STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 11/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation. See Event ID #76WF11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to accurately transcribe physician orders as instructed by the physician to administer a total of 14 units of Insulin for 1 of 3 sampled residents (Resident #138) and obtain a glucose level for 1 of 1 sampled residents (Resident #138). The findings included: 1. Resident #138 was admitted to the facility on 09/05/18 with diagnoses of Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anxiety, Depression, Asthma, Respiratory Failure. Review of the Admission Minimum Data Set (MDS) dated 09/06/18 revealed Resident #138 was cognitively intact. The MDS indicated resident #138 required one-person assistance for bed mobility, transfers, dressing, eating, and toilet use. A review of the 9/5/18 through 9/6/18 physician orders revealed an order dated 9/6/18 4:45PM which read, "Novolin R Solution (Insulin Regular Human) Inject 14 units total subcutaneously (10	F 658	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #138 no longer resides at the facility. All residents that receive insulin are at risk for this alleged deficient practice. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 11/29/18, Director of Nursing completed audit of all medical records of current residents that receive insulin beginning 9/6/18 to present to ensure insulins were transcribed accurately according to Physician and/or Nurse practitioners (NP) orders. There were no insulin transcription discrepancies identified.	12/21/18

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

Electronically Signed | 12/17/2018

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

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F 658	Continued From page 1 units of this is already scheduled) one time only for Hyperglycemia. Recheck blood sugar within two hours following administration of Insulin. " Review of Resident # 138's Medication Administration Record (MAR) revealed 10 units of Novolin R solution was administered on 9/6/18 at 5:00 PM. The MAR further revealed an additional order for Resident #138 to receive 14 units of Novolin R solution which was initialed by Nurse #2 on 9/6/18 at 4:45PM. The Nurses were instructed to give an additional 4 units of Novolin R solution, and to recheck the blood sugar within 2 hours of administration at 7:00PM. Interview conducted on 11/29/18 at 10:42 AM with Nurse #1 revealed she had transcribed the original order from the facility Nurse Practitioner. She stated the order read to give the resident 14 units total of subcutaneous Novolin R insulin. She stated resident #138 already had 10 units scheduled and the NP wanted 4 additional units given to make a total of 14 units. She stated orders were obtained to recheck Resident#138's blood sugar 2 hours following administration. She stated the order was transcribed via telephone conversation. Interview conducted on 11/30/18 at 11:12AM with Nurse #1 revealed she should have transcribed the order for Novolin R solution more clearly, including to administer 4 units in addition to Resident #138's 10 units already scheduled. Interview conducted on 11/29/18 at 12:15 PM with the facility Nurse Practitioner revealed she had completed an assessment of Resident # 138 on the morning of 9/6/18. The interview revealed she had been notified by staff that Resident #138's	F 658	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Director of Nursing (DON), Assistant Director of Nursing (ADON) and RN supervisors were in serviced by Regional Director of Clinical Operations on 11/29/18. Beginning 11/29/18, ADON and RN supervisors in-serviced all licensed nursing staff currently working. The training included how to accurately receive and transcribe physician orders. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. Training will be provided during new hire orientation for licensed nurses. Systematic change to prevent reoccurrence will be that licensed nursing staff will upon receipt of a physician order verify order as received by read back to the physician and/or nurse practitioner. Licensed nursing staff will record feedback of order within the progress notes. Prior to administration of insulin, a second licensed nurse will validate insulin dosage, and the secondary nurse□s name will be recorded within the Medication Administration Record (MAR) notes section as witnessed by. The Director of Nursing, ADON, Unit Managers/RN supervisors will review all new physician orders for appropriate transcription from written telephone order to the electronic medication administration	

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F 658	Continued From page 2 blood sugar was elevated. She stated she gave an order for Resident #138 to receive 14 units of Novolin R subcutaneously for one dose, and for resident #138's blood sugar to be reevaluated within 2 hours following administration at 7:00PM.	F 658	record and will initial the written telephone order once validated. This new systematic change was implemented by the Regional Director of Clinical Operations on 11/29/18. Director of Nursing (DON), Assistant Director of Nursing (ADON) and RN supervisors were in serviced by Regional Director of Clinical Operations on 11/29/18. ADON and RN supervisors in-serviced all licensed staff currently working. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing/Nursing Supervisors shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per week x 1 month to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes order readback/verification to physician, second nurse validation of insulin dosage, and transcription accuracy and report to QAPI. Then Director of Nursing/Nursing Supervisors shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per month x 2 to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes	

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F 658	Continued From page 3	F 658	order readback/verification to physician, second nurse validation of insulin dosage, and transcription accuracy and report to QAPI; audits will continue at the discretion of the QAPI committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to recheck blood glucose level as instructed by the physician order for 1 of 1 sampled residents (Resident #138) resulting in no glucose level obtained. (Resident #138). The findings included: 1. Resident #138 was admitted to the facility on 09/05/18 with diagnoses of Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anxiety, Depression, Asthma, Respiratory Failure. Review of the Admission Minimum Data Set (MDS) dated 09/06/18 revealed Resident #138 was cognitively intact. The MDS indicated resident #138 required one-person assistance for bed mobility, transfers, dressing, eating, and toilet use.	F 684	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #138 no longer resides at the facility. All residents that have physician orders for blood glucose level checks are at risk for this alleged deficient practice. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 11/29/18, The Director of Nursing (DON) completed an audit of all medical	12/21/18

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F 684	Continued From page 4 A review of the 9/5/18 through 9/6/18 physician orders revealed an order dated 9/6/18 4:45PM which read, "Novolin R Solution (Insulin Regular Human) Inject 14 units total subcutaneously (10 units of this is already scheduled) one time only for Hyperglycemia. Recheck Blood sugar within two hours following Insulin administration. " Review of Resident # 138's Medication Administration Record (MAR) revealed 10 units of Novolin R solution was administered on 9/6/18 at 5:00 PM. The Nurses were instructed to give an additional 4 units of Novolin R solution, and to recheck the blood sugar within 2 hours of administration at 7:00PM. Review of Resident #138's MAR revealed an order of, "recheck blood sugar in 2 hours one time only" with an initiation date of 9/6/18 at 6:45PM. The MAR further revealed a code of (9) to see progress notes, with initials at 11:01PM. Review of Nurse #2's shift handoff report revealed only a statement of "high blood sugar" beside of Resident #138's name and did not specify any follow up instructions. Review of Nurse Progress notes dated 9/6/18 at 6:14PM revealed at 4:30 PM Resident #138's blood sugar resulted in a reading of (HI). The order revealed a new order was obtained from the NP to give 14 units of Novolin R and to recheck the glucose level in 2 hours following administration. Interview conducted on 11/29/18 at 12:15 PM with the facility Nurse Practitioner revealed she had completed an assessment of Resident # 138 on the morning of 9/6/18. The interview revealed she	F 684	residents of current residents with orders for blood glucose level checks, beginning 9/6/18 to current, to ensure blood glucose levels were checked according to physician orders. There were missing documentation of blood glucose levels noted, none resulted in negative outcomes. The DON notified the physician regarding the missing documentation of blood glucose levels. No new orders were given. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Director of Nursing (DON), Assistant Director of Nursing (ADON) and RN supervisors were in serviced by Regional Director of Clinical Operations on 11/29/18. Beginning 11/29/18, ADON and RN supervisors in-serviced all licensed nursing staff currently working. The training included how to accurately receive and transcribe physician orders and follow through with physician orders including obtaining blood glucose levels as ordered by the physician and/or nurse practitioner. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. Training will be provided during new hire orientation for licensed nurses. "Indicate how the facility plans to monitor	

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F 684	Continued From page 5 had been notified by staff that Resident #138's blood sugar was elevated. She stated she gave an order for Resident #138 to receive 14 units of Novolin R subcutaneously for one dose, and for resident #138's blood sugar to be reevaluated within 2 hours following administration. Interview conducted on 11/29/18 at 2:30PM with Nurse Aide (NA) #1 revealed she was working with Resident #138 on the date of 9/6/18. The interview revealed Resident #138 was a new admission into the facility. The interview revealed Resident #138 did not eat supper on 9/6/18, and this information had been reported to the nurse on duty. She stated she was told to ensure that Resident #138 received a snack that night. During the interview NA #1 stated she had checked on Resident #138 prior to taking her break at 7:00 PM on the date of 9/6/18. She stated Resident #138 was asleep, snoring in bed at that time. Interview conducted on 11/29/18 at 4:45PM with the facility Physician. During the interview he stated his NP had assessed Resident #138 on the date of 9/6/18. He stated if the facility notified him of a resident with a high glucose level he would order a sliding scale insulin individualized to the resident's needs. He stated during the interview that hypoglycemia could be life threatening. The interview revealed his expectation of the nurse would be to obtain a blood glucose level within 2 hours of administration of the insulin.	F 684	its performance to make sure that solutions are sustained; and Director of Nursing/Nursing Supervisors shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per week x 1 month to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes order readback/verification to physician, second nurse validation of insulin dosage, blood glucose level obtained and transcription accuracy and report to QAPI. Then Director of Nursing/Nursing Supervisors shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per month x 2 to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes order readback/verification to physician, second nurse validation of insulin dosage, blood glucose level obtained and transcription accuracy and report to QAPI; audits will continue at the discretion of the QAPI committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		12/21/18

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F 842	Continued From page 6	F 842		

(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 7 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to document complete and accurate information in the medical record for1 of 3 sampled residents (Resident #138). The findings included: 1. Resident #138 was admitted to the facility on 09/05/18 with diagnoses of Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anxiety, Depression, Asthma, Respiratory Failure. Review of the Admission Minimum Data Set (MDS) dated 09/06/18 revealed Resident #138	F 842	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #138 no longer resides at the facility. All residents that receive insulin are at risk for this alleged deficient practice. The facility must ensure that resident's medical records are complete, and accurate information is documented in the	

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F 842	Continued From page 8	F 842		

was cognitively intact. The MDS indicated resident #138 required one-person assistance for bed mobility, transfers, dressing, eating, and toilet use.

A review of the 9/5/18 through 9/6/18 physician orders revealed an order dated 9/6/18 4:45PM which read, "Novolin R Solution (Insulin Regular Human) Inject 14 units total subcutaneously (10 units of this is already scheduled) one time only for Hyperglycemia. Recheck blood sugar within two hours following administration of Insulin. "

Review of Resident # 138's Medication Administration Record (MAR) revealed 10 units of Novolin R solution was administered on 9/6/18 at 5:00 PM. The MAR further revealed an additional order for Resident #138 to receive 14 units of Novolin R solution which was initialed by Nurse #2 on 9/6/18 at 4:45PM. The Nurses were instructed to give an additional 4 units of Novolin R solution, and to recheck the blood sugar within 2 hours of administration at 7:00PM.

Review of Resident #138's MAR revealed an order of, "recheck blood sugar in 2 hours one time only" with an initiation date of 9/6/18 at 6:45PM. The MAR further revealed a code of (9) to see progress notes, with initials at 11:01PM.

Interview conducted on 11/29/18 at 10:42 AM with Nurse #1 revealed she had transcribed the original order from the facility Nurse Practitioner. She stated the order read to give the resident 14 units total of subcutaneous Novolin R insulin. She stated resident #138 already had 10 units scheduled and the NP wanted 4 additional units given to make a total of 14 units. She stated orders were obtained to recheck Resident#138's medical record and in accordance with professional standards of practice.

"Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/29/18, Director of Nursing completed audit of all medical records of current residents that receive insulin beginning 9/6/18 to present to ensure complete, and accurate information is documented in the medical record and in accordance with professional standards of practice. There were no documentation discrepancies identified, all physician orders were transcribed accurately as order by the physician.

"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Director of Nursing (DON), Assistant Director of Nursing (ADON) and RN supervisors were in serviced by Regional Director of Clinical Operations on 11/29/18. Beginning 11/29/18, ADON and RN supervisors in-serviced all licensed nursing staff currently working. The training included how to accurately receive and transcribe physician orders. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. Training will be provided during new hire

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F 842	Continued From page 9 blood sugar 2 hours following administration. She stated the order was transcribed via telephone conversation. Interview conducted on 11/30/18 at 11:12AM with Nurse #1 revealed she should have transcribed the order for Novolin R solution more clearly, including to administer 4 units in addition to Resident #138's 10 units already scheduled. Interview conducted on 11/29/18 at 12:15 PM with the facility Nurse Practitioner revealed she had completed an assessment of Resident # 138 on the morning of 9/6/18. The interview revealed she had been notified by staff that Resident #138's blood sugar was elevated. She stated she gave an order for Resident #138 to receive 14 units of Novolin R subcutaneously for one dose, and for resident #138's blood sugar to be reevaluated within 2 hours following administration at 7:00PM.	F 842	orientation for licensed nurses. Systematic change to prevent reoccurrence will be that licensed nursing staff will upon receipt of a physician order verify order as received by readback to the physician. Licensed nursing staff will record read back of order within the progress notes. Prior to administration of insulin, a second licensed nurse will validate insulin dosage, and the secondary nurse□s name will be recorded within the Medication Administration Record (MAR) notes section as witnessed by. The Director of Nursing, ADON, Unit Managers/RN supervisors will review all new physician orders for appropriate transcription from written telephone order to the electronic medication administration record and will initial the written telephone order once validated. This new systematic change was implemented by the Regional Director of Clinical Operations on 11/29/18. Director of Nursing (DON), Assistant Director of Nursing (ADON) and RN supervisors were in serviced by Regional Director of Clinical Operations on 11/29/18. ADON and RN supervisors in-serviced all licensed staff currently working. No nursing staff who was absent or PRN (pro re nata) staff will be allowed to return to the floor and resident care until this training/education has been completed. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Director of Nursing/Nursing Supervisors	

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F 842	Continued From page 10	F 842	shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per week x 1 month to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes order readback/verification to physician, second nurse validation of insulin dosage, and transcription accuracy and report to QAPI. Then Director of Nursing/Nursing Supervisors shall conduct random audit of 5 resident charts/medical record of residents that receive insulin 3 times per month x 2 to ensure medication administration of insulin is administered in a safe manner in accordance with physician orders, progress note includes order readback/verification to physician, second nurse validation of insulin dosage, and transcription accuracy and report to QAPI; audits will continue at the discretion of the QAPI committee.	