| DEPART                                                                                                                  | MENT OF HEALTH AN                                                                                                                              | ID HUMAN SERVICES                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                          | FORM APPROVED     |
|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| CENTER                                                                                                                  | S FOR MEDICARE &                                                                                                                               | MEDICAID SERVICES                                                                                                                                                                                                    |                     |                                                                                                                                                                                                                                                                                                                          | OMB NO. 0938-0391 |
| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER: |                                                                                                                                                |                                                                                                                                                                                                                      |                     | (X3) DATE SURVEY<br>COMPLETED<br>C                                                                                                                                                                                                                                                                                       |                   |
|                                                                                                                         |                                                                                                                                                | 345228                                                                                                                                                                                                               | B. WING             |                                                                                                                                                                                                                                                                                                                          | 01/17/2025        |
| NAME OF PI                                                                                                              | ROVIDER OR SUPPLIER                                                                                                                            |                                                                                                                                                                                                                      | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                     |                   |
| RIDGEWO                                                                                                                 | OOD LIVING & REHAB CI                                                                                                                          | ENTER                                                                                                                                                                                                                | 1                   | 624 HIGHLAND DRIVE                                                                                                                                                                                                                                                                                                       |                   |
|                                                                                                                         |                                                                                                                                                |                                                                                                                                                                                                                      | v                   | VASHINGTON, NC 27889                                                                                                                                                                                                                                                                                                     |                   |
| (X4) ID<br>PREFIX<br>TAG                                                                                                | (EACH DEFICIENC                                                                                                                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY)                                                                                                                                                                                                    |                   |
| F 000                                                                                                                   | INITIAL COMMENTS                                                                                                                               |                                                                                                                                                                                                                      | F 000               |                                                                                                                                                                                                                                                                                                                          |                   |
|                                                                                                                         | 1/16/2025 to 1/17/202                                                                                                                          | ation was conducted from<br>25. Event ID # WITW11. The<br>e investigated NC00225825,<br>C00224610.                                                                                                                   |                     |                                                                                                                                                                                                                                                                                                                          |                   |
|                                                                                                                         | One of the nine allega<br>deficiency.                                                                                                          | ations resulted in a                                                                                                                                                                                                 |                     |                                                                                                                                                                                                                                                                                                                          |                   |
| F 925<br>SS=E                                                                                                           |                                                                                                                                                | est Control Program                                                                                                                                                                                                  | F 925               |                                                                                                                                                                                                                                                                                                                          | 2/13/25           |
|                                                                                                                         | program so that the far rodents.                                                                                                               | n an effective pest control<br>acility is free of pests and<br>is not met as evidenced                                                                                                                               |                     |                                                                                                                                                                                                                                                                                                                          |                   |
|                                                                                                                         | Based on observatio<br>interviews, physician<br>supervisor interview t<br>an effective pest cont<br>German cockroaches<br>Resident #4, Resider | ns, staff interviews, resident<br>interview, and a pest control<br>he facility failed to maintain<br>rol program that was free of<br>for 4 (Resident #3,<br>at #5, and Resident #6) of 4<br>r pest control services. |                     | <ul> <li>For residents affected by the deficient practice:</li> <li>Upon visual sighting on 1/16/25, immediate professional treatment was provided for:</li> <li>ic Room 305 (Residents #3 and #4)</li> <li>ic Room 315 (Resident #5)</li> <li>ic Room 306 (Resident #6)</li> <li>Follow-up full cleanout and</li> </ul> |                   |
|                                                                                                                         | that both interior and services, including co                                                                                                  | iated on 6/27/2022 indicated                                                                                                                                                                                         |                     | <ul> <li>professional pest control treatment</li> <li>completed for:</li> <li>¿ Room 305 on 1/28/25</li> <li>¿ Rooms 315 and 306 on 1/20/25</li> </ul>                                                                                                                                                                   |                   |
|                                                                                                                         | facility. Pest control s<br>so all wings and facili<br>least once per quarte                                                                   | ervices rotated accordingly,<br>ty rooms were serviced at<br>r.                                                                                                                                                      |                     | For identifying other residents with<br>potential to be affected:<br>- On 1/17/25, a complete facility-wic<br>visual inspection, including all resident                                                                                                                                                                  |                   |
|                                                                                                                         | on 12/11/2024 reveal                                                                                                                           | pest control contract signed<br>ed that a "Roach Cleanout"<br>poms 409, 413, 415, 417,                                                                                                                               |                     | rooms, was conducted with no addition<br>areas identified as requiring treatment<br>Systemic changes to prevent recurrent                                                                                                                                                                                                |                   |
| ABORATORY                                                                                                               | DIRECTOR'S OR PROVIDER!                                                                                                                        | SUPPLIER REPRESENTATIVE'S SIGNATUR                                                                                                                                                                                   |                     | TITLE                                                                                                                                                                                                                                                                                                                    | (X6) DATE         |
|                                                                                                                         | cally Signed                                                                                                                                   |                                                                                                                                                                                                                      | -                   |                                                                                                                                                                                                                                                                                                                          | 01/30/2025        |
|                                                                                                                         |                                                                                                                                                |                                                                                                                                                                                                                      |                     |                                                                                                                                                                                                                                                                                                                          | 01,00,2020        |

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.

PRINTED: 02/04/2025

|                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MEDICAID SERVICES                                                                     |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | OMB NO. 093                                                                                                                                         |                         |  |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--|
| STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           NND PLAN OF CORRECTION         IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPL<br>A. BUILDING                                                           | (X3) DATE SURVE<br>COMPLETED | Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                     |                         |  |
|                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                              | С                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                     |                         |  |
|                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 345228                                                                                | B. WING                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/17/202                                                                                                                                           | 25                      |  |
| NAME OF P                                                                                                                     | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       | :                            | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                     |                         |  |
| RIDGEWOOD LIVING & REHAB CENTER                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                              | 1624 HIGHLAND DRIVE<br>WASHINGTON, NC 27889                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                         |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                                      | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OULD BE COMP                                                                                                                                        | (X5)<br>PLETION<br>DATE |  |
| F 925                                                                                                                         | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | e 1                                                                                   | F 925                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                     |                         |  |
|                                                                                                                               | Continued From page 1<br>Documentation on an unsigned pest control<br>contract revealed a "Roach Cleanout" was being<br>considered for Rooms 301, 302, 303, 305, 307,<br>and 317.<br>a. An observation was conducted of Resident #4<br>in Room 305 and Housekeeper #1 on 1/16/2025<br>at 1:29 PM. Resident #4 was observed lying on<br>her back in bed with the head of her bed slightly<br>elevated. Resident #4 was still finishing her lunch<br>meal which sat on a bedside table in front of her.<br>A cockroach crawled out from under the mattress<br>and started crawling across the sheet toward the<br>head of Resident #4. Resident #4 became<br>alarmed and spoke out requesting for the<br>cockroach to be removed. Housekeeper #1, who<br>was in the doorway of the room, came into the<br>room. Housekeeper #1 responded and flicked the<br>cockroach off the bed to the floor. Housekeeper<br>#1 then left the room.<br>Housekeeper #1 was interviewed on 1/16/2025 at<br>1:29 PM. Housekeeper #1 stated she just flicked<br>the cockroaches off the bed when she saw them.<br>Housekeeper #1 revealed she often saw<br>cockroaches in the resident rooms while<br>cleaning. Housekeeper #1 further revealed she<br>did not tell anyone about the cockroaches<br>because she was "sure they knew."<br>Resident #4 was interviewed on 1/16/2024 at<br>1:31 PM. Resident #4 stated cockroaches<br>frequently crawled in her bed, on the walls, and<br>around the television. She said everyone knew<br>they were there. |                                                                                       |                              | <ul> <li>Implemented a new "Enviror<br/>Safety Checklist" protocol:</li> <li>Housekeeping staff will comproom inspections using standardic<br/>checklist</li> <li>Maintenance staff will perform<br/>detailed inspections of resident c</li> <li>Nursing staff and housekeep<br/>will be trained by the Staff Develor<br/>Coordinator or designee to immereport signs of pests to maintena<br/>supervisor or manager on duty, the<br/>be completed by 2/5/2025</li> <li>Maintenance supervisor or dowill document and coordinate restreported issues</li> <li>Findings and actions are doo<br/>in the electronic work order syste<br/>Maintenance supervisor or designed</li> </ul> | blete<br>zed<br>m weekly<br>are areas<br>bing staff<br>opment<br>diately<br>nce<br>raining to<br>esignee<br>ponse to<br>cumented<br>m by the<br>nee |                         |  |
|                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                              | recur:<br>The Maintenance Director or des<br>complete random weekly audits of<br>resident rooms for 12 consecutive<br>using a comprehensive room insp<br>monitoring checklist to ensure roof<br>free of pests and proper prevention<br>measures are in place.<br>The QAPI team will review:<br>- Completion of daily houseker<br>room inspection checklists<br>- Documentation of weekly<br>maintenance inspections<br>- Pest sighting reports and res                                                                                                                                                                                                                              | ignee will<br>of 5<br>e weeks<br>oection<br>oms are<br>on                                                                                           |                         |  |

Facility ID: 923432

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | MEDICAID SERVICES                                                                                                                                                                                                  |                              |                                                                                                                                                                                                                          | OMB NO. 093                          |                         |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------|
| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIP<br>A. BUILDING                                                                                                                                                                                         | (X3) DATE SURVE<br>COMPLETED |                                                                                                                                                                                                                          |                                      |                         |
|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 345228                                                                                                                                                                                                             | B. WING                      |                                                                                                                                                                                                                          | C<br>01/17/20                        | 25                      |
| NAME OF P                                                                    | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                    |                              | STREET ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                     | E                                    |                         |
| RIDGEWOOD LIVING & REHAB CENTER                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                    |                              | 1624 HIGHLAND DRIVE<br>WASHINGTON, NC 27889                                                                                                                                                                              |                                      |                         |
| (X4) ID<br>PREFIX<br>TAG                                                     | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                                                                              | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)                                                                                                                               | I SHOULD BE COM                      | (X5)<br>PLETIOI<br>DATE |
| F 925                                                                        | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ÷2                                                                                                                                                                                                                 | F 92                         | 5                                                                                                                                                                                                                        |                                      |                         |
|                                                                              | Room 305 and the Di<br>1/16/2025 at 1:34 PM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | rector of Housekeeping on<br>I. The Director of                                                                                                                                                                    |                              | - Environmental services le                                                                                                                                                                                              | ogs                                  |                         |
|                                                                              | <ul> <li>Housekeeping observed a cockroach crawling up the wall behind the bed of Resident #4 and he took a facial tissue and squashed the insect, ultimately depositing the insect in the garbage can.</li> <li>The Director of Housekeeping was interviewed on 1/16/2025 at 1:34 PM. The Director of Housekeeping knew that the facility had the pest control company "super treat" some of the rooms in the 400 hallway and that the pest control company sprayed the whole building once a week. The Director of Housekeeping stated the only thing that could be done was to kill the cockroaches when they saw them and sweep them up.</li> <li>c. The following observation was made of Room 315 on 1/16/2025 at 1:50 PM. Twenty cockroaches of various sizes crawled around on</li> </ul> |                                                                                                                                                                                                                    |                              | Audit records will be reviewed<br>QAPI Committee until such tin<br>consistent substantial complia<br>been achieved as determined<br>committee. Audit results will b<br>with the Resident Council for<br>and suggestions. | ne<br>ance has<br>by the<br>e shared |                         |
|                                                                              | bed. Seven cockroac<br>the door frame of the<br>cockroaches were on<br>table.<br>Nurse #1 was intervie<br>PM. Nurse #1 stated<br>that morning for main<br>cockroaches in Room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | awling up the wall behind the<br>hes were crawling around<br>closet next to the bed. Two<br>the resident's bedside<br>ewed on 1/16/2024 at 2:13<br>he wrote out a work order<br>tenance to spray for the<br>n 315. |                              |                                                                                                                                                                                                                          |                                      |                         |
|                                                                              | 1/16/2025 at 5:47 PM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | nade of Room 315 on<br>I. Five cockroaches were<br>loor frame of the closet next                                                                                                                                   |                              |                                                                                                                                                                                                                          |                                      |                         |

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|                                              | -                                                                                                                                                                               | ID HUMAN SERVICES                                                                     |                    |      |                                                                                                                                | FORM      | M APPROVED             |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------|------|--------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------|
|                                              |                                                                                                                                                                                 | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA                                      | (X2) MUL           | TIPL | LE CONSTRUCTION                                                                                                                | (X3) DATE | D. 0938-0391<br>SURVEY |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                                | A. BUILD           | ING  | ·                                                                                                                              | COMPLETED |                        |
|                                              | 345228                                                                                                                                                                          |                                                                                       | B. WING            |      |                                                                                                                                |           | C                      |
| NAME OF PROVIDER OR SUPPLIER                 |                                                                                                                                                                                 |                                                                                       | D. WING            |      | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                          | 01/       | 17/2025                |
|                                              |                                                                                                                                                                                 |                                                                                       |                    |      | 1624 HIGHLAND DRIVE                                                                                                            |           |                        |
| RIDGEWC                                      | OOD LIVING & REHAB C                                                                                                                                                            | ENTER                                                                                 |                    |      | WASHINGTON, NC 27889                                                                                                           |           |                        |
| (X4) ID<br>PREFIX<br>TAG                     |                                                                                                                                                                                 |                                                                                       | ID<br>PREFI<br>TAG |      | C PROVIDER'S PLAN OF CORRECTION<br>( EACH CORRECTIVE ACTION SHOULD BE CO<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |           |                        |
| F 925                                        | (EACH DEFICIENCY MUST BE PRECEDED BY FULL                                                                                                                                       |                                                                                       | F                  | 92   |                                                                                                                                |           |                        |
|                                              | The facility Administra<br>1/16/2025 at 1:52 PM<br>the facility determined<br>get rid of the cockroa<br>Control company to p<br>involved a two-step p<br>residents from the roo | ator was interviewed on<br>I. The Administrator stated<br>I the only effective way to |                    |      |                                                                                                                                |           |                        |

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PRINTED: 02/04/2025

|                                               |                       | (X1) PROVIDER/SUPPLIER/CLIA                                                             |                     | PLE CONSTRUCTION                                                                           |                               | 0. 0938-039               |  |
|-----------------------------------------------|-----------------------|-----------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------|-------------------------------|---------------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                       |                                                                                         | G                   | · · · ·                                                                                    | (X3) DATE SURVEY<br>COMPLETED |                           |  |
|                                               |                       |                                                                                         |                     |                                                                                            | С                             |                           |  |
|                                               |                       | 345228                                                                                  | B. WING             |                                                                                            | 0,                            | /17/2025                  |  |
| NAME OF P                                     | ROVIDER OR SUPPLIER   |                                                                                         |                     | STREET ADDRESS, CITY, STATE, ZIP COD                                                       |                               |                           |  |
|                                               |                       |                                                                                         |                     | 1624 HIGHLAND DRIVE                                                                        |                               |                           |  |
| RIDGEWC                                       | OOD LIVING & REHAB (  | ENTER                                                                                   |                     | WASHINGTON, NC 27889                                                                       |                               |                           |  |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN        | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETIO<br>DATE |  |
| F 925                                         | Continued From pag    | ne 4                                                                                    | F 92                | 25                                                                                         |                               |                           |  |
| 1 020                                         |                       | gain. The Administrator stated                                                          | F 92                |                                                                                            |                               |                           |  |
|                                               |                       | cess had already been                                                                   |                     |                                                                                            |                               |                           |  |
|                                               |                       | of the rooms in the 400                                                                 |                     |                                                                                            |                               |                           |  |
|                                               |                       | id of the cockroaches was a                                                             |                     |                                                                                            |                               |                           |  |
|                                               | work in progress.     |                                                                                         |                     |                                                                                            |                               |                           |  |
|                                               |                       |                                                                                         |                     |                                                                                            |                               |                           |  |
|                                               | •                     | e pest control company was                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | 2024 at 2:43 PM and the                                                                 |                     |                                                                                            |                               |                           |  |
|                                               | following information | out to the facility on three                                                            |                     |                                                                                            |                               |                           |  |
|                                               |                       | year to have meetings with                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | d the Director of Maintenance                                                           |                     |                                                                                            |                               |                           |  |
|                                               |                       | dress the cockroaches in the                                                            |                     |                                                                                            |                               |                           |  |
|                                               |                       | sor did not recall the dates of                                                         |                     |                                                                                            |                               |                           |  |
|                                               | the meetings with th  | e facility. The facility has                                                            |                     |                                                                                            |                               |                           |  |
|                                               |                       | s. The German cockroaches                                                               |                     |                                                                                            |                               |                           |  |
|                                               |                       | d the best way to handle an                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       | e "clean out" process. The                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | all personal items removed,                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       | d for 4 to 5 hours, and the<br>eaned. The pest control                                  |                     |                                                                                            |                               |                           |  |
|                                               |                       | an aerosol spray, bait, and                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       | baches in the room. The                                                                 |                     |                                                                                            |                               |                           |  |
|                                               |                       | epeated after 2 weeks. It was                                                           |                     |                                                                                            |                               |                           |  |
|                                               | -                     | room in each hallway receive                                                            |                     |                                                                                            |                               |                           |  |
|                                               | the "clean out" servi | ce, with one-half of the                                                                |                     |                                                                                            |                               |                           |  |
|                                               | hallway completed a   | t a time. In December 2024                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | oved by the facility to receive                                                         |                     |                                                                                            |                               |                           |  |
|                                               |                       | ce. There was another                                                                   |                     |                                                                                            |                               |                           |  |
|                                               | -                     | he "clean out" service for                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | llway but it was not yet signed<br>ne facility. If one German                           |                     |                                                                                            |                               |                           |  |
|                                               |                       | alized, there were likely a                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       | is in the room. The German                                                              |                     |                                                                                            |                               |                           |  |
|                                               |                       | ply from two to two hundred                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       | ood, crumbs, and clutter                                                                |                     |                                                                                            |                               |                           |  |
|                                               | exacerbate the prob   | lem of cockroaches. Certain                                                             |                     |                                                                                            |                               |                           |  |
|                                               |                       |                                                                                         | 1                   |                                                                                            |                               | 1                         |  |
|                                               |                       | asthma can be exacerbated nes and fecal matter of the                                   |                     |                                                                                            |                               |                           |  |

Facility ID: 923432

If continuation sheet Page 5 of 6

|                                 | -                                                                                                                                                                                                                                                                                                                                                                                                                                              | D HUMAN SERVICES<br>MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        |                                           |                                                                                      | FORM                          | ): 02/04/2025<br>APPROVED<br>0. 0938-0391 |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------|
|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                                           |                                                                                      | (X3) DATE SURVEY<br>COMPLETED |                                           |
|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                | 345228                                                                                                                                                                                                                                                                                                                                                                                                                                                                | B. WING                                |                                           | _                                                                                    |                               | C<br>17/2025                              |
| NAME OF PF                      | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5                                      | TREET ADDRESS, CITY, ST                   | ATE, ZIP CODE                                                                        |                               |                                           |
| RIDGEWOOD LIVING & REHAB CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        | 624 HIGHLAND DRIVE<br>VASHINGTON, NC 2788 | 89                                                                                   |                               |                                           |
| (X4) ID<br>PREFIX<br>TAG        | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                    | (EACH CORREC<br>CROSS-REFEREN             | PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE                |
| F 925                           | on 1/16/2024 at 4:12<br>revealed that room 31<br>had been added to the<br>the "clean out" service                                                                                                                                                                                                                                                                                                                                              | ator was interviewed again<br>PM. The Administrator<br>5 and Resident #6's room<br>e list of rooms to undergo<br>e. The Administrator did not                                                                                                                                                                                                                                                                                                                         | F 925                                  |                                           |                                                                                      |                               |                                           |
|                                 | control company to di                                                                                                                                                                                                                                                                                                                                                                                                                          | meetings with the pest<br>scuss cockroaches but<br>ree meetings had been                                                                                                                                                                                                                                                                                                                                                                                              |                                        |                                           |                                                                                      |                               |                                           |
|                                 | 1/17/2025 at 10:42 Al<br>Maintenance stated h<br>the cockroaches in the<br>Maintenance explained<br>was significant at one<br>better after the 400 ha<br>control company. The<br>revealed that the char<br>wheelchair in Room 3<br>but was cleaned. The<br>thought the facility res<br>address the clutter an<br>so the cockroaches d<br>The Director of Mainte<br>for the "clean out" ser<br>in the 300 hallway has<br>completed the followin | e did not know the cause of<br>e facility. The Director of<br>ed the cockroach problem<br>time, but it seemed to get<br>all was treated by the pest<br>e Director of Maintenance<br>rger for the electric<br>15 was full of cockroaches<br>Director of Maintenance<br>sidents and family needed to<br>d the snacks in the rooms,<br>id not have a food source.<br>enance stated the contract<br>vice for some of the rooms<br>d been signed and was to be<br>ng week. |                                        |                                           |                                                                                      |                               |                                           |
|                                 | 1/17/2025 at 12:15 Pt                                                                                                                                                                                                                                                                                                                                                                                                                          | any medical harm or                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |                                           |                                                                                      |                               |                                           |

Event ID: WITW11

Facility ID: 923432

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