PRINTED: 01/22/2019 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345228	B. WING			C	
		343226	D. WING _			12/	07/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGEWO	OD LIVING & REHAB CI	ENTER			624 HIGHLAND DRIVE		
				٧	VASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	A recertification and conducted from 12/3/ Immediate Jeopardy						
	CFR 483.25 at tag F6	689 at a scope and severity J					
	The tag F689 constitu Care.	uted Substandard Quality of					
	Immediate Jeopardy removed on 12/5/18.	began on 11/20/18 and was					
	An extended survey v	vas also conducted.					
	complaint investigation						
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)		F 6	357			1/4/19
	§483.21(b) Compreho §483.21(b)(2) A comp be-	ensive Care Plans orehensive care plan must					
	the comprehensive as	days after completion of ssessment. terdisciplinary team, that					
	includes but is not lim (A) The attending phy	nited to					
		e with responsibility for the					
	(C) A nurse aide with resident.						
	` '	and nutrition services staff.					
		cticable, the participation of					
		resident's representative(s).					
		be included in a resident's					
		participation of the resident					
	and their resident rep	resentative is determined					
L ABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>		 TITLE		(X6) DATE

Electronically Signed 12/28/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

			<u> </u>	(X3) DATE SURVEY COMPLETED	
	345228	B. WING		C 12/07/2018	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/0//2016	
			1624 HIGHLAND DRIVE		
DD LIVING & REHAB CE	ENTER		WASHINGTON, NC 27889		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
Continued From page	÷ 1	F 65	7		
not practicable for the resident's care plan. (F) Other appropriate disciplines as determior as requested by the (iii)Reviewed and reviteam after each assessments. This REQUIREMENT by: Based on resident arrecord reviews the fact and responsible participation are plan participation.	staff or professionals in med by the resident's needs e resident. sed by the interdisciplinary esment, including both the uarterly review is not met as evidenced and staff interviews and cility failed to invite residents es to participate in care plan e plan meetings for 1 of 1 esident #64) reviewed for in. The findings included:		F657 Corrective action for residents found t affected by the alleged deficient pract The Interdisciplinary team held a care plan conference with Resident #64 or	ice:	
3/17/17. His diagnos and pressure ulcer. A review of the quarte (MDS) dated 10/9/18 cognitively intact. He symptoms or rejection assistance with all action of the did not know anyth A record review of Reson 12/3/18 at 3:30 PM Multidisciplinary Care	erly Minimum Data Set revealed Resident #64 was had no behavioral n of care. He required total tivities of daily living. If during an interview with ed he had not attended a d had not received an care plan meeting. He added hing about his plan of care. Is sident #64 computer chart If revealed there were no Plan conference forms. AM Social Services (SS)		potential to be affected by the alleged deficient practice: The MDS nurses completed an audit 12/12/18, for the current facility reside to validate that care plan conferences were held with residents and/or reside representative. There were 67 reside that did not have a Multidisciplinary for completed, as evidence of a care conference being held or attendance the resident and/or resident representative, following completion or comprehensive and/or quarterly assessment. The Interdisciplinary tea (IDT), will complete care conferences 1/04/19, and document attendance by resident and/or the resident representative using the Multidisciplin	on ents, ent nts orm of of a m by the ary	
- Crr(co(toeTb)rerso F3e4(cse CFciir 4cN C	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pages not practicable for the resident's care plan. It is composited by the resident and reviewed and reviewed and reviewed and reviewed and reviewed and reviewed and residents. This REQUIREMENT by: Based on resident and resident are record reviews the fact and responsible particular record reviews the fact and responsible particular and participation. Resident #64 was add 8/17/17. His diagnost and pressure ulcer. A review of the quarter (MDS) dated 10/9/18 cognitively intact. He symptoms or rejection assistance with all action 12/3/18 at 2:18 Pl Resident #64 he state care plan meeting and retired and ret	F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Gii)Reviewed and revised by the interdisciplinary the earn after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews the facility failed to invite residents and responsible parties to participate in care plan meetings regular care plan meetings for 1 of 1 sampled residents (Resident #64) reviewed for care plan participation. The findings included: Resident #64 was admitted to the facility on 3/17/17. His diagnoses included sepsis, cellulitis	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOT practicable for the development of the desident's care plan. FOOT Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. FOOT OTHER STATES OF THE STATES	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG STATEMENT OF DEFICIENCES (EACH CORRECTIVE ACTION SHOULD PREFIX TAG SHOULD PREFIX	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345228	B. WING		C 12/07/2018	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	12/07/2010	
NAME OF T	TO VIDER OR SOLT EIER			, , ,		
RIDGEWO	OD LIVING & REHAB CE	ENTER		1624 HIGHLAND DRIVE		
				WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 657	7 Continued From page 2		F 65	7		
	care plan invitation le	tters to the family and if a		medical record.		
		ely intact she would give the				
		or she would verbally invite		Measures implemented to ensure that	at the	
		aid the MDS nurse provided		deficient practice will not recur:		
		f the residents who were		The DON and Administrator complete	ed in	
		plan meeting and she would		service education on 12/12/18, for th		
	complete the invitation			Social Service Director (SSD) and th		
		attend his meetings. She		MDS nurses regarding Updating		
		the meetings under the		assessment calendars to include nev	vlv	
	Assessment tab on th	<u> </u>		admitted residents and readmission	, I	
	Multidisciplinary Care Plan.			residents; sending letters to resident		
	, ,			and/or resident representative, invitir		
	A review of completed	d MDS documents for		care plan conferences; documentation	-	
		d he had an annual MDS on		resident record to include invite sent		
	3/21/18 and a quarter	ly MDS on 5/23/18, 7/9/18		resident and/or resident representati	ve	
	and 10/9/18.			attendance. The education will be		
				provided to newly hired SSD and/or	MDS	
	On 12/7/18 at 11:58 A	AM MDS nurse #1 stated		nurses during orientation. The MDS		
	she provided the cale	ndar to the SS person who		nurses will develop a calendar to inc	ude	
		lies and residents of the		upcoming comprehensive and quarte	rly	
		She also stated SS #1 was		assessments including new admission	ns	
	responsible to docum	ent the care plan meeting in		and readmitted residents. The calend		
		I record. MDS #1 reviewed		will be given to the SSD and the SSD) will	
		ed Resident #64 was not		send a letter to the resident and/or		
		calendar because he went		resident representative inviting them	to a	
	to the hospital. She a			care plan conference. The IDT will		
		nd returned on 9/20/18.		complete the Multidisciplinary Care		
		DS was completed on		Conference Form in the electronic		
	-	ot have been in the facility		medical record when the care		
		alendar. She stated she		conferences are held and will include		
		on the calendar. While		documentation regarding resident an	a/or	
	~	s MDS nurse #1 stated they		resident representative attendance.		
		lan meeting with each		Monitoring to assure continued		
		t. She said Resident #64		compliance:		
		n July so he should have		The Administrator and/or the DON w	/II	
		ing on 7/9/18 and he should		review calendar weekly and audit 5		
		endar in May. She observed		residents weekly for 4 weeks, then 1		
		alendar but there was no		residents monthly for 2 months, that		
	care plan meeting.			scheduled for care plan review, to va	iiuaie	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345228	B. WING _				07/2018
	ROVIDER OR SUPPLIER OD LIVING & REHAB CI	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 684 SS=D	care plan meeting for the medical record not this was the last care revealed the resident (DON), the Assistant physician were prese Resident #64's mother telephone. During an interview w 2:30 PM she stated s conference meeting transplayed the following that the conference meeting the quarterly for Resident Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident residents receive accordance with profess practice, the comprehence plan, and the resident residents receive accordance with profess practice, the comprehence plan, and the residents received accordance with profess practice, the comprehence plan, and the resident resident plan, and the resident plan plant plan	Provided a note of the last Resident #64. The date of one was 2/22/18. She stated plan conference. The note It is, SS, the Director of Nursing Director of Nursing and the one of the note also stated on the note also stated on the expected care plan of the conducted at least of the the theorem of the comprehensive of the facility must ensure of the treatment and care in the expected of the expected of the expected of the expected of the comprehensive of the theorem of the comprehensive of the theorem of the expected of th	F	that care plan conferences Multidisciplinary Care Conf completed with documenta attendance of the resident representative. The Administrator will revie identify patterns/trends and plan as necessary for conti compliance. The Administ the plan during monthly QA continue audits at the discr QAPI committee	ference form attion of and/or reside we audits to divill adjust inued rator will reviated and will retion of the retion of the retion of the value of value of the value of value of the va	ent be bece:	1/4/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا		
		345228	B. WING				07/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	0112010	
				16	624 HIGHLAND DRIVE			
RIDGEWO	OD LIVING & REHAB C	ENIER		W	VASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCE TO THE APPROPRIA		(X5) COMPLETION DATE	
					DEFICIENCY)			
F 684		mitted to the facility on	F	684	cortisone shot in that shoulder on 11/13/18, due to shoulder pain. On 11/23/18, The Director of Nursing (DON was informed about the alleged van	۷)		
	2/12/15. His active diagnoses included neurogenic bladder, hyperlipidemia, depression, calculus of the kidney, metabolic encephalopathy, repeated falls, and chronic kidney disease.				incident that occurred on 11/20/18. The DON initiated an investigation on 11/23/18, notified the Nurse Practitione and received an order for X-ray of the	r		
	Review of a wheelchair van policy signed by Van Driver #1 on 12/1/17 revealed Van Driver #1 was educated to ensure residents were appropriately secured with a seat belt prior to any transport. The education also covered what to do in case of a fall during transport. In case of a fall during transport the driver is to immediately call 911,				shoulder. X-ray results were obtained 11/24/18, and showed degenerative joi disease, which was not a result of a fal The Physician was made aware of the results on 11/24/18, with no new order given	nt I.		
	notify the Administrat the situation, and nev	or and Director of nursing of ver move the resident, to nd/or attempt to transfer			Identification of other residents having potential to be affected by the alleged deficient practice: The Director of Nursing (DON) complet an audit on 12/27/18, of current facility			
	data set assessment was assessed as cog documented to have Resident #68 was incand locomotion on ar limited assistance with	de8's most recent minimum dated 10/19/18 revealed he unitively intact. He was no moods or behaviors. Dependent with bed mobility, and off unit. He required the transfers. Resident #68 the lower extremities and a mobility device.			residents that have had incidents from 11/01/18 through 12/26/18, to validate residents were assessed for injury following an incident. Residents identif as having an incident were assessed b the licensed nurse following an inciden with appropriate treatment rendered as necessary.	fied y t,		
	Review of Resident # 10/29/18 revealed he risk for falls related to communication and opsychoactive drug us goal was for staff to reinterventions listed for interventions included	668's care plan dated was care planned to be at poor balance, poor comprehension, e, and an unsteady gait. The naximize safety through			Measures implemented to ensure that deficient practice will not recur: The DON and/or the Staff Developmen Coordinator (SDC) completed in service education for the nursing staff on 12/05/18, regarding Assessment of residents for injury following an inciden No staff who were absent or PRN (pro nata) will be allowed to return to the floand resident care until this	t ce t. re		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345228	B. WING _			1	C / 07/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	10112010	
					624 HIGHLAND DRIVE			
RIDGEWO	OOD LIVING & REHAB C	ENTER		W	VASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 5	F 6	384				
	unsafe conditions and	8 and record and report all d situations, and monitor his ess for a change in his level			training/education has been completed. This education will be included with ne hires as part of the new hire training process.			
	12:49 PM revealed the documented Resident dental appointment with consult sheet. No furtification for 11/20/18. Review of a weekly simple with the sheet of the sheet dental appointment with the sheet of the sheet dental appointment of the sheet dental a	note dated 11/20/18 at the Unit Coordinator of #68 returned from his with nothing written on the other documentation was the assessment for Resident evealed the resident was new skin abnormalities			Monitoring to assure continued compliance: The DON will audit 5 residents weekly 4 weeks then 10 residents monthly for months, to validate that residents were assessed for injury following an incider The DON will review the audits to iden patterns/trends and will adjust the plan necessary for continued compliance. DON will review the plan during month QAPI and will continue audits as the discretion of the QAPI committee.	2 nt. tify as The		
	dated 11/23/18 reveal neck and arm pain ar reported pain with rig arm pain. A prednisor right shoulder. Review of a progress PM revealed Nurse # Nurse Practitioner #1 right shoulder pain. A	n visit/communication note led Resident #68 had right and numbness. Resident #68 ht shoulder motion and right ne injection was given to the a note dated 11/23/18 at 9:34 in order was received to sident #68's right shoulder.						
	Review of a radiology revealed the results of shoulder x-ray reveal but there was narrow mild degenerative characteristics. Review of a progress 10:34 AM revealed P	report dated 11/24/18 of Resident #68's right ed the joint was in alignment ing of the joint space due to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345228	B. WING			C 1 2/07/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		12/07/2016		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	degenerative joint dino fracture or disloca orders were given. Review of a written stated 11/23/18 taker revealed Resident #back from his appoint He stated the driver slid right on the floor messed his arm up a cortisone shot in his Nursing he went down During an interview of Resident #68 stated the transportation vanot placed across hid did not call anyone for it took the driver a logical resident was not placed.	rom the x-ray were mild sease of the right shoulder, ation were noted, and no new statement by Resident #68 in by the Director of Nursing 68 stated he was coming attment in the wheelchair van. did not strap him in and he in Resident #68 stated he and they had just put a farm. He told the Director of at you on his right elbow. In 12/3/18 at 11:47 AM the fell about a month ago in an because the seat belt was in the stated the van driver or assistance at that time and ing time helping Resident #68 thair. The resident stated Van	F 68	·				
	correctly. He stated thim back to the facilithe incident to a staff remember who. He son him but there wer Resident #68 stated the fall. He stated he notified of his fall in tone assessed him who buring an interview of Resident #68 stated at the desk that he fason as he was brouncident. He further stated he fall has been stated at the desk that he fason as he was brouncident. He further stated him who has been stated at the desk that he fason as he was brouncident.	d the seatbelt on him the van driver then brought ty. He stated he mentioned f member but did not stated the facility did an x-ray re no breaks in his bones. The had shoulder pain after re did not know who was the van in the facility and no then he returned. The told the Unit Coordinator rell in the van on 11/20/18 as right into the facility after the stated he told the Unit me he had right shoulder and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345228	B. WING			C 2/07/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	the Unit Coordinator touch with the doctor he went back to his reperformed an assess stated about three dadone on his right arm stated he did not know x-ray were, and he detold about the fall in the right arm and should concluded before the cortisone shot in his could have been a rewas not sure if the patter fall or the shot. Review of a written so Nurse #1 who worke 11/20/18 on second secame to her at the mater apain pill. Resident and gave him a pain understood Resident generalized pain. The when the incident has he was propelling him without difficulty. During an interview of Nurse #1 stated during the was at her medicate shoulder was hurting him his pain medicate.	the fall in the van. He stated told him she had to get in an and the stated after he told her soom and no staff members are ment on him at that time. He says later he had an x-ray and shoulder. He further aw what the results of the id not remember who else he he van. He further stated his er were still a little sore. He wan accident he did have a right shoulder and the pain soult of the injection and he ain and soreness came from that the stated his ed with Resident #68 on shift revealed Resident #68 edication cart and asked for #68 then stated his ad the transporter fired as a seat belt. Nurse #1 at #68's shoulder was hurting pill. The nurse stated she	F6	84			

COMPLETED	
C 12/07/2018	
ORRECTION (X5) N SHOULD BE COMPLETION E APPROPRIATE DATE	
)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345228	B. WING _			C 12/07/2018		
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	•	12/0//2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 684	well. She stated she day it was, but later #68 came to the destance or ask a question he by either a phone caneeding assistance. returned he was gor about the concern a said anything about 11/23/18 the Director home questioning he anything about a vashe told her he had been fired but no fur given. She further sishe had heard about transport on 11/20/1 During an interview Driver #1 stated whi was approaching a syellow and he stated	orm her about anything as could not remember which that same week, Resident sk and said something about ad. Before she could respond ar attention was pulled away all or another staff member. She stated when she he and did not approach her gain. She stated he had not it to her since. She stated on r of Nursing called her at her if Resident #68 had said in incident. She further stated mentioned the van driver had ther information had been tated that was the first time tan incident with the van	F	684				
	Resident #68 was a and pulled into the concept Resident #68 slide of the wheelchair. He sawas sitting in the from it took about five to back into the wheelch #68 back up into the then tightened Resident Priver #1 then called and informed him of stated the Van Com	ew mirror and saw that bout to come out of his chair closest parking lot. He stated privards and partially out of stated the Responsible Party int seat at this time. He stated seven minutes to get him chair as he had to lift Resident is seat. He further stated he dent #68's seat belt. Van it the Van Company Owner what had happened. He pany Owner told him the seat een fastened more securely						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345228	B. WING			C 1 2/07/2018	
NAME OF PI	ROVIDER OR SUPPLIER	0.0220		STREET ADDRESS, CITY, STATE, ZIP CODI		12/0//2016	
RIDGEWOOD LIVING & REHAB CENTER				1624 HIGHLAND DRIVE WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 684	that time. Van Driver off Resident #68 at the anyone in the facility stated he had been the back into the seat if the wheelchair and Resimal way to the floor of the not have to contact of the contact of the seat of the terms of the terms of the chair across the seat of the chair across the seat of the chair across the seat of the chair since Resident #68 and the terms of the chair across the seat of the chair across the seat of the chair across the seat of the chair since Residuse of this legs. She Resident #68 if the words across the seat of the chair since Residuse of the legs. She Resident #68 if the words across the seat of the chair since Residuse of the words across the seat of the terms of the chair across the seat of the chair across the chair ac	#1 stated his employment at #1 stated he then dropped he facility and did not inform of the incident. He further rained how to lift the resident hey were partially out of the dent #68 did not fall all the evan which was why he did emergency medical services. In 12/3/18 at 12:40 PM onsible Party stated she had in #68 in the van to his She stated on 11/20/18 Van	F 6	,			
	#68 struggled for a w get him back in his c #68 attempted to hel in the chair by holdin pushing up while Var #68 by his pants and the chair. She stated him back up into the	while trying multiple ways to hair. She stated Resident p the driver get him back up g the chair's arm rests and n Driver #1 lifted Resident his legs to get him back into they had a hard time getting chair and it took about ten r to get Resident #68 back					

	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	345228	B. WING _			C 12/07/2018	
ROVIDER OR SUPPLIER)E		_
OD LIVING & REHAB CI	ENTER		1624 HIGHLAND DRIVE WASHINGTON, NC 27889			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION	N SHOULD BE APPROPRIA		I
		F 6	684			
wheelchair he placed stated the driver then facility. She further statem. She further statem days later to sign mentioned Resident of the van during tran Nursing. She stated to not aware of the fall volume of the fall volu	the seatbelts on him. She took the resident in to the ated she did not go in with ted she came to the facility a some paperwork and #68 had fallen on to the floor sportation to the Director of he Director of Nursing was when she told her about it. In 12/3/18 at 3:06 PM the stated he did remember on as being transported to or and Van Driver #1 had not Resident #68 had an ember did not clarify if the floor. He further stated the resident was hurt and sident had not sustained any redy placed the resident back at Van Company Owner. I from the wheelchair to the ation it was his expectation fately call 911 and not resident. He stated Van fly with him if the resident ne van or not. He further a incident he told the staff resident where he needed to fired. The Transport stated he did not inform the because the driver led him no injuries because of the red he did not believe the van cility either.					
	Continued From page into his wheelchair he placed stated the driver then facility. She further statement have a stated the driver then facility. She further statement have a stated the driver then facility. She further statement have a stated the driver to sign mentioned Resident for the van during tran Nursing. She stated the not aware of the fall without aware of the fall without aware of the fall with the statement have a statement have a statement for the driver in the driver said the resinjuries and had alread in his wheelchair. The stated if a resident fel floor during transports and the prover flower flower the floor of the stated because of the member to take the rego, and then he was a company Manager stated in the concluded driver informed the factoric flower flower the floor of the stated because of the member to take the rego, and then he was a company Manager stated in the concluded driver informed the factoric flower fl	CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 into his wheelchair. Once the driver got him in his wheelchair he placed the seatbelts on him. She stated the driver then took the resident in to the facility. She further stated she came to the facility a few days later to sign some paperwork and mentioned Resident #68 had fallen on to the floor of the van during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it. During an interview on 12/3/18 at 3:06 PM the Van Company Owner stated he did remember on 11/20/18 a resident was being transported to or from an appointment and Van Driver #1 had called him and said that Resident #68 had an incident. The staff member did not clarify if Resident #68 had hit the floor. He further stated he asked the driver if the resident was hurt and the driver said the resident had not sustained any injuries and had already placed the resident back in his wheelchair. The Van Company Owner stated if a resident fell from the wheelchair to the floor during transportation it was his expectation Van Driver #1 did not clarify with him if the resident touched the floor of the van or not. He further stated because of the incident he told the staff member to take the resident where he needed to go, and then he was fired. The Transport Company Manager stated he did not inform the facility of the incident because the driver led him to believe there were no injuries because of the incident. He concluded he did not believe the van driver informed the facility either. During an interview on 12/4/18 at 9:07 AM the	ROULDING SECONDER OR SUPPLIER ROULIVING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 11 into his wheelchair. Once the driver got him in his wheelchair he placed the seatbelts on him. She stated the driver then took the resident in to the facility. She further stated she did not go in with them. She further stated she did not go in with them. She further stated she did not go in with during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it. During an interview on 12/3/18 at 3:06 PM the Van Company Owner stated the did remember on 11/20/18 a resident was being transported to or from an appointment and Van Driver #1 had called him and said that Resident #88 had an incident. The staff member did not clarify if Resident #68 had hit the floor. He further stated he asked the driver if the resident had not sustained any injuries and had already placed the resident back in his wheelchair. The Van Company Owner stated if a resident fell from the wheelchair to the floor during transportation it was his expectation Van Driver #1 immediately call 911 and not attempt to move the resident. He stated Van Driver #1 did not clarify with him if the resident touched the floor of the van or not. He further stated because of the incident he told the staff member to take the resident where he needed to go, and then he was fired. The Transport Company Manager stated he did not inform the facility of the incident because the driver led him to believe there were no injuries because of the incident. He concluded he did not believe the van driver informed the facility either. During an interview on 12/4/18 at 9:07 AM the	ROWIDER OR SUPPLIER 345228 SITREETADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889 SUMMARY STATEMENT OF DEPICIENCIES EACH DEPICIENCY WISE TO EPECIENCIES (EACH DEPICIENCY WISE TO EPECIENCIES) (EACH ORDER CINE) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 into his wheelchair. Once the driver got him in his wheelchair he placed the seatbelts on him. She stated the driver then took the resident in to the facility. She further stated she did not go in with them. She further stated she did not go in with them. She further stated she did not go in with them. She further stated she came to the facility a few days later to sign some paperwork and mentioned Resident #68 had fallen on to the floor of the van during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it. During an interview on 12/3/18 at 3:06 PM the Van Company Owner stated he did remember on 11/20/18 a resident was being transported to or from an appointment and Van Driver #1 had called him and said that Resident #88 had an incident. The staff member did not clarify if Resident #88 had hit the floor. He further stated he asked the driver if the resident was burt and the driver said the resident was his expectation Van Driver #1 immediately call 911 and not attempt to move the resident. He stated Van Driver #1 immediately call 911 and not attempt to move the resident the stated Van Driver #1 immediately call 911 and not attempt to move the resident the stated Van Driver #1 immediately call 911 and not attempt to move the resident state of the resident there were no injuries because of the incident he concluded he did not believe the van driver informed the facility of the incident he couls the few floor inform the facility of the incident he couls the few floor inform the facility of the incident he cause the driver led him to believe there were no injuries because of the incident he couls when he was fired. The Transport Comp	A BUILDING COMPLETED 345228 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12/107/2018 SUMMARY STATEMENT OF DEFICIENCIES (ACACI DEPICIENCY MUST SEE PRECIDED BY FULL REGULATORY ON LISC DEPITIFING INFORMATION) COntinued From page 11 Into his wheelchair. Once the driver got him in his wheelchair he placed the seathbets on him. She stated the driver fine noto the resident to the facility. She further stated she did not go in with them. She further stated she amen to the facility a few days later to sign some paperwork and mentioned Resident #88 had allen on to the floor of the van during transportation to the Director of Nursing. She stated the Director of Nursing was not aware of the fall when she told her about it. During an interview on 12/3/18 at 3:08 PM the Van Company Owner stated he did not being was an appointment and Van Driver #1 had called him and said that Resident #88 had an incident. The staff member did not clarify if Resident #88 had an incident. The staff member did not clarify if Resident #88 had an incident. The staff member did not clarify if Name and had already placed the resident back in his wheelchair. The Van Company Owner stated he asked the driver file the resident back in his wheelchair. The Van Company Owner stated for resident was being transportation the driver said for resident was hire. He further stated the did not clarify with him if the resident touched the floor of the van or not. He further stated for the was fired. The Transport Company Manager stated he did not inform the facility of the incident because the driver led him to believe the rew ere no injuries because of the incident the facility of the incident because the driver led him to believe the rew ere no injuries because of the incident the facility of the incident because the driver led him to believe the rew ere no injuries because of the incident the facility of the incident because the driver led him to believe the rew even on injuries because of the incident the facility of the incident because the driver

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDI			(С
		345228	B. WING				07/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
DIDGEWO	OD LIVING & REHAB	CENTED		16	24 HIGHLAND DRIVE		
KIDGEWC	OD LIVING & REHAB	CENTER		W	ASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	some consent form there was an incide of Nursing stated shall the incident prior to bringing it to her att Responsible Party stransported back from the van driver has slide from his wan. She stated the they struggled to ge stated after learning Nurse #2 on 3 to 11 Nurse Practitioner his incident and the repfor Resident #68. A 11/23/18 and perfor returned negative for already identified do the right shoulder. Swere identified as a facility was made at During an interview Director of Nursing Resident #68 on 11 She further stated wo of the incident by Respectation the nurmore and report the Coordinator and she so because the nurincident.	Party was in the facility to sign is and happened to mention int on 11/20/18. The Director ine had not been informed of the Responsible Party ention at that time. The stated Resident #68 was being om his dentist appointment and to stop short and Resident wheelchair to the floor of the Responsible Party told her et him back into his chair. She gof the incident on 11/23/18 shift contacted the on call #1 and informed her of the port of shoulder and arm pain amobile x-ray was ordered on med on 11/24/18 which or any concerns besides the egenerative joint disease of She further stated no injuries aresult of the incident once the	F	584			
	to him on 11/23/18	after she spoke with the of Resident #68 and informed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345228	B. WING _			C 12/07/2018
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 13	F6	884		
	him of what the Res with her. He further notified if any situati of a resident that co safety of the resider During an interview Physician #1 stated well. He further state complained of right month prior to 11/13 his arm and shoulder reported to him as gresident #68. The peen on going prior and he had received shoulder on 11/13/1 after a referral for shoulder and concluded disease would not be a gradual disease phere were no other x-ray and concluded any injuries from an Physician concluded fall to the floor in the contacted emergence moved Resident #68 did not sustain and the provided fall to the floor in the contacted emergence moved Resident #68 did su 11/20/18 that Van Demergency medical	ponsible Party had shared stated he would expect to be on arose during transportation uld have compromised the at and it was not done. on 12/6/18 at 7:46 AM he knew Resident #68 very ed Resident #68 had shoulder pain for at least a /18 and denied any injury to er. The pain had been radually getting worse for onlysician stated the pain had to the incident on 11/20/18 at a cortisone shot in his right 8 from the orthopedic clinic moulder pain. He stated on 68 had a right shoulder x-ray and found only mild is ease as a significant finding. It mild degenerative joint to ecaused from a fall but was rocess. They physician stated substantial findings from the I Resident #68 did not sustain by alleged fall on 11/20/18. The dif Resident #68 did sustain a evan, Driver #1 should have by medical services and not is himself, however Resident				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345228	B. WING		C 12/07/2018
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	12/07/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684 F 689 SS=J	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio resident, family, phys the facility failed to se residents in the transp manufacturer's recom transported back to th appointment by the fac company (Resident # his wheelchair to the van during transport a Immediate Jeopardy Resident #68 was be appointment by the fac company. The reside according to manufac wheelchair during tran van floor without injur stopped at a stop ligh removed on 12/5/18 v	sident was assessed. ards/Supervision/Devices (2) . are that - sident environment remains azards as is possible; and sident receives adequate stance devices to prevent . is not met as evidenced ans, record review and ician and staff, interviews acure 1 of 1 sampled cortation van according to amendations while being are facility from a medical acility's contracted transport (68). Resident #68 slid from and was not injured. began on 11/20/18 when and transferred from an acility contracted transport and was not secured acture's instructions in the ansportation and slid to the y when Van Driver #1 t. Immediate jeopardy was when the facility provided acceptable allegation of	F 684		in a any, ny tion van elt rider tion van elt
	remains out of compli	ance at a lower scope and rm with the potential for		points. No damage or malfunction of the device was noted. Upon revisit on	ne

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345228	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343220	B: 11:110 _	CTREET ADDRESS CITY STATE 7ID CO	•	2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	יטב יי	
RIDGEWO	OD LIVING & REHA	B CENTER		1624 HIGHLAND DRIVE		
				WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From p	page 15	F 6	89		
				12/5/2018 it was observed the did not apply the devices ap Because of the above obser transport persons were again Owner on 12/5/2018. This to included a step by step dem	propriately. vation all n trained by raining	
	manufacturer's ins mechanism used company related to residents for trans. According to the volume locking straps were wheelchair to the avoided placing strear anchors for the behind the wheelch anchors and wheelch anchors traps belt was never to wheelchair's arm	on on 12/5/18 at 1:30 PM the structional video for the locking by the facility's contracted van to the correct securement of sportation was watched. Video, the rear wheelchair re to be anchored behind the inside of the wheels which tress on the anchor straps. The ne seat belt were to be placed chair inside the wheelchair strapels to avoid placing stress on and The video also stated the lap be placed around the rests and instead was to run rest and seat back of the		the owner of the company in along with return demonstra personnel will be allowed to transportation until they have re-in-service training. Additi wheelchair vehicle has been printed illustration of the dire other residents who were traduring that week of alleged i interviewed on 11/25/18 and other incidents or injuries relatively transportation. All incidents and accidents a reported to the administrator nursing(DON), or nursing su immediately via cell phone. The administrator, Director of (DON), or nursing superviso	n the van, tion. No provide e received onally, each n provided a ections. Nine ansferred incident were if reported no lated to are to be r, director of upervisor	
	2/12/15. His active neurogenic bladde kidney, metabolic and chronic kidne Review of Reside data set assessm was assessed as documented to ha Resident #68 was and locomotion or limited assistance had impairment to	admitted to the facility on e diagnoses included er, depression, calculus of the encephalopathy, repeated falls, y disease. Int #68's most recent minimum ent dated 10/19/18 revealed he cognitively intact. He was even o moods or behaviors. Independent with bed mobility in and off unit. He required with transfers. Resident #68 both lower extremities and ras a mobility device.		responsible for investigating incidents/accidents. Identification of other resider All residents that are transportation service aides a wheelchair lift van were prin-service education the transportation owner to prevent resident or any other was completed by or on Nov 2018. Upon revisit on 12/5/2 observed that the driver did devices appropriately. Becalabove observation all transp	nts: orted are at practice. All who operate ovided asportation eoccurrence resident. This vember 25, 2018 it was not apply the ause of the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY IPLETED
						С
		345228	B. WING _		12	2/07/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
DIDCEWO	OD LIVING & DELIAD	CENTED		1624 HIGHLAND DRIVE		
RIDGEWC	OOD LIVING & REHAB	CENTER		WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pa		F 6	were again trained by transp		
	Review of Resident #68's care plan dated 10/29/18 revealed he was at risk for falls related to poor balance, poor communication and comprehension, psychoactive drug use, and an			company owner on 12/5/201 training included hands on a return demonstration using t manufacturer □s instructions	pplication and he video and	
	unsteady gait. The safety through inter	goal was for staff to maximize ventions listed for Resident		personnel will be allowed to transportation until they have	provide	
I	resident to bed to p #68 and record and	ons included to assist the rovide care, observe Resident report all unsafe conditions		re-in-service training. All licensed staff members w contacted by the Director of		
	and situations, and assess for a change consciousness.	monitor his neuro status and e in his level of		Assistant Director of Nursing been made aware of any tre patterns involving any other	nds or	
	Review of a progres	ss note dated 11/20/18 at		which had not been previous No other residents were affe	sly reported. ected by this	
	documented Reside	the Unit Coordinator ent #68 returned from his with nothing written on the		alleged deficient practice. T completed on December 5, 2 Measures for system change	2018.	
		urther documentation was		Director of Nursing (DON) a Administrator were provided	nd	
		statement by Resident #68		the reporting and investigation	sident, visitor	
	revealed Resident #	en by the Director of Nursing #68 stated he was coming intment in the wheelchair van.		by Regional Director of Ope 12/5/2018. Administrator an Nursing in-serviced all depa	d Director of	
	He stated the driver	r did not strap him in and he or. Resident #68 stated he		manager staff currently work department managers provide	ing. The	
	cortisone shot in his	and they had just put a sarm. He told the Director of wn on his right elbow.		their staff currently working. were not present will be una to work until they have recei	ble to return	
	During an interview	on 12/3/18 at 11:47 AM		training. The training include Appropriate and immediate	ed 1) notification of	
	the transportation v	d he fell about a month ago in an because the seat belt was		any incident or knowledge o of any resident on or off prei	mise to the	
	did not notice he wa	im. Resident #68 stated he as not wearing a belt until he		director of nursing, administration unit coordinator. 2) Investig	ation of any	
		ner stated his Responsible		incident or knowledge of any the time of occurrence will b	e completed	

PRINTED: 01/22/2019 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						(C
		345228	B. WING _			12/	07/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
DIDCEWO	NOD LIVING & BELIAR C	ENTER		16	24 HIGHLAND DRIVE		
RIDGEWC	OOD LIVING & REHAB C	ENIER		W	ASHINGTON, NC 27889		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		:Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 689	Continued From pag	e 17	F 6	89			
		on. Resident #68 stated he			and/or unit coordinator. No facility staff	:	
		from the doctor's office and			who were absent or PRN (pro re nata)		
		stoplight and he slide			staff will be allowed to return to work u	ntil	
		neelchair and his bottom hit			this training/education has been		
		rests and his arms hit the			completed.		
	floor on both elbows	and he came to rest on his			Systematic change to prevent		
	back. He further state	ed then Van Driver #1 pulled			reoccurrence will be that all contracted		
	over into a parking lo	t. Resident #68 continued			transportation services will include		
	stating Van Driver #1	came into the back of the			language within the contract to contact	the	
	van with him and beg	gan to help him back into his			facility immediately if an incident occur	S.	
	chair. He stated the	van driver did not call anyone			This language includes any incident		
	for assistance at that			involving injury must be immediately			
		sident #68 back into the			called to the administrator or Director of		
		d the van driver then brought			Nursing. Owner of the company requi		
		ty. He stated he mentioned			a company provided cell phone be on		
	the incident to a staff				vehicle at all times. All staff members		
		stated the facility did an x-ray			report all incidents or accidents with or		
		e no breaks in his bones.			without injury to the nurse, administrate		
		he had shoulder pain after did not know who was			or Director of nursing. Upon receipt of		
		of his fall in and no one			this notification, alleged incident/accide will be fully investigated in accordance	511L	
	assessed him when				with the facility policy re: Incident/Accident	lent	
	assessed min when	ne returned.			Investigation. This new systematic cha		
	During an interview of	on 12/4/18 at 8:12 AM			was implemented by the Regional Dire		
	_	he told the Unit Coordinator			Operations on 12/05/18. Director of		
		ell in the van on 11/20/18 as			Nursing (DON), and Administrator were	e in	
	soon as he was brou	ght into the facility after the			serviced by Regional Director of		
		tated he told the Unit			Operations on 12/05/18. Administrator	-	
		me he had right shoulder and			and Director of Nursing in-serviced all		
	arm pain because of	the fall in the van.			department directors on 12/05/18. All		
					Department directors in-serviced all sta	aff	
	During an interview of	on 12/6/18 at 10:33 AM Van			currently working. No staff who was		
	Driver #1 stated follo	wing the appointment on			absent or PRN (pro re nata) staff will b	е	
	-	ed Resident #68 in the van			allowed to return to the floor and reside		
		elchair. He further stated he			care until this training/education has be	een	
		and lap belt slack on			completed. This education and		
		se he knew Resident #68 had			information will be included with all nev	V	
	-	Van Driver #1 did not want to			hires as part of the new hire training		
	have the belt tight ac	ross Resident #68's chest			process.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		l ,	_
		345228	B. WING			1	07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIDOEWO	NOD LIVING & DELLAD (CENTED		16	624 HIGHLAND DRIVE		
RIDGEWO	OOD LIVING & REHAB O	ENIER		W	ASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	approaching a stop I and he stated he did harder than a norma at the rear-view mirr was about to come of the closest parking I slide forward and pa Van Driver #1 stated no longer in the seal lower portion of Res on the front edge of with the seat belt an holding his upper bo outside of Resident come in contact with other body part of Resident #68's Resp front seat at this time. During an interview Resident #68's Resp traveled with Reside appointments twice, appointments were f dentist. She stated of forgot to place the seas she did not notice the Party stated the whe but the seatbelt strain and a stop light charthem stopped quick! the brakes causing I wheelchair. She state across the foot rests his legs out in front of the front passenger's but turned around w	Insporting the resident he was ight which turned to yellow I not press the brakes any I stop. At that point he looked or and saw that Resident #68 but of his chair and pulled into ot. He stated Resident #68 rtially out of the wheelchair. I Resident #68's buttocks was to fithe wheelchair and the ident #68's back was resting the seat of the wheelchair d lap belt across his chest dy on the chair. He stated the #68's feet and his ankles did the floor of the van, but no esident #68 touched the floor.	F	689	How corrective actions will be monitore Administrator, Director of Nursing or oth staff who have received training throug manufacturer training video on how to properly secure a resident in the wheelchair van shall conduct random visual audit of 5 resident transports per week x 1 month, then 5 times per mont times 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Administrator and Director of Nursing w monitor all incident and accidents of residents weekly, ensuring that appropriate investigation and interventi of any incidents that occur is performed. This information will be reported to QAI Modification of current plan and/or monitoring audits will continue at the discretion of the QAPI committee. Director of Nursing or Assistant director nursing will conduct random audits of nursing personnel, inquiring to the knowledge of accidents reported by residents, staff, and/or visitors which had not been communicated. This will be completed 5 times per week X 1 week and 5 times per month X 3 months and report to QAPI. Modification of current plan and/or monitoring audits will continuated the discretion of the QAPI committee. This will be monitored by the administrator. Credible allegation and elements were in place on 12/5/2018.	her h	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY
		345228	B. WING			1	C /07/2018
NAME OF P	ROVIDER OR SUPPLIER	1.0220	<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 12/	0772016
	10115211 011 001 1 2.2.1				HIGHLAND DRIVE		
RIDGEWO	OD LIVING & REHAB	CENTER			SHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ETATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	over into a parking I stated Van Driver #*Resident #68 and tr his chair since Residuse of his legs. She Resident #68 if he waid yes. Once the owneelchair he place stated Van Driver #*mistake and was quot odrive back to the passed, the driver to his boss. She stated driving back to the fais boss Resident #wheelchair. After the up and told them he fault for not placing She stated the driver the facility. She furth with them. She stated	told Van Driver #1 to pull of near them and he did. She I then got in the back with ied to help him get back up in dent #68 did not have much stated the driver asked vas okay and Resident #68	F	689			
	more about his shouside. She further stafew days later to sigmentioned Resident of the van during transuring. She stated not aware of the fall She stated she did rubirector of Nursing's the Responsible Parabout the fall since the Review of a written Director of Nursing of the Review of Nursing of	thad started complaining alder and arm on his right ated she came to the facility a n some paperwork and #68 had fallen on to the floor insportation to the Director of the Director of Nursing was when she told her about it. not remember what the sersponse was to the fall, and the ty had not heard anything then. Interview performed by the dated 11/23/18 revealed the performed a telephone					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345228	B. WING _			C 12/07/2018
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		12/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	Company Owner. The stated he was aware resident and driver. him the resident slip wheelchair because the strap. The Van Obirector of Nursing hot adjusting the stratthat the facility was a Company Owner did and stated the driver or hit his head. During an interview Van Company Owner did and stated the driver or hit his head. During an interview Van Company Owner did and stated the driver or hit his head. During an interview Van Company Owner did not company Owner did not company Owner did him and said incident. He stated the because a car in from Resident #68 slid had driver did not clarify floor. He further state manager that he had and lap belts tightly resident to slide half further stated the var which went over the that went across the	cility's contracted Van ne Van Company Owner e of an incident with the He reported the driver told ped to the front of the he (the driver) did not adjust company Owner told the ne terminated the driver for ap. The interview concluded not notified because the Van I not think the resident fell r said he did not hit the floor on 12/3/18 at 3:06 PM the er he did remember on was being transported to or t and Van Driver #1 had that Resident #68 had an /an Driver #1 hit the brakes nt of him had stopped and offred was being transported and offred way out of the chair. The if Resident #68 had hit the	F	S89		
	correct tightness, Re slid out of the wheel fault that the resider further stated he ask was hurt and the driv sustained any injurie resident back in his	esident #68 would not have chair and it was Driver #1's at slid out of the chair. He seed the driver if the resident over said the resident had not as and had already placed the wheelchair. He stated staffined on how to correctly apply				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345228	B. WING _			C 12/07/2018
	ROVIDER OR SUPPLIER OD LIVING & REHAB (ENTER		STREET ADDRESS, CITY, STATE, ZIP C 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		12/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	transported and he had not correctly apply the not excuse for not apfurther stated the variansport Service Missues identified with Owner stated he did incident because the there were no injuried concluded he did not informed the facility. Review of a written sthe Unit Coordinator appointments and the Resident #68 did sath driver getting fired water appointment, but he fall. She concluded the was with Resident #her. During an interview Unit Coordinator state appointments and the The Unit Coordinator state appointments and the Unit Coordinator state appointment and the Unit Coordinator state and the Un	esidents when they are being had no idea why the driver did he safety belts and there was aplying them appropriately. He is an ager and there were no in the van. The Van Company not inform the facility of the ediver led him to believe its because of the incident. He is because of the incident. He is believe the van driver either. Statement dated 11/23/18 by responsible for resident ansportation revealed y something about the van then he returned from the did not say anything about a the Responsible Party who 68 did not report the fall to	F	689		
	day it was, but later #68 came to the des Driver #1 getting fire contracted van comp	could not remember which that same week, Resident is and said something about d. She further stated the pany did not contact the em about the van incident				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345228	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343220	D. Willo	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	12/	/07/2018
NAME OF T	NOVIDER OR OUT FIER				HIGHLAND DRIVE		
RIDGEWO	OOD LIVING & REHAB	CENTER			SHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	van company. She expectation that the her of any incidents residents regardles injury or not. The U incident occurred at of his chair or sustas should immediately she was the primar company at the fact then notify the Direct Administrator. She did not inform her at 11/20/18 and the var paperwork from the inform her about an stated Resident #66 in the van to the ap Review of a written Nurse #1 who work 11/20/18 on second came to her at the rapain pill. Resident Responsible Party I because he did not clarified that Reside and gave him a pain understood Resider generalized pain. Twhen the incident he was propelling hwithout difficulty.	scussed the incident with the further stated it was her a van company would notify a during transportation of a fit the incident resulted in an init Coordinator stated if a van and a resident slid halfway out sined a fall, the van driver contact the facility. She stated y contact for the transport slity. She stated y contact for the transport slity. She stated she would ctor of Nursing and the further stated Resident #68 bout any pain or concerns on an driver gave her the doctor's office and did not by incidents in the van. She B's Responsible Party did ride pointment on 11/20/18. statement dated 11/23/18 by ed with Resident #68 on a shift revealed Resident #68 medication cart and asked for at #68 then stated his mad the transporter fired use a seat belt. Nurse #1 ent #68's shoulder was hurting an pill. The nurse stated she and occurred. The nurse stated imself in his wheelchair	F	689			
	to thanksgiving, Re	sident #68 came to her while					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		SURVEY LETED
		A. BOILD	NG		l ,	_
	345228	B. WING				07/2018
ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
OD LIVING & BEHAR	PENTED		162	24 HIGHLAND DRIVE		
OD LIVING & REHAD	CENTER		WA	ASHINGTON, NC 27889		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		x			(X5) COMPLETION DATE
shoulder was hurting him his pain medica he stated his Respo van driver fired. She conversation with Rereally?" Resident #6 did not have him seas She further stated she concern happened a casual conversation happened in the past report the conversatifacility or perform a was casually chattin happened that day, as needed pain medicause he did not day or recently, and himself around the froutine, she did not comment until the Da a statement from he During an interview Director of Nursing signature was an incider of Nursing stated she incident prior to bringing it to her atter Responsible Party stransported back fro and the van driver human with the state of the van driver human with the wan driver human with the state of the van driver human with the wan driver h	g. She stated she would get tion and while he was waiting insible Party had gotten the estated she then made esident #68 and stated, "oh, 8 then told her the van driver at belted during transport. The was not aware of when the and took it as him giving a because he spoke as if it st. She stated she did not ion to anyone else in the fall assessment because he g and did not say it had She stated she gave him his dication. She further stated verbalize it had happened that he had been self-propelling acility going about his daily notify anyone about the irector of Nursing requested r later that week. On 12/4/18 at 9:07 AM the stated on 11/23/18 Resident Party was in the facility to sign and happened to mention at on 11/20/18. The Director is had not been informed of the Responsible Party ention at that time. The tated Resident #68 was being in his dentist appointment and to stop short and Resident heelchair to the floor of the	F	689			
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page shoulder was hurting him his pain medica he stated his Respo van driver fired. She conversation with Re really?" Resident #6 did not have him sea She further stated sl concern happened a casual conversation happened in the pas report the conversat facility or perform a was casually chattin happened that day. as needed pain med because he did not day or recently, and himself around the froutine, she did not comment until the D a statement from he During an interview Director of Nursing s #68's Responsible F some consent forms there was an incider of Nursing stated sh the incident prior to bringing it to her atte Responsible Party s transported back fro and the van driver h #68 slide from his w van. She stated the they struggled to ge	CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 shoulder was hurting. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 then told her the van driver did not have him seat belted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he spoke as if it happened in the past. She stated she did not report the conversation to anyone else in the facility or perform a fall assessment because he was casually chatting and did not say it had happened that day. She stated she gave him his as needed pain medication. She further stated because he did not verbalize it had happened that day or recently, and he had been self-propelling himself around the facility going about his daily routine, she did not notify anyone about the comment until the Director of Nursing requested a statement from her later that week. During an interview on 12/4/18 at 9:07 AM the Director of Nursing stated on 11/23/18 Resident #68's Responsible Party was in the facility to sign some consent forms and happened to mention there was an incident on 11/20/18. The Director of Nursing stated she had not been informed of the incident prior to the Responsible Party bringing it to her attention at that time. The Responsible Party stated Resident #68 was being transported back from his dentist appointment and the van driver had to stop short and Resident #68 slide from his wheelchair to the floor of the van. She stated the Responsible Party told her they struggled to get him back into his chair. The	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 shoulder was hurting. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 then told her the van driver did not have him seat belted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he spoke as if it happened in the past. She stated she did not report the conversation to anyone else in the facility or perform a fall assessment because he was casually chatting and did not say it had happened that day. She stated she gave him his as needed pain medication. She further stated because he did not verbalize it had happened that day or recently, and he had been self-propelling himself around the facility going about this daily routine, she did not notify anyone about the comment until the Director of Nursing requested a statement from her later that week. During an interview on 12/4/18 at 9:07 AM the Director of Nursing stated on 11/23/18 Resident #68's Responsible Party was in the facility to sign some consent forms and happened to mention there was an incident on 11/20/18. The Director of Nursing stated she had not been informed of the incident prior to the Responsible Party bringing it to her attention at that time. The Responsible Party stated Resident #68 was being transported back from his dentist appointment and the van driver had to stop short and Resident #68 slide from his wheelchair to the floor of the van. She stated the Responsible Party told her they struggled to get him back into his chair. The	ROWLER OR SUPPLIER 345228 ROWLER OR SUPPLIER DO LIVING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES ELECAL DEPICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSO DENTIFYING INFORMATION) COntinued From page 23 shoulder was hurting. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 then told her the van driver did not have him seat betted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he was casually chatting and did not say it had happened that day. She stated she gave him his as needed pain medication. She further stated because he did not verbalize it had happened that day or recently, and he had been self-propelling himself around the facility oging about his daily routine, she did not notify anyone about the comment until the Director of Nursing requested a statement from her later that week. During an interview on 12/4/18 at 9:07 AM the Director of Nursing stated on 11/20/18. The Director of Nursing stated on 11/20/18. The Director of Nursing stated she had not been informed of the incident prior to the Responsible Party bringing it to her attention at that time. The Responsible Party stated Resident #88 was being transported back from his denist appointment and the van driver had to stop short and Resident #88 was being transported back from his denist appointment and the van driver had to stop short and Resident #88 was being transported back from his denist appointment and the van driver had to stop short and Resident #88 was being transported back from his denist appointment and the van driver had to stop short and Resident #88 was being transported back from his denist appointment and the van driver had to stop short and Resident #88 was being transported back from his denist appointment and the van driver had to stop s	A BUILDING 345228 345228 345228 3 WING STREET ADDRESS, CITY, STATE, ZIP CODE 1224 HIGHLAND DRIVE WASHINGTON, NC 27889 SUMMARY STATEMENT OF DEFICIENCIES (EGAH OFFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 Shoulder was hurfing. She stated she would get him his pain medication and while he was waiting he stated his Responsible Party had gotten the van driver fired. She stated she then made conversation with Resident #68 and stated, "oh, really?" Resident #68 than told her the van driver fid not have him seat belted during transport. She further stated she was not aware of when the concern happened and took it as him giving a casual conversation because he spoke as if it happened in the past. She stated she gave him his as needed pain medication. She further stated because he did not report the conversation because he spoke as if any or recently, and he had been self-propelling himself around the facility or perform a fall assessment because he was casually chatting and did not say it had happened that day or recently, and he had been self-propelling himself around the facility oging about his daily routine, she did not notify anyone about the comment until the Director of Nursing stated on 11/23/18 Resident #68 sponsible Party was in the facility to sign some consent forms and happened to mention there was an incident on 11/20/18. The Director of Nursing stated on 11/23/18 Resident #68 was being transported back from his dentist appointment and the van driver had to stop short and Resident #68 slide from his wheelchair to the floor of the van. She stated the Responsible Party told her they struggled to get him back into his chair. The

PRINTED: 01/22/2019 FORM APPROVED OMB NO. 0938-0391

O E I TI E I T	OT OIL MEDIO, ILL G	· · · · · · · · · · · · · · · · · · ·					7. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_] ,	c
		345228	B. WING			1	07/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	***************************************
				10	624 HIGHLAND DRIVE		
RIDGEWO	OD LIVING & REHAB C	ENTER		٧	VASHINGTON, NC 27889		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
F 689	Continued From page	e 24	F	689			
	further information at	oout the incident. The					
	Director of Nursing st	tated she then called the					
	contracted transporta	ation company and spoke					
	with the Van Compar	ny Owner who told her that					
	Resident #68 slipped						
		Driver #1 did not adjust the					
	_ ·	ited she was told by the Van					
		did not notify the facility					
		nink the resident had fallen,					
		head. She further stated if					
	-	nt during transport of a esident had a risk for injury					
		did not appropriately secure					
		lly if it warranted the van					
		vas her expectation the van					
	_	f the incident. She further					
		ent on 11/20/18 it was her					
		er the van driver or the owner					
	of the company would	d have notified the facility of					
	the incident. She stat	ed on 11/21/18 a routine					
		s performed on Resident #68					
		concerns were identified at					
		after learning of the incident					
	on 11/23/18 Nurse #2						
		Nurse Practitioner #1 and					
		ncident and the report of					
		in for Resident #68. A mobile 11/23/18 and performed on					
	11/24/18 which return	•					
	concerns besides the						
		sease of the right shoulder.					
		injuries were identified as a					
		once the facility was made					
		The Director of Nursing					
		ed any further transportation					
		edical Transport company					
	on 11/23/18 while the						
		s with all their staff. The					

suspension was lifted on 11/26/18. She stated

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION B	(X3) DATE S	ETED
		345228	B. WING		12/0	7/2018
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	1 12/0	772010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	During an interview Director of Nursing Resident #68 on 17 She further stated of the incident by Respectation the nurmore and report the Coordinator and she so because the nurincident. During an interview Transport Service I incident on 11/20/1 used to transport Reconcerns with any the seat belts and the concluded the iterror by Van Driver Review of a progrep M revealed Nurse Practitioner is the seat belts of the concerns with any the seat belts and the concluded the iterror by Van Driver Review of a progrep M revealed Nurse Practitioner is the seat belts of the concerns with any the seat belts and the concluded the iterror by Van Driver Review of a progrep PM revealed Nurse Practitioner is the seat belts of the concerns with any the seat belts and the concluded the iterror by Van Driver PM revealed Nurse Practitioner is the concerns with any the seat belts and the concluded the iterror by Van Driver PM revealed Nurse Practitioner is the concerns with any the seat belts and the concluded the iterror by Van Driver PM revealed Nurse Practitioner is the concerns with any the concerns w	ortation were initiated on or on 12/4/18 at 11:32 AM the stated Nurse #1 worked with /20/18 during the second shift. when Nurse #1 was informed resident #68 it was her se would have investigated e concern to her Unit re did not believe the nurse did re did not think it was an on 12/3/18 at 3:41 PM the Manager stated following the 8 he serviced the van that was resident #68 and identified no of the safety features including wheelchair anchoring straps. Incident was a result of user #1.	F 68			
	obtain an x-ray of Review of a radiolor revealed Resident in alignment but the space due to mild owere no shoulder findislocations observed. Review of a progre 10:34 AM revealed.	An order was received to Resident #68's right shoulder. gy report dated 11/24/18 #68's right shoulder's joint was ere was narrowing of the joint degenerative changes. There ractures, separations, or red. ss note dated 11/24/18 at Physician #1 was in the facility dent #68's right shoulder x-ray				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345228	B. WING _			C 12/07/2018
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		12.01.2010
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 689	Continued From page	e 26	F	689		
	degenerative joint dis no fracture or disloca orders were given.	sease of the right shoulder, tion were noted, and no new				
	Physician #1 stated h well. He further state complained of right s	ne knew Resident #68 very d Resident #68 had houlder pain for at least a				
	his arm and shoulder reported to him as gr Resident #68. The ph	The pain had been adually getting worse for hysician stated the pain had				
	and he had received shoulder on 11/13/18 after a referral for sho	a cortisone shot in his right from the orthopedic clinic oulder pain. He stated on				
	which he reviewed and degenerative joint dis The physician stated	nd found only mild sease as a significant finding. mild degenerative joint				
	a gradual disease pro there were no other s x-ray and concluded	ocess. The physician stated substantial findings from the Resident #68 did not sustain				
	Administrator stated to him on 11/23/18 at	the Director of Nursing came fter she spoke with the				
	him of what the Resp with her. He stated h					
	week and discovered concerns about their	no residents had any transportation that week. en stated he suspended				
	transportation with th	e contracted company on ntinued his contact with the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345228	B. WING			C 2/07/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		2/0//2018	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	the documentation of members at the conticompany. This was of transportation was restated he watched the appropriate way to set transportation van abute Director of Nursin had not been in service secure a resident into monitoring the transported to facility strollow up on stateme Resident #68 made to and 11/21/18. He furto be notified if any stransportation of a recompromised the saft During an interview of Director of Nursing sherself had not been appropriate way to set transportation van. Staff had received and following up on resident been secured appreporting such concept performing an interview of Unit Coordinator who transportation on 11/2 been in serviced on the resident in a transportation on 11/2 been in serviced on the resident in a transportation on staff mediate was the only staff mediate was the only staff mediate was the serviced on the	any to coordinate getting all fithe in serviced staff racted transportation completed on 11/25/18 and esumed on 11/26/18. He is training video about the ecure a resident into a cout a year ago. He stated ag and the Unit Coordinator coed on how to appropriately of a transportation van prior to cortation starting 11/26/18. The were no in services aff regarding the need to ents such as the ones to staff members on 11/20/18 and the traited he would expect expect ituation arose during sident that could have fety of the resident. The 12/4/18 at 3:45 PM the extended to ents stated the Unit Manager and in serviced about the excure a resident in the he concluded none of her ye in services related to ent statements that they had propriately in a van or about erns to their supervisors and sement. The 12/5/18 at 8:52 AM the committed the 26/18 stated she had not now to appropriately secure a retation van. She stated she	F6	89			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345228	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	<u> </u>	12/07/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	the resident was obsto to the best of her known to the best of her known to the best of her known to transportation composited he had been to transport resident secure residents for training took place of the whole the outside of the whole the straps were then secured to wrap are rear anchors for the secured on the outside and wheelchair rear belt straps to wrap a placing stress on the training an interview of the training an interview of the training took place of the training and the training took place of the training took place of the training and the training took place of the training	aps were placed properly, and served to be secure in the van owledge. on 12/5/18 at 2:20 PM Van had worked for the any for 8 years. He further in serviced on the correct way in vans including how to transport. He stated this in 11/25/18. on 12/5/18 at 2:36 PM Van wed securing the transportation van. Van rear wheelchair anchors on heelchair wheels. The anchor cured to the wheelchair frame owrap around the wheels of oth sides placing stress on er #2 then placed the seat trator. The lap belt was observed to be de of the wheelchair wheels anchors. This caused the lap round the wheelchair wheels anchors. This caused the lap round the wheelchair wheels e belt straps. on 12/5/18 at 2:40 PM Van had finished securing the wan as he would secure a tation. Upon observing the und the left arm rest, Van seat belt should not be and instead placed through in the arm rests and the seat	F 6	89		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345228	B. WING		C 12/07/2018	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 689	be moved to the corwere not correct as a across the wheelchar he did not adjust the correctly he stated hwas for demonstration. During an interview Administrator stated Van Driver #2 would correct way to secur transportation van a instructions. The Administrator wijeopardy on 12/5/18 1:52 PM the facility predible allegation of jeopardy removal: "Free from Accident. Corrective action that Tag 689 Resident #68 current Rehabilitation Center alleged incident 11/2 and allegedly falling Contract Transportation compall transportation compall transportation drive wheelchair lift van to connection of belt de 11/25/2018. Provide	#2 stated the anchors could rect positions and that they the straps should not wrap air. When asked the reason a seat belts and anchors he did not have a reason as it con. on 12/5/18 at 2:50 PM the lit was his expectation that have demonstrated the earesident in the according to manufacturer's least notified of the immediate at 12:30 PM. On 12/6/18 at corovided the following of compliance for immediate at 12:30 PM. On 12/6/18 at corovided the following for manufacturer's least notified at Ridgewood are and has no injury related to 20/2018 of not being secured from wheelchair while in a tion company transport the company, of the Contract loany has in-serviced 100% of overs who operate the ensure appropriate	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(0
		345228	B. WING _			12/	07/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DIDOEWG		SENTED		16	24 HIGHLAND DRIVE		
RIDGEWO	OOD LIVING & REHAB C	ENIER		W	ASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	review of key points. of the device was no 12/5/2018 it was obs apply the devices ap above observation al again trained by Own training included a st the owner of the comreturn demonstration allowed to provide traceived re-in-service wheelchair vehicle hallowed to provide traceived re-in-service wheelchair vehicle hallowed to provide traceived re-in-service wheelchair vehicle hallowed to provide traceived re-in-service incident were intervied reported no other incident were intervied reported no other incidents and accurate administrator, dir nursing supervisor in The administrator, Donursing supervisor winvestigating any incidentification of other All residents that are this alleged deficient service aides who opwere provided in-ser transportation compareoccurrence to this resident. This was conserved that the dri appropriately. Becautall transport persons transportation comparence to the propriately. Becautall transport persons transportation comparence to compare the propriately of the propriately. Becautall transport persons transportation comparence to the propriately of the propriately of the propriately. Becautall transport persons transportation comparence to the propriately of the p	and verbal instruction and No damage or malfunction ted. Upon revisit on served that the driver did not propriately. Because of the ll transport persons were her on 12/5/2018. This seep by step demonstration by apany in the van, along with her No personnel will be ansportation until they have the training. Additionally, each as been provided a printed ections. Nine other residents diduring that week of alleged ewed on 11/25/18 and eidents or injuries related to ector of nursing (DON), or annediately via cell phone. In irrector of Nursing (DON), or indentification in the responsible for idents/accidents. It ransported are at risk for practice. All transportation in the prevent resident or any other completed by or on November sit on 12/5/2018 it was ver did not apply the devices use of the above observation were again trained by any owner on 12/5/2018. It hands on application and	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345228	B. WING			1	07/2018		
	ROVIDER OR SUPPLIER	ENTER		16	REET ADDRESS, CITY, STATE, ZIP CODE 24 HIGHLAND DRIVE (ASHINGTON, NC 27889	1 12/	0772010		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689		ctions. No personnel will be	F	889					
	allowed to provide tra received re-in-service All licensed staff mem Director of nursing and Nursing and had not I trends or patterns inviving which had not been presidents were affected practice. This was concern to the provided in-services and provided in-services	Insportation until they have a training. Inbers were contacted by the ad Assistant Director of the training any other resident reviously reported. No other ad by this alleged deficient tompleted on December 5, change: OON) and Administrator were of the reporting and acident reported by staff,							
	Appropriate and imme incident or knowledge resident on or off prer nursing, administrator Investigation of any ir incident at the time of completed by the administrator or unit completed and or unit completed in the immediate of the incident at the time of completed by the administration and/or unit completed in the incident and	ediate notification of any e of any incident of any mise to the director of r and/or unit coordinator. 2) ncident or knowledge of any cocurrence will be ninistrator, director of pordinator. No facility staff PRN (pro re nata) staff will o work until this							
	be that all contracted include language with the facility immediate	prevent reoccurrence will transportation services will hin the contract to contact by if an incident occurs. This y incident involving injury							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345228	B. WING _		,	C 1 2/07/2018	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1624 HIGHLAND DRIVE WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	or Director of Nursing requires a company the vehicle at all time report all incidents or injury to the nurse, a nursing. Upon receip incident/accident will accordance with the Incident/Accident Invasystematic change with Regional Director Optimizetor of Nursing (Inversional Director of Nursing in directors on 12/05/18 in-serviced all staff of who was absent or allowed to return to tuntil this training/edu. This education and in with all new hires as process. How corrective action Administrator, Director who have received to training video on how resident in the wheel random visual audit of week x 1 month, the months and report to current plan and/or mat the discretion of the Administrator and Director all incident and accident in the discretion of the Administrator and Director all incident and accident in the discretion of the Administrator and Director all incident and accident and accident and accident and accident accident and accident accident and accident accident and accident accident accident and accident a	called to the administrator g. Owner of the company provided cell phone be on es. All staff members will accidents with or without dministrator or Director of ot of this notification, alleged be fully investigated in facility policy re: restigation. This new ras implemented by the perations on 12/05/18. DON), and Administrator Regional Director of 18. Administrator and reserviced all department 8. All Department directors currently working. No staff ren (pro re nata) staff will be the floor and resident care cation has been completed. Information will be included part of the new hire training through manufacturer or to properly secure a chair van shall conduct of 5 resident transports per in 5 times per month times 3 of QAPI. Modification of conitoring audits will continue the QAPI committee. The continue of the continue of the continue of the continue of the committee. The continue of the continue of the continue of the continue of the committee. The continue of the continue	F6	89			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345228	B. WING		C 12/07/2018
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	12/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 689	QAPI. Modification of monitoring audits will the QAPI committee. Assistant director of raudits of nursing persknowledge of accider staff, and/or visitors v communicated. This per week X 1 week a months and report to current plan and/or mat the discretion of th This will be monitored Credible allegation and na 12/5/2018."	rmation will be reported to current plan and/or continue at the discretion of Director of Nursing or nursing will conduct random connel, inquiring to the ats reported by residents, which have not been will be completed 5 times and 5 times per month X 3 QAPI. Modification of nonitoring audits will continue	F 68	39	
F 809 SS=E	removal was validate which removed the In 12/5/18, as evidence in-service record reviservices included inforesident statements at the facility, need for a reported incidents, an appropriately secure Frequency of Meals/S CFR(s): 483.60(f)(1)-\$483.60(f)(1) Each refacility must provide a regular times compart the community or in a needs, preferences, in	d on 12/6/18 at 3:09 PM, nmediate Jeopardy on d by staff interviews, ews, and observation. The in ormation on, following up on about accidents in and out of assessment following any nd training on how to a resident for transport. Snacks at Bedtime (3)	F 80	09	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED	
		345228	B. WING			C 2/07/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/01/2010	
DIDOEWO	OD LIVING & DELIAD O	ENTED		1624 HIGHLAND DRIVE			
RIDGEWO	OD LIVING & REHAB C	ENIER		WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 809	Continued From page	e 34	F 80	09			
	breakfast the followin nourishing snack is shours may elapse be meal and breakfast the group agrees to this in §483.60(f)(3) Suitable meals and snacks meals meals and snacks me	e, nourishing alternative ust be provided to residents on-traditional times or outside ervice times, consistent with are.					
	by: Based on observation	ns and resident and staff		Corrective action for residents			
	snack to the resident	failed to offer a substantial s when the time between the eakfast was greater than 14 included:		be affected by the alleged defice practice: There were no specific residen during survey process. The Di Manager (DM) and Administrate	ts identified etary		
	12/5/18 at 3:28 PM s delivered to each win She said the 3 snack cream cookies, orang vanilla wafers, choco cookies and graham no beverages were ir staff had water or juic the residents. The D some residents did re assigned individually residents. An observation of the on 12/5/18 from 7:45 two snack carts were	with the dietary manager on the stated snacks were greenly evening at 8:00 PM. It is trays included oatmeal greenly peanut butter nabs, late chip cookies, sugar crackers. She added that included because the nursing the on the medication cart for itetary Manager also stated exceived specific snacks to certain particular. The bedtime snacks delivered PM until 9:30 PM revealed delivered with one cart for ing stations in the facility.		with the Resident Council on 1. 1/02/19, to discuss with them a meal times for breakfast and emeals, in order to provide meal than 14 hours between meal times and the resident Council agreed on more for breakfast to begin at 7am a meal to begin at 5pm. Identification of other residents potential to be affected by the adeficient practice: Current facility residents have to potential to be affected by the adeficient practice of more than between the evening meal and meal, without being offered a sinack.	a change in vening ls no more mes. The eal times nd evening having the alleged the alleged 14 hours breakfast		

<u> </u>	OT OIT MEDIONITE OF	WEDIO/ ND CEITTIOEC				<u> </u>	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345228	B. WING			12/	07/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIDGEWO	OD LIVING & REHAB C	ENTED		10	624 HIGHLAND DRIVE		
KIDGEWO	OD LIVING & KEHAB CI	ENTER		W	ASHINGTON, NC 27889		
(X4) ID PREFIX TAG	(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)		(X5) COMPLETION DATE
F 809	crackers with 2 crack of fruit juice. The sec oatmeal cookies, 1 capackages of graham contained additional sfor specific residents. snacks were observed cracker with 2 slices of individually labeled singraham crackers with There was also one stoom to contained pureed me pureed vegetables. It resident. This Styroff refrigerator to hold "in hungry during the night of the pure o	les nabs, 5 package graham ers in each and 8 containers cond cart contained: 5 arton of Low Fat milk and 5 crackers. This cart also snacks which were labeled Three of these labeled d to be 2 packages saltine cheese. Two other nacks included a package of a container of fruit juice. Styrofoam container that at, creamed potatoes, and was labeled for a specific coam container was put in the a case this resident gets ht." M Nursing Assistant (NA) #1 e stated she knocked on the asked the residents if they M NA #2 was interviewed. gins to pass out snacks d 9:00 PM. She said she is labeled for specific the cart of snacks back to here the remainder of the case a resident specific ents who had their name on		809	Measures implemented to ensure that alleged deficient practice does not record. The Dietary Manager (DM) and Administrator met with the Resident Council on 12/28/18 and 1/02/19, to discuss with them a change in meal times for breakfast and evening meals, order to provide meals no more than 14 hours between meal times. The Resid Council agreed on meal times for breakfast to begin at 7am and evening meal to begin at 5pm. The Dietary Manager (DM) adjusted meals to begin at 5pm. The Dietary Manager (DM) adjusted meals on 12/29/18, for breakfast and evening meal so there will be no more than 14 hours between meal times. The DM and/or Director of Nursing or Staff Development Coordinator (SDC) completed education on 1/02/19, for the dietary staff and nursing staff regarding the change in meal times. Monitoring to assure continued compliance: The Dietary Manager and/or Administrational will observe and document meal times evening and breakfast meals 3 times at week for 4 weeks, then twice a week for months, to validate that meal times does not exceed more than 14 hours between evening and breakfast meals. The DM will review audits/documentation to identify patterns/trends and will adjuplan as necessary. The DM will review plan in monthly QAPI and audits will	in 4 ent neal ne for or 2 es en on st	
		the rest of the snacks were ne nursing station "in case ething".			continue at the discretion of the QAPI committee.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345228	B. WING		C 12/07/2018	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD LIVING & REHAB CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RECTIVE ACTION SHOULD BE COMPLETION RENCED TO THE APPROPRIATE	
F 809	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 809			