FEB 18 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(A) PROVIDER/SUPPLIER IDENTIFICATION NUMBER
B) NUMBER OF LOCATION
C) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER
Ridgewood Manor

STREET ADDRESS, CITY, STATE, ZIP CODE
1624 Highland Drive
Washington, NC 27889

(OK) PREFIX TAX
F276

SSB

SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE IDENTIFIED BY FULL REGULATORY OR LEGAL IDENTIFICATION INFORMATION

ID PREFIX TAX
F276

PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE IDENTIFIED BY CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY

1. Resident #78, #40, #67 MDS have been corrected.
2. All MDS have been checked to ensure that APR & completion dates are in compliance. The NDS of all residents with wounds have been reviewed to ensure coding accuracy.
3. MDS Coordinators reviewed/educated on completion instructions for Section M, A230a & Z0500b according to RAI manual.
4. DON/Designee will audit MDS Section M with weekly wound report to ensure accuracy. DON/Designee will audit MDS report on BCS to ensure Z0500b date is no more than 14 days past A230. Audits will be done weekly, 4 weeks, 2 x mo, 4 x 3 months.
5. Results will be reported to the QA committee.
6. Completion date 2-14-14

LABORATORY DIRECTOR OR PROVIDER OR PROFESSIONAL'S SIGNATURE

Administrator 2/14/14

Any deficiency statement ending with an asterisk (*) means a deficiency which the facility may be excused from correcting pending it is determined that other safeguards provide equivalent protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosed 48 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

FORM CMS-2580(05-99) 2/20/14

Facility Id: 220402
<table>
<thead>
<tr>
<th>XG ID</th>
<th>PRENAT</th>
<th>SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PRENAT</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROUPED TOGETHER BY THE APPROPRIATE CATEGORY)</th>
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<tr>
<td>F 278</td>
<td></td>
<td>Continued from page 1 for 2 of 2 (Resident #40 and Resident #67) residents. Findings included:</td>
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<td>1. Resident #78 was admitted to the facility on 12/18/13 with cumulative diagnoses of peripheral vascular disease, hypertension, and dementia.</td>
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<td>Resident #78's Admission MDS dated 12/24/13 showed Resident #78 was at risk for, but had no pressure ulcers.</td>
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<td>Review of admission wound charting dated 12/18/13 showed Resident #78 had 0 unstageable pressure ulcers on admission.</td>
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<td>In an interview on 1/17/14 at 3:15 PM MDS Nurse #1 indicated that she reviewed the weekly wound reports to gather information on wounds and did not know how the information was missed on Resident #78.</td>
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<td>In an interview on 1/17/14 at 4:44 PM MDS Nurse #1 stated she corrected the Admission MDS and was planning to resubmit the information to the state.</td>
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<td>In an interview on 1/17/14 at 5:16 PM the Director of Nursing (DON) stated she expected the MDS nurse to gather information through observation, reading the chart, and speaking with other staff members. She indicated that wound information could have been gathered from the treatment record, nursing notes, and weekly measurements or from the initial assessment. The DON stated she would expect a resident who had pressure ulcers on admission to have that information listed on their admission MDS. She indicated she would expect a correction to be done when the error was discovered.</td>
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<td>2. a.</td>
<td>Resident #40 was admitted to the facility on 04/06/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and cognitive deficit.</td>
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Resident #40's Admission Minimum Data Set (MDS) had an assessment reference date of 04/16/13, but was not signed as complete and accurate by a registered nurse (RN) until 08/26/13.

At 3:40 PM on 04/17/14 MDS Nurse #1 stated she got hold in completing her MDS assessments because of a shortage of MDS staffing. She stated at the least her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date.

At 5:12 PM on 04/17/14 the facility's director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. She said she reported at the least she would have given the nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete within 14 days of the assessment reference dates. According to the DON, having an assessment with the reference date of 04/16/13 signed as complete and accurate on 08/26/13 was definitely not acceptable.

b. Resident #40 was admitted to the facility on 04/06/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and...
Resident #80’s Quarterly Minimum Data Set (MDS) had an assessment reference date of 07/09/13, but was not signed as complete and accurate by a registered nurse (RN) until 09/25/13.

At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a shortage of MDS staffing. She stated that her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date.

At 5:12 PM on 01/17/14 the facility’s director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. If she had known, she reported she would have given the nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete and accurate within 14 days of the assessment reference date. According to the UCN, having an assessment with the reference date of 07/09/13 signed as complete and accurate on 09/25/13 was definitely not acceptable.

3. Resident #67 was admitted on 10/11/11. Her documented diagnoses included failure to thrive, dementia, restless, hypertension, and arthritis.

Resident #67’s Quarterly Minimum Data Set (MDS) had an assessment reference date of 06/23/13, but was not signed as complete and accurate by a registered nurse (RN) until 08/29/13.
F 278 Continued from page 4

At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a shortage of MDS staffing. She stated at the latest her goal was to have assessments signed as complete and accurate 14 days from the assessment reference date.

At 5:12 PM on 01/17/14 the facility's director of nursing (DON) stated she was not aware that MDS Nurse #1 was behind in completing her assessments. If she had known, she reported at the least she would have given the nurse permission to work overtime hours. The DON commented she thought MDS assessments were supposed to be signed by the RN as complete within 14 days of the assessment reference dates. According to the DON, having an assessment with the reference date of 08/23/13 signed as complete and accurate on 08/28/13 was definitely not acceptable.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and record review the facility failed to

F 278 Resident #40 has been evaluated by physical therapy and no longer ambulates well enough to be an elopement risk.

In the future if a resident is identified as an elopement risk, appropriate intervention will be put in place immediately.
Appropriate interventions might include but are not limited to a wander guard bracelet, 15 min. checks and 1 on 1.

All residents at risk for elopement will have a care plan that will list the interventions that have been put in place.

All residents at risk for elopement will be monitored weekly to ensure that identified interventions are in place for 3 weeks and then every 2 weeks for a total of 4 weeks and then monthly for 3 months.
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<tr>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
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<tr>
<td>F 323</td>
<td>Continued From page 5 put effective interventions in place to keep 1 of 1</td>
<td>F 323</td>
<td>All exit doors have been checked to insure the alarms including those doors monitored by a</td>
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<td>sampled residents (Resident #40) with confirmed elopement from attempting to exit the building a second time. The facility also failed to protect cognitively impaired residents capable of moving about the building on their own from potentially hazardous chemicals. Findings included:</td>
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<td>wanderguard system are functioning properly.</td>
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<td></td>
<td>1. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/18/13. The resident's documented diagnoses included hypertension, macular degeneration, and cognitive deficit.</td>
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<td>Nurses will be in-service as to the importance of checking placement of the wanderguard bracelet qshift and the functionality of the bracket daily and documenting said checks.</td>
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<td>A 04/08/13 nurse's note and physician order documented a Wanderguard was placed on Resident #40 because &quot;resident presents as a visitor, can be confused at times and wanders in the halls unable to find room.&quot;</td>
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<td>MAR on residents @ risk for elopement will be monitored weekly x 3 weeks, bi-weekly for 4 weeks and monthly for 3 months after to ensure that physicians orders relating to the checking of placement for wanderguard bracelets and battery checks for wanderguard bracelets are documented appropriately. Negative trends will be sent to the</td>
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<td>Beginning on 04/10/13 a section on Resident #40's medication administration record (MAR) documented, &quot;Check battery in Wanderguard every shift. Check placement of Wanderguard every shift.&quot; If these tasks were completed, they were initialed off on the MAR by the staff members completing them.</td>
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<td>Random audits of the doors monitored by the wanderguard system will be completed to insure staff are assessing the situation</td>
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<td>Resident #40's 04/15/13 Admission Minimum Data Set (MDS) documented her cognition was severely impaired, she was independent in walking in her room and the corridor, and she was observed wandering during one to three days of the assessment look back period.</td>
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<td>On 04/18/13 &quot;Potential for elopement from the facility related to impaired cognition and manifested by: wanders to exits and wanders near exits&quot; was identified as a problem in</td>
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| F 323 | Continued From page 6 | Resident #40's care plan. Interventions to this problem included "make sure wandering is on and working", "be able to identify resident, know whereabouts, directed to resident", and "exit door alarms on". A 05/17/13 incident report documented Resident #40 was found outside in the parking lot, but with no injury. A Review of Occurrences documented on 05/17/13 (Friday) at 3:00 PM Resident #40 was found outside in the parking lot after walking out of the building with a group of staff. Interventions included continued monitoring of the exit door on the back hall (through which a resident eloped prior to May 2013) and education of the reception desk personnel and direct care staff to monitor Resident #40 more carefully. A 05/19/13 incident report documented Resident #40 exited a Wanderguard compatible door off the main hall and into the lobby and possibly out into the parking lot without injury. A Review of Occurrences documented on 05/19/13 (Sunday) at 6:37 PM another resident (Resident #34) saw Resident #40 exit a Wanderguard compatible door off the main hall and proceed into the lobby area. This resident notified staff who were unable to find the resident outside. The resident was later found inside walking toward the nursing station serving the back hall of the facility. Visitors present at the time reported they saw a female they thought might be a resident exit the building, walk toward the mailbox (which was 35 feet from the front door of the facility), turn around, and re-enter the building. Interventions included placing Resident and determine that there has been no elopement, and they understand why they are cutting off alarms. Audits will be weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months. Door alarms are checked twice each week to insure that they are functioning properly. Staff will be in-serviced to report to maintenance or Administrator if they observe an alarm not functioning properly. Any negative trending will be sent to the Quality Assurance committee for recommendations. Staff will be in-serviced on the following:

1) Not shutting off door alarms until grounds have been checked to insure a resident has not wandered out of the door.

2) Resident that are at risk for wandering have their pictures at the front desk and at the nurses' stations so they can be quickly identified.

3) Alarms are checked every week to insure they are working properly.

Completion date: 2-14-14
<table>
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<th>F 323</th>
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<td>#40 on 1:1 supervision until around the clock observation could be established for the door leading to the lobby of the building.</td>
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At 2:51 PM on 01/15/14 Central Communications Manager (CCM) #1 stated on Friday, 01/17/14, Resident #40 went out the front door of the facility with a group of women. She reported the resident was later found in the parking lot. According to CCM #1, the intervention for this situation was to inform the staff to keep a close eye on Resident #40. She commented after Resident #40 once again escaped cut a Wanderingguard compatible door off the main hall and into the lobby on Sunday, 05/19/13, the resident was placed on 1:1 supervision. CCM #1 stated the following week constant observation of the door leading to the lobby was established, and Resident #40 was removed from 1:1 supervision.

At 3:03 PM on 09/15/14 the receptionist, on duty when Resident #40 exited the building on 05/17/13, stated she saw the resident leave the building, but assumed the group of ladies she was with had signed her out for a trip. She reported she was unsure whether the alarm sounded when the resident came through the door off the main hall or not because it was pay day and the lobby was very noisy. She commented one of the alarms sounded, activated by resident with Wanderingguard bracelets in place; it had to be turned off by staff. According to the receptionist, she did not turn off the alarm on 05/17/13 when Resident #40 exited the building. However, she reported Resident #40 could have set the alarm off when she went out the door, and a staff member automatically cut it of thinking a resident with a
Wanderguard just passed by the door on the way to activities and set the alarm off.

At 3:08 PM on 01/15/14 the activity aide who found Resident #40 in the parking lot stated the resident had been in an activity in the main dining room earlier, and she recalled the resident having a bright colored unit. She explained after the activity adjourned she was looking out a window in the main dining room, and saw the resident outside on the sidewalk in the parking lot (about 75 feet from the front door). In order to get them the resident would have come out the front door, made a left, gone down a slight slope, and made another left, staying on the sidewalk which was slightly uneven in places. The aids reported the resident was confused, stating she was on her way to visit her niece.

At 4:25 PM on 01/15/14 Resident #40 was in a wheelchair, and her family took her through the Wanderguard compatible door off the main hall and into the lobby. The door alarmed as the resident was wheeled near this door.

At 6:38 PM on 01/16/14 the maintenance manager (MM) checked the alarms on all exit doors in the building, including the doors with push alarms and Wanderguard compatible alarms. All the door alarms were functioning correctly. The MM stated currently Wanderguard compatible doors did not look but only alarmed, and once the alarm sounded staff had to cut the alarm off near it. The MM provided his logs which documented he checked all door alarms on Tuesdays and Fridays.

At 8:59 AM on 01/16/14 CCM #1 stated it was not unusual when Wanderguard residents passed by
Continued from page 9
the door off the main hall into the lobby for the

At 10:30 AM on 04/19/14 the MM stated when a
Wanderguard resident passed within eight feet of
a Wanderguard compatible door the alarm sounded.

During a telephone interview with CCM #92 on
04/19/14 at 10:46 AM she stated she worked on the
weekends, and before 05/10/13 the only
intervention she knew of in place for Resident #40 was her Wanderguard bracelet.
She reported prior to her 06/10/13 6:27 PM exit
through a Wanderguard compatible door, on the
same afternoon Resident #40 had been found
two or three times wandering around the building
and was returned to her room. She stated there
was some type of problem with the Wanderguard
alarm on the door into the lobby on 05/10/13, but
she could not remember what time the problem
rose and at what time the problem was resolved.
According to CCM #92, there was not a
receptionist on duty in the front lobby on the
weekends.

At 1:50 PM on 04/19/14 the MM stated he was
called to the facility to fix the Wanderguard alarm
on the door to the lobby on 05/10/13, but could
not remember what time of day it was.

At 2:30 PM on 04/19/14 the director of
nursing (DCN) stated she was not in the building on
05/17/13, but the administrator was.

At 3:32 PM on 04/19/14 the administrator stated
Continued from page 10

he was notified immediately after Resident #40 was found outside the building in the parking lot on 06/17/14. Since it was her first evening, he reported he went and talked to the receptionist and direct care staff on the resident's hall about keeping a close eye on the resident. He commented he did not conduct official in-services at that time.

At 12:12 PM on 06/17/14 Resident #34, who was identified as interventional by staff and his MDS assessments, reported he saw Resident #40 go through the WanderGuard compatible door into the lobby of the evening of 06/17/14. He stated the resident was by herself, and the door alarm did not sound.

2. Review of the Material Safety Data Sheet (MSDS) for Clorox regular Bleach lists the Health Hazard Data as, "Dangers. Corrosives. May cause severe irritation or damage to eyes and skin. Vapors or mist may irritate. Harmful if swallowed. Keep out of reach of children."

3. Review of the MSDS for Clorox ready-to-use bleach pre-diluted cleaner lists the Health Hazard Data as, "Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling."

1. A new bleach 1:10 solution diluted bottle label was made and submitted to NC Occupational Safety and Health for approval. Bottle label was approved 1-28-2014 for use. The new bottle label correctly identifies the hazards of the bleach 1:10 mix:
   a) Bottle label
   b) NC OSH Email
### F 328

**Consolidated From page 11**

Review of the unceded Preventing Accidental Ingestion/Poisoning Policy provided by the facility showed under General Procedure/Precautions, "3. All housekeeping chemicals are secured under lock when not in use or under the direct supervision of the housekeeper."

In an observation on 01/13/14 at 12:06 PM a spray bottle labeled as Glioxol was seen on the back of the commode in a resident room. The bottle was marked as corrosive, danger hazards to humans and domestic animals.

In an interview on 01/13/14 at 12:10 PM Nurse #1 stated she removed the bottle of cleaning chemicals that housekeeper must have left it and that it should not have been left in the resident bathroom. She indicated that there were cognitively impaired residents who wandered into other resident's rooms who resided in the facility.

In an interview on 01/15/14 at 2:05 PM the Housekeeping Manager (FM) stated that while not in use housekeeping chemicals should be locked up on the housekeeping cart. He stated that the housekeeper had gone to lunch leaving the container on the back of the commode. He indicated that when the surveyors entered the building he took his staff aside and in-serviced them on the facility requirements pertaining to them. He stated that when the nurse informed him of the chemicals left in the bathroom the housekeeper was in-serviced again.

In an interview on 01/16/14 at 2:05 PM Housekeeper #4 stated she had been employed for approximately 3 months. She indicated if a resident had gotten the bottle of chemicals they could have become sick and been sent to the

### F 329

2. Housekeeping staff will be re-instructed on the facility "Preventing Accidental Ingestion/ Poisoning" policy by 2/14/14.

3) Housekeeping carts will be randomly audited by housekeeping manager 10 x weekly per housekeeping maid cart to ensure that the carts are locked and chemicals are secured.
   a) Housekeeping cart chemical lock audit sheet.

4) Housekeeping carts will be audited 5 x weekly after the resident rooms cleaning housekeeping shift ends to ensure all housekeeping bottles present at the beginning of the shift are returned with the housekeeping cart to the janitor closet at the end of shift. Bottles will be recorded at 8 a.m. and recorded again at 4 p.m. to ensure no cleaning bottles were left outside of the housekeeping carts during the shift.
   a) Housekeeping cart end of shift audit sheet.

Completion date 2-14-14
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hospital or could have died. She stated she had
intention to remove the bottle from the resident
room. She stated the housekeeping chemicals
should be locked on the housekeeping cart when
not in use. She indicated she had been
instructed on the rules when the surveyors had
arrived and again when the chemicals were
found.

In an interview on 01/17/14 at 8:36 AM the GM
stated the solution that was in the spray bottle did
not match the label. He indicated the facility used
01:10 (1 part bleach to 9 parts water) solution
for cleaning the bathrooms. He stated the label
used showed the greatest risk which would have
been from straight bleach. He indicated the
solution was the pre-diluted cleanser.

In an interview on 01/17/14 at 8:16 PM the
Director of Nursing (DON) stated it was her
expectation that the housekeeping department
keep chemicals secure when not in use. She
indicated if a resident had gotten to the chemical
it could have caused skin irritation, sickness or
death.

F 325

483.25(d) MAINTAIN NUTRITION STATUS
UNLESS UNAVOIDABLE

Based on a resident's comprehensive
assessment, the facility must ensure that a
resident
(1) Maintains acceptable parameters of nutritional
status, such as body weight and protein levels,
unlesss the resident's clinical condition
demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a
nutritional problem.

The facility will ensure that
residents maintain acceptable
parameters of nutritional status
including body weight, unless
the resident's clinical condition
demonstrates this is not possible. Corrective action
was taken for the 2 residents
that experienced significant weight
loss by initiating supplements
to increase caloric intake
and stabilize weights. The 2
residents were also placed in the
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to follow its protocol for implementing intervention when 2 of 2 residents (Resident #40 and #57) experienced significant weight loss. Findings included:

1. Resident #40 was admitted to the facility on 04/08/13 and readmitted on 12/10/13. The resident’s documented diagnoses included hypertension, muscular degeneration, cognitive deficit, and cancer of the appendix.

Resident #40's weight record documented she weighed 164.1 pounds on 04/10/13.

A 04/30/13 resident progress note documented the facility notified Resident #40’s primary physician about family concerns regarding the resident's weight loss.

A 04/30/13 physician order placed the resident on weekly weights.

Resident #40's weight record documented she weighed 144.4 pounds on 05/21/13.

In one month between 04/18/13 and 05/21/13 Resident #40 lost 1.7 pounds for a 6.3% weight loss.

Record review revealed Resident #40 was not placed on any nutritional supplements, was not assessed for weight loss by the registered dietitian (RD) or dietary manager (DVM), and was not involved in weight loss interventions.

To ensure that all residents with significant weight loss are identified, the facility will use a Weight Book to document all weights, monthly and weekly. The calculations will be done by hand to determine residents that trigger for significant weight loss. 5% in 30 days, 7.5% in 90 days and 10% in 180 days. Each weekly and monthly weight will be documented in this book and reviewed weekly by dietary manager for new weight loss. In addition all residents that trigger for significant weight loss will continue to be referred to the RD for nutritional assessment and appropriate interventions. Residents with significant weight loss will continue to be reviewed weekly in the facility’s interdisciplinary "Resident At Risk" meetings until weight has stabilized again.
**continued from page 14**

Not reviewed by the facility's interdisciplinary team (IDT) until 07/10/13 when her weight decreased to 137.7 pounds.

*At 6:25 PM on 01/16/14 the facility's RD stated that the facility's computer system was not very reliable on calculating and capturing significant weight loss. She reported many times weight changes had to be figured by hand in order to determine which residents may have had a significant weight loss of 5% in 30 days, 7.5% in 60 days, and 10% in 180 days. According to the RD, when a resident experienced significant loss they were immediately assessed to determine the possible cause and followed by the IDT committee which made recommendations to promote weight gain or prevent further weight loss. The RD commented resident weights had been stable for four weeks before they were discharged from IDT review.*

*At 2:56 PM on 01/17/14 the DM stated that both she and the RD screened residents for significant weight loss, but she was the person that probably had the most direct contact with the residents and time to track weight patterns. She reported the computer system did not always flag those residents who experienced significant weight loss so percent of weight lost and gained had to be calculated by hand. The DM commented that Resident #40 probably should have been started on nutritional supplements soon after entering the building, but the resident appeared healthy and hearty.*

*At 5:12 PM on 01/17/14 the director of nursing (DON) stated the facility protocol was for a nutritional assessment, preferably conducted by the facility's RD, to be completed as soon as possible.*

**using hand calculations. All weight loss trends will be referred to Quality Team for analysis and further interventions. New admissions as well as readmits will be reviewed in the weekly interdisciplinary "Resident at Risk" meeting for 4 weeks to ensure that any changes in weight are addressed and appropriate interventions are put in place.**

*Any negative trends will be referred to the Quality Assurance Committee for recommendations.*

*The weight book will be used to document and track all weights will be in place by February 10, 2014. The weight book will be audited weekly for 3 weeks, bi-weekly for 4 weeks, and monthly for 3 months to ensure any weight changes are identified timely and interventions are put in place.*

**Completion date 2-14-14**
Continued From page 15

significant weight loss was identified. She reported it was important to determine why the resident was losing weight. Once this was determined, the DON contacted the resident was followed by the IDT committee which developed interventions based on the reason for weight loss. She stated it was not acceptable to wait until two months after significant weight loss was identified before assessing and putting interventions in place.

2. Resident #67 was admitted on 10/11/11. Her documented diagnoses included failure to thrive, dementia, reflux, hypertension, and arthritis.

Resident #67's weight record documented she weighed 124.6 pounds on 07/02/13.

A 07/12/13 physician order placed Resident #67 on as needed (PRN) Lasix 20 milligrams (mg) daily for swelling.

A 07/29/13 physician order changed the resident's Lasix to 20 mg daily.

Resident #67's weight record documented she weighed 147.7 pounds on 07/19/13. Therefore, in one month (between 07/03/13 and 08/03/13) the resident lost 6.3 pounds for a 6.9% weight loss.

Record review revealed the facility's registered dietitian (RD) did not recommend any nutritional supplements, the resident was not assessed for weight loss by the RD or dietary manager (DM), and the resident was not reviewed by the facility's interdisciplinary team (IDT) until 01/16/14 when her weight decreased to 111.7 pounds.

At 6:35 PM on 01/16/14 the facility's RD stated
The facility's computer system was not very reliable on calculating and reporting significant weight loss. She reported many times weight changes had to be figured by hand. In order to determine which resident may have had a significant weight loss of 5% in 30 days, 7.5% in 60 days, and 10% in 90 days. According to the RD, when a resident experienced significant loss they were immediately assessed to determine the possible cause and followed by the IDT committee which made recommendations to promote weight gain or prevent further weight loss. The RD commented resident weights had to be stable for four weeks before they were discharged from IDT review.

At 2:56 PM on 01/17/14 the DM stated that both she and the RD screened residents for significant weight loss, but it was the resident that probably had the most direct contact with the resident and time to track weight patterns. She reported the computer software did not always flag those residents who experienced significant weight loss so percent of weight lost and gained had to be calculated by hand. The DM commented resident #26 probably should have been started on nutritional supplements soon after entering the building, but the resident appeared healthy and hearty.

At 5:12 PM on 01/17/14 the director of nursing (DON) stated the facility protocol was for a nutritional assessment, preferably conducted by the facility's RD, to be completed as soon as significant weight loss was identified. She reported it was important to determine why the resident was losing weight. Once this was determined, the DON commented the resident was followed by the IDT committee which

F 325

Continued From page 16
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOD IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 325</td>
<td>Continued from page 17. Developed interventions based on the reason for weight loss. She stated it was not acceptable to wait until two months after significant weight loss was identified before assessing and putting interventions in place.</td>
<td>F 325</td>
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<td>F 371</td>
<td>488.35(3) FOOD PROCUREMENT, STORE/PREPARE/SERVE/SERVE - SANITARY</td>
<td>F 371</td>
<td>There were no negative outcomes for residents that consumed shrimp salad above 41 deg F. and soup below 135 deg F. Or for unlabeled foods in the dietary department. All foods are now appropriately labeled.</td>
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<td>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.</td>
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<td>To insure that soup is at or above 135 deg F. we will no longer pre-pour soup. Soup will be kept on the steam table a 165 deg F. and placed in a bowl from the steam table.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold foods at or below 41 degrees Fahrenheit and hold foods at 135 degrees Fahrenheit or above during operation of the trayline. The facility also failed to label and date opened food items in multiple storage areas. Findings include: 1. Beginning at 5:27 PM on 01/14/14, temperatures were taken on select food items at the trayline. Temperatures of the shrimp salad in croissants ranged between 44 and 52 degrees Fahrenheit. These croissants were in a tray pan over ice in a steam well which had been turned off. In an attempt to supply residents with shrimp salad croissants in which the salad was 41 degrees Fahrenheit or below, the cook removed them from the steam well, then added refrigerated shrimp salad.</td>
<td></td>
<td>To insure that cold salads are kept at 41 deg F. or below the salad will be prepared 24 hours in advance so that it can chill in the cooler. In addition cold salads will be kept in small dishes and placed in ice on the trayline to insure temps hold below 41 deg F.</td>
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<td>F 371</td>
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| shrimp salad from the walk-in refrigerator which was being stored in a large, deep tray pan. She made up eight shrimp salad croissants, but when the temperature was taken on the shrimp salad in the tray pan the thermometer registered 64 degrees Fahrenheit. A prepared bowl of soup covered with a lid was placed on a resident tray which was going to be stored in the meal cart. The temperature of the bowl of soup was 120 degrees Fahrenheit. The dietary staff stated that the trayline started operation at 4:45 PM on 01/4/14. They reported they had two more meal carts to fill and 44 more residents to serve before the trayline operation was completed. At 4:38 PM on 01/15/14 the dietary manager (DM) stated the shrimp salad was prepared on the same day that it was served. She explained on 01/14/14 the frozen shrimp was boiled, immediately placed on ice, and at about 1:45 PM was placed in the walk-in freezer until a thermometer used to check the temperature registered below 40 degrees Fahrenheit. She reported around 2:30 PM the shrimp was ground in the Robot Coupe, and mayonnaise, pickle relish, and a little lemon were added. According to the DM, the assembled salad was then placed in a deep pan of croissants and the croissants were kept in the walk-in refrigerator. She stated right before the trayline began operation a deep pan of croissants was removed. The DM provided the facility's trayline temperature log which documented as the trayline began operation the shrimp salad registered 40 degrees Fahrenheit. The DM reported cold salads made with mayonnaise should be kept at 40 degrees Fahrenheit or below.

| F 371 | Temps of hot foods and colds foods will be monitored daily for 2 weeks, weekly for 4 weeks, biweekly for 4 weeks, and monthly for 3 months to ensure proper temperatures.

<table>
<thead>
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<td>Food items will be monitored weekly for 3 weeks, biweekly for 4 weeks, and monthly for 3 months to ensure food items are labeled and dated appropriately.</td>
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<td>Any negative trends will be referred to Quality Assurance Committee for recommendations.</td>
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<td>Completion date 2-14-14</td>
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<tr>
<td>Deficiency ID</td>
<td>Description</td>
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<tr>
<td>F 371</td>
<td>Continued from page 19 during the entire operation of the trayline. She commented that during down time at the trayline sometimes three or four bowls of soup might be prepared, but her expectation would be that these bowls be placed on resident trays quickly. The DM reported hot foods such as soup should remain at 135 degrees Fahrenheit or higher during the entire operation of the trayline.</td>
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<td>At 8:40 AM on 01/15/14 an AM cook stated that personally when she was responsible for cold salads made with mayonnaise she preferred them to be at 38 degrees Fahrenheit or below. She reported cold salads were usually prepared in the morning on the same day that they were served, but they were kept chilled by refrigerated storage until they were served. She reported she did not like to prepare soups because they might be too cold when served. According to the cook, when she was responsible for hot foods she preferred them to remain at or above 165 degrees Fahrenheit during the entire operation of the trayline.</td>
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<td></td>
<td>2. During initial tour of the kitchen and food storage areas, beginning at 10:40 AM on 01/13/14, multiple food items which were opened were without labels and dates. In the dry storage room a five-pound box of cake mix, a bag of ice, a bag of pasta, a two-pound bag of confectioner's sugar, a storage container of cinnamon, a 18-ounce box of corn starch, and a five-pound bag of yellow corn meal which were all opened were without labels and dates. In the walk-in refrigerator a eight-pound container of carrot salad salad, a gallon container of golden Catalina dressing, and three packages of allard cheese which were all opened were without labels and dates. In the walk-in freezer French toast in plastic wrap, a bag.</td>
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<td>Deficiency Tag</td>
<td>Description</td>
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<tr>
<td>F 371</td>
<td>Continued from page 20 C of sweet potato wedges, and a bag of mixed vegetables which were all opened were without labels and dates. During a follow-up tour of the kitchen and food storage areas, beginning at 11:20 AM on 01/15/14, hot storage recovered from original packaging and wrapped in foil and an opened bag of biscuits were found in the walk-in freezer without labels and dates. At 4:33 PM on 01/15/14 the dietary manager (DM) stated her assistant checked storage areas two or three days a week to make sure opened food items were labeled and dated and to discard any food items past their use-by dates. However, the DM reported ultimately any dietary staff who opened food items and then placed them back into storage should place labels and dates on them so they could be used before their quality was compromised. At 8:49 AM on 01/16/14 an AM cook stated all dietary staff were responsible for making sure opened food items in storage had labels and dates on them. She reported there was an assistant who went behind the dietary staff to make sure opened food items had labels and dates on them, outdated items were disposed of, thawing meats remained on the bottom storage shelves, and all dairy products were within date.</td>
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K 000

INITIAL COMMENTS

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is type III protected construction, two story with a complete automatic sprinkler system.

The Deficiencies determined during the survey area as follows:

NFPA 101 LIFE SAFETY CODE STANDARD

K 029

One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 3.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
A. Based on observation on 02/05/2014 the soiled linen room near nurses station A failed to close and latch.
B. Based on observation on 02/06/2014 the Janitors Storage near the Maintenance Office room failed to close and latch.
C. Based on observation on 02/06/2014 there were PVC pipes penetrating the ceiling of the (1) one hour ceiling of the Boiler room that were not

K 000

FEB 24 2014

A. The door in the soiled linen room will be adjusted so it will close and latch.
B. The Janitor's storage room and the maintenance office will be adjusted so that it will close and latch properly.
C. The PVC pipes penetrating the ceiling will be sealed properly.

The maintenance supervisor or his designee will monitor doors and through ceiling penetrations monthly to insure compliance.

Any negative trending will be reported to the Quality Assurance committee for recommendations.

Completion Date: 3-23-13

LABORATORY DIRECTOR OR PROVIDER/REPRESENTATIVE'S SIGNATURE

(05) DATE
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory Or Local Identifying Information)</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K029</td>
<td></td>
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<td>Continued From page 1 sealed properly, 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1</td>
<td>K029</td>
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<td>A. The door knob to the dayroom will be replaced with door knob that can be opened with one motion.</td>
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<tr>
<td>K038</td>
<td></td>
<td>SS-D</td>
<td>This STANDARD is not met as evidenced by:  A. Based on observation on 02/06/2014 the door to the Day Room required more than one motion of the hand to exit the room.  B. Based on observation on 02/06/2014 there was no hard surface pathway from the laundry stair well exit to a public way.</td>
<td>K038</td>
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<td>B. We will construct a hard surface pathway from the laundry exit to the paved driveway.</td>
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