Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge of NC	237 Tryon Road Rutherfordton, NC 28139

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, and Legal Guardian and staff interviews, the facility failed to communicate with the Resident's Legal Guardian and obtain authorization from the Legal Guardian prior to the Resident being transferred across state lines to a hospital in South Carolina (SC) for 1 of 3 residents reviewed for discharge (Resident #366). The findings included: Resident #366 was admitted to the facility on [DATE]. Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian. Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment. Review of Resident #366's discharge Minimum Data Set (MDS) dated [DATE] revealed the discharge was coded as an unplanned discharge to hospital with return anticipated. Review of Resident #366's electronic medical record revealed no written notification to Resident #366's Legal Guardian of his transfer to the hospital in SC. A telephone interview was conducted with Resident #366's Legal Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's legal guardian through the Department of Social Services. She stated she received a telephone call on 12/20/24 from the Administrator at the facility stating Resident #366 would be moving to another skilled nursing facility within the day. Resident #366's Legal Guardian stated she informed the Administrator that Resident #366 could not be moved so quickly without her speaking with and touring the other facility. Resident #366's Legal Guardian revealed a few hours later on 12/20/24, she received a telephone call from the Administrator stating Resident #366 had been taken to a hospital in SC for an in-patient psychiatric hold and evaluation. She stated she did not receive any notification in writing or verbal notification prior to Resident #366 being transferred to the hospital in SC. Resident #366's Legal Guardian revealed she would like to have been notified prior to Resident #366 being transferred to the hospital but especially to a hospital across state lines when there was a local hospital a few minutes away that was equipped to treat him. (continued on next page)

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.

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 1/30/25 at 5:30 PM. The Administrator reported on 12/20/24 that the facility felt it would be best for Resident #366's safety due to his wandering and sexualized behavior to be sent out to the hospital for an in-patient psychiatric evaluation and treatment. She stated the facility transported Resident #366 to the hospital in SC because they have a geriatric psych unit, and their local hospital did not have a psychiatric unit and would only have provided him with a tele psychiatric visit and sent him back to the facility. The Administrator revealed she did not notify Resident #366's legal guardian prior to his transfer to the hospital in SC but did notify the Legal Guardian by telephone after Resident #366 had left the facility.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review, and interviews with residents and staff, the facility failed to ensure residents could access their light switch located behind the bed for 3 of the 3 residents reviewed for accommodation of needs (Resident #76, Resident #364, and Resident #54). The findings included: a. Resident #76 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #76 with intact cognition and indicated walking between locations inside the room for more than 10 feet was not attempted during the assessment period due to medical condition or safety concerns. During an observation conducted on 01/27/25 at 11:45 AM, the switch for the light fixture behind Resident #76's bed was attached with a broken cord 10 inches in length. It was 5 feet from the floor and 6 feet from Resident #76's bed. Resident #76 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #76 on 01/27/25 at 11:48 AM. He could not recall how long the switch cord had been broken. He stated he wanted to switch on the light fixture behind his bed at times, but he could not reach the switch cord. It was very inconvenient for him, and he wanted the switch cord to be fixed immediately. Subsequent observation conducted on 01/28/25 at 10:46 AM revealed the switch cord for the light fixture behind Resident #76's bed remained inaccessible. During joint observation and subsequent interview with Nurse Aide #4 (NA #4) and Nurse #1 on 01/28/25 at 2:33 PM, both nursing staff stated they provided care for Resident #76 frequently in the past few weeks, but they did not notice the switch cord was broken and inaccessible for Resident #76. Both nursing staff acknowledged that it needed to be fixed as soon as possible. b. Resident #364 was admitted to the facility on [DATE]. The Admission MDS assessment dated [DATE] coded Resident #364 with intact cognition and impairment on one side of her lower extremity. The MDS indicated Resident #364 required supervision or touching assistance to walk for more than 10 feet between locations inside the room. During an observation conducted on 01/27/25 at 11:55 AM, the switch for the light fixture behind Resident #364's bed was attached with a broken cord 3 inches in length. It was 5 feet from the floor and 4 feet from the bed. Resident #364 was unable to reach the switch cord from the bed if needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #364 on 01/27/25 at 11:58 AM. Resident #364 stated when she wanted to switch on the light fixture behind her bed at times, she could not stand up to reach the switch cord as she had knee surgery recently. It was very frustrating and inconvenient for her as she had to depend on the staff to switch it on each time. She hoped it could be fixed as soon as possible. Subsequent observation conducted on 01/28/25 at 10:49 AM revealed the switch cord for the light fixture behind Resident #364's bed remained inaccessible. During joint observation and subsequent interview with NA #4 and Nurse #1 on 01/28/25 at 2:33 PM, both nursing staff stated they provided care for Resident #364 frequently in the past few days and added they did not notice the switch cord was broken and inaccessible for Resident #364. Both nursing staff acknowledged that it needed to be fixed as soon as possible. c. Resident #54 was admitted to the facility on [DATE]. The quarterly MDS assessment dated [DATE] coded Resident #54 with moderately impaired cognition. The MDS indicated she could walk in between locations in the corridor up to 150 feet independently. During an observation conducted on 01/27/25 at 3:30 PM, the switch for the light fixture behind Resident #54's bed was attached with a broken cord 10 inches in length. It was 5 feet from the floor and 4 feet from Resident # 54's bed. Resident #54 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #54 on 01/27/25 at 3:31 PM. She did not know how long the switch cord had been broken. She could not reach the cord when she was lying in her bed, and it was very inconvenient to her. Subsequent observation conducted on 01/28/25 at 10:51 AM revealed the switch cord for the light fixture behind Resident #54's bed remained inaccessible. During joint observation and subsequent interview with NA #5 and Nurse #5 on 01/28/25 at 2:45 PM, both nursing staff stated they provided care for Resident #54 frequently in the past few weeks. NA #5 stated she did not notice the switch cord was broken and unreachable for Resident #54. Nurse #5 stated she noticed the switch cord was unreachable for Resident #54 on 01/28/25 in the morning and had notified the maintenance staff verbally. She did not know why the issue was not being addressed. Both nursing staff stated the cord needed to be fixed to ensure full accessibility for Resident #54. An interview was conducted with the Maintenance Director on 01/29/25 at 9:43 AM. He stated he walked through the facility at least once daily to identify repair needs. He also depended on nursing staff to report repair needs either verbally or via facility website electronically. He could not recall if he had fixed Resident #54's switch cord on 01/28/25 in the morning. He explained some of the switch cords could be broken again after he had fixed them. He acknowledged that all the broken cords needed to be fixed immediately to accommodate residents' needs. During an interview conducted on 01/29/25 at 1:25 PM, the Administrator expected the staff to be more attentive to residents' living environment and reported repair needs in a timely manner to accommodate residents' needs and ensure full accessibility to their light fixture. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing on 01/29/25 at 1:33 PM. She stated it was her expectation for all the residents to have full accessibility to their light fixture all the time to accommodate their needs.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, observations, and interviews with residents, facility staff, the Medical Director, the Lieutenant from the Police Department, resident's family friend, and the resident's responsible person (RP), the facility failed to protect the resident's right to be free from resident-to-resident abuse for 2 of 3 residents reviewed for abuse (Resident #15 and Resident #57). On 4/12/24 while completing morning rounds, Nurse Aide (NA) #6 found Resident #366 in Resident #15's room, lying on top Resident #15 while she was asleep in her bed, with his brief pulled down and his penis exposed. Resident #15's brief appeared to be sideways, undone on the left side, but was in place between her legs. Resident #366 was placed on one-to-one supervision at this time due to wandering and sexualized behaviors. Both residents were severely cognitively impaired. On 12/18/24 Resident #57 and Resident #36 (Resident #57's roommate) had their call light on and motioned for NA #1 to come into the room. Resident #36 spoke first and reported to NA #1 that Resident #366 came into the room took his pants off and got on top of Resident #57 and raped her. Resident #57 nodded her head in agreement and stated she told them to get off of her and get out of her room and they left. Both residents were assessed as cognitively intact. Resident #366 was supposed to be under one-to-one supervision at the time of the incident on 12/18/24 due to his continued wandering and sexualized behaviors and NA #2 left him unattended. A reasonable person would expect to be free from abuse in their own home and could experience altered mental condition, fear, anxiety, and depressed mood. The findings included: A. Resident #15 was admitted to the facility on [DATE]. Diagnosis included Alzheimer's disease, dementia, and muscle weakness. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was severely cognitively impaired and required substantial assistance for mobility and dependent on staff for transfers and toileting due to being incontinent of bladder and bowel. Resident #15 was also coded for having adequate hearing and vision, usually able to make herself understood, and usually able to understand others. Resident #366 was a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis included a traumatic brain injury (TBI), altered mental status, and cognitive communication deficit. Review of Resident #366's facility face sheet dated 4/14/23 revealed Cleveland County Department of Social Services as his responsible person and guardian. Review of quarterly MDS dated [DATE] revealed Resident #366 was severely cognitively impaired, independent for mobility, supervision for transfers, partial assistance with toileting as he was always continent for bowels with frequent urinary incontinence. Resident #366 was also ambulatory, utilized a wheelchair for long distances, able to make himself understood, able to understand others, adequate vision, and no hearing deficits. Resident #366 was not coded for any wandering or behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with NA #6 on 1/30/25 at 8:30 AM revealed she typically worked 11:00 PM to 7:00 AM on the locked memory care unit and was familiar with Resident #15 and the incident regarding Resident #366. She stated in April 2024 she worked in the locked memory care unit and while completing her morning rounds, she had entered Resident #15's room and saw Resident #366 on top of Resident #15 who was sleeping in her bed. NA #6 revealed Resident #366's pants and brief were pulled down with his penis exposed and Resident #15's brief was sideways, undone on the left side but still in place between her legs, her gown was pulled down, and her breasts were covered. NA #6 stated she immediately removed Resident #366 from Resident #15's bed, called for Nurse #6 to come to Resident #15's room, explained to Nurse #6 what happened and was then instructed for Resident #366 to be placed on one-to-one supervision. NA #6 revealed she assisted Resident #366 back to his room and stayed with him while Nurse #6 assessed Resident #15 and notified the Administrator. NA #6 stated after the incident, Resident #366 was moved from the memory care unit to a room on the regular hall and to her knowledge remained on one-to-one supervision. NA #6 revealed that prior to the incident with Resident #15, she was not aware of Resident #366 having any type of behavior and had never witnessed him display those types of sexualized behaviors. Attempted to contact Nurse #6 who was unable to be reached. Review of interdisciplinary team (IDT) progress note dated 4/12/24 revealed on the morning of 4/12/24 staff found Resident #366 in a severely cognitively impaired female resident's room (Resident #15). Resident #366 was observed lying on top of Resident #15 with his brief pulled halfway down and his penis exposed. Resident #15 was asleep at the time, but her brief was noted to be sideways, undone on the left side, but still in place between her legs. Resident #366 was immediately placed on one-to-one supervision which required him to always be in the staff's line of sight due to the sexualized and wandering behaviors. Resident #366 was also moved off the locked memory care unit to room [ROOM NUMBER] on B hall and one-to-one supervision to remain on-going. Review of the Medical Director progress noted dated 4/12/24 for Resident #15 revealed the following: Examination of Resident #15 due to history of a male resident [Resident #366] being on top of Resident #15 while she was in her bed. The Medical Director noted apparently around 6:30 AM a male resident [Resident #366] was found on top of Resident #15; his penis was out and Resident #15's brief was pulled to the side. According to the nursing staff, Resident #15 was asleep when they found her, was asleep when Medical Director went to see her, and remained asleep during Medical Director exam. Resident #15 had severe dementia. The Medical Director revealed to the best of his knowledge it did not seem that Resident #15 was penetrated at all, there were no scratch marks or other marks visible on Resident #15's hands, body, or in her vaginal area. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Medical Director progress note dated 4/12/24 for Resident #366 revealed the following: Around 6:30 AM, Resident #366 was found on top of a female resident [Resident #15] with his penis exposed and Resident #15's diaper was also possibly pulled to the side. Resident #366 was pulled off Resident #15 immediately and apparently placed on one-to-one. This had never happened with Resident #366 before; he did not seem agitated at the time, and there had been no knowledge of any behaviors leading up to this problem. Resident #366 did have a long mental health history he was being treated for with no recent changes to his medications. Hospital evaluation recommended by psychiatric (psych) services. Resident #366 returned from his evaluation from the local hospital and per their report, Resident #366's computed tomography (CT) scan and bloodwork showed no evidence of any acute abnormalities, and his urinalysis was negative. The Medical Director noted Resident #366 exposed himself on the way back from the hospital which was totally abnormal behavior. Resident #366 presently has one-to-one supervision for safety risks for both residents and staff. The Medical Director revealed he spoke with the psych provider who recommended new medications and agreed with Resident #366's one-to-one supervision for his and other residents' safety. Review of facility 5-day investigation report completed by the previous Administrator dated 4/18/24 revealed their investigative findings included the following: On the morning of 4/12/24 while NA #6 was making her rounds on the locked memory care unit when she entered Resident #15's room and found Resident #366 on top of Resident #15 who was sleeping, with his pants and brief pulled halfway down exposing his penis. Resident #15's gown was on, her breasts were covered, and her brief was sideways, appeared to be undone on the left side, but still in place between her legs. NA #6 notified Nurse #6 and Resident #366 was removed from Resident #15's room, taken back to his room, and immediately placed on one-to-one supervision. Resident #15 was assessed by Nurse #6 with no findings and continued sleeping. Law enforcement, Department of Social Services, State, Medical Director, and Resident #15's RP was notified of the incident. The facility Medical Director completed a physical examination of Resident #15 that included thorough examination of the vaginal and peri areas and found no indication that any sexual contact had occurred. Resident #15's RP declined the facilities offer to send her out to the hospital for any further evaluations. Both Resident #15 and Resident #366 were severely cognitively impaired and resided in the facility locked memory care unit. Resident #366 was not admitted with this type of behavior and prior to this incident had not displayed any types of behaviors that would cause staff to be aware of the potential for this type of behavior. Resident #366 was sent out to the hospital emergency department for evaluation and returned with no issues noted. Resident #366 was removed from the locked memory care unit into a room on a regular hall, remained on one-to-one supervision, monitored by the Medical Director, and was being evaluated and treated by psych services. Resident #15 was monitored for any psychosocial changes, mental anguish, change in her demeanor, or alterations in her daily activities and no issues were noted and Resident #15 remained pleasant and cooperative and appeared to have no negative impact. All facility staff were educated on abuse and neglect policies and procedures, wandering residents, new behaviors, and one-to-one supervision process. The facility was not able to substantiate abuse or neglect against any residents, and the residents involved remained without any physical injury, mental harm, pain, or anguish. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #366's care plan initiated on 4/12/24 revealed Resident #366 had exhibited inappropriate sexualized behaviors and was noted to continue sexualized behaviors such as masturbating while in bed with a goal to not exhibit any of these sexual behaviors any further through the next review. Interventions for Resident #366 included allowing privacy for masturbation in his room, new medications ordered for sexual behaviors and send out to emergency room for medical and psych clearance. Resident #366 also had a care plan approach for being an elopement risk and wanderer with goals of not leaving the facility unattended and maintaining his safety through the next review. Interventions for Resident #366 included one-to-one observation, monitoring locations, and documenting wandering behaviors. Attempted to contact the previous Administrator who was unable to be reached. B. Resident #36 was admitted to the facility on [DATE]. Diagnosis included chronic pulmonary obstructive disease (COPD) and muscle weakness. Review of quarterly MDS dated [DATE] revealed Resident #36 was cognitively intact with adequate vision and hearing, able to make herself understood, and able to understand others. Resident #57 was admitted to the facility on [DATE]. Diagnoses included mild dementia, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and muscle weakness. Review of admission Minimum Data Set MDS dated [DATE] revealed Resident #57 was cognitively intact and required partial assistance with mobility, substantial assistance with transfers, and substantial assistance with toileting as she was always incontinent for both bladder and bowel. Resident #57 was also coded for oxygen use and utilized a wheelchair for mobility, adequate vision and hearing, able to make herself understood, and able to understand others. Resident #102 was admitted to the facility on [DATE]. Diagnosis included COPD and type 2 diabetes. Review of admission MDS dated [DATE] revealed Resident #102 was cognitively intact with adequate vision and hearing, able to make herself understood, and able to understand others. Resident #366 was a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis included a traumatic brain injury (TBI), altered mental status, and cognitive communication deficit. Review of Resident #366's facility face sheet dated 4/14/23 revealed Cleveland County Department of Social Services as his responsible person and guardian. Review of Resident #366's care plan revised on 6/11/24 revealed Resident #366 had exhibited inappropriate sexualized behaviors and was noted to continue sexualized behaviors such as masturbating while in bed with a goal to not exhibit any of these sexual behaviors any further through the next review. Interventions for Resident #366 included allowing privacy for masturbation in his room, new medications ordered for sexual behaviors and send out to emergency room for medical and psych clearance. Resident #366 also had a care plan approach for being an elopement risk and wanderer with goals of not leaving the facility unattended and maintaining his safety through the next review. Interventions for Resident #366 included one-to-one observation, monitoring locations, and documenting wandering behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of quarterly MDS dated [DATE] revealed Resident #366 was severely cognitively impaired, independent for mobility, supervision for transfers, partial assist with toileting as he was always continent for bowels with frequent urinary incontinence. Resident #366 was also ambulatory, utilized a wheelchair for long distances, able to make himself understood, able to understand others, adequate vision, and no hearing deficits. Resident #366 was also coded for wandering and for physical and verbal behaviors towards others such as scratching, grabbing, threatening, screaming, cursing, or abusing others sexually. Review of facility incident report completed by the Administrator revealed on 12/19/24 at 1:30 AM the following information was reported: [Resident #36] rang her call bell to alert staff that someone had wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] had a BIMS (brief interview for mental status) of 15 and stated no inappropriate touching had taken place. Investigation was underway. [Resident #57] was being placed on one-on-one temporarily. Nursing Home Administrator (NHA) and the Director of Nursing (DON) were in the facility to conduct full investigation and ensure resident's safety. [Resident #57] stated that she felt safe at the facility. The incident report also revealed law enforcement had been contacted on 12/19/24 at 3:00 AM. An interview with Resident #57 on 01/30/2025 at 4:09 PM revealed one night a black woman [Resident #366] had come into Resident #57's room, got on top of her, and tried to feel of her. When Resident #57 told the black woman [Resident #366] to get off and get the hell out of her room initially she would not get off her so Resident #57 used her hands fight to get her off and to leave. Resident #57 stated on that night she was wearing her gown but could not remember if her gown was pulled up or was down and Resident #57 did not recall if she was wearing a brief or not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted with Nursing Aide (NA) #1 on 1/30/25 at 8:49 AM and revealed she was familiar with Resident #57 and the alleged incident regarding Resident #366. She stated on the evening of 12/18/24 she was scheduled to work 11:00 PM to 7:00 AM and was assigned to the A hall which included Resident #57's room. She revealed while reviewing her room assignments at the A hall nurse desk she observed Resident #366 sitting in his wheelchair at the desk with his assigned one on one (NA #3). NA #1 stated when she went down the A hall, she saw that three resident call lights were on including Resident #57's room. She revealed after answering the first two call lights, she went in to answer Resident #57's call light around 11:17 PM and upon entering the doorway to the room she observed both Resident #57 and her roommate Resident #36 to be alert and awake and were motioning for her to come into their room. She stated when she entered the room, she noticed there was a brief lying on the floor near the trash can and a brief lying at the end of Resident #57's bed and she asked both residents what was going on in there. NA #1 revealed Resident #36 then informed her that she saw Resident #366 come into their room, took off his pants, got on top of Resident #57 and raped her and that Resident #57 told Resident #366 to get off of her and get the hell out of their room, so he got up and left. She stated Resident #57 was shaking her head in agreement with what her roommate Resident #36 was saying and then stated, I told them to get off of me and get the hell out of the room and they left. NA #1 revealed she pulled back Resident #57's comforter and observed Resident #57 was not wearing a brief, so she immediately stopped and began yelling out for assistance from the other nursing staff to stay with the residents while she went to inform the nurse what was just reported to her. She stated she was not able to get any other staff to come into the room at that time, so she called the Director of Nursing (DON), which she believed to be around 11:30 PM to let her know what had been reported to her by both residents and that Resident #57 was not wearing a brief. She stated while on the telephone with the DON, she informed her that she was on her way and for NA #1 to stay with the residents, not to leave the room, not to touch anything in the room, and not to provide any type of personal care or incontinence care to Resident #57. She revealed the DON also inquired where Resident #366 was, and she informed her the last time she had seen Resident #366 he was sitting in his wheelchair at the nurse's desk with his assigned one to one. NA #1 stated she stayed in the resident's room until the DON and Administrator arrived and they asked her to step out of the room while they spoke with both residents privately. She revealed as she was leaving the resident's room, Resident #366's roommate (Resident #102) whose room was located directly across from Resident #57 room, motioned for her to come into their room. She stated Resident #102 informed her that earlier in the evening his roommate Resident #366's one on one had left the room and Resident #366 had gotten up out of his bed and attempted to get into bed with him. NA #1 revealed Resident #102 stated he asked Resident #366 what he was doing which seemed to startle Resident #366 and he got up from Resident #102's bed and watched him walk across the hall to Resident #57's room. She stated Resident #102 revealed he saw Resident #366 bend down, remove his pajama pants, get on top of Resident #57 and was moving around. She revealed Resident #102 stated he then heard Resident #57 yell get off of me and to get out of her room and saw Resident #366 get off the bed, put his pajama pants back on, leave Resident #57's room and walk down the hall. NA #1 stated after speaking with Resident #102 she finished her rounds with her other residents, went to the nurse station and notified NA #3 what Resident #57, Resident #36, and Resident #102 had reported and NA #3 informed her that when she had come back from her break a little before 11:00 PM, she had observed Resident #366 walking down the hallway unattended without his one to one. She revealed while at the nurse's station she began writing her handwritten statement about what had been reported to her by the residents and what she had observed, when she was asked to go back into Resident #57 room to sit with her. She revealed when she arrived back at the room, Resident #57 was still not wearing her brief, had used the bathroom on herself and was complaining about feeling wet and her gown and bedding being wet. NA #1 stated she then contacted the DON who was still in the building and asked if she could provide Resident #57 incontinence care and the DON and the Administrator came back into Resident #57 room. She revealed she was asked to step out of the room again but assumed the DON had cleaned and provided Resident #57 incontinence care, because when she returned to Resident #57 room afterwards, she was wearing a clean brief, and her gown and bedding had been changed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge of NC	237 Tryon Road Rutherfordton, NC 28139

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempted to contact NA #2 by telephone and was unable to be reached. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted with NA #3 on 1/30/25 at 9:23 AM revealed she was familiar with Resident #57 and the alleged incident regarding Resident #366. On 12/18/24, NA #3 was scheduled to work 7:00 PM to 7:00 AM on the A hall and her shift assignment was to provide one-to-one supervision for Resident #366. NA #3 revealed resident one-to-one supervision included being within arm's reach while the resident was up or ambulating around the facility and while the resident was in their room or sleeping the one-to-one was to sit outside the room and maintain line of sight. NA #3 stated on the evening of 12/18/24 she had assisted Resident #366 with turning on his TV and getting ready for bed and then asked NA #2 who was agency staff but had worked at the facility for several months and was aware of the one-to-one supervision protocol to come down and relieve her for her break which NA #2 agreed. NA #3 revealed that as she was leaving to go to break at 10:27 PM according to her watch and the time clock she notified the A hall nurse who was sitting at the nurse's desk that she was going on break and NA #2 was covering Resident #366's one-to-one supervision. NA #3 stated when she returned from her break at 10:51 PM and rounded the corner to A hall she observed Resident #366 three doors down from his room, walking the hallway unattended, wearing his pajama pants and a t-shirt. NA #3 revealed she did not see NA #2 anywhere in sight, so she assisted Resident #366 back to his room where she noticed he was not wearing a brief which was not uncommon because he would take them on and off, got him into his wheelchair and took him to sit with her at the A hall nurse's desk. NA #3 stated right after the 11:00 PM shift change while she and Resident #366 were sitting at the nurse's desk, NA #2 came up to the desk and she informed NA #2 that upon her return from break she had found Resident #366 walking around the A hall unattended and NA #2 apologized stating that she had gone to answer another resident's call light and had left Resident #366 unattended. NA #3 revealed that sometime around midnight while she and Resident #366 continued to sit at the nurse's desk, the Administrator and DON came in and went down the A hall and a few minutes later NA #1 came up to her and told her that Resident #36 had reported to her that Resident #366 had come into her and Resident #57's room, removed his pajama pants, got on top of Resident #57 while she was lying in her bed and raped her, Resident #57 yelled at Resident #366 to get off her and to get out of her room and Resident #366 left the room and walked down the hall. NA #3 stated NA #1 reported that Resident #57 had agreed with everything her roommate, Resident #36, was saying. NA #3 reported that as NA #1 was leaving Resident #36 and Resident #57's room, was when Resident #366's roommate (Resident #102) had motioned for NA #1 to come into his room. Resident #102 then reported to NA #1 that when Resident #366's one-on-one left the room, Resident #366 attempted to get into his bed and when he asked him what he was doing he got up and left. Resident #102 stated he saw Resident #366 walk across the hall into Resident #57's room, remove his pants, get on top of Resident #57 who was lying in her bed, move around on top of Resident #57, and when he heard Resident #57 yell at Resident #366 to get off of her and to get out of her room, Resident #102 saw Resident #366 get off Resident #57, put his pants back on, leave the room, and walk down the hall. NA #3 revealed she then informed NA #1 that when she had returned from her break earlier that evening, she had witnessed Resident #366 walking around the A hall unattended 3 doors down from his room. NA #3 also informed NA #1 that NA #2 was supposed to be covering her break and providing one-to-one supervision for Resident #366 but had left him attended while she went to answer a call light. NA #3 recalled a few minutes later after speaking with NA #1, was when NA #1 was asked to go back into Resident #57's room. NA #3 revealed while the Administrator and DON were walking back up the hallway from Resident #57's room was when she informed both about when she had returned from her break, she found Resident #366 walking around the A hall three doors down from his room, he was unattended wearing only his pajama pants, t-shirt, and no brief. NA #3 also reported to the Administrator and the DON that NA #2 was supposed to be covering her break and providing one-to-one supervision to Resident #366, and while providing Resident #366's one-to-one supervision NA #2 went to answer a call light and left Resident #366 unattended. NA #3 stated that after she was informed what Resident #57 had reported, she asked Resident #366 what had happened while he had been walking around the hall, and he stated that he had gone in to get into bed with his wife and he was touching and kissing on her but she didn't like it and told him to get out, so he left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #36 who on 1/29/25 at 12:40 PM revealed she recalled being roommates with Resident #57. When asked if anything had ever happened while she and Resident #57 had been roommates, she stated she did remember this one time where a black man had come into their room, got on top of Resident #57, she told them to get out and they left. She stated after that she believed Resident #57 moved rooms and nothing ever happened again. Resident #36 could not recall who she had spoken with on the night of the incident or any further details about the incident. A telephone interview with Resident #102 on 1/30/25 at 3:08 PM revealed on the evening of 12/18/24 he was lying in his bed, and his roommate Resident #366 was lying in his bed, when Resident #366's one-to-one staff left the room, Resident #366 got up out of his bed and tried to get into bed with him. Resident #102 stated it seemed to startle Resident #366 when he asked him what he was doing, and that was when Resident #366 got up from Resident #102's bed, left their room, walked across the hall, and into Resident #57's room. Resident #102 stated Resident #57's room was dark, but he was still able to see into the room with the hallway lights. Resident #102 revealed he saw Resident #366 remove his pants, get on top of Resident #57 while she was lying in her bed, and witnessed Resident #366 moving around on top of Resident #57. Resident #102 reported he could not tell if Resident #366 was wearing his brief or not while on top of Resident #57. Resident #102 stated he then heard Resident #57 tell Resident #366 to get off of her and get the hell out of her room and he saw Resident #366 exit off the left side of Resident #57's bed, walk around the end of the bed, put his pants back on, exit Resident #57's room, and walk down the hall. Resident #102 stated he would have used his call light to let staff know what had happened, but his call light had gotten tangled up and he couldn't find it. Resident #102 reported a few minutes later Resident #366's one-to-one came back into their room to get Resident #366's wheelchair, and appeared frazzled, so he did not tell her about what he had witnessed either. Resident #102 revealed a few minutes after Resident #366 one-to-one had come into his room, he saw NA #1 go into Resident #57's room and when he saw her leaving Resident #57 room was when he motioned for NA #1 to come into his room, and he told NA #1 what he had witnessed between Resident #366 and Resident #57, and then repeated this same information to the Administrator, and law enforcement. A telephone interview with Resident #57's friend on 01/30/2025 at 3:50 PM revealed she had been Resident #57 previous caretaker prior to her coming to the facility and continued to visit with her often. She stated on 12/26/24 she was visiting with Resident #57 when she suddenly became quiet, looked at her and said, I have something to tell you. Resident #57's friend stated she asked Resident #57 what she needed to tell her, and she said, I was raped. When asked what she was talking about, Resident #57 stated I was raped by a black woman [Resident #366], she got on top of me, and I had to tell her to get off me and out of my room. Resident #57's friend then asked if anyone had come into her room when this was going on and she said no. When she asked Resident #57 if she was ok and felt safe at the facility she said yes. Resident #57's friend stated she did not ask any further questions about the incident and Resident #57 had seemed fine, but it bothered her to think Resident #57 had gone through something like this. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of physician progress note written by the Medical Director on 12/20/24 indicated he was asked to see Resident #57 for questions about an incident that happened the night before and was unclear whether Resident #366 had assaulted her. While the Medical Director was talking with Resident #57, she stated that nothing happened, but someone did come into her room. It was really unclear to the Medical Director whether she knew exactly what happened, but the incident was being investigated. Resident #57 did not seem to be more anxious now or change in her mental status from previous. In speaking with Resident #57 today, it did not appear like there had been any trauma that he could think of but obviously the whole incident had to be anxiety provoking, however, he could not get a real history of what happened. Again, there were no signs of believed trauma but certainly wanted her seen by mental health provider and discussed all of this with Resident #57's RP. During an interview with the Medical Director on 1/28/25 at 11:09 AM he stated that he was aware of the alleged incident with Resident #57 and Resident #366. He stated the date of his progress note 12/20/24 was when he was notified, and he assumed the incident had occurred the night before on 12/19/24 and was not made aware the incident had occurred on the evening of 12/18/24. He revealed he did speak with Resident #57's RP on 12/19/24 regarding a sleep medication the RP wanted stopped, but he could not recall if she had mentioned anything to him about the incident, he only recalled that he discontinued Resident #57's sleep medication as requested. The Medical Director stated he was asked on 12/20/24 regarding an incident where Resident #366 had come into Resident #57's room and gotten onto her bed, she asked him to leave her room and he did, and it was unclear if any type of assault had occurred. He revealed that when he saw Resident #57 on 12/20/24 he only attempted to speak with her about the incident, but did not complete any type of physical exam. He stated Resident #57 would not really give him any details about the incident, only that someone had come into her room, but he did not feel that she was showing any signs or symptoms that any type of trauma or injuries had occurred. The Medical Director revealed to his knowledge Resident #57 had never showed any signs of increased anxiety or changes to her mental status and she was followed by psych services, and he was not aware of them noting any issues or concerns stemming from the incident. He stated Resident #366 was supposed to always be on one-to-one supervision due to sexualized behaviors, wandering, and an incident that occurred with another female resident earlier in the year. He revealed it appeared the one-on-one process failed allowing Resident #366 the opportunity to go into Resident #57's room which should have never been allowed to happen, Resident #366 was not suitable for skilled nursing level and not matter how much his medications were increased he would continue to require one-on-one supervision as long as he was at the facility because his sexualized behaviors specifically were unable to be controlled. A telephone interview was conducted with Resident #57's RP on 1/30 [TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45380 Based on record review and staff interviews, the facility failed to provide report an allegation of resident to resident abuse to the State Agency, law enforcement, and Adult Protective Services (APS) within the required timeframe and to ensure the report to all agencies included accurate information. The facility learned of an allegation of rape on 12/19/24, did not provide the information to law enforcement, and did not report the information to the State Agency until the investigation report was submitted on 12/26/24. This deficient practice affected 1 of 3 residents reviewed for abuse (Residents #57). Findings included: A review of the facility's abuse policy entitled Abuse, Neglect, Exploitation, and Misappropriation, last revised 6/13/21 revealed if an incident of suspected abuse occurs, the facility shall report immediately, but not later than 2 hours after forming the suspicion, if the events that caused the suspicion resulted in bodily harm, and no later than 24 hours if the events that caused the suspicion did not result in bodily harm to designated state agencies. Review of facility initial report completed by the Administrator indicated the incident date was 12/19/24 and the facility became aware of the incident on 12/19/24 at 1:30 AM. The fax date and time revealed the report was submitted on 12/19/24 at 3:24 AM. The initial report revealed the following information: [Resident #36] rang her call bell to alert staff that someone had wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] has a BIMS [brief interview for mental status] of 15 and states no inappropriate touching took place. Investigation underway. [Resident #57] is being placed on [one-on-one] temporarily. [The Administrator] and [the Director of Nursing] were in facility to conduct full investigation and ensure resident's [safety]. The report indicated Resident #57 stated that she felt safe at the facility and that law enforcement had been contacted on 12/19/24 at 3:00 AM. It did not indicate if APS had been contacted. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 4:03 PM. She indicated she received a telephone call from nursing staff around 11:34 PM on 12/18/24 stating Resident #57 and her roommate (Resident #36) had alleged a Resident #366 came into their room, sat down on Resident #57 bed, and when Resident #57 asked him to get out of the room he (Resident #366) left. She stated she immediately notified the Administrator and they both agreed to come into the facility to start their investigation and begin interviewing both residents and staff. The DON revealed she and the Administrator arrived at the facility sometime between 12:30 AM and 1:00 AM on 12/19/24 and immediately began interviewing residents so they could determine what type of incident had occurred and to begin their investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Police Department report dated 12/24/24 revealed on 12/22/24 detectives responded to the facility in reference to a past tense assault. Upon arrival they spoke with the Administrator who advised they had an incident that occurred on 12/19/24 around 3:00 AM and they had contacted the police department and spoke with a patrolman regarding the incident of a male resident entering the room of a female resident, sitting on the female resident's bed, and then leaving the room. The Administrator advised there was no nudity and no contact between the male (Resident #366) and female (Resident #57) resident. The Administrator stated the female resident had instructed the male resident to leave when he entered the room, and he left. As the detectives continued to receive the story of the incident from the rest of the staff there, as well as speaking with the patrolman about what was initially reported to him, it was concluded the male resident had crawled into bed with the female resident prior to getting him out of her room. This was information the Administrator did not mention to law enforcement during the initial interview about the situation. An interview conducted with the Lieutenant at the Police Department on 1/30/25 at 3:30 PM revealed on 12/19/24 at 3:00 AM they received a report from the Administrator at the facility regarding resident-to-resident abuse. The Administrator reported Resident #366 had walked into Resident #57's room, sat down on the bed, and then left the room. The Lieutenant revealed he was later notified on 12/22/24 by Resident #57's responsible person that Resident #57 had alleged she was raped. He stated he then went to the facility to take the report regarding Resident #57's allegation of rape. The Lieutenant revealed he interviewed the Administrator, and she stated on the evening on 12/18/24, Resident #366 had entered Resident #57's room, removed his pants, and got on top of Resident #57 while she was lying asleep in her bed. The Administrator revealed Resident #57 told Resident #366 to get off of her and to get out of her room, Resident #366 put his pants back on and left the room. The Lieutenant revealed this was a different story than what was initially reported on 12/19/24. He stated he attempted to interview Resident #57, but she would not really speak with him about the matter, and he also attempted to contact the staff that were working that night but none of them would return his call. He revealed the Administrator denied Resident #57 reporting to her that she was raped and the first time she had heard that word was when Resident #57's responsible person had mentioned it. Review of facility 5-day investigation report completed by the Administrator dated 12/26/24 revealed their investigative findings included the following information: Resident #102 witnessed the entire incident citing Resident #366's confusion and wandering behaviors. There was no willful intent noted on behalf of Resident #366 as evidenced by the fact that he also attempted to get into his roommate's bed just prior to the incident. There was no evidence of sexual intercourse observed during completed skin assessment and per resident reports. Resident #57's responsible person (RP) alleged Resident #57 had stated to her (the RP) that she (Resident #57) was raped. The Administrator and law enforcement attempted to interview Resident #57 about the allegation of rape, but she was not able to provide any further information. There were no reports that indicate abuse from staff interviews, or other resident interviews. The facility did not substantiate abuse, and Resident #57 remained without any physical injury, mental harm, pain, or anguish. Review of an intake letter from Adult Protective Services (APS) dated 12/31/24 revealed they had received the facility's 5-day investigation report on 12/26/24 related to the incident involving Resident #57 and Resident #366. The letter also revealed APS would not be following up on the intake report and were sending the report to the state for further review. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Administrator on 1/30/25 at 5:34 PM revealed she had completed the initial and 5-day investigation reports regarding the incident between Resident #57 and Resident #366. She stated she was contacted by the DON around midnight on 12/18/24 informing her of an alleged incident that occurred regarding Resident #57 and a male resident, who was later identified as Resident #366, coming into the room, sitting on Resident #57's bed, and then leaving the room. The Administrator revealed she and the DON arrived at the facility she believed between 12:30 AM and 1:00 AM on 12/19/24 to begin interviewing the residents. She stated that was why the initial report had was dated for 12/19/24 at 1:30 AM because that was when she was able to arrive at the facility, begin interviewing the residents, and receive the information needed for the report. The Administrator revealed based on the initial information that was provided to her by Resident #57 she did not have reason to believe anything further had happened than Resident #366 coming into Resident #57's room, getting on top of her bed, touching her shoulder area, Resident #57 telling him (Resident #366) to get out, and him leaving. She revealed the information that was initially provided to law enforcement on 12/19/24 was the information she had received after interviewing Resident #57 and the staff who were working that night. The Administrator stated it was not until later into the day on 12/19/24, after the incident had occurred on 12/18/24, that Resident #57's RP notified her that Resident #57 had said she was raped. The Administrator revealed Resident #57's RP did not provide her with any further information and when she attempted to interview Resident #57 again, she would not give her any further information. She revealed she addressed the rape allegation in the 5-day report and was not aware that she should have sent in a new report regarding that information and was also not aware that she should have contacted APS prior to the 5-day investigation since they had no information to show any alleged abuse had taken place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review and staff interviews, the facility failed to complete a thorough investigation of an allegation of resident-to-resident abuse for 1 of 3 residents reviewed for abuse (Residents #57). Findings included: The facility's Abuse Investigation and Reporting policy revised 6/13/21 indicated: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The role of the investigator included: - Review the completed documentation forms. - Resident the residents medical record to determine events leading up to the incident. - Interview the person reporting the incident. - Interview any witnesses to the incident. - Interview the resident. - Interview the residents Attending Physician as needed to determine the resident's current level of cognitive function. - Interview the resident's roommate, family members and visitors. - Interview other residents to whom the accused employee provided care or services. - Review all events leading up to the alleged incident. The following guidelines will be used when conducting interviews: - Each interview will be conducted separately in a private location. - Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. Resident #57 was admitted to the facility on [DATE]. Resident #57's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Willow Ridge of NC		STREET ADDRESS, CITY, STATE, ZIP CODE 237 Tryon Road Rutherfordton, NC 28139	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #366 was admitted to the facility on [DATE]. Resident #366's quarterly MDS assessment dated [DATE] revealed he was severely cognitively impaired. Resident #36 was admitted to the facility on [DATE]. Resident #36's quarterly MDS assessment dated [DATE] revealed she was cognitively intact. Review of Nurse Aide (NA) #1's signed statement typed by the Administrator dated 12/18/24 revealed NA #1 answered call light from Resident #36's room, she (Resident #36) called her to her bedside and stated she had seen someone come into the room and get on her roommates Resident #57's bed. Resident #36 stated it had been a black person that looked like a man. Review of NA #2's verbal statement via telephone and typed by the Administrator dated 12/18/24 revealed NA #3 asked me to watch Resident #366 while she went on break. NA #2 was sitting at the nurse's station so she could see the hall, she did however answer a few call lights while NA #3 was on break. Review of NA #3's signed statement typed by the Administrator dated 12/19/24 revealed NA #3 went to break around 10:25 PM (12/18/24) and asked NA #2 to take over one-to-one with Resident #366. When NA #3 returned she saw Resident #366 walking down the hallway near the A station dining room. Review of facility initial report completed by the Administrator indicated the incident date was 12/19/24 and the facility became aware of the incident on 12/19/24 at 1:30 AM. The fax date and time revealed the report was submitted on 12/19/24 at 3:24 AM. The initial report revealed the following information: [Resident #36] rang her call bell to alert staff that someone had wandered into their room and attempted to climb onto the bed with her roommate [Resident #57]. [Resident #57] has a BIMS [brief interview for mental status] of 15 and states no inappropriate touching took place. Investigation underway. [Resident #57] is being placed on [one-on-one] temporarily. [The Administrator] and [the Director of Nursing] were in facility to conduct full investigation and ensure resident's [safety]. Review of facility 5-day investigation report completed by the Administrator dated 12/26/24 revealed their investigative findings indicated Resident #102 witnessed the entire incident citing Resident #366's confusion and wandering behaviors. There was no willful intent noted on behalf of Resident #366 as evidenced by the fact that he also attempted to get into his roommate's bed just prior to the incident. There was no evidence of sexual intercourse during thorough skin assessment or per resident reports, and there were no reports that indicate abuse from the two resident eyewitnesses, staff interviews, or other resident interviews. Typed statements for Resident #57 and her roommate, Resident #36, were included in the investigation. The investigation did not include a resident statement from Resident #366 and no assessments were documented for either Resident #57 or Resident #366. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 4:03 PM an interview was conducted with the Director of Nursing (DON). The DON stated she assisted the Administrator with the investigation regarding the incident that occurred on 12/18/24 between Resident #57 and Resident #366. She stated she did not have anything to do with collecting the nursing staff's witness statements. She explained that the Administrator handled those statements. She stated she believed the Administrator had stated that due to the staff's written statements being hard to read, the Administrator had re-typed the staff statements and had staff to sign them. The DON revealed she had no knowledge of Resident #366 being interviewed and she was never asked to assess Resident #366. She stated she had completed a skin assessment on Resident #57 and was not aware that she needed to complete and document a more thorough physical assessment. A review of the facility investigation file and interview with the Administrator were conducted on 1/30/25 at 5:35 PM. The Administrator stated she was aware of and had completed the incident and 5-day investigation reports regarding the incident that occurred on 12/18/24 between Resident #57 and Resident #366. She revealed that two of the three nursing staff from that night provided her with their handwritten statements. She indicated after reviewing those statements, she explained to staff that some of the statements were not legible, had too much detail, only needed to include the facts, and did not need to include any resident interviews. She explained she then took the nursing staff's hand-written statements and typed up new statements and then had the staff to sign them. She stated she did offer the staff to come into her office with her while she typed up the statements and they declined. The Administrator revealed she did not keep the staff's original handwritten statements. The Administrator further revealed Resident #366 was not assessed, but she did speak with him about the incident with Resident #57, and he told her that he was going to see his wife to give her a back massage. She stated she was not aware that she needed to type up an interview statement for Resident #366 or that he should have been assessed. She revealed the DON assessed Resident #57 and completed a skin assessment, but she was not aware the DON needed to complete and document a more thorough physical assessment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, legal guardian, and staff interviews, the facility failed to notify the Resident's legal guardian in writing of a transfer to the hospital in South Carolina for 1 of 3 residents reviewed for discharge (Resident #366). The findings included: Resident #366 was admitted to the facility on [DATE]. Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian. Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment. Review of Resident #366's discharge Minimum Data Set (MDS) dated [DATE] revealed the discharge was coded as an unplanned discharge to hospital with return anticipated. Review of Resident #366's electronic medical record revealed no written notification to Resident #366's Guardian of his transfer to the hospital in SC. A telephone interview was conducted with Resident #366's Legal Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's legal guardian through the Department of Social Services. She stated she received a telephone call on 12/20/24 from the Administrator stating Resident #366 had been taken to the hospital in SC for an in-patient psychiatric hold and evaluation. She stated she did not receive any notification in writing prior to Resident #366 being transferred to the hospital in SC. The Administrator was interviewed on 1/30/25 at 5:30 PM. The Administrator reported on 12/202/4 the facility felt it would be best for Resident #366's safety due to his wandering and sexualized behavior to be sent out to the hospital for an in-patient psychiatric evaluation and treatment. She stated she did not send Resident #366's legal guardian notification in writing regarding Resident #366's transfer to the hospital in SC but did notify her by telephone.

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F 0626

Level of Harm - Actual harm

Residents Affected - Few

Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45380

Based on record review, Medical Director, Hospital Case Manager, Resident's Legal Guardian, and staff interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric evaluation. The resident remained in the hospital for over a month despite being cleared to return to the nursing home after 3 days. A reasonable person would expect once they were medically cleared from the hospital to be allowed back into their home and not being allowed back into their home could cause them to experience altered mental condition, fear, anxiety, and depressed mood. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #366).

Findings included:

Resident #366 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury (TBI), altered mental status, and cognitive communication deficit.

Review of Resident #366's facility face sheet dated 4/14/23 revealed a local Department of Social Services was appointed as his legal guardian.

Review of the Medical Director order dated 12/20/24 revealed Resident #366 was to be sent out to hospital in South Carolina (SC) for evaluation and treatment.

Review of discharge Minimum Data Set (MDS) dated [DATE] revealed Resident #366 was severely cognitively impaired with wandering, verbal, and physical behaviors towards others. Resident #366's discharge was coded as an unplanned discharge with return anticipated.

Review of hospital case manager notes for Resident #366 dated 12/20/24 through 1/22/25 revealed the following:

12/20/24- Resident #366 was brought to the hospital emergency room in SC by his current facility located in North Carolina (NC) for a psychiatric (psych) evaluation regarding his hypersexualized behavior and a complaint from another resident. Resident #366 who had a history of TBI had gotten into bed with another resident thinking she was his wife.

12/21/24- Tele psych consult completed, and initial recommendation was for involuntary commitment (IVC) and psych placement in behavioral unit.

12/23/24- Follow up psych note documented, Psych inpatient facility considered and currently NOT indicated cleared psychiatrically and medically.

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F 0626 Level of Harm - Actual harm Residents Affected - Few	12/24/24 - Hospital psych liaison, contacted the Director of Nursing (DON) at Resident #366's current facility of him being cleared by psych and inquired what time for the hospital to bring him back to the facility. The DON referred to the facility Administrator. The hospital psych liaison informed the Administrator Resident #366 was ready to return to the facility, the Administrator stated Resident #366 had been immediately discharged from their facility and was accepted to another facility in NC. 12/26/24 - Hospital case manager spoke with Admissions at the other facility who stated were unable to offer Resident #366 a bed and they had notified his current facility of this fact. 1/7/25 - Resident #366 was transferred from their hospital behavioral unit to a regular hall on their main campus until placement could be found. 1/9/25 - Hospital case manager spoke with Resident #366's guardian who communicated that his current facility was refusing to accept him back and she was working on a new placement in North Carolina. 1/10/25 - Resident #366 was agitated and wandering into other patient rooms; transferred to their only secured unit in the hospital, the Intensive Care Unit (ICU). 1/10/25 - Following transfer to the ICU, the hospital case manager questioned why the nursing home brought Resident #366 across state lines to their hospital in SC. The hospital case manager contacted the hospital in NC to inquire if they offer psych services. The facility Administrator then explained they did not send Resident #366 to their local hospital because they knew he would be evaluated and sent right back to their facility. The hospital case manager explained and advocated Resident #366's needs to return to their facility, but the Administrator continued to refuse to accept him back. 1/13/25- The hospital case manager spoke with Resident #366's guardian and stated Resident #366 current facility transported him across the state lines to their hospital for a psych evaluation which Resident #366's guardian agreed was inappropriate and stated she had filed a report with the State Agency regarding this and the facility's refusal to readmit the resident. 1/17/25- The hospital case manager noted the facility was still unwilling to accept Resident #366 back and the hospital was currently awaiting placement. 1/20/25- Resident #366 was medically stable, ready for discharge, and awaiting placement. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	A telephone interview with Resident #366's Guardian on 1/27/25 at 3:15 PM revealed she was Resident #366's Guardian through the Department of Social Services. She stated Resident #366 had a history of wandering and sexual behaviors over the past year while at his current facility and some incidents of going into other female resident's rooms and getting into their beds which had required him to be on one-to-one supervision. She revealed after the last incident on 12/18/24 of Resident #366 wandering into a female resident's room and getting into her bed, she received a telephone call on 12/20/24 from the Administrator at the facility stating Resident #366 would be moving to another skilled nursing facility within the day. Resident #366's Guardian stated she informed the Administrator that Resident #366 could not be moved so quickly without her speaking with and touring the other facility. She revealed she contacted the other facility and after discussing Resident #366 with them, the other facility refused to take him on that day and stated they would need to come and assess Resident #366 in person the following week. Resident #366's Guardian stated she contacted the Administrator at Resident #366's current facility and let her know the other facility would not be able to take Resident #366 on 12/20/24 but would be able to assess him in person the following week, and the Administrator stated Resident #366 would not be at their facility next week he would be leaving that day. Resident #366's Guardian revealed a few hours later on 12/20/24, she received a telephone call from the Administrator stating Resident #366 had been taken to the hospital in SC for an in-patient psychiatric hold and evaluation. She stated after that she began communicating with the hospital, Resident #366 was evaluated and on 12/23/24 was psychiatrically and medically cleared and recommended for discharge back to his current facility but the Administrator refused to take him back. Resident #366's guardian revealed both she and the hospital spoke with the Administrator at the facility on numerous occasions begging for them to take Resident #366 back until they could find a more appropriate placement for him and the Guardian offered that the Department of Social Services would pay for a private one-to-one for the resident and the Administrator continued to refuse to take him back. She stated during Resident #366's hospital stay, the hospital had to place him in the intensive care unit because it was the only locked unit in the hospital, and he was trying to wander in and out of patient rooms. Resident #366's Guardian revealed she contacted the State Agency for help with placement for Resident #366 and believed the state must have contacted the Administrator at the facility because a few days after she had spoken with the State Agency, she received a telephone call from the facility stating they would be readmitting Resident #366 to the facility. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	A telephone interview with the hospital case manager on 1/31/25 at 4:00 PM revealed she was familiar with Resident #366. She stated Resident #366's current facility brought him to their hospital emergency room in SC on 12/20/24 requesting an in-patient psych evaluation. She revealed Resident #366 was admitted to their behavioral unit on 12/21/24 for completion of a psych evaluation. The hospital case manager stated the follow-up recommendations from the behavioral unit on 12/23/24 revealed in-patient psych placement had been considered for Resident #366 and was not indicated. Resident #366 was psychiatrically and medically cleared for discharge. She revealed the hospital contacted Resident #366's current facility and spoke with the Administrator and advised that Resident #366 had been cleared and was ready for discharge and the hospital needed to know when they could schedule transport back to the facility. She stated the Administrator informed the hospital Resident #366 would not be returning to their facility that he had been discharged from their facility and had been accepted to another skilled nursing facility. The hospital case manager revealed the hospital contacted the other skilled nursing facility about Resident #366 and were informed that they had notified Resident #366's current facility they were unable to offer him a bed and would not be admitting him. She stated the hospital also spoke with Resident #366's guardian who informed her Resident #366's current facility was refusing to take him back. The hospital case manager revealed that during Resident #366's hospital stay she contacted Resident #366's current facility numerous times and spoke with the Administrator about Resident #366 needing to return to their facility, and the Administrator continued to refuse to allow Resident #366 to come back to their facility. The hospital case manager stated on 1/20/25 the hospital received a call from Resident #366's current facility stating they would be coming to assess Resident #366 to see if they would be able to accept him back to their facility. She revealed to the Administrator, and the Admissions Director came to the hospital to speak with Resident #366 and then agreed he could come back, and he was discharged back on 1/22/25 after being left at the hospital for over a month. An interview conducted with the Director of Nursing (DON) on 1/30/25 at 4:03 PM revealed she was familiar with Resident #366 and that he required one-to-one supervision due to his wandering and sexual behaviors. She stated there had been an incident on 12/18/24 where Resident #366's one-to-one supervision had left him unattended and he wandered into another female's residents' room, got into her bed.The DON revealed on 12/20/24, Resident #366 was supposed to be transferred to another skilled nursing facility, but that placement apparently fell through. The DON stated that she and the Administrator notified the facility Medical Director about Resident #366's placement to the other facility had fallen through and discussed with the Medical Director about Resident #366 being sent out to the hospital for a psych evaluation. She revealed the Medical Director agreed for Resident #366 to be sent out to the hospital in SC due to the local hospital not having a psych unit. The DON stated that she only spoke with the hospital in SC once which she believed was on 12/21/24, when the doctor from the hospital was requesting information on Resident #366 and stated they would be admitting him for a psych evaluation. The DON revealed she was not aware of the hospital staff or the guardian calling the facility multiple times to notify them Resident #366 was ready to return to the facility and she was not aware of the facility ever refusing to take him back. She stated she believed the facility did receive a telephone call from the State Agency regarding Resident #366's discharge and return to the facility, but to her knowledge the plan had been for him to return to their facility once they were able to assess him and make sure his psych evaluation and recommendations had been completed. She revealed that the facility had been trying to find a more appropriate placement for Resident #366 since last year due to his TBI and his behaviors. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Administrator on 1/30/25 at 5:34 PM revealed she was familiar with Resident #366. She stated Resident #366 had a history of wandering and sexual behaviors and had been on one-to-one supervision for safety. She also stated that on 12/18/24, Resident #366's one-to-one supervision had left him unattended, and he wandered into a female resident's room, got into her bed. The Administrator revealed on 12/20/24 Resident #366 was scheduled to transfer to another skilled nursing facility, but that placement fell through, and in the meantime the other facility residents had heard about the incident on 12/18/24 and had started calling Resident #366 a rapist. The Administrator revealed she and the DON had discussed their fears for Resident #366 safety and felt it might be best for him to be sent out to the hospital for a psych consultation due to his wandering and sexual behaviors. She stated she and the DON spoke with the facility Medical Director, they notified him that the other skilled nursing placement for Resident #366 had fallen through and discussed sending Resident #366 out to the hospital for a psych evaluation due to his behavior and for his safety. She revealed the Medical Director agreed for Resident #366 to be sent out to the hospital for an in-patient psych evaluation based on his sexual behaviors and for his own safety. The Administrator stated the facility transported Resident #366 to the hospital in SC because they have a geriatric psych unit, and their local hospital did not have a psych unit and would only provide him with a tele psych visit and send him back to the facility. She revealed while Resident #366 was at the hospital in SC she did speak with the hospital over the telephone and provided them with some diversion activities she thought would help with his behaviors and informed them the facility would assist them with finding other placement. She denied ever refusing to take Resident #366 back and did not have an explanation as to why the hospital had documented the facility's refusals to take him back. The Administrator stated she did receive a telephone call from the State Agency she believed on 1/17/24 advising her of the facility's responsibility to readmit Resident #366. She revealed prior to the State Agency calling the facility, she had already planned to go to the hospital and assess Resident #366 for him to return and was just waiting to make sure his recommended treatment from his psych evaluation had been completed. An interview was conducted with the facility Director of Marketing and Admissions on 1/29/25 at 11:07 AM revealed he was familiar with Resident #366. He stated he was not involved with Resident #366 discharge to the hospital and never spoke with anyone at the hospital regarding Resident #366 not being allowed to return. He revealed on 1/20/25 he was notified by the Administrator to contact the hospital in SC to let them know they would be coming to the hospital to assess Resident #366 to see if they would be able to allow him to return. The Director of Marketing and Admissions stated he accompanied the Administrator to the hospital on 1/20/25 where they assessed Resident #366 and agreed for him to return to the facility, and he assisted with scheduling Resident #366's admission and transport back to the facility on [DATE]. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Medical Director on 1/28/25 at 11:09 AM revealed he was familiar with Resident #366. He stated Resident #366 had a history of wandering and sexual behaviors and required one-to-one staff supervision for his safety. He revealed on 12/20/24, Resident #366 was supposed to be transferred to another skilled nursing facility, but that placement fell through. The Medical Director stated after Resident #366's placement fell through; the Administrator and DON spoke with him about concerns for Resident #366's safety facility along with the safety of the other's residents given his sexual behaviors and asked if he could be sent out to the hospital for a psychiatric evaluation. He revealed he agreed with the Administrator and the DON for Resident #366 to be sent out for an evaluation to the hospital in SC. The Medical Director stated that because their local hospital would more than likely have briefly evaluated Resident #366 and sent him back to the facility, he felt the behavioral unit at the hospital in SC would be able to evaluate and assist with locating a more appropriate placement for Resident #366. The Medical Director stated he did not feel Resident #366's current placement was the most appropriate for him given his age, TBI, and his behaviors and was told when he was sent out that he would not be returning to his current facility. He revealed he did speak with the hospital in SC on 12/21/24 to give some medical and background information on Resident #366 but was not aware of any further details of his stay at the hospital. He stated as far as Resident #366 being readmitted to the facility; it was his understanding the facility had received a call from the State Agency saying the facility had to allow him to return until they found him a more appropriate placement.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on record review and staff interviews, the facility failed to complete the Care Area Assessment Summary (CAAS) of the Minimum Data Set (MDS) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 6 sampled residents reviewed for unnecessary medications (Residents #48 and Resident #82). The findings included: a. Resident #48 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, and depression. The MDS assessment dated [DATE] coded Resident #48 with moderately impaired cognition. A review of the CAAS revealed 8 care areas were triggered for Resident #48. Other than listing medications received by Resident #48, the facility did not provide any information in analysis of findings for 6 of the 8 triggered areas to describe the nature of Resident 48's problems, possible causes, contributing factors, risk factors related to the care areas, and reasons to proceed with care planning for the following triggered care areas: 1. Cognitive loss/dementia 2. Activities of daily livings functional/Rehabilitation potential 3. Falls 4. Dental care 5. Pressure ulcer/injury 6. Psychotropic drug usage b. Resident # 82 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, bipolar disorder, and chronic pain. The quarterly MDS assessment dated [DATE] coded Resident #82 with intact cognition. A review of the CAAS of the annual MDS assessment date 03/29/24 revealed 5 care areas were triggered for Resident #82. Other than listing medications received by Resident #82, the facility did not provide any information in analysis of findings for all 5 triggered areas to describe the nature of Resident 82's problems, possible causes, contributing factors, risk factors related to the care areas, and reasons to proceed with care planning for the following triggered care areas: 1. Activities of daily livings functional/Rehabilitation potential 2. Falls (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Willow Ridge of NC		STREET ADDRESS, CITY, STATE, ZIP CODE: 237 Tryon Road Rutherfordton, NC 28139	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Nutritional status 4. Pressure ulcer/injury 5. Psychotropic drug use During an interview conducted on 01/29/25 at 1:19 PM, MDS Coordinator #2 confirmed 6 of the 8 triggered care areas for Resident #48's MDS dated [DATE] and all 5 triggered care areas for Resident #82's MDS dated [DATE] were submitted without providing pertinent information in the analysis of findings in the CAAS. She explained she started to work as the MDS Coordinator last July and both MDS assessments were submitted by the former MDS Coordinator. She did not know how both incidents occurred and acknowledged that it was an error to submit an annual MDS without completing analysis of findings for all the triggered areas comprehensively. An interview was conducted with the Administrator on 01/29/25 at 1:25 PM. She stated it was her expectation for all the CAAS to be completed comprehensively to include at least the underlying causes, contributing factors, and reasons to proceed with care planning. On 01/29/25 at 1:33 PM an interview was conducted with the Director of Nursing. She stated all the CAAS must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in the CAAS before submission.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on observations and staff interviews the facility failed to post daily nurse staffing in a prominent location that was readily accessible to residents on 4 of 5 days during the survey (01/27/2025, 01/28/2025, 01/29/2025, and 01/30/2025). The findings included: An observation on 01/27/2025 at 9:00 AM revealed the daily nurse staff posting was located on the wall in the front lobby. The daily nurse staffing sheet was a white, 8 by 10-inch piece of paper enclosed in a hard plastic display holder. The lobby was only accessible to the residents by entering through a closed door which had a keypad access. The facility staff had the access code for the keypad. The daily nurse staff posting was not readily visible or accessible for the residents to view. Additional observations on 01/28/2025 at 8:15 AM, 01/29/2025 at 8:15 AM, and 01/30/2025 at 7:45 AM of the facility's daily nurse staff posting revealed it was located on the wall in the front lobby and was not readily visible or accessible for residents to view. An interview was conducted with the Scheduler on 01/30/2025 at 11:34 AM. The Scheduler revealed that she had worked in her current role for [AGE] years and she was responsible for posting the daily nurse staffing. The Scheduler also stated the daily staff posting had been located in the lobby for quite a long while. An interview was conducted with the Director of Nursing (DON) on 01/30/2025 at 12:30 PM. The DON revealed that the residents could view the daily staff posting if they entered the lobby. She further stated the residents had to ask a staff member to enter the keypad code to unlock the door for the residents to enter the lobby and view the daily staff posting. An interview was conducted with the Administrator on 01/30/2025 at 1:40 PM. The Administrator revealed the facility's daily staff posting should be placed in an area that was readily accessible and visible for residents to view. She also stated the daily staff posting had been displayed in this area since she had been with the facility and was not readily accessible to residents.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142 Based on record review, and interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities related to the use of as needed (PRN) psychotropic drug (drug that affects mental state) and provide recommendations for 1 of 7 residents reviewed for unnecessary medications (Residents #25). The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #25 with moderately impaired cognition and indicated she had received antianxiety medications in the 7-day assessment periods. A physician's order dated 11/26/24 indicated- 1 tablet of Ativan 0.5 milligrams (mg) by mouth every twelve hours as needed for anxiety was ordered for Resident #25. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found in Resident #25's medical records. A review of the medication administration record (MAR) revealed Resident #25 had received 4 doses of PRN Ativan in January 2025. A review of medical records revealed the Consultant Pharmacist had conducted a medication regimen review (MRR) for Resident #25 on 11/18/24 and 12/30/24. She did not identify any drug irregularities. The only recommendation from 12/30/24 MRR was to discontinue PRN meds due to non-use which included Ativan, Senna, Preparation H, and albuterol. During a phone interview conducted on 01/28/25 at 4:08 PM, the Consultant Pharmacist confirmed she had completed MRRs for Resident #25 on 11/18/24 and 12/30/24. She stated she did not notice the drug irregularities related to the PRN Ativan order without a stop date and attributed the error to her oversight. During an interview conducted on 01/28/24 at 11:50 AM, the Medical Director was familiar with Resident #25 but did not remember the specifics of the exact order. The Medical Director stated he did not write stop dates on his orders, and stated he wrote his orders with no refills then reviewed the medication when a refill was requested before a new order was given. He stated he wrote his orders that way they would not last more than 30 days. He stated he was bad at writing stop dates. He stated he was not aware of a 14-day duration for PRN psychotropic medication. An interview was conducted with the Director of Nursing (DON) on 01/29/25 at 2:16 PM. She expected the Consultant Pharmacist to identify the drug irregularities and report the findings to the facility and provider in a timely manner. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 01/29/25 at 2:37 PM, the Administrator stated it was her expectation for the Consultant Pharmacist to identify the drug irregularities and report it in a timely manner.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142 Based on record review and interviews with residents, staff, and the Medical Director (MD), the facility failed to ensure physician's orders for as needed (PRN) psychotropic drug (drug that affects mental state) was time limited in duration and provided rationales for therapy exceeding 14 days for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #25). The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #25 with moderately impaired cognition and indicated she had received antianxiety in the 7-day assessment periods. A physician's order dated 11/26/24 indicated 1 tablet of Ativan 0.5 milligrams (mg) by mouth every twelve hours as needed for anxiety was ordered for Resident #25. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found in Resident #25's medical records. Attempts to interview Nurse #4 who confirmed the order on 11/26/2024 were unsuccessful. A review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed Resident #25 had received 4 doses of PRN Ativan in January 2025. 1/11/25 - 2 doses 1/14/25- 1 dose 1/17/25- 1 dose On 01/27/25 02:24 PM an attempt to interview Resident #25 was unsuccessful. She was unable to engage in the interview. During an interview on 01/29/25 at 12:17 PM Nurse #1 stated PRN orders for psychotropic medications were to be written for 14 days. Nurse #1 stated she would ask the Doctor for clarification if PRN psychotropic medications were written without a stop date. An interview was conducted with the Director of Nursing (DON) on 01/29/25 at 2:16 PM. The DON stated she expected orders for PRN psychotropic medications to be written per the facilities policy. The DON expected the orders to be reviewed by 3rd shift nurses for accuracy. The DON also stated during morning management meetings all orders were reviewed by being read off and double checked. The DON was unsure how the order for a PRN psychotropic with no stop date was not caught during the review process. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 01/30/25 at 09:20 AM Nurse #2, who worked 3rd shift after the order on 11/26/2024 was written, stated she did know she was supposed to, and had never reviewed the orders for accuracy while working third shift at the facility. During a telephone interview on 01/30/25 at 09:43 AM Nurse #3, who worked 3rd shift after the order on 11/26/2024 was written, stated she had never reviewed orders for accuracy while working third shift, and stated she did not know that was expected. During an interview conducted on 01/29/25 at 2:37 PM, the Administrator stated she expected orders for PRN psychotropic meds to be written per the facilities policy. During an interview conducted on 01/28/24 at 11:50 AM, the Medical Director was familiar with Resident #25 but did not remember the specifics of the exact order. The Medical Director stated he did not write stop dates on his orders, and stated he wrote his orders with no refills then reviewed the med when a refill was requested before a new order was given. He stated he wrote his orders so they would not last more than 30 days. He stated he was bad at writing stop dates. He stated he was not aware of a 14 day duration for PRN psychotropic medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review, and staff interviews, the facility failed to secure an opened tube of topical paste for 1 of 1 Resident reviewed for medication storage. (Resident #99). The findings included: Resident #99 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #99 with severely impaired cognition. During an observation conducted on 01/27/25 at 12:32 PM, one opened tube of zinc oxide paste (a topical paste for treating or preventing skin irritation) with the concentration of 15% was left unattended on top of the left bedside table in Resident #99's room. It contained approximately 75 grams of zinc oxide and was ready to be used. An interview was conducted with Resident #99 on 01/27/25 at 12:35 PM. She did not know how long the tube of zinc oxide paste had been left unattended in her room. She could not provide any additional information related to the zinc oxide paste. During an interview conducted on 01/27/25 at 12:39 PM, Nurse #5 stated the zinc oxide paste should be kept in the medication cart instead of leaving unattended in Resident #99's room. She did not notice the tube of zinc oxide paste was in Resident #99's room when she did medication pass on 01/27/25 in the morning. An interview was conducted with Nurse Aide #4 on 01/27/25 at 12:41 PM. She stated she had provided care for Resident #99 frequently in the past few weeks. She did not notice the tube of zinc oxide was left unattended on Resident #99's bedside table when she rounded her on 01/27/25 in the morning. During an interview conducted with the Director of Nursing (DON) on 01/27/25 at 12:55 PM, she stated Resident #99's daughter could have brought the zinc oxide paste to the facility for Resident #99. She stated zinc oxide paste should be kept in the medication cart. It was her expectation for all the nursing staff to be more attentive to residents' room when providing care to ensure none of the medications were left unattended in the facility. An interview was conducted with the Administrator on 01/27/25 at 4:02 PM. She expected nursing staff to pay attention to residents' room when providing care. It was her expectation for the facility to remain free of unattended medications at all time.