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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING ______ B. WING ______	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD LIVING & REHAB CENTER	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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		1/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/22/2016

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.

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to notify the Responsible Party of a new wound and a decline in the wound condition for 1 of 3 residents (Resident #1) reviewed for notification of condition change. Findings included: Record review revealed Resident #1 was admitted to the facility on 9/3/2016 with cumulative diagnoses which included Diabetes and Osteoporosis. The Admission Minimum Data Set (MDS) dated 9/14/16 indicated Resident #1 required 1 person assistance with Activities of Daily Living and was cognitively intact. The Admission Skin Assessment dated 9/3/2016 reported Resident #1 had a rash on the left foot, slight edema to both ankles and a bruise to the forehead from a fall prior to admission to the facility. The initial Care Plan dated 9/14/2016 did not list Pressure Ulcers as an area of concern. Record review of the Clinical Nursing notes revealed on 9/29/2016, Resident #1 was noted to have an area of " shallow shearing " to both buttocks. The note revealed Resident #1 denied pain to the area and Resident #1 ' s recliner and wheelchair had pressure relieving cushions. The note indicated treatment was initiated and the Physician was notified.	F 157	1. Resident #1 is no longer a resident of the facility. 2. Current representatives of residents with wounds have been notified and/or updated on the status of the wound as of 12-23-2016. 3. RN/LPN will be in-serviced on MD/Family notification of change in resident condition. This education will include notification of interested family members of residents that are their own resident representative. 4. Random Audits of resident records will be conducted by DON/Designee to ensure physician/family have been notified of change. Audits will be completed 1 x week x 4, then q 2 weeks x 4. 5. Results of the audits will be reported to the QAPPI committee for review. If negative trends are identified the action plan will be revised by the QA committee. 6. Completion date 1-5-2017.	

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F 157	Continued From page 2 Further record review of the Clinical Medical Record revealed the areas on Resident #1 ' s buttocks were assessed by the Wound Management Nurse on 9/5/2016, 10/7/2015 and 10/15/2016 with no changes in treatment. On 10/20/2016 the areas were assessed and noted to have some depth and the treatment was changed. The note indicated the Physician was aware of the changes. The Wound Management Nurse assessed the area on 10/26/2016 and documented the area was larger than the previous assessment but the depth had decreased. The assessment indicated the Physician was aware. An interview was conducted with the Wound Management Nurse on 12/7/2016 at 9:25AM. The Wound Management Nurse recalled Resident #1 and the area to her buttocks. The Wound Management Nurse reported she did not notify the Responsible Party of the initial skin areas. The Wound Management Nurse also reported she did not notify the Responsible Party of any of the wound assessments. The Wound Management Nurse indicated she did not know why she did not notify the Responsible Party of the new skin condition and the subsequent assessments and changes. The Wound Management Nurse indicated the Responsible Party should have been notified. An interview was conducted with the Responsible Party on 12/8/2016 at 11:34 AM. The Responsible Party stated he was not notified of the skin issues by the facility staff. The Responsible Party indicated a family member who visited Resident #1 observed the area and notified him. An interview was conducted with the Director of Nursing (DON) on 12/8/2016 at 1:30 PM. The DON stated she was not aware the Responsible Party was not notified of Resident #1 ' s skin	F 157		

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F 157	Continued From page 3 issues on the initial assessment or the change in the wound condition. The DON stated it is the expectation of the facility for staff to notify the resident ' s Responsible Party for any change in condition.	F 157		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280		1/5/17

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F 280	Continued From page 4 resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 280		

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F 280	Continued From page 5 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to offer the opportunity for the Responsible Party to participate in Care Plan meetings for 1 of 3 residents (Resident #1) reviewed for notification of participation in Care Plan meetings. Findings included: Record review revealed Resident #1 was admitted to the facility on 9/3/2016 with cumulative diagnoses which included Diabetes and Parkinson ' s disease. The Admission Minimum Data Set (MDS) dated 9/14/16 indicated Resident #1 required 1 person assistance with Activities of Daily Living and was cognitively intact. Medical Record review from admission date of 9/3/2016 to discharge date of 11/13/2016 revealed no documentation of Care Plan meeting notes. An interview was conducted with the facility Social Worker (SW) on 12/7/2016 at 4:57 PM. The SW indicated the initial Care Plan meeting was scheduled within 72 hours of admission and the quarterly Care Plan meetings were scheduled according to the Minimum Data Set (MDS) schedule. The SW stated the Care Plan meetings are scheduled every Tuesday and Thursday and she tried to schedule 4 to 5 residents for each day. The SW did not recall speaking with Resident #1 " s Responsible Party about the initial	F 280	1. Resident #1 is no longer a resident in the facility. 2. Residents or their responsible party will be invited to a scheduled care plan conference so they can attend if they wish to do so. Residents or their responsible party will be notified by mail, in advance of the date and time of these conferences. 3. The Social worker has been in-serviced by the administrator on 12-19-16 to send a letter noting the date and time the conferences are scheduled, make a copy of the letter that was mailed and note on it the day the letter was mailed, and place the letter in a binder to document the invitation. 4. The Administrator will audit the letter binder weekly for 4 weeks and then monthly for three months to ensure that the letters are being sent consistently with the care plan schedule. 5. Negative trends will be taken to the QA committee for review and/or recommendations. 6. Completion date 1-5-2017.	

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F 280	Continued From page 6 Care Plan meeting and did not have any documentation of an invitation to the initial meeting. The SW did not indicate a reason the Responsible Party was not notified of the initial Care Plan meeting. The SW reported she usually sent out letters to the Responsibility Party to notify of an upcoming Care Plan meeting a month or so prior to the meeting. The SW stated there was no documentation of when the letter was mailed. The SW also stated there was no follow up with families or Responsible Parties of residents to ensure the letters were received or to confirm probable attendance to the meetings. The SW reported she never had much contact with Resident #1 ' s family or Responsible Party and was unaware of any issues with participation in the Care Plan meetings. A telephone interview was conducted with the Resident #1 ' s Responsible Party on 12/8/2016 at 11:34 AM. The Responsible Party stated he never received any notification of Care Plan meetings. The Responsible Party indicated he was actively involved in the care of Resident #1 and he felt he should have had input into the development of her plan of care. The Responsible Party indicated if he had been notified of the Care Plan meetings, he would have been present or joined the meetings via conference call. An interview was conducted with the Administrator on 12/8/2016 at 3:30 PM. The Administrator reported he spoke with the Responsible Party via telephone a couple of times regarding Resident #1 ' s care and communication from the facility. The Administrator stated the facility expectation was Responsible Party notification for all Care Plan meetings.	F 280		