

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>345197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/02/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>WILLOW RIDGE OF NC</b>		STREET ADDRESS, CITY, STATE, ZIP <b>237 TRYON ROAD RUTHERFORDTON, NC 28139</b>	
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 0760  <b>Level of harm - Immediate jeopardy</b>  <b>Residents Affected - Some</b>	<p><b>Ensure that residents are free from significant medication errors.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on record review, staff, Resident, Pharmacist, and Facility Nurse Practitioner, Rheumatology Nurse Practitioner and Physician interviews the facility failed to administer five of six doses of a [MEDICAL CONDITION] arthritis medication that was ordered to be injected on a weekly basis for 1 of 3 sampled residents reviewed for unnecessary medications (Resident #2). Resident #2 experienced increased pain in her left shoulder and right knee. Immediate Jeopardy began on 08/14/20 when Resident #2 did not receive five of six doses of a [MEDICAL CONDITION] arthritis medication which was ordered to be given subcutaneously every week. Immediate Jeopardy was removed on 09/27/20 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A telephone order given by the Rheumatology Nurse Practitioner (RNP) dated 07/29/20 indicated, Resident #2 was to receive Orenzia Solution (a biologic medication that reduces the pain and swelling of moderate to severe [MEDICAL CONDITION] arthritis and can help stop further joint damage) 125 milligrams (mg) per 1 milliliter (ml) injection, 1 ml subcutaneously once a week. The telephone order also indicated, the order was faxed to the pharmacy by Nurse #3. Nurse #3 was no longer employed by the facility and unable to be interviewed. The Care Plan revised on 04/09/20 revealed, Resident #2 was at risk for pain related to [MEDICAL CONDITION] arthritis. The goal for Resident #2 was to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the next review by administering [MEDICATION NAME] per the physician's orders [REDACTED]. #2 had intact cognition and required extensive assistance with the help of two staff for bed mobility, transfers and toilet use. The MDS indicated, Resident #2 received a scheduled and a prn (as needed) pain medication for pain described as frequent and moderate. The MDS also indicated, the Resident received an opioid pain medication and did not receive an injection during the seven day look back period. Review of Resident #2's September 2020, physician's orders [REDACTED]. *Orenzia Solution 125 mg/ml subcutaneously one time a day every Friday for pain related to [MEDICAL CONDITION] arthritis ordered 07/29/20. *[MEDICATION NAME] Extended Release (ER) 40 mg give one tablet by mouth one time a day for pain, scheduled for 8:00 AM ordered on [DATE]. *[MEDICATION NAME] ER 30 mg give one tablet by mouth one time a day for pain, scheduled for 9:00 PM ordered 10/24/19. *[MEDICATION NAME] 5 mg give one tablet by mouth every two hours as needed for pain. May take with [MEDICATION NAME] if patient desired ordered 07/03/20. On 09/15/20 at 2:30 PM during a telephone interview with Resident #2 she explained, she was started on a medication for her [MEDICAL CONDITION] arthritis by the Rheumatologist but had not received the medication in several weeks. Resident #2 stated, the pain in her right knee, left shoulder and back was getting worse and there were nodules on her elbows that were painful when she laid her arms down on a flat surface, like her mattress, or when she tried to push herself up to a standing position using her arms. The Resident explained, when she did receive her arthritis injection, she could tell a major difference in her pain level in that now her pain level would get as high as a ten and when she took the prn pain medication, it would only relieve the pain for about two hours before her pain level started to increase. Resident #2 remarked, she was pretty much miserable all the time since she had not been receiving her arthritis pain medication. Resident #2's July, August and September 2020 Electronic Medication Administration Records (eMAR) revealed, there were no administration dates scheduled on the July 2020 eMAR. However, the [MEDICAL CONDITION] arthritis medication was scheduled to be administered on 08/07/20, 08/14/20, 08/21/20, 08/28/20, 09/04/20, and 09/11/20. The eMAR further revealed, the only date the Orenzia was initiated as being administered was on 08/07/20. The eMAR indicated, Nurse #1 documented the #9 for the dates of 08/14/20, 08/28/20 and 09/11/20 and Nurse #2 documented the #9 for the dates of 08/21/20 and 09/04/20 which indicated Other/Progress Notes on the chart codes. Review of Resident #2's Progress notes revealed: *08/14/20 indicated pharmacy to deliver written by Nurse #1 *08/21/20 indicated med not in stock written by Nurse #2 *08/28/20 indicated called the pharmacy to deliver tonight written by Nurse #1 *09/04/20 indicated not in stock written by Nurse #2 *09/11/20 indicated pharmacy to deliver written by Nurse #1 On 09/15/20 at 2:13 PM a telephone interview was conducted with Nurse #1 who confirmed, he was the Nurse who worked on 08/14/20 at 8:00 AM and who documented he did not give Resident #2 the Orenzia injection because he did not have the medication on hand and had to order the Orenzia from the pharmacy. Nurse #1 stated, he reported to the oncoming 7:00 PM - 7:00 AM B Station (the hall Resident #2 resided on) Nurse which was Nurse #4 that he was not able to give the Orenzia and that Nurse #4 should give Resident #2 the Orenzia when the pharmacy delivered the medications that evening. When asked if Nurse #1 followed up the next day to confirm the medication had been given to Resident #2, he stated he did not because he was assigned to a different hall. Nurse #1 added, he could not confirm whether he was the Nurse who worked on 08/28/20 or 09/11/20 but he knew there were other dates that the injection was not available, and he had to order the Orenzia from the pharmacy. Nurse #1 offered no indication that the pharmacy could not deliver Resident #2's arthritis medication. On 09/15/20 at 2:50 PM during a telephone interview with Nurse #4 she explained, she was not assigned to work B Station on 08/14/20 7:00 PM - 7:00 AM and therefore, Nurse #4 did not know anything about Resident #2's Orenzia injection. Nurse #5 was assigned to work 08/14/20 7:00 PM - 7:00 AM and several attempts were made to obtain an interview. The attempts were unsuccessful. Nurse #2 was an agency Nurse who no longer had a contract with the facility and was unable to be interviewed. Nurse #6 who worked on 08/15/20 7:00 AM - 7:00 PM was on leave of absence and was unable to be interviewed. Attempts to interview Nurse #7 who worked on 08/29/20 7:00 AM - 7:00 PM were unsuccessful. Review of several pharmacy delivery sheets for Resident #2's Orenzia revealed: *On 07/30/20 Orenzia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. *On 08/14/20 Orenzia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. *On 08/28/20 Orenzia Solution Prefilled Syringes of 125 mg/ml, 2 syringes were delivered. On 09/15/20 at 10:45 AM during a telephone interview with the Pharmacist she confirmed, the pharmacy had delivered Resident #2's Orenzia Solution 125 mg/ml, 2 syringes on 07/30/20, 08/14/20 and 08/28/20 to the facility. The Pharmacist also shared, the prescriber had approved the Orenzia in June of 2020 and the prior approval was effective through 06/2021. Review of the Nurse Practitioner's Progress Notes dated 09/14/20 revealed, Resident #2 presented with the following assessment: severe joint deformities in her bilateral hands; severe ulnar deviations of her fingers; tenderness in her knees, ankles, wrists and hands; nodules along her radius and near the elbows; no acute joint redness or swelling and her right knee and left shoulder were particularly tender. On 09/15/20 at 10:10 AM a telephone interview was conducted with the Facility Nurse Practitioner (FNP) who stated, she had assessed Resident #2 the previous evening on 09/14/20. The FNP explained, Resident #2 complained of increased pain in her right knee and left shoulder and stated she was not getting her arthritis injection that the Rheumatologist ordered for her. The FNP continued to explain, that Resident #2 was ordered to receive Orenzia injections by the RNP once a week to prevent her [MEDICAL CONDITION] arthritis flare ups and after research the FNP discovered that the last dose of the Orenzia injection was given on 08/07/20. The FNP stated, she had not been made aware that Resident #2 was not receiving the medication or that she had missed five doses. The FNP explained, if Resident #2 did not receive the Orenzia soon that she would have to start Resident #2 on course of steroids. The FNP shared, the Orenzia</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE	

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

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F 0760  <b>Level of harm - Immediate jeopardy</b>  <b>Residents Affected - Some</b>	<p>(continued... from page 1)</p> <p>required a prior authorization approval from the prescriber and that approval had already been completed. On 09/16/20 at 4:21 PM a telephone interview was conducted with the Rheumatology Nurse Practitioner who explained, Resident #2 had been a patient of the clinic for years. The RNP confirmed, in late July 2020 she had given an order for [REDACTED], #2 not receiving the ongoing treatment for [REDACTED]. During an interview with Resident #2's Physician on 09/16/20 at 9:50 AM he explained, he was made aware of the situation with Resident #2's Orenica injections not being given on Thursday (09/10/20) as he was leaving the facility and thought he would address the situation when he was back in the facility on 09/17/20. He stated, the NP saw Resident #2 more than he did, and the NP had not indicated to him that Resident #2 was not receiving her arthritis medication nor had the facility informed him that the medication had not been given. The Physician added, if the Orenica was currently an active order, then it should have been given as ordered. A telephone interview was conducted with the Director of Nursing (DON) on 09/17/20 at 12:00 PM. During the interview the DON confirmed, Resident #2's Orenica was charted as not given on 08/14/20, 08/21/20, 08/28/20, 09/04/20 and 09/11/20 with follow up progress notes that indicated the medication was either not in stock or that the medication was ordered from the pharmacy. The DON explained, the nurses should have notified her that the medication was not available so that she could have followed up with the pharmacy herself. The DON stated, when she investigated the situation, she found two syringes of Resident #2's Orenica medication in the medication room on A Station which was not the medication room in which Resident #2's medication was stored. The DON shared, she did not know why the nurses did not follow up with giving the medication when it was delivered from the pharmacy. On 09/17/20 at 2:30 PM during a follow up telephone interview with the DON she explained, that she had educated the nurses multiple times to notify her when a medication was not available from the pharmacy so that she could follow up with the pharmacy herself and that by the nurses not notifying her when Resident #2's Orenica was not available was an error on their part. During a telephone interview with the Administrator on 09/17/20 at 4:50 PM he stated, he expected the doctor's orders to be followed as they were written, and the nurses should have notified the DON when Resident #2's medication was not available from the pharmacy so that she could have followed up with the pharmacy. The Administrator and Regional Clinical Director were notified of Immediate Jeopardy on 09/26/20 at 8:18 PM. The facility provided the following credible allegation of Immediate Jeopardy removal for F 760: 1. Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance. Based on record review, staff, Resident, Pharmacist, and Nurse Practitioner interviews the facility failed to administer five of six doses of a rheumatologist ordered medication that was to be injected on a weekly basis to treat [MEDICAL CONDITION] arthritis for 1 of 3 sampled residents reviewed for unnecessary medications (Resident #2) because the nurse failed to retrieve the medication from the medication refrigerator, and instead, documented that the medication was not available. They failed to alert the Director of Nursing or Nursing Supervisor. While Nurse #1 and Nurse #2 both had progress notes for the five missed doses and indicated the medication was not in stock or the pharmacy would deliver, the root cause was that they documented this without checking the refrigerator which was where the medication was located. Further, the Nursing Supervisor failed to identify the medication as missed within the electronic medical record system. This information should have been reviewed in the daily clinical meeting which is held five days per week. The weekend Supervisor monitors this information on the weekends. The Physician was notified on 9/14/20, by the Director of Nursing regarding the missed medication, Orenica 125mg/ml for Resident #2 for the dates of 8/14, 8/21, 8/28, 9/4 and 9/11/20. The Director of Nursing stated, when she investigated the situation, she found two syringes of Resident #2's Orenica medication in the medication room on A Station which was not the medication room in which Resident #2's medication was stored. The medication was received by a Licensed Nurse who took the medications and placed them in the A nurse's station refrigerator. The other medications were also located in that same refrigerator. It was found during the investigation that the medications were received and stored in the location where the Resident had originally resided. The facility has since changed to a centralized location where all refrigerated medications are received. The Nurses were made aware of this change via telephone or in person on September 27th by the Director of Nursing and Administrator. Resident #2 received an injection on 9/16/20 and again on 9/23/20. The Physician assessed and reviewed the Resident's medications on 9/24/20 and wrote an order to hold the medication until 10/01/20 due to the medication can weaken the immune system. The Physician also documented that the Resident's pain was fairly controlled with her pain medications of [MEDICATION NAME] and [MEDICATION NAME]. Current facility residents were at risk to be affected by the alleged deficient practice of failure to receive medications as ordered. The Director of Nursing completed an audit of current facility residents' Medication Administration Record [REDACTED]. There was one Resident identified that did not receive the scheduled dose of [MEDICATION NAME] on 9/22/20 at 8:00 AM. The Nurse Practitioner was notified on 9/27/20 by the Licensed Nurse. No new orders were received. There were no adverse effects identified. The Director of Nursing and Charge Nurses completed an audit comparing the ordered medications to what was on the cart on 9/27/20, to validate that medications were available to be administered as ordered. All medications were available. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Director of Nursing and the Nursing Supervisors completed education for current Licensed Nurses on 9/27/20, regarding the protocol for obtaining medications and process for notification if a medication was not available to be administered as ordered. When a medication order is written, the Licensed Nurse will input the order in the electronic medical record and the order will be received by the pharmacy to be filled and sent to the facility. During the medication pass, if the medication is not available on the medication cart, the Licensed Nurse should look in the back up medication room and if not available there, the Licensed Nurse should get the medication out of the Emergency Stat safe kit. If the medication is not available in the kit and is not available from the back up pharmacy, the Licensed Nurse will notify the Physician and an order will be written for a medication that is available or hold the order until the medication was available. The Licensed Nurse will notify the Director of Nursing regarding the needed medication 24/7. The Medication Availability Form which is a new form will be kept on each medication cart for the Licensed Nurse to document the steps taken to obtain the medication. This new form was provided to all licensed staff, including current agency staff, with education to the new process. All new staff will be educated by the Director of Nursing or Unit Coordinators to the new procedure during orientation prior to taking an assignment. The Director of Nursing and or the Nursing Supervisor will review the Medication Availability list daily seven days a week to assure medications were available as ordered. No Nurse will be allowed to work until educated. Newly hired Licensed Nurses will be educated during the new hire orientation. The Supervisors have been informed of this responsibility. The Director of Nursing and or the Nursing Supervisors will run a report from the electronic medical record daily seven days a week to identify medications that were documented as missed or not given. The Director of Nursing and or the Nursing Supervisors will follow up when it is identified that a medication was not given or not signed out as given, to determine the reason and assure the medication is available and given as ordered. If the medication was not given as ordered the Licensed Nurse will notify the Physician for further orders. The Nursing Supervisors were informed of this responsibility as provided by the training provided on 09/27/2020 by the Director of Nursing. The facility alleges the removal of the Immediate Jeopardy on 09/27/20. On 10/02/20 the facility's credible allegation for Immediate Jeopardy removal was validated by the following: Review of in-service training records included twenty-four individuals from the nursing department which included floor nurses, supervisors, unit managers, and the management team. The topic of the education was on medication availability that included new processes regarding medication unavailability, ordering medications, notifying physicians of unavailable medication and notifying the Director of Nursing of unavailable medications. The new system introduced a new form titled Medication Availability which would be utilized in the event of unavailable medications and would be monitored by the management team. The Director of Nursing and the Administrator conducted the in-services which were held both by person and via telephone. Interviews with the facility and agency nurses revealed they received the education on 09/27/20 or on hire and could describe the new processes and the nurses could explain the reason and intent of the new Medication Availability form. Observations of the medication carts revealed the new Medication Availability form was present on the medication carts and medications that required refrigeration was noted to be stored in the centralized medication room as indicated by the new system. The facility's date of Immediate Jeopardy removal of 09/27/20 was validated.</p>		