FEB 1 8 2014

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DAYE SURVEY (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING\_ 01/17/2014 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1624 HIGHLAND DRIVE** RIDGEWOOD MANOR WASHINGTON, NC 27888 PROVIDER'S FLAN OF CORRECTION (%) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX FACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 483.20(g) ~ (J) ASSESSMENT F 278 Resident #78 ) .#40, #67 MDS Have ACCURACY/COORDINATION/CERTIFIED been corrected. 2. All MDS have been checked The assessment must accurately reflect the to ensure ARD & completion dates resident's status. are in compliance. The MDS of all residents A registered nurse must conduct or coordinate each assessment with the appropriate with wounds have been participation of health professionals... reviewed to ensure coding accuracy. A registered nurse must sign and certify that the MDS Coordinators reviewed/been assessment is completed. educated on completion instructions for Section Each individual who completes a portion of the M, A2300& Z0500b according assessment must sign and certify the accuracy of to RAI manual. that portion of the assessment. 4. DON/Designee will audit MDS Under Medicare and Medicald, an individual who willfully and knowingly certifies a material and Section M with weekly false statement in a resident assessment is wound report to ensure subject to a civil money penalty of not more than accuracy. DON/Designee \$1,000 for each assessment; or an individual who will audit MDS report on willfully and knowingly causes another individual ECS to ensure Z0500b date to certify a material and false statement in a is no more than 14 days resident assessment is subject to a civil money past A230. Audits will be done penalty of not more than \$5,000 for each qweek.x 4 weeks, 2 x mo. x assessment, 3 months. Clinical disagreement does not constitute a Results will be reported to the QA committed. material and false statement. Completion date 2-14-14 This REQUIREMENT is not met as evidenced Based on observation, record review and staff interviews the facility falled to accurately complete section M of the Minimum Data Set MDS for 1 of . 1 (Resident #78) residents. The facility also failed to obtain the necessary Registered Nurse (RN) algnatures on the MDS in a timely manner

Any deficiency statement ending with an asterisk ("ydenotes 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 offering 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.

FORM CMS-2687(02-99) Privilous Versions Obsoleto

LABORATORY DESIGNATION OR PROVIDENCE PROPERTY RESERVATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FedSty ID: 923432

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#### FORM APPROVED. DEPARTMENT OF HEALTH AND HUMAN SERVICES DMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIĎER/SUPPUER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: E RUELDING AND PLAN OF CORRECTION 01/17/2014 B. YKNG 345228 SYREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 1624 HIGHLAND DRIVE Washington, NC 27889 RIDGEWOOD MANOR CONPLETION DATE PROMOER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEK OROSS-REFERENCED TO THE APPROPRIATE (X4) !D REGULATORY OR USC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG · F 278 Continued From page 1 F 278 for 2 of 2 (Resident #40 and Resident #67) residents. Findings included; Resident #78 was admitted to the facility on 12/18/13 with cumulative diagnoses of peripheral vascular disease, hypertension and demantia, Resident #78's Admission MDS dated 12/24/13 showed Resident #78 was at risk for, but had no pressure ulcers. Review-of the admission wound charting dated 12/18/13 showed Reeldent #78 had 9 unstageable pressure utcers on admission. in an Interview on 1/17/14 at 3:25 PM MDS Nurse #1 Indicated that she reviewed the weekly wound reports to gather information on wounds and did not know how she had missed the information on Resident #78. In an interview on 1717/14 at 4:44 PM MDS Nurse #1 stated she had corrected the Admission MDS and was planning to resubmit the information to the state. In an Interview on 1/17/14 at 5:15 PM the Director of Nursing (DON) stated she expected the MDS nurse to gather information through observation, reading the chart, and also speaking with other staff members. She indicated that wound information could have been gathered from the

freatment 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DAYE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED DENTIFICATION NUMBER: **EMKLIKUE A** c : 01/17/2014 B, WNG 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1824 HIGHLAND DRIVE WASHINGTON, NC 27888 RIDGEWOOD MANOR PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) (D PREFIX PREFIX DARE CROSS-REFERENCED TO THE AFPROPRIATE YAG DEFICIENCY) F 278 Continued From page 2 a. 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. 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 08/28/13. 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 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 this 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 04/15/13 signed as complete and accurate on 08/28/13 was definitely not acceptable. b. 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 PRINTED: 02/03/2014 FORM APPROVED

#### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/17/2014 8, WMG 345228 STREET ADDRESS, CITY, SYATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1624 RIGHLAND DRIVE RIDGEWOOD MANOR -WASHINGTON, NC 27889 (AS) SOUPLEHOUS DANS PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES CEACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG . DEFICIENCY) F 278 Confinued From page 3 cognitive deficit. Resident #40's Quarterly Minimum Data Set

At 3:40 PM on 01/17/14 MDS Nurse #1 stated she got behind in completing her MDS assessments because of a chortage 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.

(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 6:12 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 this 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 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, reflux, hypertension, and arthritis,

Resident #67's Quaderly Minimum Dala 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 08/28/13.

Facility Bit 923492

if continuation sheet Page 4 of 21

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CENTERS FOR MEDICARE & MEDICAID SERVICES		7			1		
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA EDENTIFICATION NUMBER:	g		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			1
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F 278	she got behind in con assessments because staffing. She stated a have assessments significant accurate 14 days from date.  At 5:12 PM on 01/17/nursing (DON) stated MDS Nurse #1 was be assessments. If she the least she would he permission to work or commented she thou supposed to be signed within 14 days of the dates. According to the	14 MDS Nurse #1 stated apleting her MDS as of a shortage of MDS at the latest her goal was to gned as complete and in the assessment reference.  14 the facility's director of she was not aware that ehind in completing her had known, she reported at ave given this nurse vertime hours. The DON ght MDS assessments were d by the RN as complete assessment reference	F	278	Resident #40 has been evaluated by physical therapy and no longoral 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 which will	er t	
F 323 SS=D	signed as complete a was definitely not acc	nd accurate on 08/28/13 epteble. ACCIDENT	F	323	the interventions that have bee put in place.		
	as is possible; and ea	as free of accident hazards			All residents at risk for elopeme will be monitored weekly to ins that identified interventions are inplace for 3 weeks and then ex 2 weeks for a total of 4 weeks a then monthly for 3 months.	are e very	
	by: Based on observation	' is not met as evidenced n, resident interview, staff review the facility falled to					

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	Well (hirwifold unween:	A. BUILDI	NG		С	
		345228	8. WNG			01/17/2014	
NAME OF PE	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RIDGEWO	OD MANOR			1624 HIGHLAND DRIVE WASHINGTON, NC 27889			
(X4) ID PREFIX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE CONSTITUTION (xg)
	Continued From page put effective intervent sampled residents (Relopement from attent second time. The fact cognitively impaired resout the building on hazardous chemicals  1. Resident #40 was 04/08/13 and readmit resident's documente hypertension, maculate cognitive deficit.  A 04/09/13 nurse's not documented a Wandi Resident #40 becaus visitor, can be confust the halls unable to fin Beginning on 04/10/1 #40's medication admit documented, "Check every shift. Check plevery shift." If these were initialed off on timembers completing Resident #40's 04/15 Data Set (MDS) documented, structured in the set of the severely impaired, structured as walking in her room set of the set	ions in placed to keep 1 of 1 esident #40) with confirmed opting to exit the building a ilitiy also failed to protect esidents capable of moving their own from potentially . Findings included: admitted to the facility on ted on 12/18/13. The d diagnoses included or degeneration, and  the and physician order erguard was placed on e "resident presents as a ed at times and wanders in ind room."  3 a section on Resident indistration record (MAR) battery in Wanderguard tasks were completed, they the MAR by the staff them.  1/13 Admission Minimum umented her cognition was the was independent in and the corridor, and she		323		he nt nift	
	of the assessment to On 04/18/13 "Potent facility related to : im	ial for elopement from the paired cognition and ders to exits and wanders			monitored by the wanderguard system will be completed to insi staff are assessing the situation	ure	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:

A BUILDING

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345228

OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION

A BUILDING

C

01/17/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STAYE, ZIP CODE 1624 HIGHLAND DRIVE

NAME OF P	ROVIDER OR SUPPLIER .		ACOLUMNIC DENTE				
DIDORNIO	NON MANOR		1624 HIGHLAND DRIVE				
Kingewo	JOD MANOR			ASHINGTON, NC 27889			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE		
				and determine that there has			
F 323	Continued From page 6	F	323	been no elopement, and they			
	Resident #40's care plan. Interventions to this	1		understand why they are cutting			
	problem included "make sure wanderguard is on			off alarms. Audits will be weekly			
	and working", "be able to identify resident, know whereabouts, redirect as needed", and "exit door			for 4 weeks, bi-weekly for 4 weeks			
	alarms on".			and monthly for 3 months.			
	A 05/17/13 incident report documented Resident			Door alarms are checked twice			
	#40 was found outside in the parking lot, but with			each week to insure that they are			
	no injury.			functioning properly. Staff will be			
	A Review of Occurrences documented on	1		in-serviced to report to			
*	05/1713 (Eriday) at 3:00 PM Resident #40 was			maintenance or Administrator if			
	found outside in the parking lot after walking out			they observe an alarm not			
	of the building with a group of ladies. Interventions included continued monitoring of the		•	functioning properly.			
	exit door on the back hall (through which a			Any negative trending will be sent	-		
	resident eloced prior to May 2013) and education			to the Quality Assurance			
	of the reception desk personnel and direct care staff to monitor Resident #40 more carefully.	1 1		committee for recommendations.			
				Staff will be in-serviced on the			
	A 05/19/13 incident report documented Resident #40 exited a Wanderguard compatible door off			following:			
	the main hall and into the lobby and possibly out			1) Not shutting off door alarms			
	into the parking lot without injury.			until grounds have been checked			
	A Review of Occurrences documented on			to insure a resident has not			
	05/19/13 (Sunday) at 6:37 PM another resident			wandered out of the door.			
	(Resident #34) saw Resident #40 exit a			2) Resident that are at risk for			
	Wanderguard compatible door off the main hall and proceed into the lobby area. This resident			wandering have their pictures at			
	notified staff who were unable to find the resident			the front desk and at the nurses'			
	outside. The resident was later found inside .			stations so they can be quickly			
	walking toward the nursing station serving the back hall of the facility. Visitors present at the			identified.			
	time reported they saw a female they thought			3) Alarms are checked every week			
	might be a resident exit the building, walk toward			to insure they are working			
	the mailbox (which was 35 feet from the front		٠.	properly.			
	door of the facility), turn around, and re-enter the building. Interventions included placing Resident	Į.		Completion date: 2-14-14			

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AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	ABUIU	OING		.	c i
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		345226	8. W/N				17/2014
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NAME OF PE	ROMDER OR SUPPLIER				624 HIGHLAND DRIVE	<i>'</i> .	. }
	-	•	•		Vashington, NC 27888		
- RIDGEWO	OD MANOR			1 %			(X5)
		ATEMENT OF DEFICIENCIES	1	)	PROMDER'S PLAN OF COM (EACH CORRECTIVE ACTION	RECTION CHOUTD BE	COUPLETION
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F 323	Continued From page	31	-   '				1
	#40 on 1:1 supervisio	on until around the clock	- } .		ĺ		1 ' 1
	6d blues anthropeda	established tot me don	1 '		1		) (
	leading to the lobby o	of the building.	ļ				{ }
		,	. 1				
	At 2:64 PM on 01/15/	14 Central Communications	- J.				1
	Lemanar (CCM) #3 8	dated on Priday, Oprilling	}		1	•	1 1
	Danklant fide wont of	III THE TROPE GODS OF THE SERVICE	1				1 1
ì	Resident into nome	n. She reported the	- 1		1		1
	resident was later for	and in the parking lot.	- 1		1		
}	tesidetic was raid to	I, the Intervention for this			1		]
)	According to Com in	orm the staff to keep a					]
} .	elopement was to ith	ont #40. She commented .	1		1		
1	closer eye on restue	nce again escaped out a			1		
1	after Resident 440 of	ILL does off the moin hell	1		1		1.
į	Wanderguard compa	ilble door off the main hall			1		
1	and into the lobby on	Sunday, 05/19/13, the					
	resident was placed	on 1:1 supervision. CCM #1	1			•	
1	l atatod tha fallawing V	veak constant coservation of	- 1		1		
}	l the deer leading to th	je lodby waż estamianaci	1 .				
ì	and Resident #40 wa	as removed from 1:1	1		į	•	
1	auparvision.		-				1
			}				1
i	At 3:03 PM on 01/15	/14 the receptionist, on duty	Ì		Į.		1
-	L. I Hantstont HdD c	aviteri the bullding on	1				
١.	activity elelection	saw the resident leave are			1		
1	Latter but ecotions	ry the atotic of igales one	- 1		1		
	Lune with hed clarred	her out for a trip, one			1 '		
1	Oll setty one barbarers I	alite adellini die fierut	1.	20	1		
1	iind when the if	asident came infoligit kic			1		}
}	Licenseff the main hal	tor not decause it was hay			l		1
	Line and the lebby W	as vaiv noisy, 500	1				į.
	I commented once the	e alarm sounded, aduvated	1		1		}
1	L Ideals with Wa	anderguerd bracelets in					1
1	l i U had to be to	med off by staff. According	1		{		1
}	piace, it tian to be to	he did not turn off/reset the	1				l
	to tus tecebinities, a	/13 when Resident #40	١.				
1	door alarm on up/1/	Voucever she renorded			}		1.
)	exiled the building.	However, she reported have set the alarm off when			ľ		
1	Resident #40 could	Have set all arrains on more			1		1
ĺ	she went out the do	or, and a staff member	1		1		1
1	automatically cut it o	off thinking a resident with a			- 15 - 15 - 642.672	if continuation s	heel Page 8 of 21

#### FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (C3) DATE SURVEY (XX) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: a. Building c. AND PLAN OF CORRECTION 01/17/2014 B. WNG. 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1824 HIGHLAND DRIVE ' WASHINGTON, NG 27889 RIDGEWOOD MANOR OVIE CONSTELLOS (C2) PROMDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY LUST BE PRECEDED BY FULL OROSS-REFERENCED TO THE APPROPRIATE (X4) 1D PREFIX REQULATORY OR LISC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 323 Continued From page 8 Wanderguerd just passed by the door on the way to activities and set the atarm 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 on a bright colored outfit. 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 there 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 elde reported the resident was confused, staling she was on her way to visit her niece. At 4:26 PM on 01/15/14 Resident #40 was in a wheelchalr, 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 5:38 PM on 01/15/14 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 lock but only alarmed, and once the plarm sounded stalf had to cut the alarm offfreset it. The MM provided his logs which documented he checked all door alarms on Tueodays and Fridays.

At 9:50 AM on 01/16/14 CCM #1 stated it was not

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 (X3) CATE SURVEY (X2) MULTIPLE CONSTRUCTION: COMPLETED (XI) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION 01/17/2014 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1624 HIGHLAND DRIVE Washington, NC 27869 RIDGEWOOD MANOR PROVIDER'S PLAN OF CORRECTION CONSTESSOR SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (GACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX DEFICIENCY) TAG F 323 Continued From page 9 F 323 the door off the main hall into the lobby for the door alarm to go off. She reported there were times when the staff just automatically reset the alarm on the door into the lobby, thinking a Wanderguard resident passed by the door. At 10:02 AM on 01/16/14 the MM stated when a Wanderguard resident passed within eight feet of a Wanderguard compatible door the door alarm sounded. During a telephone interview with CCM #2 on 01/16/14 at 10:46 AM she stated she worked on the weekends, and before 05/19/13 the only elopement intervention that she knew of in place for Resident #40 was her Wanderguard bracelet. She reported prior to her 05/19/13 6:37 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 05/19/13, but she could not remember at what time the problem arose and at what time the problem was resolved. According to CCM #2, there was not a receptionist on duly in the front lobby on the weekends. At 1:50 PM on 01/16/14 the MM stated he was called to the facility to fix the Wanderguard alarm on the door to the lobby on 05/19/13, but could not remember what time of day it was, At 2:30 PM on 01/16/14 the director of nursing (DON) stated she was not in the building on 05/17/13, but the administrator was,

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DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				. FORM.	02/03/2014 APPROVED 0938-0391	
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NAME OF P	ROWDER OR SUPPLIER			1	TREET ADDRESS, CHY, STATE, ZIP CODE 624 HIGHLAND DRIVE		:	
RIDGEW	DOD MANOR			۰.	VASHINGTON, NC 27889 PROVIDER'S PLAN OF CORRECTION		(20) CONFLETEDA	
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F 323	La supe political forme	dialely after Resident #40	F	323				
-	was found outside the on 05/17/14. Since it reported he went and and direct care staff	e building in the parking lot twas her first elopement, he t talked to the receptionist on the resident's hall about		,		-		
	Identified as intervet assessments, report through the Wanders	/14 Resident #34, who was vable by staff and his MDS ed he saw Resident #40 go puard compatible door into hing of 05/19/13. He stated herself, and the door alarm						
	(MSDS) for Clorox of Hazard Date as, "Do severe Irritation or diversity of the MSD pre-dilluted cleaner in the MSD and the MSD pre-dilluted cleaner in the MSD and the MSD pre-dilluted cleaner in the MSD pre-dilluted cleane	S for Clorox ready-use bleach lists the Health Hazard Data ate eye initation, Avold r clothing, Wash thoroughly			1. A new bleach 1:1 diluted bottle lab and submitted to N Safety and Health Bottle label was a 1-28-2014 for use, bottle label correthe hazards of the mix.  a) Bottle label b) NC OSH Email	el was C Occu for ap pprove The r ctlv 1	pationa proval. d ew dentifi	

	and the same of th	ID DEIMAN SERVICES	• .	٠		FORM	0: 02/03/2014 APPROVED .
DEPART)	MENT OF HEALTH AN	D HUMAN SERVICES				The state of the s	0, 0938-0391
CENTER	S FOR MEDICARE &	WEDICARD SERVICES	COMB	TIPLE	CONSTRUCTION	bya) byue	SURVEY LETED
evanswert (	OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA* (DENTIFICATION NUMBER:	A BUILD!			COMP	Lester .
AND PLAN OF	CORRECTION .	(BEN)II IGNITOR RESIDENT	V BOUD	,,,,		1. (	
	·		1			03/	17/2014
٠.		346228	B, WING,			~ <del></del>	
	- Almetico				REET ADDRESS, CITY, STATE, ZIP CODE		
NAMEOFP	ROVIDER OR SUPPLIER	ь.		- 16	24 HIGHLAND DŘIVE	•	1
	AN MANOR			l w	ASHINGTON, NC 27889		
RIDGEME	OOD MANOR	-		1	DECMARKED BY AN OF CORRECT	HON	COUNTEDON
(XA) ID • PREFIX		ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	10 PREF 1749		(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ALD BE	DV4E COTNETION
TAG	REGULTION						
			7			٠	1
		. 4*	F	323	1		1.
F 323	Conlinued From page	9 11 <sub>.</sub>	,	O.C.	2. Housekeeping s	taff wi	P.1
	la a consideration de la la consideration de l	-d Downenting Accide(1)(8)			be re-inservice	ed on t	he
	I	Salled DOMIGEO BY ME INCHLY			facility "Prev	enting	1
	in a count and a Control	at Proceditiosh tocauliving		1	Accidental Ing	estion/	- }
1	Lus All boung/conjuc	chemicals are secured	1		Poisoning" pol	lav by	2-1.414
	or Will Houseweburg	In use or under the direct			Polsoning Pol	icy wy	1
1	supervision of the ho	usekeeper."	1.	1	3) Housekeeping C	STOD MY	r- r
1	1				be randomly audit	ed by	L . I
	I abnonution on	01/13/14 at 12:09 PM a	1		housekeeping mana	ger 10	*
	Language of the land of the la	as Clorox was seen on no	1		wastly ner housek	eeping	
1	the street the common	e in a resident room, the			l waid cart to ensu	re that	the
}	Dack of file common	s corrosive, danger hazards	1		carts are locked	and che	micals
1	to humans and dome	offic animals.			are secured.		1
ļ	to humans and dome	ZOLO VIIII VIII	- 1		a) Housekeeping	cart ch	emical
		/13/14 at 12:10 PM Nurse #1	1		a) Housekeeping	t choot	
ł	. In an interview on o	ed the bottle of cleaning	- 1		box lock audi	b sneet	1. I
1	stated as she remov	ousekeeper must have left it			4) Housekeeping C	arts wa	P
	chemicals that the it	t have been left in the			l be andited 5 X W	GERTA	1 1
	and that it should no	She Indicated that there were	1.		l after the reside	nt room	d cleaning
	resident bathroom.	oini benderen mar usera dere			housekeeping shi	ft ends	(to )
1.	cognitively impatred	residents who wandered into	1		ensure all house	keeping	1.
	other resident's room	ns who resided in the facility.			bottles present	at the	
		week to a prof DM the			beginning of the	chift.	hre
	in an interview on 0	1/15/14 at 2:05 PM the			returned with th	o honge	reening
1	Housekeeping Mana	ager (HM) stated that white	1	•	returned with the	tow ale	bot at
1	L - +t le tine houseakee	WIND CUSTRICKIS STRANG AD			cart to the jani	TOL CIC	1580 ac
1	I to stood you are the best	reckeeding own, the aldress			the end of shift	Bott.	res ATTT
1	at a star to a considerate of the	r nea anne le luitel leavies	'		l. he recorded at 8	a.m. a	ana j
}	I the container on the	Dack of the commode, no	1		recorded admin 8	it 4 pm	( 00 )
}	I will nated that when	the surveyors entoles mo.			l engire no cleani	ng boti	chree !
}	Leuteling to took his	etelf aside and in-services	}		were left outsid	e of th	ne l
1	I their on the facility t	ecuirements penalling $\circ$			Were Tere Outer	duri	nbr I
1	I them. Un eleter the	t when the nucle all vince	} ,		housekeeping car	. &	~P"
	I sto of the chemicals	s left in the bainroom die.			the shift.		اعما
	housekeeper was in	-serviced again.	1		a) Housekeeping	g cart	end or
1			,		shift audit	sheet.	
	In an Interview on 0	1/16/14 at 2:05 PM	1		5		1 1
1	Let a learner His obs	alay sha had deen employed			Completion date	Z-14-14	1 1
	Lt mentionataly 3	monas, and makada a a .				•	1
1	t woldent had gollen	IDG DOME OF CHRITICALS MOX					1
	lealestir tran Action	sick, been sent to the .	1				
1	COTIID USIAG DECOLUE	stand and a standard			lectite ID: 923432	coupunações ep	oel Paga 12of21

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVÎDER/SUPPLIER/CLIA SYATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/17/2014 B. WING\_ 345228 STREET ADDRESS, CITY, STATE, 21P CODE NAME OF PROVIDER OR SUPPLIER 1624 HIGHLAND DRIVE Washington, NC 27889 RIDGEWOOD MANOR PROVIDER'S PLAN OF CORRECTION (X4) COMPLETION SUMMARY STATEMENT OF DEPICIENCIES (EACH CORRECTIVE ACTION SHOULD BE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X4) IO TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX . DEFICIENCY) F 323 Continued From page 12 F 323 hospital or could have died. She stated she had forgotten 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 in-serviced on the rules when the surveyors had arrived and again when the chemicals were found. In an Interview on 01/17/14 at 9:35 AM the HM stated the solution that was in the spray bottle did not match the label. He indicated the facility used a 1:10 (1 part bleach to 10 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 5:15 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 The facility will ensure that death. 483,25(I) MAINTAIN NUTRITION STATUS residents maintain acceptable F 325 UNLESS UNAVOIDABLE parameters of nutritional status SS=D including body weight, unless Based on a resident's comprehensive the resident's clinical assessment, the facility must ensure that a condition demonstrates this is resklent -(1) Maintains acceptable parameters of nutritional not possible. Corrective action status, such as body weight and protein levels, was taken for the 2 residents. that experienced significant weight unless the resident's clinical condition demonstrates that this is not possible; and Ness by initiating supplements (2) Receives a therapeulic diet when there is a to increase caloric intake nutrillonal problem. and stabilize weights. The 2

residents were also placed in the

Pacifity 10; 023432

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FORM CMS-2567(02-99) Provious Versions Obsolete

if continuation sheet Page 13 of 21

CENTERS FOR MEDICARE & MEDICAID SERVICES						OWR MO.	0820-0291
CENTER	S FOR MEDICARE & I	LIX43 ₽ROVIDER/SUPPLIENCUA			CONSTRUCTION .	(X3) DATE S COMPL	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. SUILD	NG_	-	0	
		,				1 -	7/2014
		345228	a, Wing			<u> </u>	112014
	OVIDER OR SUPPLIER.				REET ADDRESS, CHY, STAYE, XIP CODE		1
MARKOLAN	(OVIDER OR SOFF CHAR.	•			24 HIGHLAND DRIVE		1
RIDGEWO	OD MANOR			W	ASHINGTON, NC 27889		
		OF DEPOSITION OF DEPOSITION OF THE PERSON OF	l ID	١١	PROVIDER'S PLAN OF CORRECTION	.	COWNETUDES (XR)
(X4) ID	AND THE PARTY OF T	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL.	PREF		EACH CORRECTIVE ACTION SHOULD B GROSS-REFERENCED TO THE APPROFIN	ATE	DATE
PREFIX	. REGULATORY OR	SC IDENTIFYING INFORMATION)	TAG	١ ١	DEFICIENCY)		- {
1000			<del> </del>		1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
					weekly interdiscipling	lary	ed for
F 325	Confinued From page	a 13 .	F	325	"Resident at Risk" me	secrud	S TOT
1 02.0	Communa Company				review of weekly weigh	ints c	ina f
		4	1		monitoring until weig	ine	1
			1		stabilized.	1	1
	THIS REQUIREMENT	ls not met as evidenced				1	
	bar		1		To ensure that all re	esi dej	its with
	Based on staff interv	lew and record review the	}		significant weight 10	sec al	e l
-	to slike falled to follow	ille protocol for	1		identified; the faci:	lity	7111
	turniamonting Inforce	ntions when 2 of 2 festuents			use a Weight Book to	docu	ment
	(Resident #40 and #	67) experienced significant			lall weights, monthly	and	- [
	weight loss. Finding	s included:			lwookly. The calculat:	ions	
,		admitted to the facility on	1		will be done by hand	to a	etermine
	1. Resident #40 Was	admitted to the facility on itled on 12/18/13. The			residents that trigg	er	l Ì
	04/08/13 and readm	ed diagnoses included	1		for significant weigh	ht	
	resident's document	ar degeneration, cognitive	Į		loss, 5% in 30 days,	7.5%	
	delicit, and cancer of	the annendix.	1.		lin 90 days and 10% in	ո 180	l i
			1		lagys. Rach weekly and	a mon	ch1y
	Poeldent #40's Weld	ht record documented she	1		weight will be docum	entea	1
	weighed 164.1 poun	ds on 04/16/13.	]		in this book and rev	leved	}
	1				weekly by dietary man	nager	]
	A 04/30/13 resident :	progress note documented	Ì		for new weight loss.	·In	}
Ì	l the feelilly notified R	esident #40's primary	1		addition all residen	ts	1
	physician about fami	lly concerns regarding the	1		that trigger for sig	nific	ant
1	(esident's weight los	8.	1		weight loss will con	tinue	} }
		a a salahari on	1		to be referred to th	e RD	1 1
	A 04/30/13 physician	order placed the resident on			for nutritional asse	ssmen	ŧ l
	weekly weights.				and approproate inte	rvent	lons.
	a the sentence to	ht record documented she	i		Residents with signi	fican	ŧ l
1	weighed 144.4 pour	nde on 05/24/13	1		weight loss will con	tinue	
1	Weigher 144,4 bonn	MO OH VOIK II 100	1		to be reviewed weekl	v	1
1	In one month helive	an 04/16/13 and 05/21/13			in the facility's		
	Postdent #40 tost 9.	7 pounds for a 6.3% weight			interdisciplinary "R	esi de	ht
	loss.		}		At Risk" meetings un	£11	T
1	1	•			weight has stabilize	g sus	In.
	Record review revea	aled Resident #40 was not	١.		Merdur use acanilize	a aga	T"'
	titled vos any nutrit	ional supplements, was not					
	accessed for walcht	loss by the registered			ł		
i	digition (RD) or die	tary manager (DM), and was			<u> </u>		1

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	: 02/03/2014 APPROVED : 0938-0391	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	1		*	(X3) DATE		
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILDI		CONSTRUCTION	COMP	ETED (ISTE	
·	٠.					1 '	17/2014	
,		346228	8. WING			1 01/	1//2014	
www.of.bf	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	- :	j	
NAME OF PT	(OAIODA OL OOL LOCA				24 HIGHLAND DRIVE		1	
RIDGEWO	OD MANOR			W	ASHINGTON, NC 27889 PROVIDERS PLAN OF CORRECTION		0(5)	
(X4) ID. PREFIX TAG	And the state of t	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREH TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE ]	COMPLETION DATE	
	Continued From page not reviewed by the facility's until 07/18/13 w to 137.7 pounds.  At 5:25 PM on 01/16/the facility's computer reliable on calculating weight toss. She reported that the significant weight loss of days, and 10% in RD, when a resident they were immediate possible cause and facommittee which may promote weight gain loss. The RD comme be stable for four wed discharged from IDT.  At 2:56 PM on 01/17, she and the RD screweight loss, but she had the most direct of time to track weight grouputer soft wear of residents who except	acility's interdisciplinary team when her weight decreased in the facility's RD stated in system was not very and capturing significant order many times weight jured by hand in order to dents may have had a sof 5% in 30 days, 7.5% in 180 days. According to the experienced significant loss by assessed to determine the collowed by the iDT de recommendations to or prevent further weight inted resident weights had bels before they were		325	using hand calculative ight loss trends weight loss trends weight and further new admissions as we readmits will be reveally interdiscipli "Resident at Risk" I for 4 weeks to ensurch anges in weight as and appropriate interest are put in place.  Any negative trends referred to the Qual Assurance Committee recommendations.  The weight book that used to document and all weights will be by February 10, 201. The weight book will audited weekly for 1 hi-weekly for 3 months any weight changes in the second to the second to be	Team Team Tinte Ti	for rvention in the grany ressed ions be keres k	
	calculated by hand. Resident #40 probab on nutritional supplet building, but the residently.	The DM commented ; ly should have been started ments soon after entering the dent appeared healthy and			timely and intervent put in place. Completion date 2-1		GA G	
	(DON) stated the fac	ant, preferably conducted by e completed as soon as			li comi	louation she	et Page 15 of 21	ğ

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIERCIA (X2) MULTIPLE CONSTRUCTION A BUILDING C O1/17/2014

	•	345228	B. WING		10.000
	NAME OF PROVIDER OR SUPPLIER			Sĭ	TREET ADDRESS, CITY, STATE, ZIP CODE
NAME OF PR	OMDEROK SUFFER	•			524 HIGHLAND DRIVE
REDGEWO	OD MANOR			W	VASHINGTON, NG 27889
(X4) ID PREFIX YAG	SUNMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREI TAI	PIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEPICIENCY)
			1	_	
F 325	TORONI POLICE IN LANGE INVESTIGATION	s was identified. She tant to determine why the	· - F	325	
	resident was losing was followed by the lidevoloped intervention weight loss. She sta	reight. Once this was I commented the resident DT committee which ons based on the reason for ted it was not acceptable to after eignificant weight loss assessing and putting	4.0		
	2. Resident #67 was	o. admitted on 10/11/11, Her ses included failure to thrive, bertension, and arthritis.			
·	•	ht record documented she			
	A 07/24/13 physician on as needed (PRN) daily for swelling.	n order placed Resident 1/67 Lasix 20 milligrams (mg)			
	A 07/29/13 physician resident's Lasix to 2	n order changed the D mg daily.		,	
	weighed 117.7 pour one month (between resident lost 6.8 pou	ht record documented she ds on 08/19/13, Therefore, in n 07/03/13 and 08/18/03) the ands for a 5,5% weight loss.			
-	dietitian (RD) did no supplements, the re weight loss by the F and the resident wa	aled the facility's registered t recommend eny nutritional sident was not assessed for (D or dielary manager (DM), s not reviewed by the facility's m (IDT) until 01/16/14 when ed to 111.7 pounds.	And the second s		

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICARD SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/BUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES DEMIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/17/2014 B. WING 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROMDER OR SUPPLIER 1824 HIGHLAND DRIVE WASHINGTON, NC 27889 RIDGEWOOD MANOR PROVIDER'S PLAN OF CORRECTION (KS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES . (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) lO PREFIX (EACH DEFICIENCY LIUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR USC IDENTIFYING INFORMATION) DEFICIENCY) YAG F 325 Confinued From page 16 F 326 the facility's computer system was not very reliable on calculating and capturing eignificant weight loss. She reported many times weight changes had to be figured by hand in order to determine which residents may have had a elgnificant weight loss of 5% in 30 days, 7.5% in 90 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 TDT committee which made recommendations to promote weight gain or prevent further weight loss. The RD commented resident weights had 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 she was the person that probably had the most direct contact with the residents and time to track weight patterns. She reported the computer soft wear 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 #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 nutrillonal assessment, preferably conducted by the facility's RD, to be completed as soon as

significant weight loss was identified. She reported it was importent to determine why the resident was losing weight. Once this was determined, the DON commented the resident

PRÍNTED: 02/03/2014

STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THE PERMIT	warmer ivit		A. SUILD			1	;
1		345228	8. WNG			01/17/2014	
	NAME OF PROVIDER OR SUPPLIER RIDGEWOOD MANOR			16	TREET ADDRESS, CITY, STATE, ZIP CODE 924 HIGHLAND DRIVE FASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 325 F 371 SS=E	developed intervention weight loss. She state wait until two months was identified before interventions in place 483.35(i) FOOD PROSTORE/PREPARE/S  The facility must - (1) Procure food from considered satisfactor authorities; and	ns based on the reason for ed it was not acceptable to after significant weight loss assessing and putting CURE, ERVE - SANITARY a sources approved or ry by Federal, State or local		325 371	There were no negative outcomes for residents that consumed shrimp salad above deg. F. and soup below 135 de F. Or for unlabeled foods in t dietary department. All foods now appropriately labeled.	eg. he	
	by: Based on observation facility falled to keep degrees Fahrenheit degrees Fahrenheit date opened food itel. Findings include:  1. Beginning at 5:27 temperatures were to the trayline. Temperatures were to the trayline. Temper croissants ranged be Fahrenheit. These cover ice in a steam worff. In an attempt to	or above during operation of lity also failed to label and ms in multiple storage areas.			To insure that soup is at or ab 135 deg F. we will no longer p pour soup. Soup will be kept of the steam table a 165 deg F. a placed in a bowel from the steatable.  To insure that cold salads are kept at 41 deg. F. or below the salad will be prepared 24 hour advance so that it can chill in a cooler. In addition cold salads be kept in small dishes and placed in ice on the tray/line to insure temps hold below 41 def.	e e rs In the will	

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
ANDPLANO	CORRECTION	IDEMIFICATION NOMBER	A. BUILDING			c	
		345228	B. WING_	1	01	/17/2014	
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR  CAULD SUMMARY STATEMENT OF DEFICIENCIES		, ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1824 HIGHLAND DRIVE WASHINGTON, NC 27889 PROVIDER'S PLAN OF CORRECT	TION	(208)		
(X4) ID PREFIX TAG	JEACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLÉTION DATE	
F 371	shrimp salad from the was being stored in a made up eight shrimp the temperature was the tray pan the therm degrees Fahrenheit. covered with a lid was which was going to b. The temperature of the degrees Fahrenheit. trayline started opera 01/14/14. They report carts to fill and 44 months trayline operation. At 4:38 PM on 01/15/(DM) stated the shrim the same day that it won 01/14/14 the froze immediately placed of was placed in the wastermometer used to registered below 40 or reported around 2:30 in the Robot Coupe, relish, and a little lem to the DM, the assem in a tray pan and retuent to the DM, the assem in a tray pan and retuent to the trayline began operation was removed. The Extrayline began operation the trayline began operation of the postered 40 degree reported cold salads.	walk-in refrigerator which large, deep tray pan. She is salad croissants, but when taken on the shrimp salad in nometer registered 54. A prepoured bowl of soup is placed on a resident tray is stored in the meal cart, his bowl of soup was 120. The dietary staff stated their tion around 4:45 PM on the tied they had two more meal are residents to serve before was completed.	F 37	Temps of hot foods and cold foods will be monitored daily 2 weeks, weekly for 4 weeks biweekly for 4 weeks and monthly for 3 months to insproper temperatures.  Food items will be monitore weekly for 3 weeks, biweekly 4 weeks and monthly for 3 months to insure food items labeled and dated appropriated Any negative trends will be refereed to Quality Assurant Committee for recommendations.  Completion date 2-14-14	y for i, ure d y for s are ately.		

		investorrizoro		:		PRINTED	02/03/2014 APPROVED
DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				OMB NO	. 0938-0391
CENTER	S.FOR MEDICARE &	MEDICAID SERVICES	1		CONSTRUCTION	(X3) DATE	SURVEY .
STATISMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V BOYCH		CORSIROUTION	COMP	LETED
		· .	}				
·:		346228	B, WANG			01/	17/2014
				81	TREET ADDRESS, CRTY, STATE, 21P CODE		}
NAME OF P	ROMDER OR SUPPLIER.			10	324 HIGHLAND DRIVE		. {
RIDGEWO	OD MANOR			W	ASHINGTON, NC 27888	-	
		NEMENT OF DEFICIENCIES	lb.	-	PROVIDER'S PLAN OF CORRECTION	tt tt	COMPLETION
(X4) (D	for Low retrieveness	V MINSY BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	REATE	PATE
PRÉFIX TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION	TAG	١ ١	DERCIENCY		
""							1
F 371	Continued From page	19	F	371		•	
''	duden the ordina oner	ation of the trayline. She	1				
1	dittip fire eithe dig	g down time at the trayling	1		·		'
	Cottinietries mar ann	our bowls of soup might be					
	sometimes into or it	pectation would be that			'		1
	brebonien' par us ox	d on realdent trays quickly.	1				
	The Dik renoded hot	foods such as soup should	1				1 1
	romain of 135 decree	e Fahrenhelt or higher	i	-			1. 1
	during the entire oper	allon of the trayline.	1				
		,			l ·		{ }
	At 8:48 AM on 01/16/	14 an AM cook stated that					
	necessally when she	was responsible for cold					
	entode made with ma	vonnalse she preterren					
	them to be at 38 dear	ees Fahrenheit of Delow.					
	She reported cold sal	lada ware usually prepared	Ì		1		]
	in the morning on the	same day that they were					
	languard but they were	kent chilled by tetrigetaled	1				1
	starono unili firay wai	a served. She reported she	-				1 1
'	and was like to proport	r sours because they might	i		-		1
	ha too cold when ser	ved. According to the cook,	1				l 1
	when she was respot	isiple tot hot toods atte	1				
1	weafacted them to ten	nain at or above 705	1		1		i i
	degrees Fahrenhell o	luring the entire operation of	.				}
	the trayline.						[
			ļ				1 1
	<ol><li>During Initial tour</li></ol>	of the kilchen and food			1		( )
•	storage areas, begins	ning at 10:40 AM on	1				
	01/13/14, multiple for	od items which were opened					]
	were without labels a	nd deles. In the dry storage			t		1
	room a five-pound bo	ox of cake mlx, a bag of orzo	1		(		1
	pasta, a two pound b	ag of confectioner's sugar, a palmeal, a 16-ounce box of			-	-	
	storage container of	a nation has of vellow	1		· .		1 '
	corn starch, and a liv	e-pound bag of yellow all opened were without			1		(
)	COLUMBIA MUICU MALE	the walk-in refrigerator a	1		1		
1	labels and dates, in	r of carrot raisin salad, a					
	eight-pound contains	iden Catalina dressing, and	ŀ				
1	delicu couranei oi de	ced cheese which were all .	1			-	
	INTER packages of all	labels and dates, in the	1				]
	opened were willout	h toast in plastic wrap, a bag.	1				L
!	Mark-in iteozer Frenc	di fresion un baniano in di un fi	1		M too	iniustaa cha	1 Page 20 of 21

DEPART	MENT OF HEALTH AP	ID HOWAN SEKAICES				OMB NO	0.0938-0391
		MEDICAID SERVICES	Twa ma	mple	CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES (X1) P AND PLAN OF CORRECTION (C)		(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		COMPLETED		
			1			l	C ."
i		345228	8, MNG			01/	17/2014
		348720		1 8	TREET ADDRESS, CITY, STATE, ZIP CODE		
NAMEOFP	ROYDER OR SUPPLIER	•	:		524 HIGHLAND DRIVE		
RIDGEWO	OOD MANOR	•			ASHINGTON, NC 27888		
			T 2	٠	PROVIDER'S PLAN OF CORRECTION		(955) COMPLETION
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	1D PREF		MEXICU CORRECTIVE ACTION SHOULD B	E	COMPLETION
PREFIX	REGULATORY OR	SCIDENTIFYING INFORMATION)	TAG	•	CROSS-REFERENCED TO THE APPROPRIA	WE	
٠. ""							
							į.
F 371	Confinued From page	20	, ·F	371			
	of sweet potato wedg	es, and a bag of mixed					
	vegetables which wer	e all opened were without	1		*		
	labels and dates.	•					
	Paradare a Callane sua fest	ır of the klichen and food	1		· .		
	storage areas, begint	ling at 11:20 AM on	- [				
,	04/45/44 bot doos re		1				
	nackeoing and wrapp	ed in foll and an opened			•	. :	
	bay of biscults were f	ound in the walk-in freezer		`			
	willrout labels and da	les.	1	l			
	} . ** ***** **** *** ******************	14 the dietary manager			-		
	(DM) stated her assis	iant checked storage areas	·  .				
	two or three days a W	eek to make sure opened	-				
	food items were label	ed and dated and to discard	1.		·		
	any food items past ti	neir use-by dates. However,					
the DM reported ut		ately any dietary staff who ' d then placed them back	. ]			i	
	opened tood tietus an	ace labels and dates on					
	them so they could be	used before their quality		- 1			,
	was compromised.	,		.			
	-						
	At 8:48 AM on 01/16/	14 an AM cook stated all	•	- 1	. ,		
	dietary steff were resp	1	1	•			
	opened food items in storage had labele and dates on them. She reported there was an assistant who went behind the dietary staff to		١.	. 1		- 1	
					•		
	make sure opened for	od Items had labels and	١,				
	dates on them, outdail	ed leftovers were disposed				1	• .
	of, thawing meats ren	gined on the bottom	1				
		ali dalry products were	-		_	.	*
	within date.				•	.	
			1.				
			1	ı	ь.		

PRINTED: 02/10/2014 FORM APPROVED RTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 TERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED ATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: NO PLAN OF CORRECTION 02/06/2014 345228 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1624 HIGHLAND DRIVE RIDGEWOOD MANOR WASHINGTON, NC 27889 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG K 000 INITIAL COMMENTS K 000 l FEB 2 4 2014 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 A. The door in the soiled sprinkler system. linen room will be adjusted The Deficiencies determined during the survey so it will close and latch. area as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 029 K 029 B. The Janitor's storage room SS=D One hour fire rated construction (with ¾ hour and the maintenance office fire-rated doors) or an approved automatic fire will be adjusted so that it extinguishing system in accordance with 8.4.1 will close and latch properly. and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system C. The PVC pipes penetrating option is used, the areas are separated from the ceiling will be sealed other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or properly. field-applied protective plates that do not exceed 48 inches from the bottom of the door are The maintenance supervisor 19.3.2.1 permitted. or his designee will monitor doors and through ceiling penetrations monthly to This STANDARD is not met as evidenced by: insure compliance. A. Based on observation on 02/06/2014 the soiled linen room near nurses station A failed to Any negative trending will be close and latch. B. Based on observation on 02/06/2014 the reported to the Quality Janitors Storage near the Maintance Office roo Assurance committee for failed to close and latch. recommendations. C. Based on observation on 02/06/2014 there were PVC pipes penetrating the ceiling of the (1) Completion Date: 3-23-13 one hour ceiling of the Boiler room that were not (XB) DATE YCK PROMOTRISUPPLIER REPRESENTATIVE'S SIGNATURE TITLE LABORATORY DIRECT

Any deficiency statement ending with an asterisk (\*) denotes a deliciency which the institution may be excused from correcting providing it is determined that Any deficiency statement ending with an asterisk (\*) denotes a deliciency which the institution may be excused from correcting providing the date above are disclosable 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings and plans of correction are disclosable 14 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 11,7P21

Facility ID: 923432

If continuation sheet Page 1 of 2

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

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		THE CONSTRUCTION	(X3) DATE SURV	veY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	FR/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		COMPLETED	
**		345 <u>2</u> 28	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	02/06/20	14
NAME OF F	ROVIDER OR SUPPLIER		1	1624 HIGHLAND DRIVE		
SIDGEW	OOD MANOR		1	WASHINGTON, NC 27889		
KIDOLW			10	PROVIDER'S PLAN OF CORRECT	TION (	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	E WAR CORRECTE ACTION SHOL	OLD BE COM	COMPLETION DATE
V 020	Captinuad Erom no	one 1	K 02	29		
K 029	Continued From page 1 sealed properly.			į		
K 038 SS≓D	42 CFR 483.70 (a)	AFETY CODE STANDARD	K0	A. The door knob to the		
	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1			dayroom will be replaced with door knob that can opened with one motion		
	This STANDARD	is not met as evidenced by:		B. We will construct a hard surface pathway from the laundry exit to the paved driveway.		
	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 obdervation on 02/06/2014 there was no hard surface path way from the laundry stair well exit to a public way.			Maintenance supervisor of his designee will monitor monthly for compliance.  Any negative trending will be		
				reported to the Quality	-	
_		•		Assurance committee for	1	
		-		recommendations.	ļ	
				Completion date 3-23-14		
E E	1					
1						
		a				
CORN CHE S	687/02-99\ Pravious Version	ns Obsotete Event ID: 1L7P2	21	Facility ID: 923432 if co	ntinuation sheet Pa	ge 2 of 7