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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING ______ B. WING ______	C 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD MANOR	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	INITIAL COMMENTS No deficiencies were cited as result of the complaint allegations. Event ID #O2C711.	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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345228	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 10/3/2013
NAME OF PROVIDER OR SUPPLIER: RIDGEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE: 1624 HIGHLAND DRIVE WASHINGTON, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to notify family members when medications were discontinued for 1 of 4 sampled residents (Resident #2) whose medications and well being were reviewed. Findings included:

Resident #2 was admitted to the facility on 04/09/13, readmitted on 07/14/13, and discharged home with hospice on 07/24/13. According to facility documentation, the resident's diagnoses upon admission included history of aortic stenosis, transient ischemic attacks, and hypertension.

The resident was admitted to the facility on 04/09/13 with physician orders for Aggrenox ER 25/200 milligrams (mg) one capsule twice daily (BID), Diltiazem ER 240 mg daily QD), and Spironolactone 12.5 mg QD.

A 04/11/13 physician order discontinued the administration of the Aggrenox, Diltiazem, and Spironolactone.

At 4:30 PM on 10/02/13, during a telephone interview with Resident #2's family member, this person stated that in conversation among the three family members involved in the resident's care it was determined that no family members were notified by the facility about the 04/11/13 discontinuation of medications.

At 8:54 AM on 10/03/13 the central communications nurse who wrote the order to discontinue Resident #2's medications on 04/11/13 stated any changes in medication should be relayed to a resident's responsible party. She reported she usually documented notification of family members in her electronic nurse's notes. She

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The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	Continued From Page 1

commented if she had not documented that she notified Resident #2's family member in her 04/11/13 nurse's notes then she would assume for some reason that it was not done.

A review of electronic nurse's notes from 04/09/13 - 04/24/13 revealed no documentation of family notification of the 04/11/13 discontinuation of Resident #2's medications.

At 9:02 AM on 10/03/13 the resident's primary physician at the nursing home stated when Resident #2 entered the facility she was on a lot of medications, hypotensive, and he felt the resident was over-medicated. He reported there was some duplication in her medications such as receiving aspirin and Aggrenox. Therefore, he discontinued the Aggrenox. According to the physician, there was no record of atrial fibrillation, and the resident was having no blood pressure problems so he discontinued the Diltiazem and Spironolactone.

At 10:48 AM on 10/03/13 the facilty's social worker (SW) stated that upon admission the resident was accompanied by a son who was a co-power of attorney (POA), and the son completed all the paperwork. Therefore, the son was designated as the resident's responsible party on the resident's face sheet. However, about a week before a 05/06/13 meeting with the resident's family the SW reported the son approached her suggesting that the facility notify the resident's daughter when there were changes in the resident's condition. He explained that the daughter was able to visit the resident more frequently in the nursing home. According to the SW, this request was formalized in the 05/06/13 meeting, and from that point forward the facility began notifying the daughter of changes in the resident's care/condition. The SW commented that in July 2013 the daughter then asked the facility to also notify a granddaughter about the resident because she worked in the medical field and had a great deal of medical knowledge.

At 11:21 AM on 10/03/13 the facility's assistant director of nursing (ADON) and clinical supervisor stated she accompanied Resident #2's primary physician on rounds, but that the central communications nurse actually wrote out the orders generated on rounds. The ADON reported she remembered Resident #2's initial nursing home history and physical on 04/11/13 because she had to go get the resident out of the beauty parlor. She commented that at the time of this initial physical there were no family members present in the room with whom the physician could have shared his decision to discontinue some of the resident's medications.

At 12:05 PM on 10/03/13 the director of nursing (DON) stated she would expect the responsible party to be notified about medication changes, including the addition of new medications, the discontinuation of medications, and the changes in frequency and dosage of medications. She reported the notification of family members should be documented in nurse's notes.