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 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately code medical	F 278	1. The MDS nurse modified the MDS assessment on 8-16-2017 for Resident #3 to reflect the residents' active diagnosis in Section I, of the MDS assessment. 2. The MDS nurse will complete an audit on 9-6-2017 of Section I of the most recent MDS, May 1 through August 31, 2017, for current facility residents. The MDS nurses completed modified assessments for those identified without diagnosis coded in Section I. 3. The Corporate Reimbursement nurse provided in-service education for the MDS nurses on 8-30-2017 regarding coding of Section I with the residents' active diagnosis. The DON and/or ADON will audit 10 MDS assessments Section I weekly for 4 weeks, then 15 monthly for 3 months, to validate Section I is complete with residents' active diagnosis.	

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

Administrator 9-2-17

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.

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F 278	Continued From page 1 diagnoses on the Minimum Data Set (MDS) assessment for 1 of 4 residents (Resident #3). Findings included: Resident #3 was admitted to the facility on 7/19/17. Resident #3's active diagnoses, documented in the electronic health record, included hypertension, gastro-esophageal reflux disease, osteoarthritis, spinal stenosis, and cerebral infarction. Review of Resident #3's most recent admission MDS assessment dated 7/26/17 revealed the resident was assessed to have no active diagnoses in section I. During an interview on 8/16/17 at 10:09 AM MDS Nurse #1 stated that Resident #3 did have diagnoses upon admission and that the MDS assessment dated 7/26/17 was incorrect. During an interview on 8/16/17 at 10:33 AM the Director of Nursing stated that Resident #3 did have diagnoses and that the MDS assessment dated 7/26/17 was not correct. She further stated it was her expectation that the MDS assessments accurately reflect resident diagnoses.	F 278	4. The DON will review audits for patterns/trends and will adjust the plan as necessary. The DON will review plan in monthly QA for three months or until compliance is maintained. 5. Completion Date is 9-13-17.	9-13-17
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323	1. The DON and/or unit managers reviewed Resident #2's fall care plan interventions to validate interventions remain appropriate. Therapy evaluation completed on 8-24-17, to identify safe	

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F 323	Continued From page 2 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review the facility failed to provide adequate supervision and interventions necessary to prevent recurring falls without injury for 1 of 3 residents reviewed for falls (Resident #2). Findings Included: Resident #2 was admitted to the facility on 2/12/15. His active diagnoses included neurogenic bladder, seizure disorder, and anxiety disorder. Review of the resident ' s care plan initiated 2/24/17 revealed the resident was care planned for having sustained a fall with no injury related to poor balance. Interventions were last updated on 4/20/17 and included to provide contact guard	F 323	transfer techniques. Physician reviewed medications on 8-29-17 for continued medication needs and/or changes. Pharmacist reviewed medications on 8-30-17 to identify recommendations for medication changes or monitoring. The DON/Designee educated nursing staff regarding fall prevention intervention for Resident #2 and will communicate interventions to staff using the resident Kardex. MDS nurse reviewed resident's cognitive status on 8-29-17, using the BIMS scoring and resident cognitive status is Mod. Impaired. The resident attended a care plan conference on 8-29-17, to discuss fall interventions that were in place.	

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F 323	Continued From page 3 assistance with resident for transfers, maintain fall mat at the side of his bed, and help Resident #2 get up before 9 AM to smoke. Resident #2 was also care planned for impaired cognitive function. Interventions were last updated on 2/9/17 and included to cue, reorient, and supervise Resident #2 as needed. Resident #2 was care planned for a history of non-compliance related to his refusal to call for aide for assistance with transfers. Interventions were last updated on 4/20/17 and included to evaluate ongoing educations presented to Resident #2 regarding safety with transfers. Review of a fall summary dated 11/29/16 revealed Resident #2 was found kneeling on the floor between his wheelchair and his bed. Resident #2 stated he attempted to get up and fell. The interventions put in place were to re-educate the resident on call bell use and to ask Resident #2 if he would like to get up on 11 to 7 shift. The resident did not wish to get up on that shift. Review of a fall summary dated 2/8/17 revealed Resident #2 fell while he attempted to transfer himself from his bed to his wheelchair. The wheelchair breaks were not locked and the chair moved which caused the resident to fall onto his fall matt. The intervention was to develop a routine of getting the resident up after breakfast service was completed for his smoke break. Review of a fall summary dated 2/23/17 revealed Resident #2 fell while he attempted to transfer from toilet. The Nurse Aide assisted the resident to a kneeling position. The intervention documented following this fall was for the physician to perform a medication review to	F 323	2. Current facility residents that have fallen or risk for falls has the potential to be affected by the alleged deficient practice. The DON and/or unit managers reviewed fall incidents and care plans beginning May 2017 through August 22, 2017, to validate that an investigation was completed, potential cause of incident identified and appropriate interventions were initiated. 3. The DON and/or unit mangers began in-service education on 8-17-17 for the licensed nurses Nursing Assistants, regarding investigating an incident and implementing appropriate interventions to prevent/reduce further falls. The IDT which includes the Administrator, DON, ADON, Unit Managers, Rehab manager, SW will review incidents daily at least 5 times a week, to validate	

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F 323	Continued From page 4 decrease edema in his lower extremities. No other new interventions were put in place. Review of a fall summary dated 2/24/17 revealed the resident was being transferred from the toilet to his chair and was lowered to a seated position. No new interventions were documented to be put in place and it was documented that the facility would continue to monitor effectiveness of interventions from 2/23/17. Review of a fall summary dated 5/3/17 revealed the resident fell during transfer from the bed to his chair. The nurse aide lowered the resident to the floor. The intervention put in place after the fall was to place the resident on a protein supplement. No other new interventions were documented. Review of Resident #2 ' s most recent quarterly Minimum Data Set assessment dated 5/10/17 revealed the resident was assessed as moderately cognitively impaired. Resident #2 was assessed as extensive assistance by one staff member for transfers for toilet use. Resident #2 was incontinent of bowel and had a suprapubic catheter. He had no impairment of both upper and lower extremities, and used a wheelchair for mobility. Resident #2 had sustained one fall since last admission, or prior assessment with no injury. Review of Resident #2 ' s fall summary dated 7/12/17 revealed the resident attempted to transfer off of the toilet and fell to the floor and crawled to his bed. New intervention put in place was to discuss room change with the social worker to move the resident closer to the nurse ' s station for closer observation. The room change was not done. No other interventions were	F 323	investigations completed, interventions initiated, care plan/Kardex up to date with new interventions and communicated to staff. The DON and/or the ADON/unit managers will review incidents for at least 3 days following an incident to validate interventions remain appropriate. The IDT will review incidents weekly looking back at previous week incidents to validate interventions remain appropriate and will revise care plan as needed. The IDT will review fall care plans at least quarterly, annually and significant change, to validate interventions remain appropriate and will revise care plan as needed. 4. The DON will review audits/observations to identify patterns/trends and will adjust plan as necessary. The DON will review plan during monthly QA for 3	

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F 323	Continued From page 5 documented. During observation on 8/15/17 at 4:18 AM Resident #2 was observed to be kneeling on his fall mat with his torso and head on the bed. During an interview on 8/15/17 at 4:21 AM Nurse Aide #1 stated Resident #2 usually slept in the bed and did not have any abnormal sleeping patterns. She stated he was in his bed when she rounded at 2 AM and she had not returned to the room since that time. Nurse Aide #1 observed the resident kneeling on the ground with his torso and head on the bed. She stated she would need to go get the nurse and left. She stated she needed the nurse to assess him. She walked away and returned four minutes later with Nurse #1. During observation on 8/15/17 at 4:25 AM while Nurse Aide #1 and Nurse #1 were attending to Resident #2, he stated he slipped off the bed. He further stated he could not reach his call light after he fell and that he was trying to get into his wheelchair and stated his bowels were trying to move. Resident #2 stated he did not have any injuries. During an interview on 8/15/17 at 5:21 AM Nurse #3 stated she was Resident #2 ' s nurse. She stated that Resident #2 had sustained falls in the past. She further stated he was alert and oriented to self, place, and time and he was aware of his surroundings, he just did not make the best decisions. She stated that if he fell they discussed how he fell, started a neuro check sheet, and contacted family members and physician. She stated that he usually fell trying to move from his bed to his chair and he also fell because his legs would get weak while a Nurse Aide was with him	F 323	months or until compliance is maintained. 5. Date of completions is September 13, 2017.	9-13-17

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F 323	Continued From page 6 and had to be lowered to the floor. She further stated that he was reminded to use his call bell but usually he would not use it despite the education. He also had a fall mat next to his bed and she stated they kept his bed at the lowest position. During an interview on 8/15/17 at 9:29 AM Resident #2 stated that he was trying to get into his wheelchair to go to the bathroom in the morning and fell to his knees. He further stated that he fell asleep and had been in that position for about an hour. Resident #2 stated he did not turn on his call light before attempting to transfer because the facility did not answer fast enough. He did not know of any interventions put in place to keep him from falling. He also stated that he would not take his supplements because it would give him loose stools. During an interview on 8/15/17 at 9:51 AM the Wound Care Nurse stated Resident #2 often refused to take his protein supplements. During an interview on 8/15/17 at 1:26 PM Nurse Aide #2 stated Resident #2 was aware of his surroundings and was alert and oriented to self and place and time. She stated he would let her know what he needed. She further stated that he needed contact assistance with transfers by one staff member. She stated that multiple times during night and early morning he had been found in the kneeling position he was found in this morning. She stated that he had a fall mat in place and they kept his call bell in reach and re-educated him to use the call bell. She further stated those were the only interventions she knew. During an interview on 8/16/17 at 8:10 AM the	F 323		

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F 323	Continued From page 7 Assistant Director of Nursing stated she was sometimes involved with fall investigations. She stated that Resident #2 had a fall mat beside his bed, and most of the falls have been early morning falls because he wanted to go smoke so they get him up earlier in the morning to be ready to go out and smoke. She stated they continue to encourage him to use the call light and ask for assistance. She stated he knows when he needs help but does not like to call for help. She stated they try to continue educating him to use the call light. The Assistant Director of Nursing further stated that she did see that continuing to educate Resident #2 might not be beneficial but she did not know what else they could do. She further stated that the Director of Nursing had followed his fall investigations more than she had. During an interview on 8/16/17 at 8:24 AM the Director of Nursing stated that she performed the fall investigations and if she had any questions about a fall, she interviewed the staff involved. She stated the interdisciplinary team reviewed the chart to come up with new interventions for prevention. She further stated Resident #2 was very alert and oriented and was able to tell you what he needed and understood the education they provided. She further stated that Resident #2 did not use his call bell even though they often re-educated him to use his call bell. She stated that the education did not seem effective. She stated that on 11/29/16 they re-educated Resident #2 about using the call bell and then asked Resident #2 if he would like them to get him up on 11 to 7 shift. She stated Resident #2 declined. She stated she did not have any other new intervention documented after this fall. For his fall on 2/8/17 the Director of Nursing stated that they developed a plan to get the resident up	F 323		

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F 323	Continued From page 8 after breakfast to get him to his smoke break. She stated she did not know why they did not ask him when he would like to get up after he declined being up on the 11 to 7 shift. She stated on 2/23/17 he fell again in the bathroom and the nurse aide lowered him to the floor. She stated Resident #2 had some extreme edema to his legs so they had the physician review his medications and make changes to decrease his edema. The Director of Nursing stated on 2/24/17 Resident #2 ' s fall was so close to the previous fall that they did not put any other interventions in place because they were waiting to see if his medication change would be effective. The interview continued and the Director of Nursing stated that she did not have any documentation of monitoring his edema and she did not know if it was effective although he did not have another fall until May. She stated that she measured the effectiveness of her interventions by seeing if the resident had another incident. The Director of Nursing stated on 5/3/17 he was lowered to the floor by nurse aide in the bathroom. She stated they requested the physician to review his medical regimen and started him on protein supplements because he had edema and also had low albumin. She stated that she was unaware that he refused his protein supplement at times and that if he continued to have edema then the intervention might not be effective. The Director of Nursing stated on 7/12/17 Resident #2 had a fall and they wanted to move him closer to the nurse ' s station but did not have a room closer to the nurse ' s station available. She further stated that she did not have any additional documentation about the fall on 7/12/17 but that the resident had transferred himself on to the toilet and fallen when he	F 323		

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F 323	Continued From page 9 attempted to transfer off of the toilet. The Director of Nursing stated no new interventions were put in place following this fall of 07/12/17 and prior to the fall witnessed by the surveyor on 8/15/17. When asked if she felt there was adequate supervision by the facility to prevent the recurring falls, the Director of Nursing stated she did not know if there was more the facility could do.	F 323		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.	F 431	1. The DON/ADON validated that carts were locked upon observation on 8-15-17. 2. The DON and/or Unit Manager started providing in-service education for the licensed nurses beginning 8-17-17, regarding locking medication and treatment carts when left unattended. This education will also be provided to new licensed nurses hired during the orientation process. 3. The DON and/or ADON/unit manager will observe medication/treatment carts at least 5 times a	

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F 431	Continued From page 10 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to keep an unattended medication cart locked for 3 of 5 medication carts reviewed and failed to keep an unattended treatment cart locked for 1 of 2 treatment carts reviewed. Findings included: 1.a) During observation on 8/15/17 at 4:08 AM and at 4:32 AM the 100 hall medication cart was observed to be unlocked and unattended. During an interview on 8/15/17 at 4:38 AM Nurse #2 stated that the 100 hall medication cart was	F 431	week for 4 weeks, to include all shifts, to validate that medication and treatment carts are locked when unattended by a licensed nurse. 4. DON will review audits/observations for patterns/trends and will adjust plan as necessary to maintain compliance. The DON will review plan during monthly QA meeting for 3 months or until compliance is maintained. 5. Date of completion September 13, 2017.	9-13-17

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F 431	Continued From page 11 her cart. She stated that carts were not supposed to be left unlocked. She further stated that she went to open the door for the surveyors at 4:06 AM and was in the middle of medication administration on the rehabilitation unit and forgot to lock the medication cart. She further stated that the 100 hall medication cart was unlocked since 4:06 AM. During an interview on 8/16/17 at 10:33 AM the Director of Nursing stated that medication and treatment carts were to be locked every time they are left unattended and it was her expectation that the nurses would not leave medication and treatment carts unlocked. 1.b) During observation on 8/15/17 at 4:33 AM the rehab hall medication cart was observed to be unlocked and unattended. During an interview on 8/15/17 at 4:38 AM Nurse #2 stated that the rehab hall medication cart was her cart. She stated that carts were not supposed to be left unlocked. She further stated that she went to open the door for the surveyors at 4:06 AM and was in the middle of medications on the rehabilitation unit and forgot to lock the medication cart. She further stated that the rehab hall medication cart was unlocked since 4:06 AM. During an interview on 8/16/17 at 10:33 AM the Director of Nursing stated that medication and treatment carts were to be locked every time they are left unattended and it was her expectation that the nurses would not leave medication and treatment carts unlocked. 1.c) During observation on 8/15/17 at 4:42 AM, a 300 hall medication cart was observed to be	F 431		

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 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD LIVING & REHAB CENTER	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	Continued From page 12 unlocked and unattended. During an interview on 8/15/17 at 4:43 AM Nurse #1 stated that the 300 hall medication cart was her cart. She further stated that the medication cart should not be left unattended and unlocked and that she had left it unlocked and forgot. During an interview on 8/16/17 at 10:33 AM the Director of Nursing stated that medication and treatment carts were to be locked every time they are left unattended and it was her expectation that the nurses would not leave medication and treatment carts unlocked. 2) During observation on 8/15/17 at 4:08 AM and at 4:32 AM the 100 hall treatment cart was observed to be unlocked and unattended. During an interview on 8/15/17 at 4:38 AM Nurse #2 stated that the 100 hall treatment cart was her cart. She stated there were medications used for treatments in the treatment cart and that the treatment cart was to be locked when unattended. She further stated that she went to open the door for the surveyors at 4:06 AM and was in the middle of medication administration on the rehabilitation unit and forgot to lock the treatment cart. She further stated that the 100 hall treatment cart was unlocked since 4:06 AM. During an interview on 8/16/17 at 10:33 AM the Director of Nursing stated that medication and treatment carts were to be locked every time they are left unattended and it was her expectation that the nurses would not leave medication and treatment carts unlocked.	F 431		