No additional instances were reported. On 2/7/12 and 2/8/12 The Nursing staff were instructed to observe resident's #1, #8, #9 and #10, for and signs, such as crying, increased							

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345197	B. WING		C 02/10/2012	
	ROVIDER OR SUPPLIER		s			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	bruising, etc., Observe changes have been rebehaviors or demean PROCESS TO IDEN AT RISK 1. 2/6/12 and 2/8/12 completed interviews and interviewable resewere any other incided to resident contact not felt safe or if anyone I uncomfortable. No addentified. 2. On 2/6/2012 body Charge Nurses to assinjury, on residents #1 identified as being in a resident #2. Results ovisible bruising or sign 3. On 2/6/02012, resifamilies/responsible pthe Director of Nursing family member being They were asked by the sign of the process of the p	rs, physical injuries, such as rations will be on-going. No noted in theses resident's or. ITIFY OTHER RESIDENTS the Social Worker , with all thirty four (34) alert idents, to ascertain if there nts of inappropriate resident ited. They were asked if they had made them feet iditional concerns were audits done by the Unit itess any obvious physical if, #8, #9 and #10, who were impropriately touched by if this audit revealed no ins of physical trauma. It is a were contacted by the training the proportiately touched. In appropriately touched. In the Director of Nursing if	F 48	Dunnaustin and an et a	Imission Ider of The plan olely Federal ect all of its properly d inforcement	3/2/12
	concerns were identifi 4. On 2/7/2012 and 2 were instructed by the observe resident's #1,	behavior. No additional ed. /8/2012 the Nursing staff Director of Nursing to #8, #9, #10, for signs, such		#2 was assigned a staf to be with him at all ti intervention continue resident was discharge	mes. This d until	
1	physical injuries, such Observations will be o been noted in these re demeanor. 5. 2/9/12- Twenty- Ni	n-going. No changes have skldent's behaviors or		facility 2/8/12.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			A. BUII	LDING			С	
		345197	B. WIN	G		02/	02/10/2012	
NAME OF P	ROVIDER OR SUPPLIER	***	-	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	RIDGE OF NC LLC			237	TRYON ROAD			
				RU	THERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 490		or Social Worker, to	F	490	IDENTIFYING OTHER RES			
	· ·	re aware of any inappropriate contact/abuse and educated			1. On 2/6/2012 complete	-	;	
		t any concerns. Messages			audits done by the Unit (Charge		
	were left with 11 add contacted reported a			Nurses to assess any obv	ious			
	6. 2/8/12 and 2/9/12			physical injury, on	resident			
	were interviewed by			#1, #8, #9 and #10, who	were	:		
		oserved any inappropriate		1	touched by resident #2.	Results	•	
		ontact. All staff members ble for interview will be			of this audit revealed no	visible		
		hedule until such interview is			bruising or signs of physi	cal	:	
	completed by the dep		÷	trauma.		·		
	concerns were identi	cerns were identified.			truarra.		:	
	PROCESSES IMPLE	SSES IMPLEMENTED TO PREVENT		1	2. On 2/6/2012, residen	ts # 1,	-	
	FURTHER OCCURA				#8, #9, and #10 's familie	es were		
		all available persons			contacted by the Directo		:	
	department heads we	lity were in-serviced. All			•		1	
		ent of Operations. Staff			Nursing to notify them of	1 filesi	1	
1	Development Coordin	nator, Nurse Managers,		:	family member being		1	
:	in-service the nurses				inappropriately touched	. They	į	
į	In-services contained	epartment managers.		!	were asked by the Direc	tor of	:	
į	A. Identification:	the following.		:	Nursing if they were awa	are of any	:	
:	- Staff and vendors a	re mandated to report,		:	other instances of reside	ent		
		s in which abuse and neglect			inappropriate behavior.		:	
	based on facility repo	orting policy, ely report allegations and/or						
		e and neglect based on			additional concerns wer	E		
:	facility reporting policy,			-	identified.		:	
-		tale assessment, care		1	2 2/7/12 and 2/0/12 TI		-	
		ring of residents with needs			3. 2/7/12 and 2/8/12 Th		:	
:		might lead to conflict or ividualized assessment.		:	Nursing staff were instructed to			
	B. Prevention:			:	observe resident's #1, #	8, #9 and	į	
	- Provide resident, fai							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			1			С	
		346197	B. WIN	G		02/10/2012	
	ROMDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)				OULD BE	, (XS) COMPLETION DATE
 	Continued From page on how and to whom incidents, and grieva retribution; and proviconcerns that have be. The facility will revieneglect, injury of unk effort to identify trends afe environment for and corrective/respondordinated with the Committee. C. Protection When abuse or a detail other residents from the concerne you as the ending of the crime you must stay situation to protect the you then must there "who" the alleged per This can be reported department head. You must not leave reporting occurs.	they may report concerns, nees without fear of de feedback regarding the een expressed. The reports of abuse and nown origins, incidents in an als/patterns and to maintain a residents and staff. Analysis habible action plans will be Quality Assurance Trime is witnessed the 1ST is to protect the resident and first from further abuse or crimes. In ployee suspect abuse or a with the resident in the em. In contact help to report the resident while the resident while the			#10, for and signs, such increased anxiety, new behaviors, physical injuras bruising, etc., Observill be on-going. No chave been noted in the resident's behaviors of demeanor. 4. 2/9/12-Twenty-Name Resident families were by the DON, MDS nurse Worker, to determine were aware of any incresident to resident contact/abuse and education.	#10, for and signs, such as crying, increased anxiety, new behaviors, physical injuries, such as bruising, etc., Observations will be on-going. No changes have been noted in theses resident's behaviors or demeanor. 4. 2/9/12-Twenty-Nine (29) Resident families were contacted by the DON, MDS nurse or Social Worker, to determine if they were aware of any inappropriate resident to resident contact/abuse and educated to immediately report any concerns.	
	 Once the Nurse or Department head arrives, report what you observed and who is the alleged perpetrator. The Nurse/Department Head must then immediately locate the perpetrator and immediately remove them from area of all residents. You must not leave the abused perpetrator alone. You must then immediately notify the Administrator of the situation. From this point you follow the direction of the Administrator. D. Investigate: 				contacted reported as 5. On 2/8/12 the Socion completed interviews four (34) alert and in residents, to ascertain were any other incides inappropriate resident contact note.	ny concerns. al Worker , with thirty terviewable n if there ents of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345197	B. WNG_		C 02/10/2012
NAME OF D	ROVIDER OR SUPPLIER			ACCULATION OF A STATE AND CODE	02/10/2012
	RIDGE OF NC LLC		2	IEET ADDRESS, CITY, STATE, ZIP CODE 37 TRYON ROAD RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE : COMPLETION
F 490	Continued From p	ano 43	F 490	were asked if they felt saf	e or if
1 700	:		r 490	anyone had made them for	el
	£	or or Director of Nursing will the investigative process to	-	uncomfortable. No addition	
	include:	The hitestiguate process to			21101
		e residents Involved		concerns were identified.	
	:	staff that had contact with the in the allegation of abuse		6. 2/8/12 and 2/9/12 - N	inety-
	,	lert and oriented residents who		two employees were	:
		ty to observe the alleged abuse.		interviewed by departme	nt :
	- Interview any kn	own wittess. ed residents for signs and	•	heads, and asked if they h	•
	symptoms of abus	<u> </u>		· ·	
	E. Reporting	· ·		observed any inappropria	
		or or Director of Nursing will be		resident to resident conta	act. All
	•	porting the abuse allegation to		staff members who were	not
		Authorities per required time		available for interview wi	
	frames as mandat	ed by regulation. olicy revised to state nurses are		removed from the sched	
	•	out an incident report and			:
	!	DN; call the physician; notify		such interview is complet	ted by
:		party and the Administrator at		the department head. N	o ;
		currence. In-service was		additional concerns were	•
		Unit Managers, DON,		identified.	i
	department heads			igentinea.	
		report to their immediate pect feedback from that		PROCESS IMPLEMENTE	<u>01 C</u>
		investigation has been	ŕ	PREVENT FURTHER	
		ck not provided, staff should		OCCURRENCES	
		ator directly. The Administrators		OCCORNENCES	
		n is posted at every Nurses			
:		y ancillary department.		1, On 2/7 and 2/8/12 all	available
•	•	ber that is unable to attend the vill not be allowed to work until		persons employed by th	is facility
		n-service by the Unit Manager		were in-serviced. All de	
		ad or Staff Development Nurse.			-
		or or DON will immediately		heads were inserviced b	
		ons of abuse to the Regional		Regional Vice President	
7	Vice President of Operations or Chief Clinical officer for proper guidance. The Administrator or			Operations. Staff Devel	opment
:				Coordinator, Nurse Mai	nagers,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	48 FOR MEDICARE &	MEDICAID SERVICES				OMB	O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	345197	B. WN	1G			C
	 	340197		_	· · · · · · · · · · · · · · · · · · ·	<u> </u>	10/2012
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC LLC			ı	37 TRYON ROAD		
				R	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
F 490	Continued From pag	n 44	F	490	inserviced the nurses.	All other	
		rill report to the proper	•	700	staff was in-serviced by	thair	<u>:</u>
		ours if serious bodily injury					•
		nours of a suspicion of crime.			department managers.	ın-	
		rt is a reflection of any			services contained the	following:	
		esident 's conditions and	:		100% completed on 2/	12/12.	
		24 hours. Effective 2/9/2012,			:	,	
		ng and Unit Managers and will review the 24 hour			a. The facilities Abuse	policy and	•
		note any instances of			procedure states that a	buse can	
	behavior changes an				be considered physical		į
		nt contact. On 2/9/2012,	1		•	•	:
	nurses were in-service	ced on including more			that is inappropriate, if	it is	:
	1	ent behaviors. Any allegations			uninvited by the person	n being	
		the 24 hour report identified			touched. This in-service	_	
	-	eported to the Administrator.	•			C also	
	•	ice will be conducted by the			included;		
		se. The facility has been					
	no later than Februar	date as of this writing, but v 17., 2012.	•		1. Identification:		
		Quality Assurance Tool will					-
	:	will have department heads	•		 Staff and vendors 	are	•
	make rounds 5 times	per week, monitoring for			mandated to report, in	tervene in	:
		ors, interviews with staff and			situations in which abu	se and	
		his topic, for the next 3	•				
	1	ould no occurrences of			neglect based on faci	πτγ	:
		ounds will be made weekly.			reporting policy,		•
	Assurance Committe	be monitored by the Quality			·		
		ken. The Quality Assurance			 Staff is to immedi 	ately	
		ff member to observe, and			report allegations and	or or	
		nd staff to see if there was			observations of abuse	and	
	-	ident to resident contact;					:
		mily complaints; observe or			neglect based on facili	ιγ	
	receive a report of in-	appropriate resident to			reporting policy,		1
		y will ask 2 employees the					i
		do when they observe or			- The facility will fac	cilitate	
		resident to resident contact,			assessment, care plani		
1	: ask employee to who	m they should report this.			. gasessinerity care plant	mib) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345197	B. WIN	G		1	C 0/2012	
NAME OF PR	ROVIDER OR SUPPLIER	 	<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	RIDGE OF NC LLC			237	TRYON ROAD			
· · · · · · · · · · · · · · · · · · ·				RU	THERFORDTON, NC 26139			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES V MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
					monitoring of residents	with		
F 490	Continued From page		F	490	needs and behaviors w	hich might		
		on all shifts. The Quality			lead to conflict or neglect based			
	Assurance Tool will g	ather the relevant I be taken to the morning			on Individualized assessment.		į	
		be discussed and any	•		Off fildividualized asset	311161111		
	_	rill be handled immediately			2. Prevention:			
	by the administrator of				Z. Flevention.			
		2 any residents displaying			- Provide resident, 1	amiliae		
		rs will be assessed and	:	į		-		
	-	reviewed and updated for	1	1	and staff information	on now and		
	appropriate actions within 24 hours of occurrence. Corrections or additions will be			į	to whom they may rep	ort		
		npleted by the MDS nurses.	concerns, Incidents, and grievances without fear of retribution; and provide feedback regarding the concerns that have					
	MONITORING	· • · · · · · · · · · · · · · · · · · ·						
		Managers will continue						
		hour report to for any						
		s Of any allegations of						
	abuse. Further Educa disciplinary action will	•	been expressed.					
i	2. The Department h				•			
		ality Assurance rounds for			- The facility will re-	/iew		
:		compliance is obtained. At	1		reports of abuse and neglect,			
1		Assurance committee will		i	•			
:	review this process ar				injury of unknown orig			
	determine the frequer		:		incidents in an effort t	o identify		
	continue to be comple process.	eted as a Quality Assurance			trends/patterns and to	maintain		
	•	Abuse will be immediately			a safe environment fo	r residents		
:		Istrator. The allegations will			and staff. Analysis and			
		nd reported per regulations.			•			
i		notify the Regional Vice			corrective/responsible			
:		Chief Clinical Officer for			plans will be coordina	ted with		
:		re that the facility's policy			the Quality Assurance			
	has been followed. 4. The results of the	Quality Assurance			Committee.			
		ur report, and investigations			Committee.			
	of any inappropriate re				3. Protection			
•		d in the monthly Quality			5. Flotection			
:	Assurance Committee	meeting for three months			- When abuse or a	crime is		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			B. WNG		С		
		345197			02/10/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD				
WILLOW	RIDGE OF NC LLC		RU	THERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 490	F 490 Continued From page 46		F 490	witnessed the 1 st that has to	be		
	and quarterly thereafter until deemed resolved by			done is to protect the reside	nt		
	the committee.			and all other residents from	<u>:</u>		
		erdy was removed on following interviews with	<u>:</u>	further abuse or crimes.	:		
	administrative, licensed and direct care staff on all three shifts related to mandatory education on abuse; interviews with residents; interviews with		1	- Once you as the employ	ree		
			· .	suspect abuse or a crime you			
families; review of in-service rosters on education of staff on abuse; review of revised abuse policy; review of the 24 hours communication sheets;		1	must stay with the resident	in the			
		rs communication sheets;		situation to protect them.	: :		
	and review of the quality assurance tool put into			- You then must then con	tact		
	place.			help to report "who" the all	-		
				perpetrator is.	:		
				- This can be reported to	a		
	:			charge nurse or department	į.		
	<u>-</u> - - -			head.	· :		
				- You must not leave the			
	-			resident while the reporting			
	: -			occurs.			
			i	- Once the Nurse or	;		
;				Department head arrives, re	eport		
				what you observed and who			
;				the alleged perpetrator.			
į				- The Nurse/Department	Head		
			:	must then immediately loca			
:			;	the perpetrator and immed			
			:	• •			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/24/2012 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		·	A. BUILI			c	
		345197	B. WING	3		02/10/2012	
	VIDER OR SUPPLIER DGE OF NC LLC			237 TR	ADDRESS, CITY, STATE, ZIP CODE LYON ROAD ERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE AT 11'C' DIFFICIENCY)	D BE COMPLETION	
F 490			F 4	90 .	remove them from area of residents.	all	
:			ŧ	:	- You must not leave the	: :	
i			-	:	abused perpetrator alone.		
				i	- You must then immedia	ately	
:				•	notify the Administrator of	the	
į	•-			i	situation.	÷	
			ì		- From this point you fol	low	
				:	the direction of the		
ļ			:		Administrator.		
			:		4. Investigate:		
			:		- The Administrator or D	irector	
	- /	to the special expression great courts. The first section is	r my r c officer .		of Nursing will immediately		
				1	the investigative process to	,	
<u> </u>			;	-	include:		
					- Interview the resid involved	ents	
ł					- Interview of staff t	hat had	
ļ			į	i	contact with the residents	\$	
į					involved in the allegation	of	
:					abuse	: :	
1 6 1 2			· ·	<u>:</u>	- Interview other al	ert and	
į			-	i	oriented residents who ha	ad the	
:			:	•	opportunity to observe th	e	
			. i		alleged abuse.	<u> </u>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 346197 02/10/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD WILLOW RIDGE OF NC LLC **RUTHERFORDTON, NC 28139** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AC 11 CORINTE DEFICIENCY) - Interview any known F 490: F 490 witness. - assess all involved residents for signs and symptoms of abuse. 5. Reporting - The Administrator or Director of Nursing will be responsible for reporting the abuse allegation to all State and Local Authorities per required time frames as mandated by regulation. b. Immediately protect all residents when inappropriate resident to resident contact is Identified, by staying with the resident to protect them. You must immediately notify the administrator. c. Immediately report all events of inappropriate resident to resident contact to the Administrator. If the Administrator is not available,

the employee reporting the

PRINTED: 02/24/2012

FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		345197	B. WING		02/10/2012	
	OVIDER OR SUPPLIER		237 T	ADDRESS, CITY, STATE, ZIP CODE RYON ROAD HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COL TAG CROSS-REFERENCED TO THE ACTION THATE DEFICIENCY)			
F 490;	-		F 490	alleged abuse should rep	ort it to	
;	;		F 480°	his/her supervisor who c	ontacts	
			1 .	the Administrator or Dire	ector of	
1			· !	Nursing.		
		•	;	d. 2/8/12 Abuse policy r	evised to	
: -		•	•	state nurses are to imme	diately	
				fill out an incident report	and	
į	1.0		-	submit it to the DON; cal	l the	
				physician; notify	:	
:				family/responsible party	at the	
i				time of the occurrence. I	n-service	
			:	was conducted by the U	nit	
<u>\$</u>				Managers, DON, departr	nent	
i			; <u>:</u>	heads on 2/8/12. The Nu	ırse's	
				Responsibilities when all	eged	
1		Commence of the commence of th	÷	abuse is suspected and t	he	
į.			•	facility's Policy and Proce	edure on	
!			:	Abuse was placed at eac	h Nurses	
; 			:	station.	\$ •	
į				e. All staff should report	to their	
i				immediate supervisor ar	nd expect	
:			:	feedback from that supe	rvisor	
,				that an investigation has	been	
;			:	initiated, if feedback not	:	
ŗ			:	provided, staff should co	ntact	
			; }	Administrator directly. T	he	
Í			:	Administrators contact		
			:	information is posted at	every	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A BUILDING	CONSTRUCTION	(X3) DATE SU COMPLE			
			B. WING		02/	C 10/2042		
	IDER OR SUPPLIER GE OF NC LLC		237 ד	STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E AT TOTRIATE	(X6) COMPLETION DATE		
F 490			F 490	Nurses station and ancillary departm	•			
		· .		f. Any staff member unable to attend a service will not be work until they reservice by the Un Department Head Development Nuccompleted on 2/2	the Abuse in- e allowed to eceive this in- it Manager or d or Staff rse. 100%			
	**************************************			g. The Administrate immediately report allegations of abuse Regional Vice Presions or Chief officer for proper administrator or Development authorities within a serious bodily injusting there is a reasonal crime.	tor or DON will thany the to the ident of cf Clinical guidance. The irector of to the proper 2 hours if ry occurs, or if			
				2. The 24 hour represent to the condition of any under the condition of any under the condition of the condi	nusual changes	•		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICAT		1 .				E SURVEY PLETED	
ľ						С		
		346197	B. WIN	G		02/1	0/2012	
ł	ROVIDER OR SUPPLIER			237 1	r address, city, state, zip code rryon road Herfordton, NC 28138			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AT : DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 490			F	490		anagers sor will rses report nces of for opriate ontact. On -serviced ormation on ny entified will		
	nd magazinas mai, d ha na hamilimi na napimajimi n na		: - 1	· · · · · · · · · · · · · · · · · · ·	Administrator. These of discussed in the morn meeting.			
design design entered to the state of the st					3. On 2/9/12 a Quality Tool was started. This have department hear rounds 5 times per we monitoring for inapprobehaviors, interviews and residents related topic, until Substantia Compliance is obtained that should no further	tool will ds make ek, opriate with staff to this d. After		
	2.991 Providers Varsions Obs	· · · · · · · · · · · · · · · · · · ·	: :		that, should no furthe of non-compliance be rounds will be comple	identified,		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	B. WIN	G		C 02/10/2012	
	NAME OF PROVIDER OR SUPPLIER WILLOW RIDGE OF NC LLC			237 T	ADDRESS, CITY, STATE, ZIP CODE RYON ROAD HERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF : TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE AT A C DIFFICIENCY)	LO BE COMPLETIO	ÓN
F 490			F	490	by the managers thereaft	er. This	
i	ı			;	information will be monit	÷	
			:		the Quality Assurance Co	· }	
·				:	monthly and any necessa		
		•		:	actions taken. The Quality	1	
; ;		•		:	Assurance Tool instructs	:	
					member to observe, and		
; 1					question residents and st	aff to	- 1
			:	•	see if there was any	The state of the s	
					inappropriate resident to		
- - 1			:		resident contact; heard a	ny	
				į	resident/family complain	ts;	
į			: :		observe or receive a repo	ort of	
			Í		inappropriate resident to)	
ì	•		•	į	resident contact. They wi	il ask 2	
				!	employees the first thing	they are	
į			:	1	to do when they observe	or hear	
!			:		of inappropriate resident	to	
				:	resident contact, ask emp	ployee	
!					to whom they should rep	ort this.	
:					This will be conducted or	ı all	
į			:		shifts. The Quality Assura	ance	
: :					Tool will gather the relev	ant	
·					information, which will b		
!					to the morning meeting,	where it	
:					will be discussed and any		
i			;		negative responses will b	e	
į				:	-	:	
				i			- 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		345197	B. WNG		02/10/2012	
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE ACTION SHOULD BE DIFFICIENCY)			
F 490			F 490	handled immediatel administrator or his, designee.		
_			\$	uesignee.		
:			:	4. Beginning on 2/9/	12 any	
=			:	residents displaying		
i	-	,	÷	inappropriate behav	iors were	
;				assessed and their c	are plans	
1	••		i.	were reviewed and	updated for	
1			3	appropriate actions.	This was	
•				completed by the MI		
j				••••••••••••••••••••••••••••••••••••••		
1			!	5. On 2/17/12 all Nur	se	
1				Managers were in-se	rviced by	
ļ			:	the Chief Clinical Offi	cer on;	
		The state of the s		a. The facility's Skin Policy and Procedure		
) -	Toney and Troccadio	•	
:				b. Properly investig	ating Skin	
-			1	Tears and Bruises to	rule out	
1				Abuse.		
				c. How to properly possible causative fa may have contribute tear or bruise such a and staff statements medications, behavio	ctors that d to the skin s; Resident	
:			<u> </u>	conditions and envir	onmental	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/24/2012 FORM APPROVED OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	tocarri torritori nomozna	A. BUILDING	c			
	345197	B. WNG		02/10/2012		
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
WILLOW RIDGE OF NC LLC	WILLOW RIDGE OF NC LLC 237 RUT					
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION		
F 490		F 490	factors.			
·			d. The facility's Q	uality		
		į	Assurance Investig	ational tool for		
:		1	Skin Tears and Bru	ises.		
<u>:</u>		i	e. The requireme	nt that these		
			be reviewed daily	as they occur,		
; ;			orders obtained as	s needed,		
!		•	interventions impl	emented as		
1 1		!	appropriate, care j	plans updated		
; i		:	and revised as nec	and revised as necessary and		
į		1	Suspicious skin tears/bruises that a plausible causative factor could			
! !		! -				
		İ	not be derived from	m a		
***			investigation be re	ported as a		
and the second s	A CARACTER AND A CONTRACT VALUE OF THE ACT O	tan camana dist	treated as a possib	le Abuse		
		ĺ	scenario. If Abuse	can not be		
		•	ruled out, these ev	ents will be		
		ĺ	reported and inves	stigated as		
<u> </u>			Alleged Abuse case	es.		
i *		į	6. The 7 types of abus	se was		
i i		;	posted in numerous v	risual areas		
!			in the facility on 2/14	/2012.		
* -			7. The contact phone	numbers		
		•	for the Administrator	, Director of		
			Nursing, Social Service	e Director		
		ļ	and the Corporate Co	mpliance :		
; 			Hotline was posted in	numerous		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		3451 9 7	B. WNG		C 02/10/2012
1	ROVIDER OR SUPPLIER		237	ET ADDRESS, CITY, STATE, ZIP CODE 7 TRYON ROAD 1THERFORDTON, NC 28139	, , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE ACTION DIFFICIENCY)	LD BE COMPLETION
F 490			F 490	visual areas in the facil 2/13/12. This will allov	v staff,
			•	families and outside v e	
,			÷	immediately contact K	eγ facility
i		•	:	staff if they have conc	erns.
! •			-	8. On 2/10/12 the faci	lity
				implemented a weekly	
i i	. **		•	Council meeting. This	
:			<u> </u>	will allow the resident	-
			į	any concerns that the	
				If concerns are identif	•
ļ			ì	will be immediately re	
•			• • • • • • • • • • • • • • • • • • •	the Administrator per	
İ			İ	grievance policy.	
1				-	
, i e i i i i i i i i i i i i i i i i i	 Ottobroddinianum in Literamensum sense al Literament 	Committee of the Section of the Management of the Section of the S	1 1777 T	9. On 2/17/12 the Adi	
į			<u> </u>	and Director of Nursin	
			-	placed on a mentorsh	
į			į	This mentorship will b	
Ì			1	by the Regional Vice (
:			:	and the Chief Clinical	
:				mentorship will be co	
!				weekly for 4 weeks. A	
:			•	an evaluation of prog	
				completed for the go	
			<u>;</u>	After the 4 weeks the	-
			1	Executive Staff will re	
				plan and at that time	make the
			į į	necessary revisions to	o ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDII	NG	c		
		345197	B. WNG		02/10/2012		
	DER OR SUPPLIER		s	IREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 490			;	that the residents	of the facility		
1 400			F 49	are properly care	d for. This		
			:	program will;			
!				a. Identify strengths			
; • •		•		b. Identify areas tha improvement.	t need		
i İ				c. Provide Corporate	e direction		
•				and guidance.			
				d. Direction on State	e/Federal		
į				and corporate expec	tations.		
1				e. Provide realistic g	goals.		
į			; :	f. Provide weekly			
		s fembroks resembled and common distributions for the section of t	7	documentation and	feedback		
į				towards the achieve	ment of the		
!				goals.	:		
-				10. On 2/17/12 a ail	staff		
i				Directed in-service			
				conducted by a repr			
Ĺ				The Adult Protective	1		
; ;				Department. This In- included:	-service -		
: !				a. Signs and sympto	ms of abuse.		
				b. Types of abuse.			
!					:		
į				İ	<u>.</u>		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			B. WNG	***		С		
	A1 40 TO 4 TO 1	345197			02/10/	2012		
}	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, 237 TRYON ROAD RUTHERFORDTON				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DIRRECTIVE ACTION SHOULD BE ERENAED TO THE ACTIC ORIATE DIFFICIENCY)	(X5) COMPLETION DATE		
F 490			F 49	00 c. Pr	eventing abuse.			
			:	d. Pr	otection against abuse.			
:				1	otection of residents when			
		•		abus	se is suspected.			
1.				f. Im	mediately reporting abuse.			
i 1				MOI	NITORING			
:				1. T	ne DON and Unit Managers			
				will	continue review the facility's			
į				24 h	our report to for any			
				doc	umented instances of			
;				inap	propriate resident to			
į			•	resi	dent contact or any			
: 	and the second of the second o	nem Marie Survived (e demonistratio n entre esta e esta e	en a market a	alle	gations of abuse. Further			
i				Edu	cation and possible			
j				discip	linary action will occur as			
				need	ed.			
i				2. Th	e Department heads will			
<u>:</u>				conti	nue to complete the daily			
i				Quali	ty Assurance rounds for			
†			:	abus	e until substantial			
•				comp	oliance is obtained. At that			
, J				time	the Quality Assurance			
i				comi	nittee will review this			
: i				proce	ess and these rounds will			
ļ					ucted weekly there after by			
<u> </u>				į				

STATEMENT OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0.45407	B. WING		С
NAME OF PROVI	IDER OR SUPPLIER	345197	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2012
WILLOW RID	WILLOW RIDGE OF NC LLC			237 TRYON ROAD RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 490				each Departmen	t Head.
,				3. All allegation	ns of Abuse will
				be immediately r	reported to the
•				Administrator, T	he allegations
:		•		will be fully inves	stigated and
; }•				reported per reg	ulations. The
				Administrator w	ill notify the
į				Regional Vice Pro	esident and/or
į				the Chief Clinical	Officer for
:				guidance and to	ensure that the
				facility's policy h	as been
!				followed.	
4) 			-	4. The Regional V	Vice President
ļ			:	and/or the Chief	Clinical Officer
	enter a construencia de la const	the history to come an experimental processing and the contract of the contrac		will provide guid	lance and
į				support to the fa	acility on each
				reported Abuse	scenario.
				5. The weekly Re	esident Council
1				Meeting will cor	ntinue until
•				Substantial Com	pliance is
i		:		obtained. At tha	t time the
; }				Resident Counci	l will vote on
<u>:</u>				whether to cont	inue this
*				practice.	
		:		6. The results of	f the Quality
ļ		:		Assurance moni	
ì					investigations of
11.0140.0507400.000	Pravious Versions Obsol				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILOING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345197	в. wng	<u>.</u>	C 02/10/20	012
	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPY DEFICIENCY)	ULD BE CO	(X6) OVPLETFON SIAC
F 490			F 490	any inappropriate resi	dent	•
			-	contact will be reviewe	ed and	
			: .	analyzed in the month	ly Quality	
				Assurance Committee		
		-	:	for three months and o	quarterly	
			:	thereafter until deeme		
				by the committee.	-	
:				7. Monthly in-services	will be	
				provided to all facility s		
				the next 3 months, the		
-			:	quarterly there after. T	hese in-	
			•	services will review the		
:				Abuse Policy and Proce		
:			ś	facility will attempt to a		
- · · · · · · · · · · · · · · · · · · ·			**************************************	Outside speakers with a		
:				Prevention knowledge		
			:	these in-services.		
: :				8. The Medical Director	was	
,				consulted on these alleg	gations.	
				the facilities processes,	•	
i				interventions implemen	ited,	
				suggestions and/or guid		
				facility will continue to i	nvolve	
				the Medical Director in		
i			:	Quality Assurance proce		
				seek guidance, support a		
:			÷	further educational need		

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE SU		
		INCHII IONIION NOMBEK:	A, BUI	A. BUILDING		Į.		
		346197	B. WA	16		C 02/10/2012		
	IDER OR SUPPLIER			237 T	ADDRESS, CITY, STATE, ZIP CODE RYON ROAD HERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION STAC	
F 490			: :	490	Regional Vice Preside	nt and/or	•	
				ч е-)	the Chief Clinical offic	er will		
					provide weekly onsite	guidance	•	
				•	for the next 30 days.	After 30	:	
				,	days a Corporate Exec	cutive		
:			:	:	Meeting will occur to	review the		
•			:		facility's progress in o	btaining		
			:		substantial compliand	e.		
•			1		9. The Regional Vice	President		
					and/or the Chief Clini	cal officer		
į			:		will provide weekly or	nsite	í	
			:		guidance for the next	30 days.	•	
į					After 30 days a Corpo	rate	:	
!			1		Executive Meeting wil	occur to	-	
:		· · · · · · · · · · · · · · · · · · ·			review the facility's pr	ogress in		
:					obtaining substantial o	ompliance.	i	
					10. On 2/17/12 the Ad	ministrator		
: : :			•	:	and Director of Nursin	g were	:	
ı				_	placed on a mentorshi	p program.		
					This mentorship will b	e provided		
ì					by the Regional Vice P	resident		
:					and the Chief Clinical (Officer. The	•	
·				-	mentorship will be co	nducted		
:					weekly for 4 weeks. A	that time		
i			:	:	an evaluation of progr	ess will be		
; ;			:		completed for the goa	ls set forth.	•	
i			-		After the 4 weeks the			
,			:			•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
. <u>. </u>		345197	B. WNG		C 02/10/2012	
	IDER OR SUPPLIER		237	T ADDRESS, CITY, STATE, ZIP CODE TRYON ROAD THERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE CONFLETION	
F 490				Executive Staff wil	I review this	
			F 490	plan and at that time make the		
,			, .	necessary revision		
				that the residents		
			:	are properly cared		
:		,.	1		:	
•			-	11. The Administra		
i				responsible for co	npliance.	
·			:			
•			•			
;			:		!	
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