	-	D HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				PLETED
		345197	B. WING				C 29/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC			23	7 TRYON ROAD		
WILLOW				Rl	JTHERFORDTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
F 658	complaint investigatio	cited as a result of this n. See Event ID #76WF11. eet Professional Standards	F6	58			12/21/18
SS=D	CFR(s): 483.21(b)(3)((i)					
	as outlined by the cor must- (i) Meet professional s	d or arranged by the facility, nprehensive care plan,					
	Based on record revi facility failed to accura orders as instructed b administer a total of 1	4 units of Insulin for 1 of 3			"Address how corrective action will be accomplished for those residents found have been affected by the deficient practice;	l to	
	glucose level for 1 of (Resident #138).	esident #138) and obtain a 1 sampled residents			Resident #138 no longer resides at the facility.		
	The findings included				All residents that receive insulin are at r for this alleged deficient practice.	risk	
	09/05/18 with diagnos Hypertension, Diabete Anxiety, Depression, Review of the Admiss	es Mellitus, Hyperlipidemia, Asthma, Respiratory Failure. ion Minimum Data Set			"Address how the facility will identify oth residents having the potential to be affected by the same deficient practice;		
	was cognitively intact resident #138 require	3 revealed Resident #138 . The MDS indicated d one-person assistance for s, dressing, eating, and toilet			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	of	
		through 9/6/18 physician			insulins were transcribed accurately according to Physician and/or Nurse practitioners (NP) orders. There were n	0	
	which read, "Novolin	der dated 9/6/18 4:45PM R Solution (Insulin Regular s total subcutaneously (10			insulin transcription discrepancies identified.		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE

Electronically Signed

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.

12/17/2018

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		
						С
		345197	B. WING		1	1/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WILLOW	RIDGE OF NC			237 TRYON ROAD		
	1			RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 658	Continued From page	e 1	F 65	58		
		y scheduled) one time only	1 0.	"Address what measures will	he put into	
		echeck blood sugar within		place or systemic changes m		(X3) DATE SURVEY COMPLETED C 11/29/2018
		idministration of Insulin. "		ensure that the deficient prac		
				recur;		
	Review of Resident #					
		d (MAR) revealed 10 units of		Director of Nursing (DON), A		
		as administered on 9/6/18 at		Director of Nursing (ADON) a		
		urther revealed an additional 38 to receive 14 units of		supervisors were in serviced Director of Clinical Operation	, ,	
		hich was initialed by Nurse		11/29/18. Beginning 11/29/18		
		PM. The Nurses were		RN supervisors in-serviced a		
	instructed to give an	additional 4 units of Novolin		nursing staff currently working		
	R solution, and to rec	check the blood sugar within		training included how to accu	rately	
	2 hours of administra	tion at 7:00PM.		receive and transcribe physic		
				No nursing staff who was abs		
		on 11/29/18 at 10:42 AM with		(pro re nata) staff will be allow		
		ne had transcribed the e facility Nurse Practitioner.		to the floor and resident care		
		read to give the resident 14		training/education has been of Training will be provided during		
		neous Novolin R insulin. She		orientation for licensed nurse	•	
	stated resident #138				-	
		P wanted 4 additional units		Systematic change to preven	t	
	given to make a total	of 14 units. She stated		reoccurrence will be that licer	•	
		to recheck Resident#138's		staff will upon receipt of a phy		
		following administration. She		verify order as received by re		
	conversation.	transcribed via telephone		the physician and/or nurse pr Licensed nursing staff will rec		
	conversation.			feedback of order within the		
	Interview conducted	on 11/30/18 at 11:12AM with		notes. Prior to administration		
		ne should have transcribed		second licensed nurse will va		
	the order for Novolin	R solution more clearly,		dosage, and the secondary n	urse□s	
	-	er 4 units in addition to		name will be recorded within		
	Resident #138's 10 u	inits already scheduled.		Medication Administration Re	· · ·	
		on 11/20/19 of 12:15 DM		notes section as witnessed b		
		on 11/29/18 at 12:15 PM with		Director of Nursing, ADON, L		
	-	ctitioner revealed she had sment of Resident # 138 on		Managers/RN supervisors wi new physician orders for app		
	-	3. The interview revealed she		transcription from written tele		
	had been notified by			to the electronic medication a		

Facility ID: 923438

If continuation sheet Page 2 of 11

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/31/2018 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345197	B. WING				C 29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
WILLOW	RIDGE OF NC			23	37 TRYON ROAD		
				RI	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	blood sugar was elev an order for Resident Novolin R subcutaned resident #138's blood	e 2 ated. She stated she gave #138 to receive 14 units of ously for one dose, and for l sugar to be reevaluated ng administration at 7:00PM.	F	658	record and will initial the written teleph order once validated. This new system change was implemented by the Regi Director of Clinical Operations on 11/29/18. Director of Nursing (DON), Assistant Director of Nursing (ADON) RN supervisors were in serviced by Regional Director of Clinical Operation on 11/29/18. ADON and RN supervisi in-serviced all licensed staff currently working. No nursing staff who was ab or PRN (pro re nata) staff will be allow to return to the floor and resident care until this training/education has been completed. "Indicate how the facility plans to mon its performance to make sure that solutions are sustained: Director of Nursing/Nursing Superviso shall conduct random audit of 5 reside charts/medical record of residents that receive insulin 3 times per week x 1 month to ensure medication administration of insulin is administere a safe manner in accordance with physician orders, progress note includ order readback/verification to physicia second nurse validation of insulin dos and transcription accuracy and report QAPI. Then Director of Nursing/Nursing Supervisors shall conduct random aud 5 resident charts/medical record of residents that receive insulin 3 times per month x 2 to ensure medication administration of insulin is administere a safe manner in accordance with physician orders, progress note include order readback/verification to physicia second nurse validation of insulin dos and transcription accuracy and report QAPI. Then Director of Nursing/Nursin Supervisors shall conduct random aud 5 resident charts/medical record of residents that receive insulin 3 times per month x 2 to ensure medication administration of insulin is administere a safe manner in accordance with physician orders, progress note include	natic onal and hs ors osent yed itor rs ent t ed in les n, age, to ng dit of per ed in	

Event ID: 76WF11

Facility ID: 923438

If continuation sheet Page 3 of 11

					PRINTED: 12/31/20 FORM APPROVE
TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345197	B. WING		C 11/29/2018
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1
			2	37 TRYON ROAD	
WILLOW	RIDGE OF NC		R	UTHERFORDTON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 658	Continued From page 3		F 658	order readback/verification to physici second nurse validation of insulin dos and transcription accuracy and repor QAPI; audits will continue at the disc of the QAPI committee.	sage, t to
F 684 SS=D	Quality of Care CFR(s): 483.25		F 684		12/21/18
	applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profi- practice, the compret care plan, and the resident This REQUIREMENT by: Based on record rever facility failed to recher instructed by the physical sampled residents (R glucose level obtained The findings included 1. Resident #138 w 09/05/18 with diagnose Hypertension, Diabet Anxiety, Depression, Review of the Admiss (MDS) dated 09/06/1 was cognitively intactor resident #138 required	 is not met as evidenced iew, and staff interviews, the ck blood glucose level as sician order for 1 of 1 tesident #138) resulting in no d. (Resident #138). trans admitted to the facility on ses of Heart Failure, es Mellitus, Hyperlipidemia, Asthma, Respiratory Failure. sion Minimum Data Set 8 revealed Resident #138 		"Address how corrective action will b accomplished for those residents fou have been affected by the deficient practice; Resident #138 no longer resides at th facility. All residents that have physician orde for blood glucose level checks are at for this alleged deficient practice. "Address how the facility will identify residents having the potential to be affected by the same deficient practice On 11/29/18, The Director of Nursing	nd to ne ers risk other ce;

Event ID: 76WF11

Facility ID: 923438

If continuation sheet Page 4 of 11

		MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE S	0938-03
		IDENTIFICATION NUMBER:	1 ° <i>î</i>		(X3) DATE S COMPL	
					с	
		345197	B. WING		11/2	9/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 4	F 68	4		
		8 through 9/6/18 physician		residents of current residents with	orders	
		rder dated 9/6/18 4:45PM		for blood glucose level checks, be		
	which read, "Novolin	R Solution (Insulin Regular		9/6/18 to current, to ensure blood		
	Human) Inject 14 uni	ts total subcutaneously (10		levels were checked according to		
	-	y scheduled) one time only		physician orders. There were mis		
		echeck Blood sugar within		documentation of blood glucose le	evels	
	two hours following Ir	nsulin administration. "		noted, none resulted in negative		
	Review of Resident #	t 129's Madiantian		outcomes. The DON notified the		
		d (MAR) revealed 10 units of		physician regarding the missing documentation of blood glucose le	avals	
		as administered on 9/6/18 at		No new orders were given.	evels.	
		s were instructed to give an		No new orders were given.		
		Novolin R solution, and to				
	recheck the blood su			"Address what measures will be p	ut into	
	administration at 7:00	OPM.		place or systemic changes made t	to	
				ensure that the deficient practice v	will not	
		#138's MAR revealed an		recur;		
		ood sugar in 2 hours one				
		tiation date of 9/6/18 at		Director of Nursing (DON), Assista		
		irther revealed a code of (9)		Director of Nursing (ADON) and R		
	to see progress notes	s, with initials at 11:01PM.		supervisors were in serviced by R	egional	
	Review of Nurse #2's	s shift handoff roport		Director of Clinical Operations on 11/29/18. Beginning 11/29/18, AD	DN and	
		ment of "high blood sugar"		RN supervisors in-serviced all lice		
		138's name and did not		nursing staff currently working. Th		
	specify any follow up			training included how to accurately		
				receive and transcribe physician of		
	Review of Nurse Prog	gress notes dated 9/6/18 at		and follow through with physician		
		1:30 PM Resident #138's		including obtaining blood glucose		
	-	in a reading of (HI). The		as ordered by the physician and/o		
		order was obtained from		practitioner. No nursing staff who		
		its of Novolin R and to		absent or PRN (pro re nata) staff		
	administration.	level in 2 hours following		allowed to return to the floor and r care until this training/education ha		
	อนเทททอนสแบท.			completed. Training will be provide		
	Interview conducted	on 11/29/18 at 12:15 PM with		during new hire orientation for lice		
		ctitioner revealed she had		nurses.		
	-	sment of Resident # 138 on				
		3. The interview revealed she		"Indicate how the facility plans to r	monitor	

Facility ID: 923438

If continuation sheet Page 5 of 11

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345197	B. WING		C 11/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
WILLOW	RIDGE OF NC			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 SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETIC
F 684	Continued From page	e 5	F 684		
	had been notified by blood sugar was elev	staff that Resident #138's ated. She stated she gave #138 to receive 14 units of		its performance to make sure that solutions are sustained; and	at
		ously for one dose, and for I sugar to be reevaluated ng administration.		Director of Nursing/Nursing Super shall conduct random audit of 5 charts/medical record of resident receive insulin 3 times per week	resident ts that
	Nurse Aide (NA) #1 r	on 11/29/18 at 2:30PM with evealed she was working n the date of 9/6/18. The		month to ensure medication administration of insulin is admin a safe manner in accordance wit	nistered in
	admission into the fac	esident #138 was a new cility. The interview revealed t eat supper on 9/6/18, and		physician orders, progress note order readback/verification to ph second nurse validation of insuli	ysician,
	on duty. She stated s Resident #138 receiv	been reported to the nurse he was told to ensure that ed a snack that night.		blood glucose level obtained and transcription accuracy and repor Then Director of Nursing/Nursing	t to QAPI.
	break at 7:00 PM on	NA #1 stated she had #138 prior to taking her the date of 9/6/18. She was asleep, snoring in bed		Supervisors shall conduct rando 5 resident charts/medical record residents that receive insulin 3 ti month x 2 to ensure medication	of
	at that time.			administration of insulin is admin a safe manner in accordance wit	th
	the facility Physician. stated his NP had as	on 11/29/18 at 4:45PM with During the interview he sessed Resident #138 on e stated if the facility notified		physician orders, progress note order readback/verification to ph second nurse validation of insuli blood glucose level obtained an	ysician, n dosage,
	him of a resident with would order a sliding	a high glucose level he scale insulin individualized ls. He stated during the		transcription accuracy and repor audits will continue at the discret QAPI committee.	t to QAPI;
	blood glucose level w administration of the	rse would be to obtain a rithin 2 hours of insulin.			
F 842 SS=D			F 842	2	12/21/18

Facility ID: 923438

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						FORM	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
		I OF HEALTH AND HUMAN SERVICES FORM APPROVED IMEDICARE & MEDICAID SERVICES OWB NO. 0938-0391 ICENDORS (x) PROVORRSUPPUERCLA IDENTIFICATION NUMBER (x) MULTIPLE CONSTRUCTION A BUILDING (x) OLT SURVEY COMPLETED STREET ADDRESS, CITY, STATE, ZIP CODE 237 TRYON ROAD RUTHERFORDTON, NC 28139 C IS OF NC STREET ADDRESS, CITY, STATE, ZIP CODE C IS MUMARY STATEMENT OF DEFICIENCIES (EAC) DEFICIENCIES ID PROVDERS PLAN OF CORRECTION ICEACI DEFICIENCIES C IS INMARY STATEMENT OF DEFICIENCIES (EAC) DEFICIENCY MUST ED FROEDEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) PROVDERS PLAN OF CORRECTION ICEACI DEFICIENCY CMSI INTERFX CMAIN CONSTRUCTION ICEACI DEFICIENCY CMSI INTERFX Itinued From page 6 facility may not release information that is fent-identifiable to an agent oinformation eso to use or disclose the information por disclose the information por disclose the information por to the extent the facility itself is permitted os o. F 842 F 3.70(() Medical records. 3.70(() Medical records. 3.70(() Medical records on each resident are- omplete; vocurately documented; Readity accessible; and Systematically organized A facility and the resident seconds, urdess of the form or storage method of the rds, except when release is- be individual, or their resident seconds as permitted by applicable law; tequired by Law; For treatment, payment, or health care ations, as permitted by and in compliance 43 CFR 146056; Healthas an an an an a					
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC			:	237 TRYON ROAD		
WILLOW					RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
F 842	 (i) A facility may not reresident-identifiable to resident-identifiable to accordance with a coagrees not to use or cexcept to the extent the to do so. §483.70(i) Medical registrations and and must maintain medications at that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facial information contair regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitti with 45 CFR 164.506 (iv) For public health and law enforcement purp purposes, research purp medical examiners, fur a serious threat to health and to the serious threat to health and the series and thead the series and the series and the ser	elease information that is o the public. lease information that is o an agent only in intract under which the agent disclose the information he facility itself is permitted cords. cords. dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings,	F	842	2		

Facility ID: 923438

If continuation sheet Page 7 of 11

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345197	B. WING				C 29/2018
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	RIDGE OF NC				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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	 §483.70(i)(3) The facility factoring in the particular of the period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The me (i) Sufficient information (ii) A record of the rese (iii) The comprehension provided; (iv) The results of any and resident review endeterminations condured (v) Physician's, nurse professional's progress (vi) Laboratory, radiol services reports as rese This REQUIREMENT by: Based on record revia facility failed to docum information in the meres sampled residents (R The findings included 1. Resident #138 w 09/05/18 with diagnost Hypertension, Diabeted Anxiety, Depression, and the set of the set of the sampled resident (N C) Physician's (R C) (R C)	lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed as notes; and ogy and other diagnostic quired under §483.50. ' is not met as evidenced ew, and staff interviews, the nent complete and accurate dical record for1 of 3 esident #138). : as admitted to the facility on ses of Heart Failure, es Mellitus, Hyperlipidemia, Asthma, Respiratory Failure.	F	842	Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; Resident #138 no longer resides at the facility. All residents that receive insulin are at for this alleged deficient practice. The facility must ensure that resident's	risk	
l	Review of the Admiss	ion Minimum Data Set 3 revealed Resident #138			medical records are complete, and accurate information is documented in		

Facility ID: 923438

If continuation sheet Page 8 of 11

					NATRUATION		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	1 Y /	E SURVEY PLETED
			A. DOILDIN	0			С
		345197	B. WING				/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
	RIDGE OF NC			237 1	TRYON ROAD		
WILLOW	RIDGE OF NC			RUT	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 8	F 84	42			
1 012	was cognitively intact		10-		medical record and in accordance wit	h	
		ed one-person assistance for			professional standards of practice.		
		s, dressing, eating, and toilet					
	use.				Address how the facility will identify o	other	
					residents having the potential to be		
	A review of the 9/5/18 orders revealed an or	affected by the same deficient practic	e;				
		R Solution (Insulin Regular			On 11/29/18, Director of Nursing		
		ts total subcutaneously (10			completed audit of all medical records	sof	
		y scheduled) one time only			current residents that receive insulin		
		echeck blood sugar within		b	beginning 9/6/18 to present to ensure		
	two hours following a	dministration of Insulin. "			complete, and accurate information is		
		4201a Madiastian			documented in the medical record an		
	Review of Resident #	d (MAR) revealed 10 units of			accordance with professional standar practice. There were no documentation		
		as administered on 9/6/18 at			discrepancies identified, all physician	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		urther revealed an additional			orders were transcribed accurately as	;	
	order for Resident #1	38 to receive 14 units of		c	order by the physician.		
		nich was initialed by Nurse					
	#2 on 9/6/18 at 4:45F						
	-	additional 4 units of Novolin			Address what measures will be put in	nto	
	2 hours of administra	heck the blood sugar within tion at 7:00PM.		e	place or systemic changes made to ensure that the deficient practice will recur;	not	
	Review of Resident #	138's MAR revealed an					
		ood sugar in 2 hours one			Director of Nursing (DON), Assistant		
	-	iation date of 9/6/18 at			Director of Nursing (ADON) and RN		
		rther revealed a code of (9)			supervisors were in serviced by Regio	onal	
		s, with initials at 11:01PM.			Director of Clinical Operations on 11/29/18. Beginning 11/29/18, ADON	and	
	Interview conducted	on 11/29/18 at 10:42 AM with			RN supervisors in-serviced all license		
		he had transcribed the			nursing staff currently working. The		
	-	e facility Nurse Practitioner.			raining included how to accurately		
		read to give the resident 14			eceive and transcribe physician orde		
		neous Novolin R insulin. She			No nursing staff who was absent or P		
	stated resident #138	-			pro re nata) staff will be allowed to re		
		P wanted 4 additional units of 14 units. She stated			o the floor and resident care until this raining/education has been complete		
	-	to recheck Resident#138's			Fraining will be provided during new h		

Facility ID: 923438

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/31/2018 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345197	B. WING				C / 29/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
WILOW	RIDGE OF NC			23	37 TRYON ROAD		
				R	UTHERFORDTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page	e 9	F 8	342			
	blood sugar 2 hours f	following administration. She transcribed via telephone			orientation for licensed nurses.		
	conversation.	·			Systematic change to prevent		
	Interview conducted	on 11/30/18 at 11:12AM with			reoccurrence will be that licensed nur staff will upon receipt of a physician of	0	
		he should have transcribed			verify order as received by readback		
	the order for Novolin	R solution more clearly,			the physician. Licensed nursing staff		
		er 4 units in addition to			record read back of order within the		
	Resident #138's 10 u	inits already scheduled.			progress notes. Prior to administration insulin, a second licensed nurse will	on of	
	Interview conducted	on 11/29/18 at 12:15 PM with			validate insulin dosage, and the		
	-	ctitioner revealed she had			secondary nurse s name will be reco	orded	
		ment of Resident # 138 on			within the Medication Administration	aaad	
		3. The interview revealed she staff that Resident #138's			Record (MAR) notes section as withe by. The Director of Nursing, ADON, I		
		vated. She stated she gave			Managers/RN supervisors will review		
		t #138 to receive 14 units of			new physician orders for appropriate	_	
		ously for one dose, and for I sugar to be reevaluated			transcription from written telephone o to the electronic medication administr		
		ng administration at 7:00PM.			record and will initial the written telep		
		J			order once validated. This new system		
					change was implemented by the Reg	ional	
					Director of Clinical Operations on 11/29/18. Director of Nursing (DON),		
					Assistant Director of Nursing (DON)	and	
					RN supervisors were in serviced by		
					Regional Director of Clinical Operatio		
					on 11/29/18. ADON and RN supervis in-serviced all licensed staff currently	SOLS	
					working. No nursing staff who was a	osent	
					or PRN (pro re nata) staff will be allow	ved	
					to return to the floor and resident care	9	
					until this training/education has been completed.		
					"Indicate how the facility plans to mor	nitor	
					its performance to make sure that solutions are sustained		
					Director of Nursing/Nursing Supervise	ors	
					5 - 5 - Former		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/31/201 MAPPROVE O. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345197	B. WING			C 11/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		123/2010
WILLOW	RIDGE OF NC			237	TRYON ROAD		
melon				RU	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	Continued From page	e 10	F		shall conduct random audit of 5 resid charts/medical record of residents th receive insulin 3 times per week x 1 month to ensure medication administration of insulin is administe a safe manner in accordance with physician orders, progress note inclu order readback/verification to physic second nurse validation of insulin do and transcription accuracy and repor QAPI. Then Director of Nursing/Nurs Supervisors shall conduct random ai 5 resident charts/medical record of residents that receive insulin 3 times month x 2 to ensure medication administration of insulin is administe a safe manner in accordance with physician orders, progress note inclu order readback/verification to physic second nurse validation of insulin do and transcription accuracy and repor QAPI; audits will continue at the disc of the QAPI committee.	red in ides ian, sage, t to judit of per red in ides ian, sage, t to	

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