



March 19, 2015

Sharon Neusen, RN
Facility Survey Consultant
NC Department of Health and Human Services
Division of Health Services Regulations
Nursing Home Licensure & Certification Section
2711 Mail Service Center
Raleigh, North Carolina 27699-2711

Dear Ms. Neusen:

Attached you will find our Plan of Correction for survey completed on February 27, 2015 for recertification. All Plans of Corrections addressed, corrective action accomplishments, measures that will be put in place, facility monitoring, and dates that corrective action will be completed.

If you have any questions regarding our Plan of Correction please do not hesitate to give me a call.

Sincerely,

A handwritten signature in black ink, appearing to read 'Michael Kelly', is written over a faint, larger version of the signature.

Michael Kelly
Administrator
Attachment 11 pages POC

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</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 record review and staff and resident interviews, the facility failed to assist a resident to the bathroom as requested by a continent resident, Resident #195, resulting in an episode of bowel incontinence and loss of dignity for one of three residents reviewed for dignity. Findings included:</p> <p>A review of the Minimum Data Set (MDS) Admission Assessment for Resident #195 revealed the assessment was not complete and did not provide information regarding the resident's diagnoses, functional status, or bowel and bladder status. The Entry Assessment dated 02/20/2015 indicated Resident #195 was admitted to the facility on 02/15/2015 from a hospital.</p> <p>There was no interim nursing care plan as of 02/27/2015 developed for Resident #195 regarding her bowel status or dignity.</p> <p>A review of the admission physician's orders dated 02/15/2015 indicated that the resident was status post a left hip endoprosthesis (a prosthesis used inside the body.)</p> <p>A review of a Nurse's Note dated 02/22/2015 at</p>	F 241	<p>F 241</p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u> Resident #195 no longer resides in the facility.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u> All residents have the potential to be affected by these identified concerns.</p> <p>All resident will receive assistance with toileting as requested. <u>Measures that will be put into place to ensure that this deficiency does not recur:</u> A staff in-service on all identified concerns will be conducted by 3/20/15.</p> <p>The DON/Designee will complete a weekly audit/rounds, times four weeks and then monthly thereafter times three months, to ensure no dignity issues are identified. Specifically, that staff honor resident requests for toileting needs.</p> <p>The DON or Social Service Worker will interview 5 residents, weekly times 4 weeks and then monthly thereafter times 3 months to ensure they have no concerns with dignity issues. Specifically, there toileting needs are being met.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Administrative (X6) DATE 3/30/15

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.

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 241	<p>Continued From page 1</p> <p>6:10 PM indicated Resident #195 required the assistance of one aide to provide limited assistance for toilet use and that a commode was used. There were no nurse's notes regarding an incontinent bowel movement on 02/24/2015.</p> <p>A review of the Nursing Assistant Bowel Output Record revealed the resident had a large soft incontinent bowel movement on 02/21/2015, and a large soft continent bowel movement on 02/23/2015 at 2:55 PM, and another large, loose continent bowel movement at 6:54 PM. On 02/24/2015 the resident had a large loose incontinent bowel movement at 8:09 PM.</p> <p>In an interview with Resident #195 on 02/25/2015 at 12:15 PM, she was cognitively alert and oriented to person, place, and time. During the interview she stated that she had called for a staff member to assist her to the bathroom on 02/24/2015, and that no one came to assist her until at least 30 minutes later. She explained that someone came to tell her she would be back to assist her, but no one ever came back. Resident #195 stated that she had to soil herself because she got no assistance and that she felt very embarrassed. She also stated that she was typically continent of her bladder and bowel.</p> <p>An interview via telephone was conducted with Nursing Assistant (NA) #1 on 02/27/2015 at 10:36 AM, she explained the resident told her about the episode of not getting to the bathroom on time on the second shift (3:00 PM to 11:00 PM.) NA #1 stated the resident told her she was upset about it and stated she reported this to the unit manager.</p>	F 241	<p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Any discrepancies identified in the audits will be documented, investigated and corrected immediately by the Administrator.</p> <p>From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.</p> <p>If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee.</p> <p>As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided.</p> <p>The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur.</p> <p>Facility alleges compliance with this deficiency on 3/24/15.</p>	

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 241	<p>Continued From page 2</p> <p>On 02/27/2015 at 11:25 AM, an interview was conducted via telephone with the nursing assistant (NA#2) who was on duty for the resident when the incontinent episode happened on 02/24/2015. NA #2 stated she went to Resident #195's room before she left the floor to eat supper at approximately 7:00 PM on 02/24/2015 and asked her if she needed anything. NA #2 stated the resident told her she would be needing to go to the bathroom, but said she could hold it for a while, so she took her supper break. NA #2 stated that while she was having her supper break, someone paged her to assist the resident, but she did not hear the page at first. She further explained the charge nurse on duty then came to the break room to ask her to assist the resident. NA #2 stated that the resident was already incontinent of bowel when she reached her, and that the resident told her she was embarrassed.</p> <p>At 12:19 PM on 02/27/2015, an interview was conducted over the phone with the Charge Nurse (CN) for the 3:00 PM to 11:00 PM shift on 02/24/2015 when the incontinent episode happened. The CN stated that she paged NA #2 to come assist Resident #195 after the resident rang her call bell to inform her she had been incontinent of bowel. The CN could not remember exactly what time it was when the resident used her call bell. The CN explained that she was unable to find NA #2, so she paged her. The CN added that NA #2 did not respond, so she went to look for her and found her in the break room having supper. She explained that NA #2 left the break room and went to assist the resident, and that she was not sure what time that was. The CN stated that she did not recall</p>	F 241			

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 241	<p>Continued From page 3</p> <p>getting a report that the resident felt embarrassed or upset. In addition, she explained at times, another nursing assistant would be asked to cover for residents who were not assigned to them, and that nurses were also able to provide incontinent care or toilet assistance. She stated that she had not been asked by the resident to provide assistance to the bathroom, so she did not do so.</p> <p>In an interview with the day shift Unit Manager (UM) on 02/27/2015 at 3:21 PM, she stated Resident #195 was status post a left hip endoprosthesis and that she was continent of her bladder and bowel. In addition, the UM stated that she had not heard a report that Resident #195 had felt embarrassed about an incontinent episode when assistance to the bathroom was delayed. She stated that if she had heard about such an incident, she would have been concerned about the resident's dignity. She also stated that if a nursing assistant is not available to provide assistance with toileting when it was needed, she would expect for the nurse to provide assistance or find another staff member to provide assistance.</p> <p>In an interview with the Director of Nursing (DON) on 02/27/2015 at 4:59 PM, she stated that NA #2 might not have interpreted the resident's statement that she would need to go to the bathroom as a request to use the bathroom at that moment. The DON stated she would have wanted NA #2 to ask the resident if she wanted to go to the bathroom at that time. In addition, she stated that she would have expected the nursing assistant to inform the nurse on duty that she would be leaving the floor to go to supper.</p>	F 241			

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

PRINTED: 03/10/2015
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 C 02/27/2015
NAME OF PROVIDER OR SUPPLIER RIDGWOOD 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 241	Continued From page 4	F 241		
F 309 SS=D	<p>Also, the DON stated that she knew this was an embarrassing event for the resident. The DON stated she felt that NA #2 was trying to do the right thing and provide the resident with necessary care.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to prevent constipation and to follow the bowel movement protocol as ordered for one of one resident, Resident #188, who was reviewed for constipation. Findings included:</p> <p>A review of the Minimum Data Set (MDS) Assessment dated 02/24/2015 revealed Resident #188 was admitted to the facility from the hospital on 02/15/2015 and was cognitively intact. The MDS Admission Assessment data was not completed, and no further information was available regarding Resident #188's diagnoses or functional status.</p> <p>A review of Resident #188's Physical Therapy Progress Notes indicated the resident had the</p>	F 309	<p>F 309</p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u> Resident #188 no longer resides in the facility</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u> All residents have the potential to be affected by these identified concerns.</p> <p>All residents will be assessed at time of admit for their last bowel movement.</p> <p>The AM nurse will review the bowel movement documentation daily, any residents who have not had a documented bowel movement times three days will be placed on the Bowel Protocol Sheet. The PM nurse will then verify with the resident the last bowel movement and initiate the Bowel Protocol, if indicated.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u> A staff in-service on all identified concerns will be conducted by 3/20/15.</p> <p>The Unit Manager will complete an audit on the Bowel Protocol Sheets weekly, times four weeks and then monthly thereafter times three months, to ensure residents who have not had bowel movements times 3 days have a bowel protocol initiated and bowel movements are appropriately documented in the medical record.</p>	

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 5 following diagnoses:</p> <p>Treatment Diagnosis #1: Difficulty in Walking Treatment Diagnosis #2: Rehabilitation Proc Nec (Care Involving other Specified Rehabilitation Procedure) Treatment Diagnosis #3: Muscle Weakness Treatment Diagnosis #4: Joint Replaced Knee</p> <p>A Nurse's Note dated 02/15/2015 indicated the resident required one nursing assistant to provide assistance for toilet use.</p> <p>A review of the Physician's Orders revealed the following orders:</p> <p>02/15/2015: MOM (Milk of Magnesia) 30 ml (milliliters) if no bowel movement x (in) 3 days at bedtime as needed. 02/15/2015: If no bowel movement by 6:00 AM the following morning (after the MOM dose), give Dulcolax 10 mg suppository for no results. 02/15/2015: If no bowel movement by 8:00 AM the day the Dulcolax was given, give Fleets (enema) or S.S.E. (soap suds enema) daily as needed.</p> <p>Resident #188's Nursing Care Plan dated 02/18/2015 indicated there was no problem, goal, or interventions related to her bowel status or constipation.</p> <p>A review of the Medication Administration Record revealed there were no initials to indicate the MOM, Dulcolax suppository, a Fleets enema or</p>	F 309	<p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Any discrepancies identified in the audits will be documented, investigated and corrected immediately by the Administrator.</p> <p>From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.</p> <p>If trends or discrepancies are noted this Quality Assurance process will be revised by the Quality Assurance Committee.</p> <p>As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided.</p> <p>The Quality Assurance Committee will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure this deficient practice does not re-occur.</p> <p>Facility alleges compliance with this deficiency on 3/24/15.</p>	

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 6</p> <p>soap suds enema was administered on any dates to the resident between 02/16/2015 and 02/26/2015.</p> <p>A Nurse's Note dated 02/17/15 at 6:45 PM indicated that Resident #188 required one aide to assist her for toilet use, and that Resident #188 maintained personal hygiene independently.</p> <p>A review of Resident #188's bowel movement flow record indicated she had a large, soft, continent bowel movement on 02/16/2015. Further review of the same bowel flow record indicated there were no bowel movements on 02/17/2015, 02/18/2015, 02/19/2014, 02/20/2014, 02/21/2014, 02/22/2014, 02/23/2015, or 02/24/2015. In addition, the record revealed Resident #188 had a large, hard, continent bowel movement on 02/25/2015.</p> <p>An interview was conducted with Resident #188 on 02/25/2015 at 2:38 PM. During the interview she stated that she had been very uncomfortable due to constipation and that she had not had a bowel movement in a number of days. She explained that she had been given an enema on 02/25/2015, and that the nurse had to "dig her out," and that she was still in pain from the process.</p> <p>During an observation and interview on 02/26/2014 at 12:42 PM, the resident stated she was feeling better that day and that she had used an ointment around her rectal area to get pain relief due to the hard stool she had on 02/25/2015. Resident #188 explained she had told the nursing staff upon admission on 02/15/2015 that she had not had a bowel</p>	F 309		

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 7</p> <p>movement since the day of her surgery for knee replacement on 02/12/2015, and that a staff member administered MOM to her on 02/15/2015. The resident stated that after she had a bowel movement on 02/16/2015 she had informed nursing staff she was constipated and felt bloated at least 5 or 6 times, although she could not remember the exact dates she had told them.</p> <p>In an interview with Nurse #1 on 02/26/2015 at 3:40 PM, she stated the resident's condition regarding her rehabilitation process for her total right knee replacement had gradually improved and that she was able to ambulate to the bathroom using her rolling walker. In addition, she stated that when she checked on the resident on 02/25/2015, she was in the bathroom and stated that she was very constipated and needed some help, saying that the stool would not pass. Nurse #1 stated the resident had stool partially visible in the rectum and that it was not moving. Nurse #1 stated she offered the resident Milk of Magnesia and a Dulcolax suppository at that time, but the resident stated she would need an enema instead. Nurse #1 explained that she administered a Fleets enema to the resident, but that it really did not work. Nurse #1 stated that she manipulated around the resident's rectal area with her fingers to help expel the stool, and that the stool came out and broke apart. Nurse #1 also stated she did not recall the resident reporting to her that she was constipated, and that it was the nursing assistant's responsibility to record when the residents were having bowel movements. Nurse #1 stated that some of the nursing assistants would report to the nurse when the resident had a bowel movement, but</p>	F 309		

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 8</p> <p>others did not. In addition, Nurse #1 stated that the Physical Therapy Assistant (PTA) and the Occupational Therapy Assistant (OTA) worked with the resident and might have noted whether the resident had bowel movements.</p> <p>An interview with the OTA was conducted at 4:00 PM on 02/26/2015. The OTA stated that her responsibilities were to assist the resident with ambulation, to facilitate her independence with activities of daily living such as lower body dressing and bathing, standing balance, and upper body exercise. She explained that she had helped the resident ambulate to the bathroom where she was able to complete her personal hygiene and toileting on her own. The OTA also stated she had not been present with the resident when she actually had a bowel movement. Also, the OTA stated that on 02/25/2015, the resident had reported to her that she was constipated and that the nurse had to "dis-impact her" that day. In addition, the OTA stated she had worked with Resident #188 on 02/26/2015 and that the resident reported to her she was still a little uncomfortable due to episode with constipation yesterday. The OTA stated she did not work with the resident as long as she typically would on 02/26/2015 because she was not feeling well.</p> <p>In an interview with the PTA on 02/27/2015 at 9:47, she stated that she worked with the resident to improve her ambulation and flexion of her right knee, and that the resident was progressing nicely. The PTA also stated the resident complained of right knee pain and that she also had complained of constipation. The PTA added that this was documented in her</p>	F 309			

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 9</p> <p>Physical Therapy (PT) Daily Treatment Note. In addition, she stated she reported this to Nurse #1, who then administered an enema to the resident. She also stated that she had not been present in the resident's room when she had a bowel movement, but that she had smelled the odor of it when she had worked with her during her rehabilitation process.</p> <p>The PTA provided a copy of the PT Daily Treatment Note on 02/27/2015 on 02/27/2015 at 10:30 AM. A review of the note which was dated 02/25/2015 at 3:02 PM revealed that there was care coordination with the resident's nurse regarding the resident's complaint of constipation.</p> <p>An interview was conducted with the Nursing Assistant (NA) #1 on 02/27/2015 at 10:45 AM via telephone. NA #1 stated that in general, the nursing assistant would ask the resident if she had a bowel movement, and then would let the nurse know. She stated she did not really recall talking with Resident #188 regarding whether she had bowel movements until 02/25/2015 when the resident told her she had not had a bowel movement since the day of her knee surgery on 02/12/2015. NA #1 stated she reported this to the nurse, and that the nurse then gave her an enema. She explained that the nurse was the only staff member with the resident when the enema was given. In addition, NA #1 stated that on 02/26/2015, the day after the enema was given, the resident had a large bowel movement which was loose in consistency.</p> <p>In an interview at 3:35 pm on 2/27/15 with the Unit Manager (UM) for day shift for the 100 Hall,</p>	F 309			

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

PRINTED: 03/10/2015
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 C 02/27/2015
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 309	<p>Continued From page 10</p> <p>she stated there was a bowel movement protocol to follow if a resident had not had a bowel movement in 3 days. She explained that on day shift, 7:00 AM to 3:00 PM, a bowel movement flow sheet was printed out for all residents, and that the bowel movement sheets were passed to the next shift nurse for 3:00 PM to 11:00 PM. The UM stated the nurse on the 3:00 PM to 11:00 PM nurse would then determine whether 3 days had passed since the resident's last bowel movement according to the bowel movement flow sheets and would administer MOM if necessary, and then monitor whether the resident needed follow up with a suppository or enema depending on whether the resident had bowel movements on subsequent days.. The UM stated it was her expectation that each nursing assistant to find out whether a resident had a bowel movement every day and then record this on the bowel movement record in the computer. The UM also stated that the bowel movement sheets were not routinely saved after the 3:00 PM to 11:00 PM nurse reviewed it.</p> <p>In an interview with the Director of Nursing on 02/27/2015 at 5:00 PM, she stated that it was the routine to follow the bowel protocol, and that if a resident had not had a bowel movement in 3 days, the protocol should be initiated by administering MOM, then a suppository and/or an enema on subsequent days if the resident continued to go without bowel movements. The DON stated that this protocol was to be followed for all residents.</p>	F 309			