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 03/16/2016

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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to safely transfer 1 of 3 sampled residents (Resident #2) known to require assistance of two staff for transfers, resulting in a fall. The findings include: Resident #2 was admitted to the facility on 2/26/16 with diagnoses including Dementia, Muscle Weakness and Ambulatory dysfunction. Review of the Admission 5 day Minimum Data Set (MDS) Assessment dated 3/1/16 did not identify Resident #2 ' s cognitive status. Resident #2 required extensive two person assistance with transferring and walking in the room did not occur. She was not steady and only stabilized with human assistance with moving from a seated to a standing position and surface-to-surface transfers. She had no upper extremity range of motion limitations but had impairment on both sides of the lower extremities. She was frequently incontinent of bowel and bladder. She had one fall since admission with an injury (not major). Review of the Care Area Assessment dated 3/1/16 revealed the assessment was not	F 323	1. Resident #2 is no longer in the facility. 2. Facility will access transfer status on all resident and will ensure this information is documented on the Nurses Aide information Sheet and on the Care Plan. The assessment process will be completed on April 8, 2016. 3. All nursing staff will be in-serviced on transfer status, the types, and where to find documentation of transfer status. In-services will be held March 28 - April 1, 2016. 4. DON/Designee will audit ten transfers, ten Nurses Aide Information sheets, and ten Care Plans once a week x four weeks, then ten a month x three months - Results of audits will be reported to Quality Assurance Committee. 5. Completion date April 08, 2016	4/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2016

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F 323	Continued From page 1	F 323		

completed before the resident discharged on 3/1/16. There was not a care plan related to falls.
A review of the Physical Therapy initial assessment dated 2/26/16 documented Resident #2 required moderate assistance of two persons for transferring from the bed to the chair, from sitting to standing, from standing to sitting and her fall risk was high. She had impaired sensation to the right and left lower extremities.
A review of the Nurse Aide ' s Information Sheet revealed it was blank with the exception of the resident ' s name and room number.
A review of the Nursing Note dated 2/27/16 indicated Resident #2 was being transferred in her room and fell hitting the right back of her head and right ear. There was no bruising and neurological checks were initiated. The physician and responsible parties were notified.
Review of the Occurrence Report dated 2/27/16 revealed Resident #2 was being transferred and fell.
During an interview on 3/16/16 at 1:13PM, the Physical Therapist who performed the initial assessment stated Resident #2 required two persons to assist her with transferring. She stated the resident was weak and she was unsteady on her feet. She stated that once she assessed the resident she made a note for all staff on the white board in the resident ' s room.
During an interview on 3/16/16 at 1:40pm Nurse #1 stated once Physical Therapy assessed a resident the Physical Therapist informed the nursing staff of how the resident would be transferred. A Nurse Aide (NA) information sheet would have been completed and placed in a book at the desk and the nursing assistants referred to this sheet on how to care for their resident. The NA might have spoken with the Physical Therapist for clarification and there was a white

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F 323	Continued From page 2	F 323		

board in the resident ' s room with transferring information written on the board.
During an interview on 3/16/16 at 2:15pm, the Staff Development Nurse stated that usually she talked with the 7am-3pm nurse so she could complete the NA information sheet. If it was not completed when she left for the day it was left at the desk for the 3pm-11pm shift to complete. She stated she was not sure why it was not completed and it was not any one person ' s responsibility to complete, but this form was the facility ' s way of communicating with the Nursing Assistants.
During an interview on 3/16/16 at 3:08PM with Nursing Assistant (NA) #1 she stated she was making rounds on 2/27/16 in the evening and Resident #2 wanted to use the bathroom. She stated Resident #2 was in bed and was positioned to sit on the side of the bed and her walker was placed in front of her. NA #1 stated Resident #2 was shuffling her feet and moving side to side and she asked the resident to sit down in the chair so she would not fall. The resident refused. NA #1 asked the resident again to sit down and the resident agreed. NA #1 stated she had one hand on the resident and one hand reaching for the wheelchair and the walker moved forward and the resident began to fall backwards. The nursing assistant stated she herself fell onto the bed and Resident #2 fell backwards landing on her, and then slid downward. The resident hit the right side of her head and ear on the bed frame and then went onto the floor. NA #1 stated she had worked with Resident #2 the day she was admitted but this was the first day she had transferred the resident. She stated if there was something written on the white board regarding transferring and using two persons she must not have seen it. She stated the resident seemed so

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F 323	Continued From page 3 confident that she could walk that she did not believe there would be any problem. During an interview on 3/16/16 at 3:30PM with the Director of Nursing (DON) she stated she did an investigation into the fall interviewing the nursing assistant and Physical Therapist. She stated the facility did begin using two persons during transfers for Resident #2 after the fall. The investigation did not include the root cause of the fall or how this incident could affect other residents, a monitoring tool or taking the concern to the Quality Assurance team. The DON stated the Nurse Aide information sheet was started on admission and the unit manager typically completed the form and the SDC checked weekly to ensure the form is complete. She stated the Nurse Aide information sheet would have been reviewed after day 7 of the admission but the resident left the facility on day 4 of her admission.	F 323		