FEB 18 2014

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING ______ B. WING ______	C 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD MANOR	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 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to accurately complete section M of the Minimum Data Set MDS for 1 of 1 (Resident #78) residents. The facility also failed to obtain the necessary Registered Nurse (RN) signatures on the MDS in a timely manner	F 278	1. Resident #78) #40, #67 MDS have been corrected. 2. All MDS have been checked to ensure ARD & completion dates are in compliance. The MDS of all residents with wounds have been reviewed to ensure coding accuracy. 3. MDS Coordinators reviewed/been educated on completion instructions for Section M, A2300& Z0500b according to RAI manual. 4. DON/Designee will audit MDS Section M with weekly wound report to ensure accuracy. DON/Designee will audit MDS report on ECS to ensure Z0500b date is no more than 14 days past A230. Audits will be done qweek x 4 weeks, 2 x mo. x 3 months. 5. Results will be reported to the QA committed. 6. Completion date 2-14-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 2/12/14

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 278	Continued From page 1 for 2 of 2 (Resident #40 and Resident #67) residents. Findings included: 1. Resident #78 was admitted to the facility on 12/18/13 with cumulative diagnoses of peripheral vascular disease, hypertension and dementia. Resident #78's Admission MDS dated 12/24/13 showed Resident #78 was at risk for, but had no pressure ulcers. Review of the admission wound charting dated 12/18/13 showed Resident #78 had 9 unstageable pressure ulcers on admission. In an interview on 1/17/14 at 3:25 PM MDS Nurse #1 indicated that she reviewed the weekly wound reports to gather information on wounds and did not know how she had missed the information on Resident #78. In an interview on 1/17/14 at 4:44 PM MDS Nurse #1 stated she had corrected the Admission MDS and was planning to resubmit the information to the state. In an interview on 1/17/14 at 5:15 PM the Director of Nursing (DON) stated she expected the MDS nurse to gather information through observation, reading the chart, and also speaking with other staff members. She indicated that wound information could have been gathered from the treatment record, nursing notes and weekly measurements or from the initial assessment. The DON stated she would expect a resident who had pressure ulcers on admission to have that information listed on their admission MDS. She indicated she would expect a correction to be done when the error was discovered.	F 278		

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F 278	Continued From page 2 2. a. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and cognitive deficit. Resident #40's Admission Minimum Data Set (MDS) had an assessment reference date of 04/15/13, but was not signed as complete and accurate by a registered nurse (RN) until 08/28/13. At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a shortage of MDS staffing. She stated at the latest her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date. At 5:12 PM on 01/17/14 the facility's director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. If she had known, she reported at the least she would have given this nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete within 14 days of the assessment reference dates. According to the DON, having an assessment with the reference date of 04/15/13 signed as complete and accurate on 08/28/13 was definitely not acceptable. b. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and	F 278		

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F 278	Continued From page 3 cognitive deficit. Resident #40's Quarterly Minimum Data Set (MDS) had an assessment reference date of 07/09/13, but was not signed as complete and accurate by a registered nurse (RN) until 09/25/13. At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a shortage of MDS staffing. She stated at the latest her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date. At 6:12 PM on 01/17/14 the facility's director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. If she had known, she reported at the least she would have given this nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete within 14 days of the assessment reference dates. According to the DON, having an assessment with the reference date of 07/09/13 signed as complete and accurate on 09/25/13 was definitely not acceptable. 3. Resident #67 was admitted on 10/11/11. Her documented diagnoses included failure to thrive, dementia, reflux, hypertension, and arthritis. Resident #67's Quarterly Minimum Data Set (MDS) had an assessment reference date of 06/23/13, but was not signed as complete and accurate by a registered nurse (RN) until 08/28/13.	F 278		

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F 278	Continued From page 4 At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a shortage of MDS staffing. She stated at the latest her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date. At 5:12 PM on 01/17/14 the facility's director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. If she had known, she reported at the least she would have given this nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete within 14 days of the assessment reference dates. According to the DON, having an assessment with the reference date of 06/23/13 signed as complete and accurate on 08/28/13 was definitely not acceptable.	F 278	Resident #40 has been evaluated by physical therapy and no longer ambulates well enough to be an elopement risk. In the future if a resident is identified as an elopement risk, appropriate intervention will be put in place immediately. Appropriate interventions might include but are not limited to a wander guard bracelet, 15 min. checks and 1 on 1. All residents at risk for elopement will have a care plan which will list the interventions that have been put in place.	
F 323 SS=D	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 observation, resident interview, staff interview, and record review the facility failed to	F 323	All residents at risk for elopement will be monitored weekly to insure that identified interventions are inplace for 3 weeks and then every 2 weeks for a total of 4 weeks and then monthly for 3 months.	

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F 323	Continued From page 5 put effective interventions in placed to keep 1 of 1 sampled residents (Resident #40) with confirmed elopement from attempting to exit the building a second time. The facility also failed to protect cognitively impaired residents capable of moving about the building on their own from potentially hazardous chemicals. Findings included: 1. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and cognitive deficit. A 04/09/13 nurse's note and physician order documented a Wanderguard was placed on Resident #40 because "resident presents as a visitor, can be confused at times and wanders in the halls unable to find room." Beginning on 04/10/13 a section on Resident #40's medication administration record (MAR) documented, "Check battery in Wanderguard every shift. Check placement of Wanderguard every shift." If these tasks were completed, they were initialed off on the MAR by the staff members completing them. Resident #40's 04/15/13 Admission Minimum Data Set (MDS) documented her cognition was severely impaired, she was independent in walking in her room and the corridor, and she was observed wandering during one to three days of the assessment look back period. On 04/18/13 "Potential for elopement from the facility related to : impaired cognition and manifested by: wanders to exits and wanders near exits" was identified as a problem in	F 323	All exit doors have been checked to insure the alarms including those doors monitored by a wanderguard system are functioning properly. Nurses will be in-serviced as to the importane of checking placement of the wanderguard bracelet qshift and the functionality of the bracklet daily and documenting said checks. MAR on residents @ risk for elopement will be monitored weekly x 3 weeks, bi-weekly for 4 weeks and monthly for 3 months after to ensure that physicians orders relating to the checking of placement for wanderguard bracelets and battery checks for wanderguard bracelets are documented appropriately. Negative trends will be sent to the Random audits of the doors monitored by the wanderguard system will be completed to insure staff are assessing the situation	

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F 323	Continued From page 6 Resident #40's care plan. Interventions to this problem included "make sure wanderguard is on and working", "be able to identify resident, know whereabouts, redirect as needed", and "exit door alarms on". A 05/17/13 incident report documented Resident #40 was found outside in the parking lot, but with no injury. A Review of Occurrences documented on 05/1713 (Friday) at 3:00 PM Resident #40 was found outside in the parking lot after walking out of the building with a group of ladies. Interventions included continued monitoring of the exit door on the back hall (through which a resident eloped prior to May 2013) and education of the reception desk personnel and direct care staff to monitor Resident #40 more carefully. A 05/19/13 incident report documented Resident #40 exited a Wanderguard compatible door off the main hall and into the lobby and possibly out into the parking lot without injury. A Review of Occurrences documented on 05/19/13 (Sunday) at 6:37 PM another resident (Resident #34) saw Resident #40 exit a Wanderguard compatible door off the main hall and proceed into the lobby area. This resident notified staff who were unable to find the resident outside. The resident was later found inside walking toward the nursing station serving the back hall of the facility. Visitors present at the time reported they saw a female they thought might be a resident exit the building, walk toward the mailbox (which was 35 feet from the front door of the facility), turn around, and re-enter the building. Interventions included placing Resident	F 323	and determine that there has been no elopement, and they understand why they are cutting off alarms. Audits will be weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months. Door alarms are checked twice each week to insure that they are functioning properly. Staff will be in-serviced to report to maintenance or Administrator if they observe an alarm not functioning properly. Any negative trending will be sent to the Quality Assurance committee for recommendations. Staff will be in-serviced on the following: 1) Not shutting off door alarms until grounds have been checked to insure a resident has not wandered out of the door. 2) Resident that are at risk for wandering have their pictures at the front desk and at the nurses' stations so they can be quickly identified. 3) Alarms are checked every week to insure they are working properly. Completion date: 2-14-14	

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F 323	Continued From page 7 #40 on 1:1 supervision until around the clock observation could be established for the door leading to the lobby of the building. At 2:54 PM on 01/15/14 Central Communications Manager (CCM) #1 stated on Friday, 05/17/13, Resident #40 went out the front door of the facility with a group of women. She reported the resident was later found in the parking lot. According to CCM #1, the intervention for this elopement was to inform the staff to keep a closer eye on Resident #40. She commented after Resident #40 once again escaped out a Wanderguard compatible door off the main hall and into the lobby on Sunday, 05/19/13, the resident was placed on 1:1 supervision. CCM #1 stated the following week constant observation of the door leading to the lobby was established, and Resident #40 was removed from 1:1 supervision. At 3:03 PM on 01/15/14 the receptionist, on duty when Resident #40 exited the building on 05/17/13, stated she saw the resident leave the building, but assumed the group of ladies she was with had signed her out for a trip. She reported she was unsure whether the alarm sounded when the resident came through the door off the main hall or not because it was pay day and the lobby was very noisy. She commented once the alarm sounded, activated by residents with Wanderguard bracelets in place, it had to be turned off by staff. According to the receptionist, she did not turn off/reset the door alarm on 05/17/13 when Resident #40 exited the building. However, she reported Resident #40 could have set the alarm off when she went out the door, and a staff member automatically cut it off thinking a resident with a	F 323		

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F 323	Continued From page 8 Wanderguard just passed by the door on the way to activities and set the alarm off. At 3:08 PM on 01/15/14 the activity aide who found Resident #40 in the parking lot stated the resident had been in an activity in the main dining room earlier, and she recalled the resident having on a bright colored outfit. She explained after the activity adjourned she was looking out a window in the main dining room, and saw the resident outside on the sidewalk in the parking lot (about 75 feet from the front door). In order to get there the resident would have come out the front door, made a left, gone down a slight slope, and made another left, staying on the sidewalk which was slightly uneven in places). The aide reported the resident was confused, stating she was on her way to visit her niece. At 4:26 PM on 01/15/14 Resident #40 was in a wheelchair, and her family took her through the Wanderguard compatible door off the main hall and into the lobby. The door alarmed as the resident was wheeled near this door. At 5:38 PM on 01/15/14 the maintenance manager (MM) checked the alarms on all exit doors in the building, including the doors with push alarms and Wanderguard compatible alarms. All the door alarms were functioning correctly. The MM stated currently Wanderguard compatible doors did not lock but only alarmed, and once the alarm sounded staff had to cut the alarm off/reset it. The MM provided his logs which documented he checked all door alarms on Tuesdays and Fridays. At 9:50 AM on 01/16/14 CCM #1 stated it was not unusual when Wanderguard residents passed by	F 323		

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F 323	Continued From page 9 the door off the main hall into the lobby for the door alarm to go off. She reported there were times when the staff just automatically reset the alarm on the door into the lobby, thinking a Wanderguard resident passed by the door. At 10:02 AM on 01/16/14 the MM stated when a Wanderguard resident passed within eight feet of a Wanderguard compatible door the door alarm sounded. During a telephone interview with CCM #2 on 01/16/14 at 10:46 AM she stated she worked on the weekends, and before 05/19/13 the only elopement intervention that she knew of in place for Resident #40 was her Wanderguard bracelet. She reported prior to her 05/19/13 6:37 PM exit through a Wanderguard compatible door, on the same afternoon Resident #40 had been found two or three times wandering around the building and was returned to her room. She stated there was some type of problem with the Wanderguard alarm on the door into the lobby on 05/19/13, but she could not remember at what time the problem arose and at what time the problem was resolved. According to CCM #2, there was not a receptionist on duty in the front lobby on the weekends. At 1:50 PM on 01/16/14 the MM stated he was called to the facility to fix the Wanderguard alarm on the door to the lobby on 05/19/13, but could not remember what time of day it was. At 2:30 PM on 01/16/14 the director of nursing (DON) stated she was not in the building on 05/17/13, but the administrator was. At 3:32 PM on 01/16/14 the administrator stated	F 323		

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F 323	Continued From page 10 he was notified immediately after Resident #40 was found outside the building in the parking lot on 05/17/14. Since it was her first elopement, he reported he went and talked to the receptionist and direct care staff on the resident's hall about keeping a close eye on the resident. He commented he did not conduct official in-services at that time. At 2:12 PM on 01/17/14 Resident #34, who was identified as interviewable by staff and his MDS assessments, reported he saw Resident #40 go through the Wanderguard compatible door into the lobby of the evening of 05/19/13. He stated the resident was by herself, and the door alarm did not sound. 2. Review of the Material Safety Data Sheet (MSDS) for Clorox regular bleach lists the Health Hazard Data as, "Danger: Corrosive. May cause severe irritation or damage to eyes and skin. Vapor or mist may irritate. Harmful if swallowed. Keep out of reach of children." Review of the MSDS for Clorox ready-use bleach pre-diluted cleaner lists the Health Hazard Data as, "Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling."	F 323	1. A new bleach 1:10 solution diluted bottle label was made and submitted to NC Occupational Safety and Health for approval. Bottle label was approved 1-28-2014 for use. The new bottle label correctly identifies the hazards of the bleach 1:10 mix. a) Bottle label b) NC OSH Email	

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F 323	Continued From page 11 Review of the undated Preventing Accidental Ingestion/Poisoning Policy provided by the facility showed under General Procedures/Precautions, "3. All housekeeping chemicals are secured under lock when not in use or under the direct supervision of the housekeeper." In an observation on 01/13/14 at 12:09 PM a spray bottle labeled as Clorox was seen on the back of the commode in a resident room. The bottle was marked as corrosive, danger hazards to humans and domestic animals. In an interview on 01/13/14 at 12:10 PM Nurse #1 stated as she removed the bottle of cleaning chemicals that the housekeeper must have left it and that it should not have been left in the resident bathroom. She indicated that there were cognitively impaired residents who wandered into other resident's rooms who resided in the facility. In an interview on 01/15/14 at 2:05 PM the Housekeeping Manager (HM) stated that while not in use housekeeping chemicals should be locked up on the housekeeping cart. He stated that the housekeeper had gone to lunch leaving the container on the back of the commode. He indicated that when the surveyors entered the building he took his staff aside and in-serviced them on the facility requirements pertaining to them. He stated that when the nurse informed him of the chemicals left in the bathroom the housekeeper was in-serviced again. In an interview on 01/16/14 at 2:05 PM Housekeeper #1 stated she had been employed for approximately 3 months. She indicated if a resident had gotten the bottle of chemicals they could have become sick, been sent to the	F 323	2. Housekeeping staff will be re-inserviced on the facility "Preventing Accidental Ingestion/ Poisoning" policy by 2-14-14. 3) Housekeeping carts will be randomly audited by housekeeping manager 10 x weekly per housekeeping maid cart to ensure that the carts are locked and chemicals are secured. a) Housekeeping cart chemical box lock audit sheet. 4) Housekeeping carts will be audited 5 x weekly after the resident room cleaning housekeeping shift ends to ensure all housekeeping bottles present at the beginning of the shift are returned with the housekeeping cart to the janitor closet at the end of shift. Bottles will be recorded at 8 a.m. and recorded again at 4 pm. to ensure no cleaning bottles were left outside of the housekeeping cart during the shift. a) Housekeeping cart end of shift audit sheet. Completion date 2-14-14	

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	345228	A. BUILDING ______ B. WING ______	C 01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD MANOR	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 323	Continued From page 12 hospital or could have died. She stated she had forgotten to remove the bottle from the resident room. She stated the housekeeping chemicals should be locked on the housekeeping cart when not in use. She indicated she had been in-serviced on the rules when the surveyors had arrived and again when the chemicals were found. In an interview on 01/17/14 at 9:35 AM the HM stated the solution that was in the spray bottle did not match the label. He indicated the facility used a 1:10 (1 part bleach to 10 parts water) solution for cleaning the bathrooms. He stated the label used showed the greatest risk which would have been from straight bleach. He indicated the solution was the pre-diluted cleanser. In an interview on 01/17/14 at 5:15 PM the Director of Nursing (DON) stated it was her expectation that the housekeeping department keep chemicals secure when not in use. She indicated if a resident had gotten to the chemical it could have caused skin irritation, sickness or death.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	The facility will ensure that residents maintain acceptable parameters of nutritional status including body weight, unless the resident's clinical condition demonstrates this is not possible. Corrective action was taken for the 2 residents that experienced significant weight loss by initiating supplements to increase caloric intake and stabilize weights. The 2 residents were also placed in the	

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F 325	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to follow its protocol for implementing interventions when 2 of 2 residents (Resident #40 and #67) experienced significant weight loss. Findings included: 1. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, cognitive deficit, and cancer of the appendix. Resident #40's weight record documented she weighed 164.1 pounds on 04/16/13. A 04/30/13 resident progress note documented the facility notified Resident #40's primary physician about family concerns regarding the resident's weight loss. A 04/30/13 physician order placed the resident on weekly weights. Resident #40's weight record documented she weighed 144.4 pounds on 05/21/13. In one month between 04/16/13 and 05/21/13 Resident #40 lost 9.7 pounds for a 6.3% weight loss. Record review revealed Resident #40 was not placed on any nutritional supplements, was not assessed for weight loss by the registered dietitian (RD) or dietary manager (DM), and was	F 325	weekly interdisciplinary "Resident at Risk" meetings for review of weekly weights and monitoring until weight stabilized. To ensure that all residents with significant weight loss are identified; the facility will use a Weight Book to document all weights, monthly and weekly. The calculations will be done by hand to determine residents that trigger for significant weight loss, 5% in 30 days, 7.5% in 90 days and 10% in 180 days. Each weekly and monthly weight will be documented in this book and reviewed weekly by dietary manager for new weight loss. In addition all residents that trigger for significant weight loss will continue to be referred to the RD for nutritional assessment and approproate interventions. Residents with significant weight loss will continue to be reviewed weekly in the facility's interdisciplinary "Resident At Risk" meetings until weight has stabilized again,	

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F 325	Continued From page 14 not reviewed by the facility's interdisciplinary team (IDT) until 07/18/13 when her weight decreased to 137.7 pounds. At 5:25 PM on 01/16/14 the facility's RD stated the facility's computer system was not very reliable on calculating and capturing significant weight loss. She reported many times weight changes had to be figured by hand in order to determine which residents may have had a significant weight loss of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. According to the RD, when a resident experienced significant loss they were immediately assessed to determine the possible cause and followed by the IDT committee which made recommendations to promote weight gain or prevent further weight loss. The RD commented resident weights had be stable for four weeks before they were discharged from IDT review. At 2:56 PM on 01/17/14 the DM stated that both she and the RD screened residents for significant weight loss, but she was the person that probably had the most direct contact with the residents and time to track weight patterns. She reported the computer soft wear did not always flag those residents who experienced significant weight loss so percent of weight lost and gained had to be calculated by hand. The DM commented Resident #40 probably should have been started on nutritional supplements soon after entering the building, but the resident appeared healthy and hearty. At 5:12 PM on 01/17/14 the director of nursing (DON) stated the facility protocol was for a nutritional assessment, preferably conducted by the facility's RD, to be completed as soon as	F 325	using hand calculations. All weight loss trends will be referred to Quality Team for analysis and further interventions. New admissions as well as readmits will be reviewed in the weekly interdisciplinary "Resident at Risk" meeting for 4 weeks to ensure that any changes in weight are addressed and appropriate interventions are put in place. Any negative trends will be referred to the Quality Assurance Committee for recommendations. The weight book that will be used to document and track all weights will be in place by February 10, 2014. The weight book will be audited weekly for 3 weeks, bi-weekly for 4 weeks and monthly for 3 months to insure any weight changes are identified timely and interventions are put in place. Completion date 2-14-14	

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F 325	Continued From page 15 significant weight loss was identified. She reported it was important to determine why the resident was losing weight. Once this was determined, the DON commented the resident was followed by the IDT committee which developed interventions based on the reason for weight loss. She stated it was not acceptable to wait until two months after significant weight loss was identified before assessing and putting interventions in place. 2. Resident #67 was admitted on 10/11/11. Her documented diagnoses included failure to thrive, dementia, reflux, hypertension, and arthritis. Resident #67's weight record documented she weighed 124.5 pounds on 0703/13. A 07/24/13 physician order placed Resident #67 on as needed (PRN) Lasix 20 milligrams (mg) daily for swelling. A 07/29/13 physician order changed the resident's Lasix to 20 mg daily. Resident #67's weight record documented she weighed 117.7 pounds on 08/19/13. Therefore, in one month (between 07/03/13 and 08/19/03) the resident lost 6.8 pounds for a 5.5% weight loss. Record review revealed the facility's registered dietitian (RD) did not recommend any nutritional supplements, the resident was not assessed for weight loss by the RD or dietary manager (DM), and the resident was not reviewed by the facility's interdisciplinary team (IDT) until 01/16/14 when her weight decreased to 111.7 pounds. At 5:25 PM on 01/16/14 the facility's RD stated	F 325		

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F 325	Continued From page 16 the facility's computer system was not very reliable on calculating and capturing significant weight loss. She reported many times weight changes had to be figured by hand in order to determine which residents may have had a significant weight loss of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days.. According to the RD, when a resident experienced significant loss they were immediately assessed to determine the possible cause and followed by the IDT committee which made recommendations to promote weight gain or prevent further weight loss. The RD commented resident weights had be stable for four weeks before they were discharged from IDT review. At 2:56 PM on 01/17/14 the DM stated that both she and the RD screened residents for significant weight loss, but she was the person that probably had the most direct contact with the residents and time to track weight patterns. She reported the computer soft wear did not always flag those residents who experienced significant weight loss so percent of weight lost and gained had to be calculated by hand. The DM commented Resident #40 probably should have been started on nutritional supplements soon after entering the building, but the resident appeared healthy and hearty. At 5:12 PM on 01/17/14 the director of nursing (DON) stated the facility protocol was for a nutritional assessment, preferably conducted by the facility's RD, to be completed as soon as significant weight loss was identified. She reported it was important to determine why the resident was losing weight. Once this was determined, the DON commented the resident was followed by the IDT committee which	F 325		

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F 325	Continued From page 17 developed interventions based on the reason for weight loss. She stated it was not acceptable to wait until two months after significant weight loss was identified before assessing and putting interventions in place.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold foods at or below 41 degrees Fahrenheit and hold foods at 135 degrees Fahrenheit or above during operation of the trayline. The facility also failed to label and date opened food items in multiple storage areas. Findings include: 1. Beginning at 5:27 PM on 01/14/14 temperatures were taken on select food items at the trayline. Temperatures of the shrimp salad in croissants ranged between 44 and 52 degrees Fahrenheit. These croissants were in a tray pan over ice in a steam well which had been turned off. In an attempt to supply residents with shrimp salad croissants in which the salad was 41 degrees Fahrenheit or below, the cook removed	F 371	There were no negative outcomes for residents that consumed shrimp salad above 41 deg. F. and soup below 135 deg. F. Or for unlabeled foods in the dietary department. All foods are now appropriately labeled. To insure that soup is at or above 135 deg F. we will no longer pre-pour soup. Soup will be kept on the steam table a 165 deg F. and placed in a bowel from the steam table. To insure that cold salads are kept at 41 deg. F. or below the salad will be prepared 24 hours in advance so that it can chill in the cooler. In addition cold salads will be kept in small dishes and placed in ice on the tray/line to insure temps hold below 41 deg. F.	

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F 371	Continued From page 18 shrimp salad from the walk-in refrigerator which was being stored in a large, deep tray pan. She made up eight shrimp salad croissants, but when the temperature was taken on the shrimp salad in the tray pan the thermometer registered 54 degrees Fahrenheit. A prepoured bowl of soup covered with a lid was placed on a resident tray which was going to be stored in the meal cart. The temperature of this bowl of soup was 120 degrees Fahrenheit. The dietary staff stated their trayline started operation around 4:45 PM on 01/14/14. They reported they had two more meal carts to fill and 44 more residents to serve before the trayline operation was completed. At 4:38 PM on 01/15/14 the dietary manager (DM) stated the shrimp salad was prepared on the same day that it was served. She explained on 01/14/14 the frozen shrimp was boiled, immediately placed on ice, and at about 1:45 PM was placed in the walk-in freezer until a thermometer used to check the temperature registered below 40 degrees Fahrenheit. She reported around 2:30 PM the shrimp was ground in the Robot Coupe, and mayonnaise, pickle relish, and a little lemon were added. According to the DM, the assembled salad was then placed in a tray pan and returned to the walk-in freezer. At approximately 3:30 PM the DM commented the shrimp salad was placed inside croissants, and the croissants were kept over ice in the walk-in refrigerator. She stated right before the trayline began operation a tray pan of croissants was removed. The DM provided the facility's trayline temperature log which documented as the trayline began operation the shrimp salad registered 40 degrees Fahrenheit. The DM reported cold salads made with mayonnaise should be kept at 40 degrees Fahrenheit or below	F 371	Temps of hot foods and colds foods will be monitored daily for 2 weeks, weekly for 4 weeks, biweekly for 4 weeks and monthly for 3 months to insure proper temperatures. Food items will be monitored weekly for 3 weeks, biweekly for 4 weeks and monthly for 3 months to insure food items are labeled and dated appropriately. Any negative trends will be refereed to Quality Assurance Committee for recommendations. Completion date 2-14-14	

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F 371	Continued From page 19 during the entire operation of the trayline. She commented that during down time at the trayline sometimes three or four bowls of soup might be prepoured, but her expectation would be that these bowls be placed on resident trays quickly. The DM reported hot foods such as soup should remain at 135 degrees Fahrenheit or higher during the entire operation of the trayline. At 8:48 AM on 01/16/14 an AM cook stated that personally when she was responsible for cold salads made with mayonnaise she preferred them to be at 38 degrees Fahrenheit or below. She reported cold salads were usually prepared in the morning on the same day that they were served, but they were kept chilled by refrigerated storage until they were served. She reported she did not like to prepour soups because they might be too cold when served. According to the cook, when she was responsible for hot foods she preferred them to remain at or above 165 degrees Fahrenheit during the entire operation of the trayline. 2. During initial tour of the kitchen and food storage areas, beginning at 10:40 AM on 01/13/14, multiple food items which were opened were without labels and dates. In the dry storage room a five-pound box of cake mix, a bag of orzo pasta, a two-pound bag of confectioner's sugar, a storage container of oatmeal, a 16-ounce box of corn starch, and a five-pound bag of yellow cornmeal which were all opened were without labels and dates. In the walk-in refrigerator a eight-pound container of carrot raisin salad, a gallon container of golden Catalina dressing, and three packages of sliced cheese which were all opened were without labels and dates. In the walk-in freezer French toast in plastic wrap, a bag	F 371		

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	345228	A. BUILDING ______ B. WING ______	C 01/17/2014

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F 371	Continued From page 20 of sweet potato wedges, and a bag of mixed vegetables which were all opened were without labels and dates. During a follow-up tour of the kitchen and food storage areas, beginning at 11:20 AM on 01/15/14, hot dogs removed from original packaging and wrapped in foil and an opened bag of biscuits were found in the walk-in freezer without labels and dates. At 4:38 PM on 01/15/14 the dietary manager (DM) stated her assistant checked storage areas two or three days a week to make sure opened food items were labeled and dated and to discard any food items past their use-by dates. However, the DM reported ultimately any dietary staff who opened food items and then placed them back into storage should place labels and dates on them so they could be used before their quality was compromised. At 8:48 AM on 01/16/14 an AM cook stated all dietary staff were responsible for making sure opened food items in storage had labels and dates on them. She reported there was an assistant who went behind the dietary staff to make sure opened food items had labels and dates on them, outdated leftovers were disposed of, thawing meats remained on the bottom storage shelves, and all dairy products were within date.	F 371		

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

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	345228	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD MANOR	1624 HIGHLAND DRIVE WASHINGTON, NC 27889

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K 000	INITIAL COMMENTS 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 protected construction , two story with a complete automatic sprinkler system. The Deficiencies determined during the survey area as follows:	K 000	FEB 24 2014	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 02/06/2014 the soiled linen room near nurses station A failed to close and latch. B. Based on observation on 02/06/2014 the Janitors Storage near the Maintance Office roo failed to close and latch. C. Based on observation on 02/06/2014 there were PVC pipes penetrating the ceiling of the (1) one hour ceiling of the Boiler room that were not	K 029	A. The door in the soiled linen room will be adjusted so it will close and latch. B. The Janitor's storage room and the maintenance office will be adjusted so that it will close and latch properly. C. The PVC pipes penetrating the ceiling will be sealed properly. The maintenance supervisor or his designee will monitor doors and through ceiling penetrations monthly to insure compliance. Any negative trending will be reported to the Quality Assurance committee for recommendations. Completion Date: 3-23-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (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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	345223	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/06/2014

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K 029	Continued From page 1 sealed properly. 42 CFR 483.70 (a)	K 029		
K 038 SS=D	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: A. Based on observation on 02/06/2014 the door to the Day Room required more than one motion of the hand to exit the room. B. Based on obdervation on 02/06/2014 there was no hard surface path way from the laundry stair well exit to a public way.	K 038	A. The door knob to the dayroom will be replaced with door knob that can be opened with one motion. B. We will construct a hard surface pathway from the laundry exit to the paved driveway. Maintenance supervisor or his designee will monitor monthly for compliance. Any negative trending will be reported to the Quality Assurance committee for recommendations. Completion date 3-23-14	