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 10/02/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced on-site COVID-19 Focused Survey was conducted on 09/10/20. Additional record review and interviews occurred through 10/02/20. The survey exit date was changed to 10/02/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# ILM611.	E 000		
F 000	INITIAL COMMENTS An unannounced on-site COVID-19 Focused Infection Control Survey and complaint investigation was conducted 09/10/2020. Additional information was obtained through 10/02/20. The surveyor team returned to the facility on 10/02/20 to validate the credible allegation of compliance. Therefore, the exit date was changed to 10/02/20. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were ten allegations investigated and all allegations were unsubstantiated. Event ID# ILM611. Immediate Jeopardy (IJ) was identified at CFR 483.45 at tag F 760 at a scope and severity of K. Tag F 760 constituted Substandard Quality of Care. Immediate Jeopardy (IJ) began on 08/14/2020 and was removed on 09/27/2020. An extended survey was conducted.	F 000		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		10/2/20

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

Electronically Signed | 10/20/2020

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 10/02/2020

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 760	Continued From page 1 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Resident, Pharmacist, and Facility Nurse Practitioner, Rheumatology Nurse Practitioner and Physician interviews the facility failed to administer five of six doses of a rheumatoid arthritis medication that was ordered to be injected on a weekly basis for 1 of 3 sampled residents reviewed for unnecessary medications (Resident #2). Resident #2 experienced increased pain in her left shoulder and right knee. Immediate Jeopardy began on 08/14/20 when Resident #2 did not receive five of six doses of a rheumatoid arthritis medication which was ordered to be given subcutaneously every week. Immediate Jeopardy was removed on 09/27/20 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level E (no actual harm with the potential for more that minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #2 was admitted to the facility on 07/01/19 with diagnoses which included rheumatoid arthritis. A telephone order given by the Rheumatology Nurse Practitioner (RNP) dated 07/29/20	F 760	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Physician was notified on 9/14/20, by the Director of Nursing regarding the missed medication, Orencia 125mg/ml for Resident #2 for the dates of 8/14, 8/21, 8/28, 9/4 and 9/11/20. The Director of Nursing found two syringes of the medication stored in the medication room on A station, which was not the medication room in which Resident #2□s medication was stored. The licensed nurse that received the medication from delivery, placed the medication in the medication A nurses station refrigerator. The facility has changed all medications to one centralized location, where all refrigerated medications will be stored. The licensed nurses were educated regarding this change via telephone or in person on 9/27/20, by the Director of Nursing and/or the Administrator. Resident #2 received the Orencia injection on 9/16/20 and again on 9/23/20. The physician assessed and reviewed the residents medications on 9/24/20, and wrote an order to hold the medication until 10/01/20, due to the medication can weaken the immune system. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 10/02/2020

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 760	Continued From page 2 indicated, Resident #2 was to receive Orencia Solution (a biologic medication that reduces the pain and swelling of moderate to severe rheumatoid arthritis and can help stop further joint damage) 125 milligrams (mg) per 1 milliliter (ml) injection, 1 ml subcutaneously once a week. The telephone order also indicated, the order was faxed to the pharmacy by Nurse #3. Nurse #3 was no longer employed by the facility and unable to be interviewed. The Care Plan revised on 04/09/20 revealed, Resident #2 was at risk for pain related to rheumatoid arthritis. The goal for Resident #2 was to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the next review by administering analgesics per the physician's orders. The recent quarterly Minimum Data Set (MDS) assessment dated 08/20/20 revealed, Resident #2 had intact cognition and required extensive assistance with the help of two staff for bed mobility, transfers and toilet use. The MDS indicated, Resident #2 received a scheduled and a prn (as needed) pain medication for pain described as frequent and moderate. The MDS also indicated, the Resident received an opioid pain medication and did not receive an injection during the seven day look back period. Review of Resident #2's September 2020, Physician's orders revealed current orders for: *Orencia Solution 125 mg/ml subcutaneously one time a day every Friday for pain related to rheumatoid arthritis ordered 07/29/20. *Oxycontin Extended Release (ER) 40 mg give one tablet by mouth one time a day for pain,	F 760	physician also documented that the residents pain was fairly controlled with her pain medications of oxycontin and oxycodone. Her next ordered injection was given on 10/07/20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility resident were at risk to be affected by the alleged deficient practice of failure to receive medications as ordered. The Director of Nursing completed an audit of current facility residents Medication Administration Record (MAR) 9/01/20 through 9/22/20, to identify medications that were not administered as ordered. There was one resident identified that did not receive the scheduled dose of Xanax on 9/22/20 at 8am. The licensed nurse notified the nurse practitioner on 9/27/20 regarding the missed dose. No new orders were received. The Director of Nursing and Charge nurses completed an audit on 9/27/20, comparing the ordered medications to what was available, to validate that medications were available to be administered as ordered. All medications were available. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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 10/02/2020

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 760	Continued From page 3 scheduled for 8:00 AM ordered on 07/29/20. *Oxycontin ER 30 mg give one tablet by mouth one time a day for pain, scheduled for 9:00 PM ordered 10/24/19. *Oxycodone 5 mg give one tablet by mouth every two hours as needed for pain. May take with Oxycontin if patient desired ordered 07/03/20. On 09/15/20 at 2:30 PM during a telephone interview with Resident #2 she explained, she was started on a medication for her rheumatoid arthritis by the Rheumatologist but had not received the medication in several weeks. Resident #2 stated, the pain in her right knee, left shoulder and back was getting worse and there were nodules on her elbows that were painful when she laid her arms down on a flat surface, like her mattress, or when she tried to push herself up to a standing position using her arms. The Resident explained, when she did receive her arthritis injection, she could tell a major difference in her pain level in that now her pain level would get as high as a ten and when she took the prn pain medication, it would only relieve the pain for about two hours before her pain level started to increase. Resident #2 remarked, she was pretty much miserable all the time since she had not been receiving her arthritis pain medication. Resident #2's July, August and September 2020 Electronic Medication Administration Records (eMAR) revealed, there were no administration dates scheduled on the July 2020 eMAR. However, the rheumatoid arthritis medication was scheduled to be administered on 08/07/20, 08/14/20, 08/21/20, 08/28/20, 09/04/20, and 09/11/20. The eMAR further revealed, the only date the Orencia was initialed as being	F 760	The Director of Nursing and the Nursing supervisors completed education for current Licensed nurses on 9/27/20, regarding the protocol for obtaining medications and process for notification if a medication was not available to be administered as ordered. When a medication order is written, the Licensed nurse will input the order into the electronic medical record and the order will be received by the pharmacy to be filled and sent to the facility. During the medication pass, if the medication is not available on the medication cart, the licensed nurse should look in the back up medication room, and if not available there, the licensed nurse should get the medication out of the emergency stat safe kit. If the medication is not available in the kit and is not available from the back up pharmacy, the licensed nurse will notify the physician and an order will be written for a medication that is available or hold the medication until the medication is available. The licensed nurse will notify the DON regarding the needed medication 24/7. The Medication Availability Form, which is a new form, will be kept on each medication cart for the licensed nurse to document the steps taken to obtain the medication. The new form was provided to all licensed nurses including current agency staff, with education to the new process. Newly hired licensed nurses and new agency staff will receive education during new hire orientation.	

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 10/02/2020

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 760	Continued From page 4 administered was on 08/07/20. The eMAR indicated, Nurse #1 documented the #9 for the dates of 08/14/20, 08/28/20 and 09/11/20 and Nurse #2 documented the #9 for the dates of 08/21/20 and 09/04/20 which indicated "Other/Progress Notes" on the chart codes. Review of Resident #2's Progress notes revealed: *08/14/20 indicated "pharmacy to deliver" written by Nurse #1 *08/21/20 indicated "med not in stock" written by Nurse #2 *08/28/20 indicated "called the pharmacy to deliver tonight" written by Nurse #1 *09/04/20 indicated "not in stock" written by Nurse #2 *09/11/20 indicated "pharmacy to deliver" written by Nurse #1 On 09/15/20 at 2:13 PM a telephone interview was conducted with Nurse #1 who confirmed, he was the Nurse who worked on 08/14/20 at 8:00 AM and who documented he did not give Resident #2 the Orencia injection because he did not have the medication on hand and had to order the Orencia from the pharmacy. Nurse #1 stated, he reported to the oncoming 7:00 PM - 7:00 AM B Station (the hall Resident #2 resided on) Nurse which was Nurse #4 that he was not able to give the Orencia and that Nurse #4 should give Resident #2 the Orencia when the pharmacy delivered the medications that evening. When asked if Nurse #1 followed up the next day to confirm the medication had been given to Resident #2, he stated he did not because he was assigned to a different hall. Nurse #1 added, he could not confirm whether he was the Nurse who worked on 08/28/20 or 09/11/20 but he knew there were other dates that the injection was not	F 760	The Director of Nursing and/or the nursing supervisors will review the Medication Availability form daily, seven days a week to assure medications are available as ordered. The DON and/or nursing supervisors will run a report from the electronic medical record daily, seven days a week to identify medications that were documented as missed or not given. The Director of Nursing and/or the nursing supervisors will follow up when it is identified that a medication was not given, to determine the reason and assure the medication is available and administered as ordered. If the medication was not administered as ordered the licensed nurse will notify the physician for further orders. The nursing supervisors were informed of this responsibility as provided by the training on 9/27/20 by the Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing and/or nursing supervisors will complete a Missed medication audit daily, seven days a week for 4 weeks then 3 times a week for 2 months, to validate that medications were administered as ordered. The Director of Nursing and/or Nursing supervisor will review the audits monthly to identify patterns/trends and will adjust	

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 10/02/2020

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 760	Continued From page 5 available, and he had to order the Orencia from the pharmacy. Nurse #1 offered no indication that the pharmacy could not deliver Resident #2's arthritis medication. On 09/15/20 at 2:50 PM during a telephone interview with Nurse #4 she explained, she was not assigned to work B Station on 08/14/20 7:00 PM - 7:00 AM and therefore, Nurse #4 did not know anything about Resident #2's Orencia injection. Nurse #5 was assigned to work 08/14/20 7:00 PM - 7:00 AM and several attempts were made to obtain an interview. The attempts were unsuccessful. Nurse #2 was an agency Nurse who no longer had a contract with the facility and was unable to be interviewed. Nurse #6 who worked on 08/15/20 7:00 AM - 7:00 PM was on leave of absence and was unable to be interviewed. Attempts to interview Nurse #7 who worked on 08/29/20 7:00 AM - 7:00 PM were unsuccessful. Review of several pharmacy delivery sheets for Resident #2's Orencia revealed: *On 07/30/20 Orencia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. *On 08/14/20 Orencia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. *On 08/28/20 Orencia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. On 09/15/20 at 10:45 AM during a telephone interview with the Pharmacist she confirmed, the	F 760	the plan as necessary to maintain compliance. The Director of Nursing and/or the Nursing supervisor will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; Oct 2, 2020	

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 10/02/2020

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 760	Continued From page 6	F 760		

pharmacy had delivered Resident #2's Orencia Solution 125 mg/ml, 2 syringes on 07/30/20, 08/14/20 and 08/28/20 to the facility. The Pharmacist also shared, the prescriber had approved the Orencia in June of 2020 and the prior approval was effective through 06/2021.

Review of the Nurse Practitioner's Progress Notes dated 09/14/20 revealed, Resident #2 presented with the following assessment: severe joint deformities in her bilateral hands; severe ulnar deviations of her fingers; tenderness in her knees, ankles, wrists and hands; nodules along her radius and near the elbows; no acute joint redness or swelling and her right knee and left shoulder were particularly tender.

On 09/15/20 at 10:10 AM a telephone interview was conducted with the Facility Nurse Practitioner (FNP) who stated, she had assessed Resident #2 the previous evening on 09/14/20. The FNP explained, Resident #2 complained of increased pain in her right knee and left shoulder and stated she was not getting her arthritis injection that the Rheumatologist ordered for her. The FNP continued to explain, that Resident #2 was ordered to receive Orencia injections by the RNP once a week to prevent her rheumatoid arthritis flare ups and after research the FNP discovered that the last dose of the Orencia injection was given on 08/07/20. The FNP stated, she had not been made aware that Resident #2 was not receiving the medication or that she had missed five doses. The FNP explained, if Resident #2 did not receive the Orencia soon that she would have to start Resident #2 on course of steroids. The FNP shared, the Orencia required a prior authorization approval from the prescriber and that approval had already been completed.

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 10/02/2020

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 760	Continued From page 7	F 760		

On 09/16/20 at 4:21 PM a telephone interview was conducted with the Rheumatology Nurse Practitioner who explained, Resident #2 had been a patient of the clinic for years. The RNP confirmed, in late July 2020 she had given an order for Resident #2 to receive an injection of Orencia Solution 125 mg/ml subcutaneously once a week to prevent an inflammatory flare up of her rheumatoid arthritis. The RNP stated, that by Resident #2 not receiving the ongoing treatment for the rheumatoid arthritis could put her at risk for other health conditions such as a heart attack, stroke and even COVID-19 so therefore, she expected the Orencia injection to be given the way she ordered it to be given.

During an interview with Resident #2's Physician on 09/16/20 at 9:50 AM he explained, he was made aware of the situation with Resident #2's Orencia injections not being given on Thursday (09/10/20) as he was leaving the facility and thought he would address the situation when he was back in the facility on 09/17/20. He stated, the NP saw Resident #2 more than he did, and the NP had not indicated to him that Resident #2 was not receiving her arthritis medication nor had the facility informed him that the medication had not been given. The Physician added, if the Orencia was currently an active order, then it should have been given as ordered.

A telephone interview was conducted with the Director of Nursing (DON) on 09/17/20 at 12:00 PM. During the interview the DON confirmed, Resident #2's Orencia was charted as not given on 08/14/20, 08/21/20, 08/28/20, 09/04/20 and 09/11/20 with follow up progress notes that indicated the medication was either not in stock

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 10/02/2020

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 760	Continued From page 8	F 760		

or that the medication was ordered from the pharmacy. The DON explained, the nurses should have notified her that the medication was not available so that she could have followed up with the pharmacy herself. The DON stated, when she investigated the situation, she found two syringes of Resident #2's Orencia medication in the medication room on A Station which was not the medication room in which Resident #2's medication was stored. The DON shared, she did not know why the nurses did not follow up with giving the medication when it was delivered from the pharmacy.

On 09/17/20 at 2:30 PM during a follow up telephone interview with the DON she explained, that she had educated the nurses multiple times to notify her when a medication was not available from the pharmacy so that she could follow up with the pharmacy herself and that by the nurses not notifying her when Resident #2's Orencia was not available was an error on their part.

During a telephone interview with the Administrator on 09/17/20 at 4:50 PM he stated, he expected the doctor's orders to be followed as they were written, and the nurses should have notified the DON when Resident #2's medication was not available from the pharmacy so that she could have followed up with the pharmacy.

The Administrator and Regional Clinical Director were notified of Immediate Jeopardy on 09/26/20 at 8:18 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal for F 760:

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 10/02/2020

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 760	Continued From page 9	F 760		

1. Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance.

Based on record review, staff, Resident, Pharmacist, and Nurse Practitioner interviews the facility failed to administer five of six doses of a rheumatologist ordered medication that was to be injected on a weekly basis to treat rheumatoid arthritis for 1 of 3 sampled residents reviewed for unnecessary medications (Resident #2) because the nurse failed to retrieve the medication from the medication refrigerator, and instead, documented that the medication was not available. They failed to alert the Director of Nursing or Nursing Supervisor. While Nurse #1 and Nurse #2 both had progress notes for the five missed doses and indicated the medication was not in stock or the pharmacy would deliver, the root cause was that they documented this without checking the refrigerator which was where the medication was located.

Further, the Nursing Supervisor failed to identify the medication as missed within the electronic medical record system. This information should have been reviewed in the daily clinical meeting which is held five days per week. The weekend Supervisor monitors this information on the weekends.

The Physician was notified on 9/14/20, by the Director of Nursing regarding the missed medication, Orencia 125mg/ml for Resident #2 for the dates of 8/14, 8/21, 8/28, 9/4 and 9/11/20. The Director of Nursing stated, when she investigated the situation, she found two syringes of Resident #2's Orencia medication in the medication room on A Station which was not the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 10/02/2020

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 760	Continued From page 10	F 760		

medication room in which Resident #2's medication was stored. The medication was received by a Licensed Nurse who took the medications and placed them in the A nurse's station refrigerator. The other medications were also located in that same refrigerator. It was found during the investigation that the medications were received and stored in the location where the Resident had originally resided. The facility has since changed to a centralized location where all refrigerated medications are received. The Nurses were made aware of this change via telephone or in person on September 27th by the Director of Nursing and Administrator.

Resident #2 received an injection on 9/16/20 and again on 9/23/20. The Physician assessed and reviewed the Resident's medications on 9/24/20 and wrote an order to hold the medication until 10/01/20 due to the medication can weaken the immune system. The Physician also documented that the Resident's pain was fairly controlled with her pain medications of Oxycontin and Oxycodone.

Current facility residents were at risk to be affected by the alleged deficient practice of failure to receive medications as ordered. The Director of Nursing completed an audit of current facility residents' Medication Administration Record (MAR) 9/01/20 through 9/22/20, to identify medications that were not administered as ordered. There was one Resident identified that did not receive the scheduled dose of Xanax on 9/22/20 at 8:00 AM. The Nurse Practitioner was notified on 9/27/20 by the Licensed Nurse. No new orders were received. There were no adverse effects identified. The Director of Nursing

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 10/02/2020

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 760	Continued From page 11	F 760		

and Charge Nurses completed an audit comparing the ordered medications to what was on the cart on 9/27/20, to validate that medications were available to be administered as ordered. All medications were available.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The Director of Nursing and the Nursing Supervisors completed education for current Licensed Nurses on 9/27/20, regarding the protocol for obtaining medications and process for notification if a medication was not available to be administered as ordered. When a medication order is written, the Licensed Nurse will input the order in the electronic medical record and the order will be received by the pharmacy to be filled and sent to the facility. During the medication pass, if the medication is not available on the medication cart, the Licensed Nurse should look in the back up medication room and if not available there, the Licensed Nurse should get the medication out of the Emergency Stat safe kit. If the medication is not available in the kit and is not available from the back up pharmacy, the Licensed Nurse will notify the Physician and an order will be written for a medication that is available or hold the order until the medication was available. The Licensed Nurse will notify the Director of Nursing regarding the needed medication 24/7.

The Medication Availability Form which is a new form will be kept on each medication cart for the Licensed Nurse to document the steps taken to obtain the medication. This new form was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 10/02/2020

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 760	Continued From page 12	F 760		

provided to all licensed staff, including current agency staff, with education to the new process. All new staff will be educated by the Director of Nursing or Unit Coordinators to the new procedure during orientation prior to taking an assignment.

The Director of Nursing and or the Nursing Supervisor will review the Medication Availability list daily seven days a week to assure medications were available as ordered. No Nurse will be allowed to work until educated. Newly hired Licensed Nurses will be educated during the new hire orientation. The Supervisors have been informed of this responsibility.

The Director of Nursing and or the Nursing Supervisors will run a report from the electronic medical record daily seven days a week to identify medications that were documented as missed or not given. The Director of Nursing and or the Nursing Supervisors will follow up when it is identified that a medication was not given or not signed out as given, to determine the reason and assure the medication is available and given as ordered. If the medication was not given as ordered the Licensed Nurse will notify the Physician for further orders. The Nursing Supervisors were informed of this responsibility as provided by the training provided on 09/27/2020 by the Director of Nursing.

The facility alleges the removal of the Immediate Jeopardy on 09/27/20.

On 10/02/20 the facility's credible allegation for Immediate Jeopardy removal was validated by the following: Review of in-service training records included twenty-four individuals from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 10/02/2020

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 760	Continued From page 13	F 760		

nursing department which included floor nurses, supervisors, unit managers, and the management team. The topic of the education was on medication availability that included new processes regarding medication unavailability, ordering medications, notifying physicians of unavailable medication and notifying the Director of Nursing of unavailable medications. The new system introduced a new form titled Medication Availability which would be utilized in the event of unavailable medications and would be monitored by the management team. The Director of Nursing and the Administrator conducted the in-services which were held both by person and via telephone. Interviews with the facility and agency nurses revealed they received the education on 09/27/20 or on hire and could describe the new processes and the nurses could explain the reason and intent of the new Medication Availability form. Observations of the medication carts revealed the new Medication Availability form was present on the medication carts and medications that required refrigeration was noted to be stored in the centralized medication room as indicated by the new system.

The facility's date of Immediate Jeopardy removal of 09/27/20 was validated.