

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

APR 09 2013

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PRINTED: 04/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/21/2013
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>The State contact information will be updated to reflect the correct names and phone numbers for each of those agencies. This list will be posted prominently in a public area.</p> <p>The posting will be monitored weekly through the month of May and June. Then monitored monthly in July, August, September, and then quarterly thereafter.</p> <p>Administrator/designee will trend findings and submit to QA committee for analysis and recommendations.</p> <p>Completion date: April 12, 2013.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator 4/8/13

(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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post accurate state agency contact information for all residents in the facility.</p> <p>An observation on 3/18/13 at 11:27 PM revealed that the state contact information posted on the bulletin board near the administrative offices was incorrect. The name for the state agency was listed as Division of Facility Services and the phone numbers were not the current contact numbers for the agency</p> <p>In an interview on 3/20/13 at 2:40 PM, the administrator stated that he was the person responsible for posting the state contact information and that he updated the board, as necessary, when any changes were made to the information. He reported that the last updated state contact information that he recalled receiving was approximately 5 years ago.</p> <p>In an interview with the administrator on 3/21/13 @ 5: 15 PM, he stated that he was aware that the name of the state agency was the Division of Health Service Regulation and not Division of Facility Services and that he would be able to locate the correct contact information and update the board accordingly.</p>	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	<p>Continued From page 3</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to treat residents in a dignified and respectful manner for 1 of 1 sampled residents (Resident #132) whose records were reviewed. Findings include:</p> <p>Resident #132 was admitted to the facility on 10/31/12 with cumulative diagnoses of weakness and falls.</p> <p>Resident #132's Quarterly Minimum Data Set (MDS) dated 1/3/13 showed that Resident #132 was moderately cognitively impaired.</p> <p>In an interview on 3/18/13 at 11:31 AM Resident #132 stated Nursing Assistant (NA) #1 was rude, mean and "ugly" in conversation and that she had a bad attitude. Resident #132 indicated that Nurse #1 had been informed of the incidents.</p> <p>In an interview on 3/21/13 at 3:25 PM Resident #132 elaborated on his previous interview by stating NA #1 had used name calling, a bad tone of voice and had a bad attitude. Resident #132 stated the actions of NA #1 had made him feel "lousy".</p> <p>In an interview on 3/18/13 at 12:23 PM Nurse #1 stated she had been told by Resident #132 that NA #1 had been rude to him.</p>	F 241	<p>We have conducted a thorough investigation of resident #132's complaint. Staff education and assignment adjustments were made based upon the findings of the investigation.</p> <p>Nurse #1 will be in-serviced on her responsibilities related to reporting of resident's concerns.</p> <p>Administrator/designee will provide education to the nursing staff regarding providing care and services to our residents in a respectful manner that maintains their dignity.</p> <p>Alert and oriented residents will be interviewed weekly for 4 weeks; every-other week for 2 months and monthly for 2 months.</p> <p>Administrator/designee will trend interviews and submit the results to the QA committee for recommendations.</p> <p>Completion date: April 18, 2013.</p>		

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F 241	Continued From page 4  In an interview on 3/20/13 at 2:08 PM Nurse #1 stated she had not told anyone about Resident #132's complaint of being treated disrespectfully.  In an interview on 3/20/13 at 5:15 PM the facility Social Worker (SW) stated if a staff member was rude to a resident it should be written up and taken to the Director of Nursing for investigation.  In an interview on 3/20/13 at 6:12 AM Nurse #2 stated the incident should have been written up as a grievance and been investigated.  In an interview on 3/21/13 at 2:35 PM the Director of Nursing (DON) indicated that all allegations should be investigated.	F 241		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to evaluate and identify the cause of the falls so that effective interventions could be implemented for 1 of 3 residents (Resident #87) who had a history of falls. The resident fell and resulted in a head injury and C2 cervical spine fracture. The facility	F 323	Resident #87 is receiving additional supervision to promote safety. This supervision will be maintained until the IDT team determines Resident #87's plan of care can be adjusted. Resident #70 also receives additional supervision that will be maintained until the IDT team determines resident #70's plan of care can be adjusted.  Residents at risk for falls and unsafe wandering have the potential to be affected.	

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F 323	<p>Continued From page 5</p> <p>also failed to evaluate the blue hall exit door for resident safety and failed to implement interventions for prevention of residents exiting through the door for 1 of 1 residents (Resident #70) who was confused and wandered out the blue hall exit door down 2 flights of stairs. Findings included:</p> <p>1. Resident #87 was admitted to the facility on 02/28/11. Cumulative diagnoses included congestive heart failure, dementia, vertigo, glaucoma and hypertension.</p> <p>A Significant Change Minimum Data Set (MDS) of 02/18/13 indicated Resident #87 had long and short term memory problems as well as impaired decision making skills. There were no behaviors noted. She needed limited assistance with bed mobility, transfer and walking in her room or corridor. She needed extensive assistance with locomotion. She was not steady when moving from a seated to a standing position and was only able to stabilize with human assistance. Resident #87 was not steady when walking or turning around and was only able to stabilize with human assistance. The Care Area Assessment (CAA) summary for this assessment indicated she triggered for falls and activities of daily living (ADL). The falls CAA detail identified her as being at risk for falls and had not had any falls recently. The ADL CAA noted she had declined recently due to pneumonia and was requiring more assistance than usual due to weakness.</p> <p>The March 2013 Physician 's orders noted that a bed alarm was added to Resident #87 's bed on 07/07/12.</p>	F 323	<p>cont'd from page 5</p> <p>The IDT reviewed these residents' charts, completed comprehensive fall risk assessments and unsafe wandering assessments and reviewed/revised care plans to reflect current needs.</p> <p>Stairwell door is monitored 24-hours-a-day, 7 days a week. This will be maintained until this door can be secured. The facility is currently working with a vendor, the state construction office, and the fire marshal to get the appropriate security system installed.</p> <p>DON/designee will provide education to staff nurses and certified nursing assistants on fall management strategies that will include the use of supportive devices and their responsibilities related to ensuring they are in place and functioning. Social Services/designee will provide education to facility staff on unsafe wandering and their responsibilities to maintain the safety of the residents.</p>	

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F 323	<p>Continued From page 6</p> <p>According to a progress note in Resident #87 's electronic record, she was observed on the floor at 1:00 AM on 03/07/13. The note indicated she was confused and disoriented. Resident #87 was transferring herself and sat on the floor. There were no injuries.</p> <p>The facility 's occurrence report of 03/07/13 for Resident #87 's fall at 1:00 AM, indicated she was observed sitting on the floor in front of her bed and was confused and disoriented. She was bare foot and had attempted a non-capable walk and/or transfer. It was noted Resident #87 had poor safety judgment and had climbed out of bed without assistance slipping on the floor and fell. The intervention to prevent further falls was to place non-skid socks on Resident #87.</p> <p>According to the Quality Assurance worksheet for this fall investigation, Resident #87 was attempting to get out of bed and was in her normal state of confusion. She had been non-compliant with use of the call light. It was also noted on this worksheet that staff had been in 15 minutes prior to the fall to check on her. A bed alarm was in place and functioning at the time of the fall. The new intervention was non-skid socks and to offer to toilet her every 2 hours.</p> <p>According to the ECS computer care plan printout, Resident #87 was identified as having a history of falls on 03/11/13. Staff were to encourage her to ask for assistance and offer to toilet every 2 hours.</p> <p>A nurse progress note of 03/17/13 at 11:32 PM written by Nurse #3 indicated Resident #87 was observed on floor at 3:45 PM in her room. It was</p>	F 323	<p>cont'd from page 6</p> <p>Nurse managers/designees will complete an audit of fall management supportive device placements and functioning 5 times a week for 2 weeks, 3 times per week for 2 weeks, and weekly times 4 weeks.</p> <p>Social services will evaluate residents for unsafe wandering upon admission, quarterly, and with a significant change. Residents identified as at risk for unsafe wandering will have a care plan initiated to promote safety.</p> <p>DON/designee will trend the audit results and submit these trends to QAA for further analysis and recommendations.</p> <p>Completion date: April 18, 2013</p>	

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F 323	<p>Continued From page 7</p> <p>noted that the pad alarm was turned off. Resident #87 had a laceration with bleeding noted, a skin tear and complained of pain at a level of 5 out of 10 on the pain scale. Injuries were noted to the right ear, right eye, and right cheek. Resident #87 was sent to the emergency room.</p> <p>A telephone physician ' s order of 03/17/13 noted to send Resident #87 to the emergency room for evaluation.</p> <p>The facility ' s transfer form of 03/17/13 indicated Resident #87 was sent out to the emergency room for evaluation of a head injury following a fall. According to the emergency room records, she was discharged back to the facility with a face laceration and a C2 cervical spine fracture.</p> <p>The facility ' s occurrence report and investigation of 03/17/13 for Resident #87 ' s fall at 3:45 PM indicated she was observed on the floor. The possible cause was slipping on the floor. There was injury to the right ear, right eye and right cheek and nose as well as a skin tear. The physician and family were notified. It was noted that the fall had occurred during shift change from day shift to evening shift. It was noted Resident #87 was found on the floor alone after hearing " help " and a noise. The contributing factor indicated the bed or chair alarm was not on. Resident #87 had gotten up without assistance. Xray results from the emergency room indicated Resident #87 had a C2 cervical spine fracture. It was noted in the Quality Assurance worksheet attached to the report that the alarm was not sounding and the fall had been caused by no wheelchair and/or bed alarm being on.</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>Interventions to prevent further falls included all alarms to be checked and implement one on one supervision for Resident #87. The last fall risk assessment score of 02/21/13 was 21 which indicated she was at high risk for falling.</p> <p>A nurse progress note of 03/18/13 at 3:19 AM indicated Resident #87 had returned to the facility at approximately 12:15 AM with a cervical collar in place with a dressing to the right eye. There were sutures to the right forehead in an almost circular pattern approximately the size of a quarter. Neurological checks were started. The nurse documented she was unable to obtain light reaction in the right eye due to the amount of swelling and bruising. It was noted that the bed alarm and the tabs alarm units were in place and functioning. There was a fall mat placed on the floor.</p> <p>Resident #87 ' s care plan for falls, last updated 03/20/13, indicated she was found on the floor. Staff were to ensure that the bed alarm was in place at all times with one on one care.</p> <p>Resident #87 was observed in bed wearing a cervical collar on 03/20/13 at 10:00 AM. Her right eye was swollen and black purplish bruising with sutures just above the right eyebrow. There was no staff member present in her room at the time of the observation. There was a bed alarm noted in place. Nurse Aide #2 (NA #2) was observed sitting in a chair at the doorway of Resident #70 ' s room which was located next to Resident #87 ' s room. When NA #2 was interviewed at 10:02 AM on 03/20/13, she stated she was monitoring Resident #87 ' s room as well as Resident #70 from Resident #70 ' s doorway.</p>	F 323		

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F 323	Continued From page 9  Resident #87 was observed in the wheelchair at 3:30 PM on 03/20/13. There was a clip alarm attached to the wheelchair and to her clothing. NA #3 was observed sitting in a chair just outside her doorway. When interviewed at 3:35 PM, NA #3 reported that Resident #70 had been moved to the room with Resident #87 so she could monitor both of them as well as the exit door. She added that Resident #87 was ambulatory prior to the fall of 03/17/13. NA#3 stated Resident #87 had poor vision and was not independent with ambulation since the fall. NA #3 commented that she was able to stand and pivot for transfers and had both a bed alarm and a clip alarm.  The Director of Nurses (DON) was interviewed on 03/21/13 at 9:55 AM. She stated when a resident falls the nurse who assessed the resident completes a fall report as to the circumstances of the fall. She stated it then comes to her for review and she passes it on to Nurse #8 to complete the follow-up investigation. The DON reported that resident falls were discussed in the morning meetings to determine appropriate interventions. She commented that after Resident #87 fell on 03/17/13 a monitoring tool had been created for administrative nursing staff to start checking for placement of the alarms and their function. The DON stated the electronic charting system (ECS) was being checked to ensure that all residents with alarms were documented in the ECS. She stated the alarms would be added to the ECS medication administration record (MAR) for the nurses to make sure they were aware that the resident had an alarm. The DON stated in-services were in process to make sure all staff knew who had	F 323			

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F 323	<p>Continued From page 10</p> <p>alarms and where to find the information in the ECS. The DON remarked she would be conducting audits. When questioned about the one on one supervision for Resident #87, she responded that they had placed the two residents who were currently on one on one supervision in the same room so as to utilize only one staff person.</p> <p>NA #4 was observed sitting just inside Resident #87 ' s doorway on 03/21/13 at 10:30 AM. Resident #87 was sitting in a wheelchair wearing yellow non-skid socks with the cervical collar in place. She was also noted to have a clip alarm in place. When interviewed about the function of the alarm at 10:35 AM, NA#4 stated she checked for placement of the alarm at the beginning of the shift and demonstrated its function by disconnecting it resulting in an audible sound. NA #4 also reported Resident #87 was non-ambulatory and she was assigned to supervise her to ensure that she did not attempt to get up unassisted.</p> <p>The nurse aide (NA #5) who had worked with Resident #87 on 03/17/13 day shift was interviewed on 03/21/13 at 10:57 AM. NA #5 stated Resident #87 needed total care and was alert but confused. NA #5 stated she was non-ambulatory and could stand and pivot to transfer. When questioned about the fall of 03/17/13, NA #5 stated she had been told that Resident #87 had fallen during shift change that day. She added that she had already left the premises when Resident #87 fell. NA #5 stated Resident #87 ' s family member had assisted her with placing Resident #87 back into bed toward the end of her shift on 03/17/13. She stated the</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>sensor alarm was in place and working when she left the room. NA #5 stated if a resident had an alarm it was noted on the ADL sheet in the ECS. NA #5 added that she left at 3:00 PM on 03/17/13 and the second shift aide took over care at 3:00 PM.</p> <p>Nurse #6 was interviewed on 03/21/13 at 11:20 AM. She stated fall risk assessments were completed after each incident and if the resident had no falls, the falls risk assessment was completed quarterly with the MDS. Nurse #6 commented that Resident #87 was at risk for falls and her care plan had been updated to include the new intervention of one on one supervision.</p> <p>A telephone interview was conducted with Nurse #3 on 03/21/13 at 1:30 PM. She stated she was just coming on duty on 03/17/13 and received report about 3:30 PM. She stated at about 3:45 PM she walked down Resident #87 ' s hallway and heard someone calling for help. She stated she noticed upon entry into the room that there was no alarm sounding and when she checked the alarm was not turned on. Nurse #3 reported that Resident #87 ' s wheelchair was positioned next to the bed and her walker was placed behind the wheelchair. She stated she went into the room and found Resident #87 on the floor near the bathroom with bleeding noted over her right eyebrow. Nurse #3 stated she applied pressure and assessed her on the floor. She stated Resident #87 was left on the floor with supervision until the emergency service arrived to transport her to the emergency room. Nurse #3 commented she did not lose consciousness. She stated the resident reported she had gotten up to close the door. Nurse #3 stated she could not</p>	F 323			

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F 323	Continued From page 12 determine where Resident #87 had been positioned prior to the fall. She stated the on-coming nurse aides were getting their assignments and supplies in preparation for providing care during the time Resident #87 fell. When questioned how many nurse aides were on the hall, she replied that she knew one was there and another aide was late. Nurse #3 commented that one nurse aide did not show up for her shift. Nurse # stated when a resident fell the nurse assessed them, completed a fall report, an investigation form and a handwritten fall report. She stated the family as well as the physician were notified of the fall and the incident report was faxed to the physician. Nurse #3 added that Resident #87 had returned to the facility shortly after midnight with sutures to her upper right eyebrow.  Nurse #8 was interviewed about Resident #87 ' s fall on 03/21/13 at 3:15 PM. She stated she completed the Quality Assurance worksheet incident prevention addendum for the fall of 03/17/13. When questioned as to her investigation, she stated she had not yet interviewed any of the staff who worked with Resident #87 the day she fell. Nurse #8 reported when Resident #87 fell, the staff working were PRN (as needed) staff and were often difficult to reach and had not been back into the building to work since 03/17/13. Nurse #8 commented that one of the nurse aides (NA #5) who worked on 03/17/13 had actually worked on day shift today but she did not interview her. She stated the fall prevention equipment was not in place when Resident #87 fell. Nurse #8 stated she was responsible for making sure there was a physician ' s order written and that staff knew	F 323		

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F 323	<p>Continued From page 13 about the new interventions.</p> <p>Attempts to contact the second shift nurse aide were unsuccessful so the DON was interviewed again on 03/21/13 at 4:30 PM. She provided a written statement from the second shift nurse aide (NA #8) which indicated NA #8 went into Resident #87 's room and she was on the floor near the bathroom. NA #8 assisted the nurse. There was no other information in this document. The DON stated she had not interviewed NA #8 since she had asked the nurse to obtain the statement.</p> <p>2. Resident #70 was admitted to the facility on 07/16/08. Cumulative diagnoses included dementia and diabetes mellitus.</p> <p>According to the electronic computer system (ECS) for Resident #70, the last elopement/unsafe wandering risk assessment was completed on 12/18/12. She was not identified as being at risk for elopement or wandering.</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 01/12/13 indicated Resident #70 was not cognitively intact. She required limited assistance for bed mobility, transfer and to walk in her room. She was not steady when moving from a seated position to a standing position and could not stabilize without human assistance. She was not steady when walking but could stabilize without human assistance with the use of an assistive device.</p> <p>A physician 's telephone order of 02/27/13 at 6:15 AM noted to obtain a UA (urine for analysis).</p>	F 323		

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F 323	Continued From page 14  A nurse ' s note of 02/27/13 at 6:26 AM indicated Resident #70 was noted to have confusion this morning. She attempted to exit the facility at 5:45 AM. The note indicated she had gone down hall 3 (her hall), went out the exit door and down 2 flights of steps before staff could get to her. She was put back in bed. It was also noted that the writer had attempted to find a wander guard for her but none were available so a tabs unit was placed on Resident #70 and a note was left for the Director of Nurses (DON).  A physician ' s telephone order of 02/27/13 noted to check Resident #70 ' s wander guard bracelet every shift and to check the battery every night.  On 02/27/13 at 9:22 AM, the family was notified about the incident of Resident #70 getting out of bed and going out of the door at the end of the hall and down 2 flights of stairs. The note indicated it was reported to the family that one on one supervision was instituted and staff would be attempting to obtain a urine specimen for urinalysis.  A nurse ' s note of 02/27/13 at 3:35 PM indicated Resident #70 had delusional behaviors stating " I was chasing after those children last night " . The note indicated she was receiving one on one supervision at this time.  Resident #70 ' s care plan, last updated 02/28/13 identified her as a wanderer. Staff were to check her wander guard bracelet to make sure intact.  A physician ' s telephone order of 02/28/13 noted to give Septra DS (antibiotic for treatment of	F 323			

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F 323	<p>Continued From page 15 urinary tract infections) twice daily for 10 days.</p> <p>A late entry nurse ' s note of 02/28/13 at 10:00 AM indicated a wander guard bracelet was placed on Resident #70 ' s right wrist.</p> <p>A nurse ' s note of 02/28/13 at 3:37 AM indicated Resident #70 was resting quietly with one on one care. She had not attempted to wander this shift and her wander guard was on and functioning.</p> <p>A nurse ' s note of 03/01/13 noted her to be resting quietly in bed talking loudly in her sleep. Resident #70 had not attempted to exit her room. The tabs unit was on and functioning. Staff were sitting in front of her room when not having to attend to other residents. Resident #70 was monitoring closely and was receiving an antibiotic for a urinary tract infection (UTI).</p> <p>During a family interview with Resident #70 ' s family on 03/19/13 at 9:25 AM, she reported concern about the issue of Resident #70 getting out of the door and down 2 flights of stairs before staff came to get her. The family member stated Resident #70 could have been seriously injured.</p> <p>Nurse # 4 was interviewed on 03/19/13 at 3:30 PM. She stated she did not know if the wander guard alarm was on all of the exit doors. She stated she did not know what the circumstances were when Resident #70 attempted to leave the building but as a result she had a bed alarm, a clip alarm and a wander guard bracelet. Nurse #4 also stated she was receiving one on one supervision.</p> <p>On 03/19/13 at 4:00 PM the maintenance</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>supervisor (MS) stated he checked all of the alarms twice weekly but they were not checked on weekends. He stated there were 7 exit doors in the building. The wander guard system was set up for the entrance door into the building, the service hall door which was in the center of the red hall (100/200 hall) and the vending room door. He stated the other doors alarmed when opened. The MS stated he had worked at the facility since October 2012 and one resident had attempted to leave the building. He walked to the blue hall or B3 as he referred to it. There was a door with the notation of " NO EXIT alarm will sound ". He walked to the end of the blue hall (Resident #70 ' s hall) and pushed open the exit door. Upon opening, a loud audible alarm sounded. He pressed in a code and the alarm stopped sounding. The MS commented that the door isn ' t locked from the inside but once the door closed you were not able to go back into the building. Once through the door to the immediate right were 2 flights of concrete steps which led down to a small hallway. Once to the hallway, there was a door noted on the left side which he reported as entry into the laundry room and a door to the right which was an exit door leading into the parking lot. The MS stated that the door to the right of the stairs had no alarms but was kept locked when the laundry room was closed. The exit door was not included with his twice weekly checks.</p> <p>Resident #70 was observed sitting in a gerichair on 03/19/13 at 4:40 PM. There was a clip alarm stretched across the bed but not attached to her clothing. There were no staff members present either in the room or just outside her room.</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>At 4:45 PM on 03/19/13, Nurse Aide #6 was observed in the hallway across the hall from Resident #70. Upon interview, she stated Resident #70 was confused but ambulatory with her walker. NA #6 stated she had no alarms but did have a bracelet that alarmed if she attempted to exit the building. She explained that she thought Resident #70 had attempted to leave going out of the wrong door but staff got to her before she got out of the building. When questioned about monitoring, she stated she checked on Resident #70 about every 2 hours. NA #6 stated she had not been to any in-services on elopement.</p> <p>During an interview with Nurse #8 and Nurse #5 on 03/19/13 at 4:55 PM, both nurses reported that a recent in-service had been provided to staff regarding elopement. Nurse #8 commented that Resident #70 had attempted to leave the building. She stated Resident #70 went down 2 flights of stairs before staff got to her. Nurse #8 stated the alarm had sounded when Resident #70 went through it. When questioned as to whether that back door was kept locked, both nurses stated they did not know as they didn't use that exit. During the interview, the Director of Nurses (DON) came into the room. Nurse #8 asked the DON if the back door that led to the outside was kept locked and she replied she did not know.</p> <p>The DON was interviewed at 5:00 PM on 03/19/13. When questioned as to the investigation and the incident report for Resident #70's attempt to leave the building, she replied that she didn't complete an incident report since the resident didn't actually get out of the building. The DON reported since the incident,</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>Resident #70 had been on constant supervision on all three shifts for her safety. She stated she had a summary of her investigation that she could provide. She provided a document which documented she had spoken to one nurse and was given the particulars of the incident. It was also documented in the summary that she had in-serviced all staff on all shifts about elopement and staff were asked to sign in as evidence they attended. When questioned about the investigation, she stated she did not interview any other staff since the nurse who was working when the incident happened had provided her with the details</p> <p>During a telephone interview with Nurse #2 on 03/20/13 at 6:45 AM, she stated she worked the night that Resident #70 went out the exit door. She reported she was not assigned to the blue hall (hall where Resident #70 resided) but was at the nurses' station and heard the exit door alarm sound and the door shut. She stated she proceeded down the blue hall (where Resident #70 resided) to see what was going on with the exit door. Nurse #2 stated the nurse aides were in rooms providing care and came out of the rooms when the alarm sounded. She reported that she as well as other staff went to check the exit door. Nurse #6 stated when she got to the door, NA #7 as well as 2 other aides were assisting Resident #70 back up the stairs. When questioned where the nurse was that was assigned to the blue hall, she responded she was in the front of the building and didn't get to the room until staff had brought Resident #70 back into her room. Nurse #2 stated she did not know whether the door at the end of the stairway that exits to the outside of the building was locked or</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>not as staff didn ' t usually go out that door. Nurse #7 commented that a bed alarm was placed on her bed upon return to her room and staff monitored her one on one that night. Nurse #2 reported an in-service was held the next day.</p> <p>A telephone interview was conducted with NA #7 on 03/20/13 at 7:55 AM. She stated she was working the night Resident #70 attempted to exit the facility and was one of the aides who assisted her back up the stairway. NA #7 stated she was on the blue hall in a room providing care as were all of the aides. She stated she heard the exit door alarm sound and came out of the room she was in to see what was going on. NA #7 stated staff were headed toward the exit door at the end of the blue hall. She commented that Resident #70 was in the stairway wearing pajamas and socks when she got to her. When questioned about the last time she had seen Resident #70 she remarked that she couldn ' t remember the last time she had checked on her but she was sleeping every time she went into the room. NA #7 stated she had started her rounds about 4:45 AM that morning. NA #7 stated Resident #70 was not restless that night and usually toileted herself. She stated she seemed a bit more confused that night than usual.</p> <p>Resident #70 was observed in bed on 03/20/13 at 10:00 AM. There was a clip alarm attached to her clothing. NA #2 was sitting in a chair at her doorway. When NA#2 was questioned, she stated she was assigned to her today and was also watching Resident #87 ' s room. She reported that Resident #70 had attempted to go out of the back door so staff were assigned to sit with her one on one. NA #2 stated she had a clip</p>	F 323		

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F 323	<p>Continued From page 20 alarm when she was in bed and in the chair.</p> <p>During an interview with laundry room staff #1 (LR #1) on 03/20/13 at 2:20 PM, she stated that she as well as other staff report to work at 8:30 AM and leave at 3:30 PM daily. She reported that another staff person (LR #2) reported to work early starting at 6:00 AM and leaves at 2:30 PM daily. LR #1 reported that the day Resident #70 had left the floor and came down the stairs LR #2 had told her when she got to work that day, Resident #70 was outside the laundry room. LR #1 stated LR #2 had stated she telephoned upstairs and alerted staff that she was down stairs.</p> <p>During an observation of Resident #70 on 03/20/13 at 2:45 PM, NA #1 was sitting outside the doorway of her room.</p> <p>On 03/20/13 at 6:05 PM when observed from the parking lot, the laundry area exit door was unlocked.</p> <p>LR #2 was interviewed on 03/21/13 at 8:15 AM. She stated she came in early the day Resident #70 went out the exit door on her hall. She stated she was not allowed to clock in early so she ate breakfast until 5:55 AM when she could clock in. LR #2 remarked that LR #1 must have misunderstood her communications to her. She stated when she came into the building the day Resident #70 went out the door staff commented to her that she had a visitor downstairs that morning. When questioned who used the exit door at the bottom of the stairs located in back of the building, she responded that the laundry room staff and the maintenance department were the</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>only staff who went in or out that back door and it was always unlocked. LR #2 commented it was unlocked the morning Resident #70 made her way downstairs.</p> <p>The DON and the Administrator were interviewed on 03/21/13 at 9:00 AM. The DON stated Resident #70 did not exit the building but she did go out the door and down 2 flights of stairs. She commented that she did not talk with other staff regarding the incident as she felt Nurse #7 had given her the details. She stated the alarm on the door sounded and staff responded. The DON stated her first reaction was to make sure none of the other residents made their way out that door. She stated in-services were started and all staff had attended. According to the DON, that was the first time a resident had gone out the exit door and Resident #70 was not identified as a wanderer. The Administrator commented that it was a concern for them as no resident had attempted to leave the building from that door in the past. He stated he had always "hated" that exit door and the way it was set up. He commented that since the incident with Resident #70 he was looking into changing the alarm system and installing a better system. The Administrator reported 2 different companies had been out to look at the area but he had to clear any changes with life safety. The Administrator stated when the laundry room staff exit through the back door when their shift ended it was their responsibility to lock it. He commented that once it was locked no one could enter from the outside but it was possible to exit through that door from the inside when it was locked.</p> <p>During an interview with NA #4 on 03/21/13 at</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	
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F 323	Continued From page 22 10:30 AM, she stated she had not attended an in-service on elopement since Resident #70 attempted to exit the building.  Nurse #6 was interviewed on 03/21/13 at 11:20 AM. She stated she had not completed in-services for all of the staff in regards to Resident #70 's attempt to exit the building. She stated she had a list of all staff and was marking them off as they attended. She also provided a wandering risk assessment, dated 02/28/13, for Resident #70 which indicated she was at risk for wandering as she had attempted to go out the fire exit door.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain nutritional value to frozen vegetables by exposing them to prolonged heat. Findings include:  On 03/20/13 at 9:57 AM a large pot filled halfway up with green beans and water was observed to be rapidly boiling on the stovetop. At 10:25 AM, the green beans continued to boil rapidly.  At 10:48 AM, on 03/20/13 the cook stirred the pot with the green beans as it continued to boil	F 364	No residents were identified as being affected by this practice. Residents within the facility do have the potential to be affected. Cooks will be in-serviced on cooking method for foods that preserve nutritional values and following recipes/ manufacturer guidelines. These in-services will be completion date : April 12, 2013.  A log will be maintained and signed by the cooks, with cooking times for vegetables. This log to include time that cooking started and ending time. Management will sign daily for first	

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F 364	<p>Continued From page 23 rapidly.</p> <p>At 11:19 AM, on 03/20/13, the cook lowered the flame on the pot of boiling green beans and left the pot on the stovetop with a low flame.</p> <p>On 03/20/13 at 12:35 AM, the cook said she had put the frozen green beans on the stove to cook about 8:30 AM. The cook said frozen vegetables usually took about 2.5 hours to cook the vegetables after they started boiling. The cook said it took about ½ hour to bring the beans to a boil. The cook said the beans started to boil rapidly around 9:05 AM and she reduced the flame about 20 minutes before she transferred them to the steam table.</p> <p>During an interview with the Food Service Manager (FSM) on 03/20/13 at 3:50 PM, she said there was no policy for the exact time for cooking frozen vegetables. The FSM said her expectation was for frozen vegetables to boil no longer than one hour in order to preserve their nutritive value.</p>	F 364	<p>Cont'd from page 23</p> <p>two weeks and then monitor logs weekly to ensure compliance. This log is to continue for 30 days after initial two weeks. Trends will be brought to QA for review and recommendations.</p> <p>Completions date April 18, 2013.</p>		

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NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	
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K 000	INITIAL COMMENTS  Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.  The deficiencies determined during the survey are as follows:	K 000	The opening above the ceiling tile entering the dining room will be sealed,  All of the walls constructed of 1/2 hour fire resistance rating will be inspected and any openings will be sealed. The maintenance supervisor/designee will inspect all of the walls monthly to ensure compliance. Any negative trends will be sent to the Quality Assurance committee for recommendations.  Date of completion: 6-7-13	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE \_\_\_\_\_

*Ma Hancy RN, NHA*

5/22/13

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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K 018	Continued From page 2 126) and central supply door would not close and latch for smoke tight seal.	K 018			
K 038 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: Accounting, Social Services and Janitors closet by room 124 doors, require more than one range of motion to exit area.	K 038	The door knobs in the accounting, social services and janitor's closet by room 124 will be changed to a knob that only needs one range of motion to exit the area.  All knobs will be inspected to ensure they meet requirements.  Maintenance supervisor/designee will inspect the door knobs quarterly to insure ongoing compliance.  Negative trends will be referred to the Quality Assurance Committee for recommendations. Date of completion: 6-7-13		
K 056 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the	K 056	Sprinkler heads will be installed in the men and women's bathrooms to provide complete coverage.  The building will be inspected to insure it is sprinkled appropriately.  The buildings will be inspected quarterly to insure compliance.		

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K 056	Continued From page 3 building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: men's and women's bathrooms on service hall do not have adequate coverage in back corner of both bathroom's.	K 056	Any negative trends will be sent to the Quality Assurance Committee for recommendations.  Date of completion: 6-7-13		
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: 1. facility could not provide proper documentation that 5 year obstruction investigation has been performed on sprinkler system. 2. heads in kitchen show signs of corrosion. 3. heads in laundry room have excess lent on bulb.	K 062	We will schedule and have performed an obstruction investigation on the sprinkler system.  The two sprinkler heads in the kitchen will be replaced. The sprinkler heads in the laundry will be cleaned.  An obstruction investigation will be done again in 2018.  Sprinkler heads will be checked quarterly to insure they are not corroded or have lent on them.  Negative trends will be referred to the Quality Assurance Committee for recommendations.  Date of completion: 6-7-13		

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K 062	Continued From page 4 42 CFR 483.70(a)	K 062			
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: both residents in room 121 were using multi power strip for TV and refrigerator.  42 CFR 483.70(a)	K 147	The power strip has been removed from room 121. All rooms will be inspected to insure that there are no non-compliant power strips in the rooms.  We will check each room monthly to insure ongoing compliance.  Any negative trends will be referred to the Quality Assurance Committee for recommendations.  Date of completion: 6-7-13		