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 ______	01/07/2016

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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility did not provide privacy for 1 of 1 sampled residents (Resident #35) who was observed receiving a complete bed bath. Findings included:	F 164	1. Corrective action for residents found to have been affected by this deficiency: Resident #35 has been provided privacy while receiving personal Care. CNA #4 has been educated and given written counselling on her deficient practice.	2/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/28/2016

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.

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 ______	01/07/2016

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 164	Continued From page 1 Resident #35 was admitted to the facility on 02/26/14. Cumulative diagnoses included hypertension, depression and neurogenic bladder. The most recent Quarterly Minimum Data Set (MDS) assessment of 10/16/15 noted she was independent with all decision making and was cognitively intact. She required extensive assistance from staff for dressing and hygiene. She required total assistance with bathing. Resident #35 was incontinent of both bowel and bladder. She had no behaviors. Resident #35's care plan, last reviewed on 10/28/15, identified a problem with incontinence. Approaches included providing privacy and keep the skin clean and dry. During an observation of a complete bed bath being provided to Resident #35 on 01/04/16 beginning at 11:45 AM, Nurse Aide #4 (NA #4) prepared supplies for the bed bath. She pulled the privacy curtain but did not close the blinds. Resident #35's bed was up next to the window which overlooked the side parking lot of the facility. There were several men working in the parking lot while NA #4 was providing the bath to Resident #35. NA #4 was also noted to look out the window on several occasions while she was bathing Resident #35. She completed the bath and dressed Resident #35. NA #4 was interviewed immediately following the bed bath on 01/04/16 at 12:15 PM. She stated she did look out the window during the bath and thought about closing the blinds but didn't. NA #4 reported that she should have closed the blinds during the bath for privacy.	F 164	2. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by this identified concern. All residents will be provided privacy while they are receiving personal care. 3. Measures to b put into place to ensure that this deficiency does not occur: Staff in-service will be conducted by 2-1-16. The DON/Designee will complete weekly audit/rounds, times four weeks and then monthly thereafter times three months to ensure privacy is provided to residents during personal care. The DON/Social worker will interview 5 residents weekly times 4 weeks and then monthly thereafter times 3 months to ensure they have no concerns with privacy. 4. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected. Any discrepancies identified in the audits will be documented and corrective action will be taken immediately. If discrepancies are identified further education and or disciplinary action will occur with the staff member responsible. If trends are noted this quality assurance process will be revised by the QA committee and additional staff education and training will be provided. The QA committee will review facility progress on this identified concern for three months. If problems are identified revisions to the plan will be implemented.	

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 ______	01/07/2016

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 164	Continued From page 2 During an interview with Resident #35, on 01/06/16 at 11:40 AM, she stated Nurse Aide #4 didn't close the blinds when she provided her bed bath yesterday. She stated her bed faced the window. She commented that staff members smoked outside her window. When questioned about privacy, she stated she didn't like being naked with the blinds left open for fear someone might see her. The Assistant Director of Nurses (ADON) was interviewed on 01/06/16 at 12:30 PM. She stated when staff were providing personal care the blinds should always be closed. She stated Resident #35's room overlooked the side parking lot and faced the area where staff went to smoke.	F 164	5. Facility alleges compliance with this deficiency on 2-4-16.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility did not provide personal care services resulting in neglect of 1 of 1 sampled dependent residents (Resident #35) who was in need of personal care. Findings included:	F 224	1. Corrective action for residents found to have been affected by this deficiency: Resident #35 has had personal care provided in a timely manner. 2. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be	2/4/16

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 ______	01/07/2016

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 224

Continued From page 3

Resident #35 was admitted to the facility on 02/26/14. Cumulative diagnoses included hypertension, depression and neurogenic bladder.

The most recent Quarterly Minimum Data Set (MDS) assessment of 10/16/15 noted she was independent with all decision making and was cognitively intact. She required extensive assistance from staff for dressing and hygiene. She required total assistance with bathing. Resident #35 was incontinent of both bowel and bladder. She had no behaviors.

Resident #35's care plan, last reviewed on 10/28/15, identified a problem with self-care deficit and needed total assistance from staff. Approaches included assisting with grooming, bathing and toileting. A problem was also identified with bowel and bladder incontinence. Approaches included to provide incontinent care as needed and keep her clean and dry.

During a resident interview on 01/04/16 at 10:55 AM, Resident #35 reported that she had not been checked for incontinence since third shift. She stated she was "messy" and had been that way since shortly after breakfast this morning. Nurse Aide #4 (NA #4) came into the room and asked Resident #35 if she wanted to get out of bed today. Resident #35 reported she was "messy" and needed to be changed. NA #4 told her that she had to go out with the residents for their smoke break in a few minutes but would change her when the smoke break was over. NA #4 left the room. Resident #35 stated she did not like being left wet and messy.

NA #4 went down to the nurse's station and

F 224

affected by this identified concern.
All residents will receive personal care in a timely manner per policy and per request of resident.
3. Measures to be put in place to ensure that this deficiency does not reoccur:
A staff in-service on all concerns will be held by 2-1-16. The DON/Designee will conduct weekly audits/rounds times four weeks and then monthly x 3 months to ensure residents are receiving personal care in a timely manner.
The DON/Social Worker will interview 5 residents weekly x 4 weeks and then monthly thereafter times 3 months to ensure they have no concerns with receiving personal care in a timely manner.
4. 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 reoccur:
Any discrepancy identified in the audits will be documented, investigated and corrected immediately. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.
If trends or discrepancies are noted, the QA process will be revisited by the QA committed and further education and training will be provided. The QA 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 reoccur.
Facility alleges compliance on 2-4-16.

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 ______	01/07/2016

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 224	Continued From page 4	F 224		

obtained a box of smoking supplies and went out into the courtyard to supervise the residents who were smoking at 11:05 AM on 01/04/16.

The residents' smoke break ended at 11:30 AM on 01/04/16. NA #4 was questioned as to when she planned to provide care to Resident #35. She responded that the lunch trays would be coming out soon and she would change her after lunch and proceeded down the hallway to the nurses' station. NA #4 walked into another resident's room at 11:35 AM and came out after approximately 5 minutes. She talked with other staff in the hallway and then went into the clean utility room. She came out with towels and walked down to Resident #35's room.

On 01/04/16 at 11:45 AM, NA #4 explained to Resident #35 that she was about to provide her bed bath. She washed and rinsed her upper body and reported she was about to provide personal care. She removed the soiled brief and commented that she was not "messy" and was only wet. She cleansed the front of her body and asked Resident #35 to roll onto her right side. When Resident #35 rolled over, she was noted to have a large soft bowel movement. She provided care and proceeded with her bath.

NA #4 was interviewed immediately following completion of Resident #35's bed bath on 01/04/16 at 12:15 PM. She stated Resident #35 had reported that she was messy before she went out to be with the residents on smoke break. She stated she told Resident #35 that she would provide care when the smoke break was over but she had forgotten about it. When questioned as to the last time she had checked Resident #35, NA #4 reported that she had not provided any

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 ___	01/07/2016

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 224	Continued From page 5 incontinence care that day prior to the observation of the bed bath. She reported being too busy to get to her and this was the first time she had provided care. When questioned as to the timeliness of care, she stated she had decided to go ahead and provide care rather than waiting until after lunch since Resident #35 had told her she was "messy". NA #4 stated she was assigned to smoke break and there was no one available to provide care to Resident #35. The Assistant Director of Nurses (ADON) was interviewed on 01/06/16 at 12:30 PM. She reported it was her expectation that residents were kept clean and dry. She stated nurse aides should be rounding at least every 2 hours and more often if needed. She stated nurse aides were assigned to smoke breaks at times but they should provide personal care regardless. The ADON stated if staff were assigned to smoke breaks and a resident needed incontinent care then the aide should either ask someone to provide the care or report to the nurse that the resident needed care. She commented in either case the resident's care should be provided timely. The ADON stated NA #4 should not have waited to provide incontinent care as it should have been provided as soon as she was advised by the resident that she needed to be changed. The ADON also stated that waiting until 11:45 AM to do the first check was not acceptable.	F 224		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252		2/4/16

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 ______	01/07/2016

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 252	Continued From page 6 to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to provide a clean interior for 5 of 5 bathrooms (Rooms #213, #214, #215, #309, #311), observed for cleanliness. Findings included: Review of the undated 7 Step Cleaning Method Job Breakdown revealed under Job: Step 4, Sanitize Sink and Tub, 1: Clean sink basin, fixtures, and pipes underneath with germicide. Under Job: Step 5, Clean and sanitize inside bowl, 1: Clean and sanitize inside bowl. 2: Wipe down all other areas of commode. Job: Step 6, Spot Clean Walls and/or Partitions, 1: Spot clean walls. Under Job: Step 7, Damp Mop Floor 3: Mop corners and edges. Apply pressure on edges and baseboards. Use foot on top of mop in corners to "dig" out debris. Use a scraper to clean build-up. In an observation on 01/03/16 at 3:00 PM the bathroom in room 214 had a very strong odor of urine. The floor was stained black around the base of the toilet. The floor around the walls was thick with brown matter. The base of the commode contained dark grime up the sides. In an observation on 01/04/16 at 11:00 AM the bathroom in room 214 still had a very strong urine odor. The floor was stained black around the base of the toilet. The floor around the walls was thick with brown matter. The base of the commode contained dark grime up the sides. In an observation on 01/05/16 at 11:28 AM there was a strong urine odor emanating from the doorway of room 214 into the hallway. On entry into the bathroom the odor was much stronger.	F 252	Bathrooms in rooms 213, 214, 215, 309, and 311 will be deep cleaned and the old wax stripped off the floor and new wax applied. All residents bathrooms will be inspected for cleanliness. Any bathroom that is not clean will be deep cleaned and if necessary stripped and re-waxed. All housekeeping staff will be re-in-serviced on the seven step cleaning method. Going forward residents bathrooms will be cleaned daily using the 7-step cleaning method. Resident bathrooms will be inspected 5 days a week for one month, 2 days a week for one month, and once per week for three months. Any trending negative outcomes will be referred to the QA Committee for review. Facility alleges compliance by 2-4-16.	

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 ______	01/07/2016

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 252	Continued From page 7 The floor around the walls was thick with brown matter. The base of the commode contained dark grime up the sides and the floor was stained black around the base of the toilet. In an observation on 01/05/16 at 11:25 AM the bathroom floor in room 311 contained multiple spots of brownish/black grainy matter trailing into the bedroom. There was dark caked on black matter along the edges of the walls. A strong urine odor was noted. There were 2 smeared areas of brown matter noted to the walls. Brown liquid was pooled in the indentation at the base of the commode. The commode seat contained dried brown matter. A white/gray build-up of mineral deposits was noted on the sink faucet handles. Brownish/orange matter was noted around the base of the commode. In an observation on 01/05/16 at 11:33 AM the bathroom in room 309 had a bath basin under the sink with unfolded paper towels lining the inside. Dark brown matter was noted on the unfolded paper towels and on the inside walls of the basin. White/gray mineral deposits were noted on the sink faucet handles. An orange/brown build-up was noted on the right side of the commode at the base. In an observation on 01/05/16 at 11:38 AM the bathroom in room 213 showed a build-up of a brownish/orange matter where the bathroom floor tiles met in front of the commode. The seat of the commode showed a build-up of grainy blackish/brown matter. There was a white/gray build-up of mineral deposits on the sink faucet handles. In an observation on 01/05/16 at 11:40 AM damp and crumpled paper towels were seen next to the trash receptacle in the bathroom of room 215. A bath basin with brown matter inside was sitting on the back of the commode. Dark matter was noted	F 252		

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 ______	01/07/2016

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 252	Continued From page 8	F 252		

at the edges of the walls. The commode had blackish/brown grainy matter from the floor up the front of the commode. There was an orange colored substance around the base of the commode. The sink faucet had a build-up of white/gray mineral deposits. There was a missing portion of tile on the right side of the commode with a build-up of black/brown matter. The over commode seat had brown smears down the left side.

In an observation on 01/05/16 at 2:30 PM with the Director of Nursing (DON) there had been no changes in the cleanliness or odors in the bathrooms of rooms 311, 214, 213, and room 215. Room 309 was not visualized at that time due to care being provided in that room.

In an interview on 01/05/16 at 2:30 PM during the tour of the bathrooms the DON indicated the bathrooms were not comfortable and homelike. She indicated the rooms were not clean and she expected the housekeepers to keep the bathrooms clean.

In an interview on 01/07/16 at 2:05 PM Housekeeper #1 stated her usual job assignment contained rooms 311, 214, 309, 213, and 215. She indicated the bathroom in room 214 had smelled very strongly of urine since she started working in the facility six months ago. She indicated she and the Housekeeping Manager had deep cleaned room 214 two weeks ago and the odor remained. She indicated she used the enzymatic spray to try to control odors but it did not work in room 214. Housekeeper #1 stated sometimes she used the 7 step method to clean and sometimes she did not. She indicated it would depend on the cleanliness of the room.

In an observation on 01/06/16 at 9:55 AM Housekeeper #1 was cleaning the bathroom in room 311. A scraping tool was used to get up the

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 ______	01/07/2016

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 252	Continued From page 9 orange/brown matter from around the commode. The brown liquid was still pooled in the indentation at the base of the commode. A cloth was used to easily remove the liquid. The housekeeper wiped the bowl of the toilet, mopped the floor and stated she was finished. When the brown smears on the walls were pointed out she wiped them off with a cloth. In an interview on 01/05/16 at 4:45 PM Resident #27 stated the facility was nasty and it stunk. He stated you could smell the urine odor when you came down the hall. He also indicated the housekeepers did not clean his bathroom, they only mopped the floor and emptied the trash. In an interview on 01/06/16 at 4:15 PM Resident #28 stated the resident rooms and bathrooms were not always clean. He indicated housekeeping issues were an ongoing concern but the facility continued to work on solutions for cleanliness. In an interview on 01/07/16 at 9:42 AM the Housekeeping Manager stated he did not go into the bathrooms to check for cleanliness. The Housekeeping Manager stated when the housekeepers went into a resident's room they dust mopped, swept and emptied the trash. He indicated they cleaned the rooms based on the 7 step method. He indicated when cleaning the commode he expected the housekeepers to clean from the top down to the floor. The Housekeeping Manager indicated if the bathrooms had an odor there was a special enzymatic spray that was used. He indicated the housekeeping staff worked from 8:00 AM-3:00 PM and no housekeepers were available after that time. He indicated he expected the housekeepers to keep the rooms and bathrooms clean by following the 7 step method. In an interview on 01/07/16 at 2:25 PM the	F 252		

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 ______	01/07/2016

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 252	Continued From page 10 Maintenance Manager stated he did not go in every room or bathroom every day. He indicated he had not been informed there was an odor issue in room 214. He indicated the odor could signify the toilet needed to be replaced as urine could have gotten under the commode or urine may have even gotten under the walls in the bathroom. In an interview on 01/07/16 at 3:10 PM the Director of Nursing stated she expected the residents to have a clean, comfortable and homelike environment.	F 252		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility did not provide incontinent care to 1 of 2 sampled dependent residents (Resident #35) who were observed receiving personal care. The facility also did not provide grooming services for 2 of 2 sampled residents (Resident #37 and #98) who needed facial hair removed. The facility did not provide grooming services for 1 of 1 sampled residents (Resident #36) who had long and dirty fingernails. Findings included: 1. Resident #35 was admitted to the facility on 02/26/14. Cumulative diagnoses included	F 312	1. Corrective action for residents found to have been affected by this deficiency: Resident #35 has received the assistance with bathing and toileting. Resident #37 and #98 had their facial hair removed. Resident #36 had her nails trimmed and cleaned. 2. Corrective action for the residents that may be affected by this deficiency: All resident have the potential to be affected by these identified concerns. All residents will receive assistance with their ADLs including bathing, toileting,	2/4/16

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 ______	01/07/2016

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 312

Continued From page 11

hypertension, depression and neurogenic bladder.

The most recent Quarterly Minimum Data Set (MDS) assessment of 10/16/15 noted she was independent with all decision making and was cognitively intact. She required extensive assistance from staff for dressing and hygiene. She required total assistance with bathing. Resident #35 was incontinent of both bowel and bladder. She had no behaviors.

Resident #35's care plan, last reviewed on 10/28/15, identified a problem with self-care deficit and needed total assistance from staff. Approaches included assisting with grooming, bathing and toileting. A problem was also identified with bowel and bladder incontinence. Approaches included to provide incontinent care as needed and keep her clean and dry.

During a resident interview on 01/04/16 at 10:55 AM, Resident #35 reported that she had not been checked for incontinence since third shift. She stated she was "messy" and had been that way since shortly after breakfast this morning. Nurse Aide #4 (NA #4) came into the room and asked Resident #35 if she wanted to get out of bed today. Resident #35 reported she was messy" and needed to be changed. NA #4 told her that she had to go out with the residents for their smoke break in a few minutes but would change her when the smoke break was over. NA #4 left the room. Resident #35 stated she did not like being left wet and messy.

NA #4 went down to the nurse's station and obtained a box of smoking supplies and went out into the courtyard to supervise the residents who

F 312

shaving, and nail care.
3. Measures that will be put into place to ensure that this deficiency does not reoccur.
All staff in-service will be held by 2-1-16. The DON/Designee will complete a weekly audit/rounds times four weeks and then monthly thereafter times four months to ensure ADL care is being provided. Special attention will be paid to bathing, toileting, facial hair removal, and nail care.
4. Measures that will be implemented to monitor the continued action taken to ensure that this deficiency has been corrected and will not reoccur.
Any discrepancies identified in the audits will be documented, investigated and corrected immediately. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible.
If trends or discrepancies are noted this QA process will be reviewed by the QA committee. As discrepancies and trends are identified through these QA audits further education and training will be provided.
The QA committed will review facility progress on the identified concerns for at least three months and if problems are identified revisions will be completed to ensure the deficient practice does not reoccur.
5. Facility alleges compliance on 2-4-16.

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 ______	01/07/2016

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 312	Continued From page 12 were smoking at 11:05 AM on 01/04/16. The resident's smoke break ended at 11:30 AM on 01/04/16. NA #4 was questioned as to when she planned to provide care to Resident #35. She responded that the lunch trays would be coming out soon and she would change her after lunch and proceeded down the hallway to the nurses' station. NA #4 walked into another resident's room at 11:35 AM and came out after approximately 5 minutes. She talked with other staff in the hallway and then went into the clean utility room. She came out with towels and walked down to Resident #35's room. On 01/04/16 at 11:45 AM, NA #4 explained to Resident #35 that she was about to provide her bed bath. She washed and rinsed her upper body and reported she was about to provide personal care. She removed the soiled brief and commented that she was not "messy" and was only wet. She cleansed the front of her body and asked Resident #35 to roll onto her right side. When Resident #35 rolled over, she was noted to have a large soft bowel movement. She provided care and proceeded with her bath. NA #4 was interviewed immediately following completion of Resident #35's bed bath on 01/04/16 at 12:15 PM. She stated Resident #35 had reported that she was messy before she went out to be with the residents on smoke break. She stated she told Resident #35 that she would provide care when the smoke break was over but she had forgotten about it. When questioned as to the last time she had checked Resident #35, NA #4 reported that she had not provided any incontinence care that day prior to the observation of the bed bath. She reported being	F 312		

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 _____	01/07/2016

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 312	Continued From page 13	F 312		

too busy to get to her and this was the first time she had provided care. When questioned as to the timeliness of care, she stated she had decided to go ahead and provide care rather than waiting until after lunch since Resident #35 had told her she was "messy". NA #4 stated she was assigned to smoke break and there was no one available to provide care to Resident #35.

The Assistant Director of Nurses (ADON) was interviewed on 01/06/16 at 12:30 PM. She reported it was her expectation that residents were kept clean and dry. She stated nurse aides should be rounding at least every 2 hours and more often if needed. She stated nurse aides were assigned to smoke breaks at times but they should provide personal care regardless. The ADON stated if staff were assigned to smoke breaks and a resident needed incontinent care then the aide should either ask someone to provide the care or report to the nurse that the resident needed care. She commented in either case the resident's care should be provided timely. The ADON stated NA #4 should not have waited to provide incontinent care as it should have been provided as soon as she was advised by the resident that she needed to be changed. The ADON also stated that waiting until 11:45 AM to do the first check was not acceptable.

2. Resident #37 was admitted to the facility on 02/16/15. Cumulative diagnoses included hypertension, congestive heart failure and anxiety.

The most recent Quarterly Minimum Data Set (MDS) assessment of 10/14/15 noted she needed extensive assistance with activities of daily living which included dressing and bathing.

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 ______	01/07/2016

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 312	Continued From page 14	F 312		

There was no rejection of care noted.

Resident #37's care plan, last reviewed on 10/21/15, identified a problem with self-care deficit as needing total assistance from staff. In the approach section, it indicated that the nurse aide would assist with hygiene and grooming.

Resident #37 was observed resting in bed during initial tour on 01/03/16 at 2:35 PM. She was noted to have thick white facial hair on her upper lip.

Resident #37 was observed sitting in the hallway on 01/05/16 at 2:00 PM. There was no change noted to the thick white facial hair growth on her upper lip. She reported that she had asked her aide today about shaving her but she had not done it.

Resident #37 was observed again on 01/05/16 at 5:00 PM. The thick white facial hair was still present to her upper lip.

Resident #37 was observed sitting in her wheelchair on 01/06/16 at 10:45 AM. She reported that she had her bath and was on her way to activities. There was no change to the thick white facial hair on her upper lip.

Nurse Aide #2 (NA #2) was interviewed on 01/06/16 at 2:30 PM. She stated she shaved the female residents who were able to request to be shaved upon request. She stated the female residents who were not able to voice their needs were usually shaved when facial hair was visible. When questioned as to Resident #37, NA #2 stated that she was busy today but would try to shave her before end of her shift today.

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 ______	01/07/2016

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 312	Continued From page 15	F 312		

Nurse #7 was interviewed on 01/06/16 at 11:45 AM. She stated it was left up to the nurse aides as to when they shaved the female residents. She stated it was usually done during the morning bath or the shower. Nurse #7 stated there was no specific assigned time to shave the female residents but should be done when facial hair was present. She commented that if she noticed facial hair she would report it to the nurse aide. Nurse #7 commented that she would not want long facial hair on her face.

The Director of Nurses (DON) was interviewed on 01/06/16 at 3:00 PM. She stated there was no specific assigned time for nurse aides to shave the female residents. She stated shaving was usually done with the daily bath. The DON stated the female residents should be shaved when facial hair was noticed on their face.

Resident #37 was observed resting in bed on 01/07/16 at 3:00 PM. The facial hair had been removed.

3. Resident #98 was admitted to the facility on 04/08/11. Cumulative diagnoses included alzheimer's disease.

The most recent Significant Change Minimum Data Set (MDS) assessment of 10/19/15 noted Resident #98 required extensive assistance with hygiene and bathing. There were no behaviors noted.

Resident #98's care plan, last reviewed on 10/19/15, identified a problem with self-care deficit. It was noted she needed total assistance

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 ______	01/07/2016

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 312	Continued From page 16	F 312		

from staff.

Resident #98 was observed resting in bed during initial tour on 01/03/16 at 3:30 PM. She was noted to have white facial hair on her upper lip as well as numerous long white chin hairs.

Resident #98 was observed sitting in the geri-chair in the hallway on 01/04/16 at 2:20 PM. She had white facial hair on her upper lip and the long white chin hairs.

Nurse Aide #3 (NA #3) was finishing Resident #98's bed bath on 01/05/16 at 9:45 AM. She reported that Resident #98 was having a really good day and was very cooperative today. When questioned about grooming, NA #3 stated she probably would allow her to do just about anything today as she was having a good day. She commented sometimes she would resist. The facial hair was still present to her upper lip and her chin.

Resident #98 was observed resting in bed on 01/05/16 at 11:45 AM. The facial hair was still present to her upper lip and her chin.

Resident #98 was observed resting in bed on 01/05/16 at 4:55 PM. There was no change in the appearance of her facial hair.

Resident #98 was observed in her geri-chair sitting in the hallway on 01/06/16 at 10:40 AM. The facial hair was still noted to her upper lip and chin.

NA #3 was interviewed on 01/06/16 at 11:10 AM. She stated female residents were shaved when needed. She reported that it was her personal

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 ______	01/07/2016

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 312	Continued From page 17	F 312		

preference to shave the female residents on shower days. NA #3 stated Resident #98's shower days were Mondays and Thursdays. She commented that she had not worked with her every day this week but if needed she could ask the second shift aide to provide care if she did not have time to provide it. When questioned about Resident #98's facial hair, NA #3 stated she was in need of shaving and if she had time she would shave her before leaving today.

Nurse #7 was interviewed on 01/06/16 at 11:45 AM. She stated it was left up to the nurse aides as to when they shaved the female residents. She stated it was usually done during the morning bath or the shower. Nurse #7 stated there was no specific assigned time to shave the female residents but should be done when facial hair was present. She commented that if she noticed facial hair she would report it to the nurse aide. Nurse #7 commented that she would not want long facial hair on her face.

On 01/06/16 at 2:15 PM, Nurse #7 reported that she had spoken with NA #3 in regards to shaving Resident #98. She commented she was shaved and looked so much better. She added that Resident #98 did not resist.

The Director of Nurses (DON) was interviewed on 01/06/16 at 3:00 PM. She stated there was no specific assigned time for nurse aides to shave the female residents. She stated shaving was usually done with the daily bath. The DON stated the female residents should be shaved when facial hair was noticed on their face.

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 ______	01/07/2016

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 312	Continued From page 18	F 312		

4. Resident #36 was re-admitted to the facility on 04/28/15 with cumulative diagnoses of cerebrovascular accident (CVA), non-Alzheimer's dementia, and hypertension (HTN).
Resident #36's Quarterly Minimum Data Set (MDS) dated 10/18/15 revealed that Resident #36 was severely cognitively impaired and totally dependent on one person for hygiene.
In an observation on 01/04/16 at 4:37 PM Resident #36 was lying in bed with the head of the bed elevated. Resident #36's hands were on top of the bedspread. Dark matter was noted underneath her long fingernails.
In an observation on 01/05/16 at 10:10 AM Resident #36 was lying in bed with the head of the bed elevated. Resident #36's fingernails were long and had dark matter underneath them.
In an observation on 01/05/16 at 4:45 PM Resident #36's nails had been trimmed and cleaned.
In an interview on 01/06/16 at 10:00 AM Nurse #4 stated she had cut and cleaned Resident #36's fingernails the previous day because they were long and dirty.
In an interview on 01/07/16 at 9:30 AM Nursing Assistant (NA) #1 stated during morning care the residents were washed head to toe and had lotion applied to their bodies. He indicated mouth care and hair grooming was also done at that time. NA #1 stated fingernail care was provided by the NA's if the resident was not diabetic. He indicated he was not sure if Resident #36 was diabetic.
In an interview on 01/07/16 at 9:40 AM Nurse #6 stated the NA's checked resident fingernails daily when they bathed the residents. She indicated if a

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 ______	01/07/2016

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 312	Continued From page 19 resident was diabetic the nurse would trim their toenails. Nurse #6 also indicated the nurse should observe resident's fingernails during medication administration times and anytime they were in the room with the resident. In an interview on 01/07/16 the Director of Nursing (DON) stated she expected fingernail care to be done when nails became long or if they were dirty. She stated she expected resident fingernails to be checked daily during the resident's bath. The DON indicated any NA or nurse could trim and clean resident fingernails but only nurses could trim toenails.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to apply a palm protector as ordered for 1 of 2 sampled residents (Resident #36) who were observed for splinting services. Findings included: Resident #36 was re-admitted to the facility on 04/28/15 with cumulative diagnoses of cerebrovascular accident (CVA), non-Alzheimer's dementia, and hypertension (HTN). Resident #36's Quarterly Minimum Data Set (MDS) dated 10/18/15 revealed that Resident #36	F 318	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #36 has had her palm protector in place. The nurse's aide information sheet has been updated o include splint usage. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same	2/4/16

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	01/07/2016

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 318	Continued From page 20 was severely cognitively impaired and totally dependent on one person for dressing (donning/removing prosthesis). Review of the January 2016 Physician Orders showed an order written 04/28/15 for a right palm protector and circular positioner to be applied in the AM (morning) after breakfast and removed at bedtime. In an observation on 01/04/16 at 2:30 PM Resident #36 was lying in bed with the head of the bed elevated. Resident #36's hands were covered by the bedspread. A fleece lined palm protector was on top of a plastic storage bin next to the wall toward the foot of the bed. The palm protector was easily visible on top of the bin. In an observation on 01/04/16 at 4:37 PM Resident #36 was lying in bed with the head of the bed elevated. The hands were visible and no palm protector was in place on the right hand. The palm protector was still lying on top of the plastic storage bin. In an observation on 01/05/16 at 10:10 AM Resident #36 was lying in bed with the head of the bed elevated. The right hand was bare and no palm protector was noted. The palm protector was on top of the plastic storage bin located next to the wall by the foot of the bed. The palm protector was easily seen from Resident #36's bedside. In an observation on 01/05/16 at 4:45 PM Resident #36 did not have a right hand palm protector in place. The palm protector was on top of the plastic storage bin near the foot of the bed. The palm protector was in view from Resident #36's bedside. In an observation on 01/06/16 at 9:48 AM Resident #36 was up in a reclining chair at the bedside. No palm protector was in place. The palm protector was on top of a plastic bin near	F 318	deficient practice. All residents who have orders for splints have the potential to be affected by the identified concern. All residents with splint orders will have splints available and applied correctly. All other residents will be assessed by nursing for possible contractures . If problems with contractures are identified a referral to OT/PT will be made. These referrals will be made before 2-4-16. Therapy will then screen each resident and if treatment is indicated an MD order will be obtained for an evaluation from OT/PT. 3. Measures that will be put into place to ensure that this deficiency does not reoccur. In servicing for licensed nurses began on 1-7-16. More in-servicing will be held by 2-1-16 to review splinting applications and documentation. All C.N.A. will be in-serviced on how to identify contractures, and how to start the referral process to OT/PT for treatment. They will also be instructed on the process/ procedure on splint replacement should they be unable to locate a splint. This in-servicing will begin 2-2-16 and end 2-4-16. The DON/Designee will do 100% audits of all splints weekly times 4 weeks and then monthly thereafter times three months to ensure splints are being applied as ordered. 4. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected.	

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 ______	01/07/2016

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 318	Continued From page 21 the foot of the bed in view from Resident #36's bedside. In an interview on 01/06/16 at 9:50 AM Nursing Assistant (NA) #1 stated he was Resident #36's usual aide. He indicated Resident #36 did not need a splint that he was aware of. NA #1 indicated if something like heel protectors, palm protectors or other splints were needed a sign was posted on the wall or the nurse would inform the NA's. He indicated no sign was posted and the nurse had not informed him Resident #36 needed a palm protector. When the palm protector was pointed out he stated it was for Resident #36's hand and he had not applied it because Resident #36's hands were still wet from the bath. In an interview on 01/06/16 at 10:00 AM Nurse #4 stated she did not tell the aides which residents needed splinting or palm protectors as they should already know. In an interview on 01/06/16 at 4:00 PM Nurse #5 stated the nurses had to trust that the NA's knew what they should be doing. She indicated there was no care guide to direct the care of the aides. She stated she did not give report to the NA's. Nurse #5 indicated the nurses should check to make sure splinting devices were applied and removed as ordered but could not recall if she had seen Resident #36 wearing the palm protector. In an interview on 01/07/16 at 3:10 PM the Director of Nursing (DON) stated it was her expectation the nurses apply and remove splinting devices themselves since they were initialing it was done. She indicated at the very least she expected the nurses to verify the splints were placed and removed as ordered.	F 318	Any discrepancies identified in the audits will be documented, investigated, and corrected immediately. From any discrepancies identified further education or disciplinary action will occur with the staff member responsible. If trends or discrepancies are noted this QA process will be revised by the QA committed. As discrepancies and trends are identified through these QA audits further education and training will be provided. The QA 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 the deficient practice does not reoccur. 5. Facility alleges compliance on 2-4-16.	
F 371	483.35(i) FOOD PROCURE,	F 371		2/4/16

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 ____	01/07/2016

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 371 SS=E	Continued From page 22 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 discard kitchenware with abraded surfaces which made contact with food and failed to monitor food storage areas which resulted in the potential for compromised food quality and increased risk for bacterial contamination. Findings included: 1. At 11:07 AM on 01/05/16, during an observation of kitchenware used for preparing and serving food, the non-stick coating on a large fry/saute pan was scratched and sloughing off. 6 of 24 plastic soup/cereal bowls (25%) were abraded inside. The dietary manager (DM) stated this was caused by the repetitive scraping of resident utensils against the bowls as the residents were eating their food. At 9:57 AM on 01/07/16, during a follow-up observation of kitchenware, 9 of 31 plastic soup/cereal bowls (29%) were abraded inside. At 10:07 AM on 01/07/16 the DM stated kitchenware that was compromised with scraped	F 371	All cookware, small ware, and serving pieces were audited for wear and those found to show signs of wear were thrown out. An order was placed with food service for all new serving pieces Dishwashing aides will check all dishes and cookware for cracks, abrasions, sloughing of non-sticking coating, and other abnormalities as dishes/cookware are placed on rack/shelves after cleaning. This task will be added to the daily cleaning and initialed daily by aide completing the task. Dishes and cookware that are found to be damaged will be left with Dietary Manager for replacement. Dietary staff will participate in an in-service by 1-31-16 regarding the importance of checking dishes/cookware daily and discarding those with cracks, breaks, abrasions, sloughing of non-stick coatings, and other abnormalities in order to prevent ingestion of bacteria and non-stick chemicals and reporting	

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 ______	01/07/2016

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 371	Continued From page 23 and abraded surfaces posed a risk because it was more likely to harbor bacteria. In addition, she reported it was not safe for residents to ingest non-stick coating which sloughed off the frying/saute pan and into food during the cooking process. The DM commented cooks and dietary employees placing sanitized kitchenware into storage were supposed to check to make sure it was not compromised with cracks, chips, and abrasions. She explained these staff members were supposed to pull all damaged kitchenware and bring it to her so she could examine it, assess the cause of damage, and reorder. The DM reported she currently had no new soup/cereal bowls in stock to replaced the abraded ones found on 01/05/15 and 01/07/16. At 10:12 AM on 01/07/16 the AM cook stated any dietary employee who observed damaged kitchenware with cracks, chips, and abrasions was supposed to pull the items and present them to the DM so she could order replacements. 2. During initial tour of the kitchen and storage areas on 01/03/16, beginning at 1:40 PM, opened food items were found without labels and open dates in the dry storage room, walk-in refrigerator, and walk-in freezer. In the dry storage room a bag of elbow macaroni, a 10-ounce box of cornstarch, and 5-pound bag of all purpose flour were found opened but without labeling and dating. In the walk-in refrigerator a 40-ounce package of Swiss cheese slices, one bag of low-fat mozzarella cheese, and a gallon container of honey mustard dressing were found opened but without labeling and dating. In the walk-in freezer a bag of sausage patties, a bag of chicken breast, a bag of salami, and three repackaged pieces of ham wrapped in plastic and	F 371	damage to Dietary Manager. All food items were reviewed and those found to be opened with no date or beyond expiration date were thrown out. Dietary staff will participate in an in-service 1-31-16 regarding the importance of labeling, dating, and discarding foods past their "use by" dates in order to prevent food borne illness. This in-service will include both refrigerated foods and dry storage foods. Expirations date, date opened, discard dates will be reviewed. Tasks will be assigned based on schedule and will be added to the daily cleaning schedule. Foods beyond expiration date will be discarded when found during daily rounds. Foods that are past "use by" date will be discarded. Foods with expiration dates will be discarded. This task will be added to the daily cleaning schedule and initialed by the person completing the task. Dietary Manager (or designee) will monitor the above for compliance daily for seven days, every other day for 2 weeks, and then weekly for one month. A Audit information will be brought to the Quality assurance committee for review and any needed action This facility alleges compliance by 2-4-16.	

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 ______	01/07/2016

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 371	Continued From page 24	F 371		

foil were found opened but without labeling and dating. In addition, a tray pan dated 12/17/15 containing deli turkey, a tray pan dated 12/22/15 containing deli ham, leftover vegetable soup with a discard date of 01/02/16, barbecue with a discard date of 12/30/15, and a 5-pound container of chunky pimento cheese with a use-by date of 12/09/15 were found in the walk-in refrigerator.

At 11:28 AM on 01/05/16, during a follow-up tour of the kitchen, a gallon container of golden Italian dressing found in the walk-in refrigerator was opened but without a label and date.

At 10:07 AM on 01/07/16 the dietary manager (DM) stated storage areas were monitored by a stock person who worked on Mondays and Thursdays and by all dietary employees entering the storage areas on a daily basis. She reported staff were supposed to make sure opened food items, food removed from its original packaging, and leftovers were labeled and dated. The DM commented the facility did not use leftovers which were past their discard dates and perishable foods which were past their use-by dates. According to the DM, it was too risky to use foods past their use-by or discard dates due to the potential for foodborne illness. She also explained the facility used the same dedicated tray pans over and over for storing thawed deli meats in refrigeration, and the staff was not changing the pull/discard labels on the tray pans as they used deli meats up and refilled the tray pans with fresh deli meats. The DM commented thawed deli meats were supposed to be discarded if they were not used up during a three-day period.

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 ______	01/07/2016

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 371	Continued From page 25 At 10:12 AM on 01/07/16 the AM cook stated all dietary employees entering storage areas were supposed to check to make sure opened food items, food removed from its original packaging, and leftovers were labeled and dated. The cook commented the facility did not use leftovers which were past their discard dates and perishable foods which were past their use-by dates. She reported the facility did not like to keep leftovers and thawed deli meats for more than three days.	F 371		