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 12/21/2017

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 000	INITIAL COMMENTS No defeciencies were cited as a result of the complaint investigation. Event ID D5D911 exit date 12/21/17. Intake numbers NC00134260 and NC00131634	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		1/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/28/2017

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 12/21/2017

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 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity by failing to knock on doors or announce their presence before entering resident rooms for 3 of 32 residents observed (Resident #91, Resident #321, and Resident #74). Findings included: 1. Resident #91 was admitted to the facility on 10/16/14. His active diagnoses included heart failure, hypertension, anxiety disorder, and depression. Review of Resident #91 ' s most recent minimum data set assessment dated 11/21/17 revealed he was assessed as cognitively intact. During observation on 12/18/17 at 10:59 AM Nurse Aide #1 was observed to enter Resident #91 ' s room without knocking or asking permission to enter. During an interview on 12/18/17 at 11:05 AM Resident #91 stated Nurse Aide #1 never knocked before entering his room and he wanted staff to knock or announce their presence before entering his room. He further stated he was	F 550	Regarding the alleged deficient practice of failure to knock on resident□s # 91, #321 and #74 door or announce prior to entry, the Staff Development Coordinator provided in service education on 12-26-2017, for NA #1, regarding Resident Rights: Dignity and Respect, knocking on doors and announcing prior to entry into resident room. Current facility residents are at risk of the alleged deficient practice of failure to knock on resident door or announce their presence before entering the residents□ room. The Staff Development Coordinator provided in service education for current facility staff beginning on 12-26-2017, regarding Resident Rights: Dignity and Respect. The Staff Development Coordinator provided in service education for current facility staff beginning on 12-26-2017, regarding Resident Rights: Dignity and Respect. In service education will be provided during new hire orientation. The Administrator, DON, ADON, Staff Development Coordinator, MDS Coordinators, and Social Worker will observe 15 resident rooms weekly for 4	

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 12/21/2017

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 550	Continued From page 2 frustrated that Nurse Aide #1 did not announce herself or let him know she was entering his room. During an interview on 12/18/17 at 2:22 PM Nurse Aide #1 stated staff should always knock and announce their presence before they entered a resident's room. She further stated she should have knocked before entering Resident #91's room and she would from now on. During an interview on 12/18/17 at 10:47 AM the Director of Nursing stated it was her expectation staff would knock or announce their presence before entering a resident rooms including residents who were cognitively impaired. She further stated Nurse Aide #1 should have knocked before entering Resident #91 ' s room. 2. Resident #321 was admitted to the facility on 9/22/17. Her active diagnoses included anemia, heart failure, hypertension, diabetes mellitus, and functional quadriplegia. This identifies the resident Review of Resident #321 ' s most recent minimum data set assessment dated 10/13/17 revealed she was moderately cognitively impaired. During observation on 12/18/17 at 12:36 PM Nurse Aide #1 entered Resident #321 ' s room without knocking or announcing her presence. During an interview on 12/18/17 at 2:15 PM Resident #321 ' s family stated staff should knock before entering the resident ' s room for the dignity of residents and visitors. During an interview on 12/18/17 at 2:22 PM	F 550	weeks then 15 resident rooms monthly for 3 months to validate that staff members are knocking on resident doors prior to entering or announcing their presence prior to entering the residents room. The Staff Development Coordinator will review Resident Rights monthly with facility staff as an ongoing training/education. The Activity Director will review Resident Rights during monthly Resident Council meeting. The Administrator and/or the Social Worker will identify resident concerns that are related to resident right issues as they are voiced or observed and will implement appropriate interventions to prevent deficient practice. The Administrator, Staff Development Coordinator and/or the Social Worker will review audits to identify patterns and/or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meeting for at least 6 months or until compliance is maintained.	

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 12/21/2017

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 550	Continued From page 3	F 550		

Nurse Aide #1 stated staff should always knock and announce their presence before they entered a resident's room. She further stated she should have knocked before entering Resident #321's room and she would from now on.

During an interview on 12/18/17 at 10:47 Director of Nursing stated it was her expectation staff would knock or announce their presence before entering a resident rooms including residents who were cognitively impaired. She further stated Nurse Aide #1 should have knocked before entering Resident #321 ' s room.

3. Resident #74 was admitted to the facility on 8/26/17. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, and anxiety disorder.

Review of Resident #74 ' s most recent minimum data set assessment dated 11/17/17 revealed she was assessed as severely cognitively impaired.

During observation on 12/18/17 at 11:45 AM Nurse Aide #1 entered Resident #74 ' s room without knocking or announcing her presence.

During an interview on 12/18/17 at 2:22 PM Nurse Aide #1 stated staff should always knock and announce their presence before they entered a resident's room which included cognitively impaired residents. She further stated she should have knocked before entering Resident #74's room and she would from now on.

During an interview on 12/18/17 at 10:47 AM the Director of Nursing stated it was her expectation staff would knock or announce their presence before entering a resident rooms including

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 12/21/2017

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 550	Continued From page 4 residents who were cognitively impaired. She further stated Nurse Aide #1 should have knocked before entering Resident #74 ' s room.	F 550		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff and pharmacy interviews the facility failed to discard expired insulins for 1 (Medication Cart B2) of 5 medication carts observed for medication storage.	F 761	Regarding the alleged deficient of failure to discard 1 vial of expired Lantus insulin and 1 vial of expired Novolog insulin that was found on Medication cart B2, Nurse #1 removed the expired insulins from the	1/18/18

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 12/21/2017

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 761	Continued From page 5 Findings included: During an observation on 12/19/17 at 9:24 AM a vial of Lantus was observed with the open date labeled as 11/11/17, a vial of Novolog was observed with an open date labeled 11/11/17 and a vial of Novolog with an open date of 11/8/17. During an interview on 12/19/17 at 9:25 AM Nurse #1 stated that the Lantus and Novolog insulins expired 30 days after they were opened and that the insulins had expired over 10 days ago. Nurse #1 was observed taking the expired insulin bottles from the medication cart. The Director of Nursing (DON) on 12/19/17 at 9:56 AM stated that nurses should date insulins when they were opened, should look at the insulin open date and check prior to administration to make sure the insulin had not expired. The DON further stated that the medication carts should have been checked on Monday (12/18/17) and did not know why there were expired insulins on the medication cart. On 12/20/17 at 4:04 PM the Pharmacist stated that she went by the manufacturer's recommendation and both the Lantus and the Novolog would expire 28 days after opening the insulins and the nurses should have discarded the insulins when they expired.	F 761	medication cart on 12/19/17, and returned them to the pharmacy for disposal. The Staff Development Coordinator provided in service education to Nurse #1 on 12-19-2017 regarding Policy and Procedure for dating and labeling and expiration dates for medications once opened. Current facility residents are at risk of being affected by the alleged deficient practice related to labeling and storage of medications. The DON, Assistant DON, Staff Development Coordinator, MDS Coordinators, and unit coordinators performed and audit of facility medication carts, treatment carts and medication rooms on 12-21-2017, to assure medications were dated/labeled and discarded according to facility policy and procedure. Medications were dated/labeled appropriately, and no medications were observed to be expired. The Staff Development Coordinator provided in service education for current facility licensed nurses beginning on 12-19-2017, regarding Dating/Labeling/Storage of medications and recommended expiration dates once medications are opened. Education will be provided for new hires during orientation. The DON, ADON, Staff Development Coordinators, MDS Coordinators, and/or the Unit Coordinators will audit medication carts and medication rooms daily for 4 weeks, then 3 times a week for 4 weeks then once weekly ongoing to validate medications are dated/labeled/stored and disposed of according to facility policy.	

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 12/21/2017

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 761	Continued From page 6	F 761	The DON, ADON, MDS Coordinators, and Staff Development Coordinator will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to non-compliance at the regulatory grouping of 483.45 on two consecutive annual recertification surveys. A deficiency in the area of medication storage at the regulatory grouping of 483.45 was cited during the facility's 11/2/16 annual recertification survey, and was recited again on the current 12/21/17 annual recertification survey. This failure was also related to non-compliance at the regulatory grouping of 483.10 on two consecutive annual recertification surveys. A deficiency in the area of dignity at the regulatory grouping of 483.10 was originally cited during the facility ' s 11/2/16 annual recertification survey, and recited again on the current 12/21/17 annual recertification survey.	F 867	1)Regarding the alleged deficient practice of failure to discard 1 vial of expired Lantus insulin and 1 vial of expired Novolog insulin that was found on Medication cart B2, Nurse #1 removed the expired insulins from the medication cart on 12/19/17, and returned them to the pharmacy for disposal. The Staff Dev elopement Coordinator provided in service education to Nurse #1 on 12-19-2017 regarding Policy and Procedure for dating and labeling and expiration dates for medications once opened. Current facility residents are at risk of being affected by the alleged deficient practice related to labeling and storage of medications. The DON, Assistant DON, Staff Development Coordinator, MDS Coordinators, and unit coordinators	1/18/18

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 12/21/2017

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 867	Continued From page 7 The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included: 1. This tag is cross referenced to: 483.45: Labeling of Drugs and Biologicals: Based on medical record review, observation, and staff and pharmacy interviews the facility failed to discard expired insulin for 1 (Medication Cart B2) of 5 medications carts observed for medication storage. 483.45 was originally cited during the November 2016 recertification survey for failing to discard expired medications. During an interview on 12/21/17 at 10:55 AM the Administrator stated that to correct medication storage issues the facility was auditing the medication carts weekly, every other week, and then monthly and no further issues were identified for medication storage. He further stated the medications that were expired were missed. 2. This tag is cross referenced to: 483.10: Resident Rights: Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity by failing to knock on doors or announce their presence before entering resident rooms for 3 of 32 residents observed (Resident #91, Resident #321, and Resident #74). 483.10 was originally cited during the November	F 867	performed an audit of facility medication carts, treatment carts and medication rooms on 12-21-2017, to assure medications were dated/labeled and discarded according to facility policy and procedure. Medications were dated/labeled appropriately, and no medications were observed to be expired. The DON and Staff Development Coordinator provided in service education for current facility licensed nurses beginning on 12-19-2017, regarding Dating/Labeling/Storage of medications and recommended expiration dates once medications are opened. Education will be provided for new hires during orientation. The DON, ADON, Staff Development Coordinator, MDS Coordinators and/or the Unit Coordinators will audit medication carts and medication rooms daily for 4 weeks, then 3 times a week for 4 weeks then once weekly ongoing to validate medications are dated/labeled/stored and disposed of according to facility policy. The Regional Director of Clinical Services will provide in service education on 01-03-2018 for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS coordinators, Social Worker, Activities Director and Infection Control Nurse, regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan	

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 12/21/2017

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 867	Continued From page 8 2016 recertification survey for failing to provide a dignity for residents in the dining room by serving meals on trays. During an interview on 12/21/17 at 10:55 AM the Administrator stated they audited the meal deliveries in the dining room in order to ensure dignity for the residents. The audits were performed weekly, every other week, and then monthly and no further issues were identified with meal service in the dining room. He further stated that concerns about knocking on doors before entering resident rooms was not a part of the audits at that time and that was why the issue was missed.	F 867	during the monthly QAPI meeting for 6 months or until compliance is maintained. 2)Regarding the alleged deficient practice of failure to knock on resident□s # 91, #321 and #74 door or announce prior to entry, the Staff Development Coordinator provided in service education on 12-26-2017, for NA #1, regarding Resident Rights: Dignity and Respect, knocking on doors and announcing prior to entry into resident room. Current facility residents are at risk of the alleged deficient practice of failure to knock on resident door or announce their presence before entering the residents□ room. The Staff Development Coordinator provided in service education for current facility staff beginning on 12-26 -2017, regarding Resident Rights: Dignity and Respect. The Staff Development Coordinator provided in service education for current facility staff beginning on 12-26-2017, regarding Resident Rights: Dignity and Respect. In service education will be provided during new hire orientation. The Administrator, DON, ADON, Staff Development Coordinator, MDS Coordinators, and Social Worker will observe 15 resident rooms weekly for 4 weeks then 15 resident rooms monthly for 3 months to validate that staff members are knocking on resident doors prior to entering or announcing their presence prior to entering the residents□ room. The Staff Development Coordinator will review Resident Rights monthly with facility staff as an ongoing training/education. The Activity Director	

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 12/21/2017

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 867	Continued From page 9	F 867	will review Resident Rights during monthly Resident Council meeting. The Administrator and/or the Social Worker will identify resident concerns that are related to resident right issues as they are voiced or observed and will implement appropriate interventions to prevent deficient practice. The Regional Director of Clinical Services will provide on 1-3-2018 in service education for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS coordinators, Social Worker, Activities Director and Infection Control Nurse, regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The Administrator, Staff Development Coordinator and/or the Social Worker will review audits to identify patterns and/or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meeting for at least 6 months or until compliance is maintained.	