

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

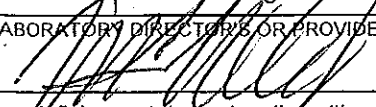
PRINTED: 03/10/2011  
FORM APPROVE  
OMB NO. 0938-036

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <b>MAR 21 2011</b>	(X3) DATE SURVEY COMPLETED  03/03/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard 1 opened vial of insulin dated 1/29/11 from the prep room medication refrigerator at the 100 hall nurse station, failed to discard 3, 30 tablet boxes of famotidine (antacid) in the storage room on the 100 hall with an</p>	F 431	<p>All expired medications found during the survey were immediately returned to the pharmacy for destruction.</p>	
---------------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/17/11
---	------------------------	----------------------

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.

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

PRINTED: 03/10/2011  
FORM APPROVED  
OMB NO. 0938-0302

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/03/2011
NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 1</p> <p>expiration date of 12/10, and failed to date 4 open vials of insulin on the B3 medication cart located on the 300 hall.</p> <p>On 3/3/11 at 11:20 am an opened 10 ml vial of insulin 100 units/milliliter (ml) was found in the prep room refrigerator at the 100 hall nurse station labeled with an expired date of 1/29/11. On 3/3/11 at 11:30 am in an interview with the nurse she stated, " I don ' t know why the opened vial of insulin with an expired date is in here (prep room). " She said the expired insulin should not be in here (prep room). The nurse stated when medication was identified to have an expired use date the medication should be discarded and reordered for the resident.</p> <p>On 3/3/11 at 11:25 am in the prep room refrigerator at the 100 hall nurse station there was 1 opened vial of insulin 100 units/milliliter dated 1/29/11. In an interview on 3/3/11 at 11:28 am the nurse stated " I don ' t know why insulin would be in here (prep room refrigerator) the insulin should have been placed on the appropriate medication cart when it was opened. " The nurse said the insulin was good for 28 days after being opened and after 28 days the insulin should be discarded.</p> <p>On 3/3/11 at 11:40 am in the storage room on the 100 hall there were 3 unopened boxes (each box with 30 tabs) of famotidine 20 milligrams (antacid) with an expiration date of 12/10. On 3/3/11 at 11:40 am in an interview the nurse stated the storage room was audited to verify medication expiration dates at least monthly but most of the time as often as weekly by a designated nurse. The nurse said pharmacy also audits the medication storage areas periodically for identification of expired medications.</p> <p>On 3/3/11 at 11:50 am in the B3 medication cart on the 300 hall there were 4 open, undated vials of insulin 100 units/ml. In an interview on 3/3/11</p>	F 431	<p>All medication carts, med rooms, and OTC in the nursing supply room have been checked and all expired meds have been returned to the pharmacy for destruction.</p> <p>All licesed nursing department personnel will attend an in-service medication storage. Central supply clerk will be in-serviced on rotation of OTC stocks.</p> <p>Tools will be provided on each med cart (i.e. calendars pens, and markers) so that each nurse can properly label all insulin vials with open date and exp. date.</p>	

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

PRINTED: 03/10/2011  
FORM APPROVED  
OMB NO. 0938-0392

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/03/2011
NAME OF PROVIDER OR SUPPLIER  RIDGWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 2</p> <p>at 11:55 am with the nurse she said opened vials of insulin should be dated when opened and the opened vials were good for 30 days. She said the opened vials of insulin should be thrown away after 30 days. The nurse stated a sticker was placed on the vial when opened to record the date. She said she did not know why the 4 opened vials were not dated because these vials of insulin were currently being administered to residents on the 300 hall.</p> <p>On 3/3/11 at 1:35 pm in an interview the Director of Nursing stated " My expectation is that the nursing staff would check medication expiration dates before giving any medication to a resident. " The DON said frequent audits of the medication storage areas and the carts were conducted at a minimum monthly and more often the audits were done weekly. She said her expectation was that the medication storage areas would be audited and expired medications would be given to the pharmacy or discarded immediately. The DON said her expectation was that the storage areas should be free from any medications with expired use dates.</p> <p>On 3/3/11 at 11:30 am in an interview with the Assistant Director of Nursing she stated " The medication storage areas are audited frequently and when expired medications or open, undated insulin is found it should be thrown away immediately or given to the pharmacy. "</p>	F 431	<p>Med carts, med rooms, &amp; nursing Supply storage room will be audited every week x 8 weeks to ensure compliance with new labeling policy, then bi-weekly x 8 weeks and then once monthly. Problems will be addressed by the QA committee.</p> <p>Completion date March 31, 2011.</p>		

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

PRINTED: 03/10/2011  
FORM APPROVED  
OMB NO. 0938-0385

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/03/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited as a result of the complaint investigation Event ID CE8K11</p>	F 000		
-------	--	-------	--	--

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

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.

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


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by:        Surveyor: 08661        42 CFR 483.70(a)        By observation on 3/30/11 at approximately noon the building construction was non-compliant, specific findings include leak in roof above switch gear in main electrical equipment room.</p>	K 012	<p>A roofing contractor has been hired to fix the leak. Maintenance will check for leaks after each rain storm.        Completed 05-14-2011</p>	
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by:        Surveyor: 08661        42 CFR 483.70(a)        By observation on 3/30/11 at approximately noon the following exit discharge illumination was observed as noncompliant: specific findings include exit discharge path next to playground did not have lighting on emergency power. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single</p>	K 045	<p>Lighting will be installed to illuminate the path next to the playground, which is the means of egress to the public way. The lighting which will be installed will illuminate to a value of at least 1 ft candle and will be tied into the generator in the event of power loss. The lighting will be added to the monthly safety check list. Maintenance will be responsible.        Completion Date 05-14-2011</p>	

**RECEIVED**  
 APR 25 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE Administrator 12/21/11 (X8) DATE
--	--

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.

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

PRINTED: 04/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  RIDGEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 045	Continued From page 1 lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 3/30/11 at approximately noon the means of egress was non-compliant, specific findings include a mattress under stair on the 300 hall.	K 072	The mattress which was under the stairs on 300 hall has been removed. Checking means of egress will be added to the monthly safety check list. Maintenance will be responsible for compliance. Completed 04-30-2011	