| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **425132** | A. BUILDING _____ B. WING _____ | **08/26/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **RIDGELAND NURSING CENTER INC** | **1516 GRAYS HIGHWAY RIDGELAND, SC 29936** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and review of facility policy the facility failed to ensure housekeeping and maintenance services were provided to maintain a safe, sanitary, orderly, and comfortable interior. Tour of the facility throughout the survey dates of 8/23/2020 - 8/26/2020 revealed numerous concerns with floors in residents' rooms, bathrooms, and common areas being stained and dirty. Resident equipment was observed to be dirty and in need of repair. Peeling paint and drywall was noted in several areas and electrical outlets were cracked/broken with wires exposed. Findings include: Review of a policy titled Preventative Maintenance Program (Implemented January 2018) revealed a policy statement A preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The procedures for implementation revealed the Maintenance Director would asses all aspects of the physical plant to determine if preventative maintenance was required. If preventative maintenance was required, the Maintenance Director would decide what tasks needed to be completed and how often to complete them. The Maintenance Director would obtain assistance with keeping track of all tasks by having yellow maintenance request slips dated in the computer. All repair requests were to be made in writing, using the maintenance requisition forms and work orders would be completed according to the nature of the problem. 1. A tour of the A and B Units on 8/23/2020, initiated at 3:30 p.m. revealed the following: room [ROOM NUMBER] - The floor was noted to have dirt, paper, and debris pushed up against the walls and in the corners. The area behind bed A was noted to have a build-up of dirt and papers. A fall mat was observed lying on the floor to the left side of each of the two residents' beds in the room. The two (2) fall mats were observed to be dirty and stained as well as torn in areas with foam padding exposed. The bathroom shared by residents in room [ROOM NUMBER] and #124 was noted to have dirt against the walls. Also, the toilet bowl in the room was stained and dirty. There was a wheelchair stored in the bathroom blocking the bathroom from use. Rooms #125 and #126 shared an adjoining bathroom. The bathroom floor tile was noted to be stained and dirty. The toilet in the bathroom was stained and had dirt/debris accumulated around the bottom of the toilet bowl. room [ROOM NUMBER] - A wheelchair was positioned to the side of Bed A. The wheelchair was observed to have a large hole in the left arm of the chair and foam padding was exposed. The floor in the room was noted to be dirty, with dirt and debris pushed up against the walls and in the corners. The bathroom shared by rooms #127 and #128 was noted with new tile on the floors. The thresholds leading to both rooms were observed to be slightly higher than the floors in rooms #127 and #128. Blue tape was observed to be placed on the thresholds to both rooms. The slightly raised bathroom floor created a hazard for residents or anyone who entered from the rooms into the bathroom, due to the need to step up in order to enter the bathroom. The bathroom also had exposed wires where the light switch cover was missing. room [ROOM NUMBER] had a bathroom door that was extensively scratched with paint missing from the bottom to approximately up the door. Inside the bathroom the floors were noted to have dirt and debris built up in the corners by the walls and around the base of the toilet bowl. The wall underneath the sink also had missing paint. In addition, the floor tile around the door frame had a dark brown stain in the corners. room [ROOM NUMBER] was observed to have an outlet cover that was broken with wires exposed. This outlet was beside bed A and would be adjacent to the resident's head when laying down and easily within reach. The floor around the B unit Nursing Station was also noted to have a buildup of dirt and debris pushed up against the walls in the corners of the floor. The resident dining room area was observed to have excessive amounts of dirt and debris against the walls and in the corners of the room. Vending machines located in an alcove of the dining room were observed to have dirt, paper, and debris particles beside and behind the machine. Continued observations revealed these areas of environmental and housekeeping concerns continued to exist throughout the survey dates. 2. An environmental tour was conducted on 8/26/2020, initiated at 2:40 p.m. The Maintenance Director and Housekeeping Supervisor accompanied surveyors on the tour. Environmental and housekeeping concerns were shown to the supervisors. The hole in the wall of room [ROOM NUMBER], beside bed B was noted to have been repaired on the last day of the survey (8/26/2020). However, pieces of wood with nails protruding were noted to be leaned against the wall of the room. The Maintenance Director indicated these wood pieces had been removed when the hole in the drywall of the room was repaired earlier. Staff had forgotten to remove them. Both the Maintenance Director and Housekeeping Supervisor acknowledged the presence of the environmental concerns. The environmental concerns identified on 8/23/2020 at 3:30 p.m. were noted to continue to exist during the tour with the Maintenance Director and Housekeeping Supervisor. Interview was conducted on 8/26/2020 at 2:40 p.m. with the Maintenance Director while the environmental tour was being conducted. The Maintenance Director indicated that in accordance with facility policy, nursing and other staff members were required to complete a yellow maintenance request slip when they identified any concerns with the environment. According to the Maintenance Director the physical plant concerns identified during the environmental tour should have been reported to maintenance by using these maintenance slips. The Maintenance Director denied that any of the concerns had been reported to maintenance. Interview with the Maintenance Director on 8/26/2020 at 3:00 p.m. while the environmental tour was being concluded, he acknowledged the exposed wires were a safety concern. He stated contractors were in a few months ago and they must not have completed their job. |
| F 0604<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, interviews and review of facility policy, the facility failed to ensure there was medical justification for use of a physical restraint, failed to release the physical restraint as planned, and failed to ensure the physical restraint was the least restrictive intervention for one (1) of five (5) residents reviewed for the use of physical restraints (Resident #4). Findings include: Resident #4 was admitted to the facility on [DATE]; the resident's [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#4 may be out of bed in the wheelchair with a soft waist (physical restraint) every shift. The Quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of one (1) indicating severe cognitive impairment and the resident rejected care one to three (1-3) days during the seven (7) day observation period. The resident required limited assistance with bed mobility and transfers and required extensive assistance with ambulation, locomotion, toileting, and personal hygiene. The resident had one (1) fall without injury since the previous assessment, received antianxiety and antidepressant medications seven (7) days of the seven (7) day observation period and utilized a trunk restraint and bed and wander alarms daily. The Physical Restraint Care Area Assessment (CAA) for the Annual MDS dated [DATE] documented the resident used a soft waist |

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.

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| F 0604<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>restraint related to history of falls and cognitive loss. The care plan included the problem of the resident requiring assistance with activities of daily living, with the goal to have no falls with injuries, dated 7/21/2020. The following interventions were documented: responsible party has declined use of Geri chair with restraint, verbalizes understanding of increased risk for falls/injury when ambulatory with wheelchair; wheelchair with soft waist restraint related to deter self-transfers with falls; and physical restraint will be released for toileting/incontinence care management (with the start date 3/7/19), repositioning, exercises/range of motion every two (2) hours as well as supervised activities and supervised meal times. Review of the Physical Restraint Informed Consent dated 2/13/18 lacked documentation of the specific type of restraint being used, the specific targeted behaviors, the medical symptoms for the use of the restraint, and the risk versus benefits for the use of the restraint. This was the only consent form found in the record; there was no evidence it had been updated. Review of the Restraint/Positioning Device - Quarterly Re-assessment dated [DATE] documented the reason for the restraint was unsafe mobility, postural instability, (examples of, leaning forward, sliding, side leaning,) and frequent falls/history of falls. Review of the Restraint/Positioning Device - Quarterly Re-assessment dated [DATE] documented the reason for the restraint was unsafe mobility, postural instability, (examples, leaning forward, sliding, side leaning,) and frequent falls/history of falls. Review of the Fall Investigations documented: 4/19/20 at 12:12 p.m. - the resident's roommate stated the resident wiggles with the waist restraint until he/she got it loose and attempted to get into bed and fell . 7/12/20 at 9:30 a.m. - the certified nurse aide (CNA) responded to the chair alarm and found the resident slid under the waist restraint and was sitting on the floor. Further review of the quarterly Restraint/Positioning Device-Quarterly Re-Assessments dated 3/7/19 and 8/24/2020, under recommendations for a referral to therapy for restraint reduction trial, the staff documented no each time. Further review of the Re-Assessments revealed the safety concern of the resident sliding out of the chair while wearing the restraint was not identified. Furthermore, the restraint was used in part to prevent falls. The resident experienced 28 falls between 2/24/19 - 7/19/2020. Although the restraint use was ineffective to prevent falls, the Re-Assessments failed to identify this. Review of the Physical Therapy Discharge Summary for treatment from 10/10/19 to 2/27/2020 and the Occupational Therapy Discharge Summary for treatment from 5/14/20 to 8/5/2020 lacked an assessment of the physical restraint. Review of the clinical record lacked medical justification for the use of the restraint. The facility utilized the physical restraint and the resident continued to fall. Observation on 8/23/20 at 5:06 p.m. revealed the resident sat in a wheelchair with a waist restraint tied to the lower bars on the back of the wheelchair. The resident wheeled him/herself up and down the hall. Observation on 8/24/20 at 10:03 a.m. revealed the resident sat in his/her room in a wheelchair with the waist restraint on. Observation on 8/24/20 at 11:58 a.m. revealed the resident sat in a wheelchair in his/her room. The resident had slid partially down in the wheelchair and the tied waist restraint was positioned tight under his/her armpits. The room was slightly dark and the room lights were not on. A staff member was alerted, entered the room and repositioned the resident/adjusted the restraint. Observation on 8/25/20 at 12:46 p.m. revealed the resident sat in the wheelchair with the tied waist restraint on. The resident was eating his/her lunch. Interview with CNA #1 on 8/25/20 at 12:53 p.m. revealed physical restraints should be released at meal-times. He/she stated they just forgot to untie Resident #4's restraint. Observation on 8/26/20 at 5:25 p.m. revealed the resident sat in the wheelchair with the tied waist restraint on. The resident was eating his/her dinner and staff were sitting with him/her. Interview with Licensed Practical Nurse (LPN) #2 on 8/25/20 at 11:15 a.m. revealed everyone on admission signed a form regarding physical restraints, as to whether they want them or not. Under the type of restraint, it says per policy. The restraint consent was completed at admission without any specific information regarding what type of restraint might be used. LPN #2 stated the Consent was not redone when the resident got a restraint unless the resident went to the hospital (and was readmitted ). LPN #2 also stated that every week the department heads had a meeting where they discussed and reviewed residents with physical restraints and decided if anything different needed to be done. Interview with Occupational Therapist (OT) on 8/26/20 at 3:45 p.m. revealed they had tried everything to prevent falls and the resident continued to fall so now they used a waist restraint, including a bed and chair alarm and a clip alarm. Interview with LPN #1 on 8/26/20 at 2:01 p.m. revealed Resident #4 tried to get up unassisted and fell . The staff tried a chair alarm but since he/she already had a waist restraint, it was considered a double restraint. Staff removed the chair alarm, but not the waist restraint. Interview with CNA #1 on 8/26/20 at 2:37 p.m. revealed Resident #4 had the waist restraint because he/she had a history of [REDACTED].#1 also stated staff should release the physical restraint when the resident ate and when he/she went to bed. Interview with the Director of Nursing (DON) on 8/26/20 at 2:51 p.m. revealed the medical justification for Resident #4's physical restraint was dementia or frequent falls. We cannot medicate the resident anymore, so we use the physical restraint. The DON further stated staff should release the restraint every two (2) hours and at meals and check on the resident every 30 minutes. Review of the facility's Restraint Policy, dated 3/12/15, documented restraints will be utilized in order to . alleviate or reduce the occurrence of life-threatening medical problems, injuries, falls, or risk of falls. Further review of the policy documented, residents and/or responsible parties are notified upon admission of the potential benefits, potential risks and alternatives to restraints. A signed consent is obtained. Review of the Physical Restraint Informed Consent provided at admission documented under restraint type/frequency: Per Policy, Under the areas for Specific Target Behaviors and Medical Symptoms they were blank. According to the policy, the resident is checked every two (2) hours for placement, function, safety and release, reposition, and range of motion and/or ambulation. The Recommended Protocol consisted of . second fall or if alarms are ineffective, may utilize self-release belts, breakaway straps or lap buddies as alternative, third fall and/or above devices are ineffective the risk management team is to assess for restraint needs. The facility failed to ensure the least restrictive device was utilized for this cognitive impaired resident with a history of falls. The facility failed to have medical justification for the use of the restraint, failed to attempt a reduction in the use of the restraint, failed to release the restraint as planned and failed to do an analysis of the risk versus the benefits of the restraint. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and review of facility policy the facility failed to develop and/or implement a comprehensive person-centered care plan for five (5) of 17 sampled residents (Residents #2, #4, #11, #12, #17) when the need to do so was identified in the comprehensive assessment. Specifically, -Care plans for restorative services/range of motion (ROM) were not implemented for Residents #2, #11, #12 and #17. -The care plan to release the physical restraint for Resident #4 was not implemented. Findings include: Review of a policy titled Plan of Care Assessments (not dated) revealed a policy statement Each resident will have a plan of care in order to receive the care necessary to enable the resident to achieve and/or maintain the highest practical physical, mental and psychological well-being. Procedures identified to implement the policy included detailed care planning will be documented on the resident's plan of care. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 1. Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the medical record revealed a physician's orders [REDACTED].#2 to receive a restorative nursing program for ambulation. The order specified the resident should receive the restorative ambulation program five (5) days each week, for six (6) months. Review of Physical Therapy notes revealed Resident #2 received Physical Therapy services from 3/6/2020 to 6/4/2020. The Physical Therapy discharge summary documented the resident had made substantial functional gains in response to skilled interventions. The discharge documentation specified Resident #2 had a baseline of being non-ambulatory on 3/16/2020 (start of Physical Therapy services) to ambulating 100 feet with minimal assist and a four-wheel walker on 6/4/2020 (end of Physical Therapy services). Furthermore, the discharge summary stated the resident's prognosis to maintain the current level of function was excellent with participation in a restorative nursing program. Resident #2 was discharged from Physical Therapy with a restorative nursing ambulation program planned to facilitate maintaining the current level of performance and in order to prevent decline. The discharge note indicated development of and instruction in the following of a restorative nursing program had been completed with the interdisciplinary (IDT) care team. Review of the medical record revealed a restorative nursing care plan was developed on 6/8/2020. The plan of care was signed by a Therapist, the Director of Nursing (DON), and the Restorative Nursing Aide (RNA). The stated objective on the care plan was for Resident #2 to maintain ambulation status. Interventions planned to meet the stated objective included to |

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>provide minimal assistance to the resident while ambulating 50 feet with a four-wheel walker, gait belt, and a wheelchair following. The frequency of the interventions was to provide the resident with the restorative nursing ambulatory program five (5) times each week. Continued review of the medical record revealed the restorative nursing ambulation program had not been provided for Resident #2 as planned in the plan of care. Documentation from June 6, 2020 to August 22, 2020 revealed there had been no week for which the resident was provided the restorative nursing ambulation program a total of five (5) times per week as specified in the plan of care. The documentation reflected there had been weeks when Resident #2 had not ambulated at all or had ambulated only one (1) time for the week. Other weeks the resident was provided the care planned restorative program two (2) or three (3) times. The week of 8/15-22/2020 the documentation reflected Resident #2 had been provided the restorative program four (4) times which was the only time the resident had received ambulation services more than three (3) times in a single week since the care plan had been developed for implementation (6/8/2020). The Restorative Nurse Aide (RNA) who was responsible for providing Resident #2 with the restorative nursing program was interviewed on 8/25/2020 at 12:25 p.m. The RNA confirmed that Resident #2 had not been ambulated as was outlined in the resident's plan of care. The RNA stated she was aware the resident was to be provided the restorative nursing program five (5) times each week, however, due to scheduling she (RNA) had not been able to provide the care planned program as outlined. According to the RNA, she was the only restorative aide working due to a second restorative aide being off work for illness. The RNA stated she also worked on the schedule as a Certified Nursing Aide (CNA) and during these times the residents who had care plans to receive restorative services did not have the services implemented. The RNA had not reported to anyone the failure to implement the plan of care interventions as planned. Resident #2 was observed on 8/26/2020 at 10:26 a.m., being aided with ambulation by a Physical Therapy Assistant (PTA). Resident #2 was being assisted to ambulate down the hallway outside of his/her room using a four-wheel walker and wearing a gait belt. The PTA was observed to be holding onto the gait belt and pulling a wheelchair behind the resident. Resident #2 was observed to be bent forward at the waist and had an unsteady gait. The resident was noted to state I've got to sit down after having ambulated approximately 30 feet and the PTA assisted the resident to sit down in the wheelchair behind him/her. Interview was conducted on 8/26/2020 at 10:50 a.m. with the Physical Therapy Aide (PTA) who was observed to provide ambulation assistance to Resident #2. The PTA stated this was the first time she had provided ambulation assistance with the resident since the resident was discharged from Physical Therapy on 6/4/2020. The PTA stated after the resident was discharged from therapy it was a nursing responsibility to ensure the restorative nursing care plan was implemented. The PTA stated she did notice a decline in Resident #2's activity tolerance when ambulating. The PTA stated she also noticed Resident #2 did not stand as straight as he/she had been doing when discharged from therapy services. 2. Resident #11 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. The order specified services should be provided five (5) times each week, for six (6) months. Review of the plan of care revealed Resident #11 had a restorative nursing care plan developed on 6/10/2020. The stated objective was to maintain ambulation ability. Interventions included providing minimum assistance with ambulating 50 feet with a four (4)-wheel walker, gait belt and a wheelchair following. The interventions were to be provided a frequency of five (5) times each week. Review of the medical record revealed the planned interventions to address maintaining the ambulatory ability for Resident #11 were not implemented as described in the plan of care. Review of documentation by the RNA revealed from 6/10/2020 through 8/22/2020 there had been no weeks the interventions of a restorative nursing program for ambulation had been provided five (5) times per week. The documentation reflected there were some weeks the resident received no ambulation program. Other weeks the resident was provided the ambulation program one (1) to three (3) times. The RNA who was responsible for providing Resident #11 with the restorative nursing program was interviewed on 8/25/2020 at 12:25 p.m. The RNA stated residents who were scheduled to receive the care planned intervention of a restorative nursing ambulation program for five (5) times each week were not receiving the intervention. According to the RNA, the staffing schedule required him/her to work as a Certified Nursing Assistant (CNA) on some shifts. Due to this, there was not enough time scheduled to implement the restorative nursing program for each resident. 3. Resident #17 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the medical record revealed a physician's orders [REDACTED].#17 to receive a restorative nursing program for ambulation. The order specified the resident should receive the program five (5) times per week for six (6) months. Review of a Physical Therapy Discharge Summary for Resident #17 revealed Physical Therapy services were provided from 5/19/2020 to 6/4/2020. The discharge summary indicated Resident #17 could ambulate up to 20 feet when Physical Therapy services were initiated. At the time services were discontinued the summary noted the resident could ambulate up to 40 feet. The resident's prognosis to maintain the current level of function was excellent with participation in a restorative nursing program. The resident was discharged to the restorative nursing program to facilitate the resident maintaining the current level of performance and to prevent decline. The discharge summary documentation indicated a plan of care for ambulation was developed and completed with the interdisciplinary team (IDT). Review of the medical record revealed a restorative nursing care plan was developed on 6/8/2020. The care plan was signed by a Therapist, Director of Nursing, and Restorative Nursing Aide. The objective on the care plan was to maintain ambulation. The interventions specified the resident was to ambulate fifty feet with a front wheeled walker and gait belt. These interventions were to be performed five (5) times per week for six (6) months. Review of documentation of the ambulation program for Resident #17 from 6/10/2020 - 8/25/2020 revealed the program was not provided as ordered. For the month of June 2020: The week of 6/07/2020 - 6/13/2020, the resident was seen three times. The week of 6/14/2020 - 6/20/2020, the resident was seen 5 times. The week of 6/21/2020 - 6/27/2020, the resident was not seen at all. The week of 6/28/2020-7/4/2020 the resident was seen three times. The month of July 2020: The week of 7/5/2020-7/11/2020, the resident was seen one time. 7/12/2020 - 7/18/2020, the resident was seen four times, 7/19/2020- 7/25/2020 the resident was seen one time. 7/26/2020-7/31/2020, the resident was seen one time. The month of August 2020: 8/2/2020-8/8/ , the resident was seen 3 times. The week of 8/9/2020-8/15/2020 the resident was seen three times. The week of 8/16/2020-8/22/2020 the resident was seen 4 times. Interview with the Director of the Therapy Department on 8/26/2020 at 1:05 p.m. revealed the decision to develop a Functional Management Program was a collaborative effort between therapy and nursing. The therapy department developed a resident's restorative nursing plan and it was reviewed as part of an interdisciplinary (IDT) team. It was then a nursing responsibility to ensure the program was being implemented for each resident. Interview with the DON on 8/25/2020 at 2:07 p.m. revealed s/he also served as the Registered Nurse overseeing the restorative nursing program. The nurse stated s/he did not review documentation by the RNA regarding whether or not the care planned programs were being implemented. The DON stated the expectation was for the RNA to come to her/him and report if a resident's care plan interventions were not being implemented. The DON further stated s/he had received no reports that restorative nursing care plans were not being consistently implemented. 4. Resident #4 was admitted to the facility on [DATE] and [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The updated care plan dated 7/21/2020 included the interventions: wheelchair with soft waist restraint and physical restraint will be released for toileting/incontinence care management, repositioning, exercises/range of motion every two (2) hours as well as supervised activities and supervised meal-times. Observation on 8/25/2020 at 12:46 p.m. revealed the resident sat in the wheelchair with the waist restraint on. The resident was eating his/her lunch. Interview with CNA #1 on 8/25/2020 at 12:53 p.m. revealed physical restraints should be released at meal-times. S/he stated they just forgot to untie Resident #4's restraint. Observation on 8/26/2020 at 5:25 p.m. revealed the resident sat in the wheelchair with the waist restraint on. The resident was eating his/her dinner and staff were sitting with him/her. Interview with CNA #1 on 8/26/2020 at 2:37 p.m. revealed staff should release the physical restraint when the resident ate and when he/she went to bed. Interview with the Director of Nursing (DON) on 8/26/2020 at 2:51 p.m. revealed staff should release the restraint every two (2) hours and at meals and check on the resident every 30 minutes. The facility failed to follow the care plan for the releasing of the restraint. 5. Resident #12 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The physician order [REDACTED]. The care plan dated 6/19/20 listed the intervention for staff to ensure the left-hand roll is in place and functioning properly as ordered. Observations on 8/23/20 at 4:20 p.m., 8/24/20 at 10:08 a.m., and 8/25/20 at 10:58 a.m. and 12:20 p.m. revealed no hand roll in the left hand. Interview with Occupational Therapist (OT) on 8/26/20 at 1:06 p.m. revealed the care givers (CNAs) were responsible for placing the palm guards in Resident #12's hands. Interview with Licensed Practical Nurse (LPN) #1 on 8/26/20 at 2:01 p.m. revealed the TASK screen on the computer alerts the CNAs as to what care the resident required. Resident #12 should have a palm guard in his/her left hand. S/he also stated the charge nurses and house supervisors were responsible for ensuring the CNAs were providing the care for the residents as planned. The facility failed to follow the care plan for the placement of the palm guard in the left hand. |
| F 0676<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Ensure residents do not lose the ability to perform activities of daily living unless** |

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| F 0676<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>**there is a medical reason.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure appropriate services and assistance was provided to maintain or improve ambulation ability for three (3) of 17 sampled residents (Residents #2, #11, and #17). Residents #2, #11, and #17 were discontinued from skilled therapy services with a care plan developed for each resident to receive assisted ambulation services through the facility's restorative nursing program. The facility failed to ensure each resident received the planned restorative ambulation program, in an attempt to maintain each resident's maximum practicable level of independence. The failure to provide Resident #2 with the planned ambulation program resulted in the resident experiencing a decline in the ability to walk. Findings include: Review of a policy titled Restorative Nursing Program (no date) revealed a statement When it is determined by the doctor, nursing, or therapist that a patient is in need of restorative nursing care, the therapist will write a functional maintenance program for that patient. The therapist will inform and instruct all appropriate staff members on the need for restorative care and the nature of restorative program for that particular patient. Procedures outlined for implementation of the policy included the therapist providing written instructions that outlined the restorative plan of care and the plan was placed in a Restorative Nursing Program (RNP) book. The Restorative Technician was to document daily checks and weekly notes in the electronic medical record after a resident received restorative services. It was the responsibility of nursing and therapy to ensure the restorative program was carried out according to the plan. The policy specified both therapy and nursing would oversee the restorative nursing program. Programs were to be updated and revised as needed. All residents were to have doctor's orders to perform under the restorative nursing program. 1. Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) Assessment, dated 2/17/2020 revealed Resident #2 was severely impaired in cognitive skills for daily decision making. The resident was assessed to require the extensive assistance of one person with walking in room and walking in corridor. The resident required the extensive assistance with locomotion both on and off the unit. The MDS assessment indicated the resident used the mobility devices of a wheelchair and a walker. Review of a Quarterly MDS assessment dated [DATE] revealed Resident #2 had improved in locomotion both on and off the unit. The resident was assessed to require limited assistance with the Activities of Daily Living (ADL) function of locomotion. This MDS assessment demonstrated the resident was showing improvement while receiving Physical Therapy services. Review of the medical record revealed Skilled Therapy Notes indicating Resident #2 was evaluated for Physical Therapy (PT) services on 3/16/2020 and a determination was made the resident could benefit from receiving a Physical Therapy treatment program. PT services were initiated on 3/17/2020. Gait training with emphasis on increasing safety and performance within the facility was initiated as part of the PT services. PT services included strengthening exercises until 3/30/2020 when the Physical Therapy Aide (PTA) documented the resident ambulated 15 feet, twice, with a four-wheel walker and moderate assistance. Resident #2 continued to receive PT services until being discharged on [DATE]. The PT Discharge Summary, dated 6/4/2020, noted the resident's baseline for ambulation at the start of the therapy program had been 0 feet and total dependence without attempts to initiate. On the PT Discharge Summary it was noted the resident could ambulate 100 feet with minimal assistance. A PT discharge recommendation was made for Resident #2 to continue with a Restorative Nursing Program to facilitate maintaining the current level of performance and to prevent decline. A care plan was developed with the interdisciplinary team (IDT) to address the need to implement the restorative nursing ambulation plan. Review of the medical record revealed Resident #2 had a physician's orders [REDACTED]. The physician's orders [REDACTED]. Review of a restorative nursing care plan revealed on 6/8/2020 planned interventions were developed with the objective to maintain Resident #2's ambulatory status. Ambulation frequency was to be five times each week with minimal assistance. Devices to be used were a four-wheel walker, gait belt, and follow with a wheelchair. The goal was for the resident to ambulate 50 feet each day. Review of documentation of the implemented ambulatory restorative nursing plan for Resident #2 revealed for the week of 6/21/2020 - 6/27/2020, the resident was not provided ambulation assistance the entire week. For the week of 6/28/2020 - 7/4/2020, the ambulation program was provided three (3) times. For the week of 7/5/2020 -7/11/2020, the ambulation program was provided once. For the week of 7/12/2020 - 7/18/2020, the ambulation program was provided three (3) times; For the week of 7/26/2020 - 8/1/2020, the ambulation program was provided once. For the week of 8/2/2020 - 8/8/2020, the ambulation program was provided three (3) times. For the week of 8/9/2020 - 8/15/2020, the ambulation program was provided twice. For the week of 8/15/2020 - 8/22/2020, the ambulation program was provided four (4) times. Interview was conducted on 8/25/2020 at 12:25 p.m. with the Restorative Nurse Aide (RNA) who provided restorative services for Resident #2. The RNA stated he/she had provided Resident #2 with ambulation earlier that day. The RNA indicated the resident had walked from his/her bedroom to the nurses' station, which was approximately 50 feet. The RNA stated he/she provided ambulation assistance approximately three (3) times each week, not the care planned five (5) times. The RNA stated he/she worked different shifts as a Certified Nursing Assistant (CNA) and couldn't implement the restorative nursing care plan as written for Resident #2. According to the RNA, Resident #2 was stiff when he/she tried to walk him/her because he/she (resident) did not get enough exercise. Interview was conducted on 8/26/2020 at 10:50 a.m. with a Physical Therapy Aide (PTA) who was observed providing Resident #2 with ambulation assistance that morning. The PTA stated he/she had worked with Resident #2 when the resident was receiving Physical Therapy services. The PTA stated at the end of the physical therapy program, Resident #2 could ambulate 100 feet to the therapy gym and back to his/her room with minimal assistance, a roller walker, gait belt, and wheelchair following. The PTA stated he/she noticed a decline in the resident's activity tolerance while providing him/her with ambulatory assistance earlier. Additionally, the resident could not stand as straight as he/she had achieved while receiving physical therapy. The PTA stated Resident #2 could benefit and demonstrate improvement if the ambulatory rehab nursing program was consistently implemented in accordance with the plan of care. The PTA stated Resident #2 might also benefit from a rescreen by Physical Therapy. Interview was conducted via telephone on 8/26/2020 at 4:55 p.m. with the responsible party (RP) for Resident #2. The RP stated the facility had conducted a care plan conference earlier in the month and he/she (RP) had participated via telephone. The RP stated he/she was not aware Resident #2 was supposed to be receiving a restorative nursing program to maintain his/her ambulation ability. Ambulation was not part of the discussion during the care plan conference. The RP was aware the resident had received Physical Therapy services and the RP had seen Resident #2 walking down the hallway at that time. The RP stated Resident #2 also received arm exercises as part of Physical Therapy. The RP was concerned when he/she was notified that physical therapy services were being discontinued because he/she felt the service had helped Resident #2 to maintain strength. Resident #2 was observed on 8/26/2020 at 10:26 a.m. to be ambulating in the hallway with the assistance of the Physical Therapy Assistant (PTA), a four-wheel walker, gait belt, and wheelchair pulled behind the resident. Resident #2 was noted to be approximately 30 feet from his/her bedroom doorway when the resident stated, I've got to sit down. The PTA assisted Resident #2 to sit down in the wheelchair. The resident was wheeled back to his/her room where he/she informed the PTA that he/she had to go to the bathroom. The PTA assisted the resident with transferring from the wheelchair to the commode. Upon exiting the bathroom, the PTA assisted Resident #2 with standing at the wash basin to wash his/her hands. The resident was noted to be bent over at the waist and was saying I can't do this anymore. Resident #2 sat back down in the wheelchair and was wheeled into him/her room by the PTA. The failure to implement a restorative nursing program for ambulation as ordered by the physician and planned in the restorative nursing care plan resulted in Resident #2 experiencing a decline in the ability to ambulate. 2. Resident #11 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 6/10/2020, revealed the resident required limited assistance of one person with ambulation. The Quarterly Assessment did not identify Resident #11 to be receiving skilled therapy services or restorative nursing services. Resident #11 had a physician's orders [REDACTED]. The order specified the resident should ambulate 50 feet with a four-wheeled walker and gait belt, followed by a wheelchair. The ambulation program was to be implemented five (5) times each week, for six (6) months. Review of a restorative nursing care plan, dated 6/10/2020, for Resident #11 revealed an ambulation plan was developed to maintain the resident's ambulation ability. The care plan specified minimum assistance should be provided with a four-wheel walker, gait belt, followed by a wheelchair. The plan specified the intervention should be implemented five (5) times each week and the resident should ambulate a total of 50 feet. Review of Resident #11's ambulation program documentation from 6/21/2020 - 8/22/2020 revealed the program had not been provided as ordered or care planned. Resident #11 was not provided the ambulation program at all for the week of 6/21/2020 - 6/27/2020. The resident was provided the ambulation program three times the week of 6/27/2020 - 7/4/2020; one time the week of 7/5/2020 -7/11/2020; three (3) times |

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|---|---|---|---|
| | 425132 | A. BUILDING _____ B. WING _____ | 08/26/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| RIDGELAND NURSING CENTER INC | 1516 GRAYS HIGHWAY RIDGELAND, SC 29936 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0676<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 4)<br>the week of 7/12/2020 - 7/18/2020; zero times the week of 7/19/2020 - 7/25/2020; once the week of 7/26/2020 - 8/1/2020; three (3) times the week of 8/2/2020 - 8/8/2020; twice the week of 8/9/2020 - 8/15/2020; and four (4) times the week of 8/16/2020 -8/22/2020. 3. Resident#17 was admitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set, dated dated [DATE], coded the resident as having severely impaired cognition. The MDS also coded the resident as needing extensive assistance with one person for ambulation on and off the unit. The resident was also coded as using a walker for mobility. Resident #17 had a physician's orders [REDACTED]. The order specified the resident was to ambulate fifty feet with a front wheeled walker and gait belt. Review of a Physical Therapy Discharge Summary for Resident#17, dated 6/8/2020, revealed Physical Therapy services were provided from 5/19/2020 to 6/4/2020. The Discharge Summary indicated Resident #17 could ambulate up to 20 feet when Physical Therapy services were initiated. At the time services were discontinued, the resident could ambulate up to 40 feet. The resident's prognosis to maintain the current level of function was excellent with participation in a restorative nursing program. The resident was discharged to the restorative nursing program to facilitate the resident maintaining the current level of performance and to prevent decline. The Discharge Summary indicated a plan of care for ambulation was developed and completed with the interdisciplinary team (IDT). Review of documentation of the ambulation program for Resident #17 from 6/10/2020 - 8/25/2020 revealed the program was not provided as ordered. For the month of June 2020: The week of 6/07/2020 - 6/13/2020, the resident was seen three (3) times. The week of 6/14/2020 - 6/20/2020, the resident was seen five (5) times. The week of 6/21/2020 - 6/27/2020, the resident was not seen at all. The week of 6/28/2020-7/4/2020 the resident was seen three (3) times. The month of July 2020: The week of 7/5/2020- 7/11/2020, the resident was seen one time. 7/12/2020 - 7/18/2020, the resident was seen four (4) times, 7/19/2020- 7/25/2020 the resident was seen one time. 7/26/2020-7/31/2020, the resident was seen one time. The month of August 2020: 8/2/2020-8/8/ , the resident was seen three (3) times. The week of 8/9/2020-8/15/2020 the resident was seen three (3) times. The week of 8/16/2020-8/22/2020 the resident was seen four (4) times. Interview was conducted on 8/25/2020 at 12:25 p.m. with the Restorative Nurse Aide (RNA) who provided restorative services for Resident #11, #13, and #17. The RNA stated, that due to also being assigned to work shifts providing care as a CNA, he/she could not consistently implement the restorative nursing program for each resident whose care plan specified an ambulation program. According to the RNA there were currently no other staff providing restorative services for residents. Interview was conducted on 8/25/2020 at 2:07 p.m. with the Director of Nursing (DON) who also served as the Registered Nurse (RN) over the facility's restorative nursing program. The DON stated the Restorative Nurse Aide (RNA) was responsible for reporting to him/her if a resident had experienced a decline or if the planned restorative program was not being implemented. The DON stated he/she had received no reports regarding the residents not receiving assistance with ambulation as outlined in each of their restorative nursing care plans. The DON stated he/she did not review documentation to confirm a resident's restorative nursing care plan was being implemented. The DON stated the facility had a risk management meeting every Thursday and residents receiving physical and occupational therapy were discussed, as well as all residents who were receiving a restorative nursing program. The DON stated there had been no mention of care planned ambulation programs not being implemented. Interview was conducted on 8/26/2020 at 1:05 p.m. with the Director of the Therapy Department. The Director stated it was a collaborative effort between nursing and therapy to make decisions regarding who would benefit from a Functional Management Program and this included restorative nursing services. The Director stated however, it was a nursing responsibility to oversee the restorative program and make sure the program was being implemented. |
| F 0688<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, interviews, and review of facility policy, the facility failed to provide restorative services to maintain range of motion (ROM) to one (1) out of 17 sampled residents with a limitations in ROM (Resident #12). Findings include: 1. Resident #12 was admitted the facility on 1/31/12 and the [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. Review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed the resident had short and long-term memory problems, displayed no behaviors, and required extensive assistance of two (2) people with bed mobility, dressing, toilet use, and personal hygiene. The resident required total assistance with transfers and did not walk. The MDS documented the resident had limited range of motion (ROM) on one (1) side of the upper and lower extremity and received no therapy or restorative services. The care plan dated 6/19/2020 listed the intervention for staff to ensure the left-hand roll was in place and functioning properly as ordered. The TASK section on computer listed the left-hand palm protector with the start date of 11/15/16. Observations on 8/23/2020 at 4:20 p.m., 8/24/2020 at 10:08 a.m., and 8/25/2020 at 10:58 a.m. and 12:20 p.m. revealed no hand roll in the left hand. Interview with Certified Nurse Aide (CNA) #2 on 8/25/2020 at 1:05 p.m. stated the resident used to have a palm guard in the left hand and the CNAs are responsible for putting it in and out. CNA #2 also stated the resident would not allow them to put anything in his/her right hand. This staff looked in two (2) of the resident's drawers and could not find the palm guard. Interview with the Occupational Therapist (OT) on 8/26/2020 at 1:06 p.m. revealed the care givers (CNAs) were responsible for placing the palm guards in Resident #12's hands. Interview with Licensed Practical Nurse (LPN) #1 on 8/26/2020 at 2:01 p.m. revealed the TASK screen on the computer alerts the CNAs as to what care the resident requires. Resident #12 should have a palm guard in his/her left hand. He/she also stated the charge nurses and house supervisors were responsible for ensuring the CNAs were providing the care for the residents as planned. Interview with the Director of Nursing (DON) on 8/26/2020 at 2:51 p.m. revealed the CNAs should follow the TASK when providing care for the residents. The DON also stated the charge nurses should monitor to make sure the CNAs were providing care for the residents as planned. The facility failed to place the palm guard in this dependent resident's hand as ordered and planned. |
| F 0689<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, interviews, and review of facility policy the facility failed to provide effective and individualized interventions for the prevention of accidents for two (2) of four (4) sample residents (Resident #2 and Resident #4) reviewed for accidents. Resident #4 experienced 28 falls resulting in fractures to the anterior and posterior walls of the left maxillary sinus (sinus located near the nose), left lateral orbital wall and left orbital floor (breaks in the eye socket). The facility failed to ensure Resident #2's siderail was functioning properly to prevent entrapment. Findings include: 1. Resident #4 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of zero (0) indicating severe cognitive impairment. The resident had hallucinations and delusions and rejected care one to three (1-3) days of the seven (7) day observation period. The resident required limited assistance with bed mobility and eating, required extensive assistance of one (1) staff with walking, locomotion, dressing, toilet use and personal hygiene and required extensive assistance of two (2) staff with transfers. The resident utilized a walker and wheelchair and the resident was not steady and was only able to stabilize with staff assistance with moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers. The MDS documented the resident had two (2) or more falls since the last assessment. The resident did not receive therapy or restorative services and utilized a wander alarm daily. The Fall Care Area Assessment (CAA) dated 1/18/19 revealed the resident was a risk for falls related to cognitive loss, impaired mobility and incontinence. Review of the care plan revealed the fall interventions in place on 2/24/19, (the first fall reviewed): Encourage resident to allow staff to pack belongings for any upcoming outings; staff to monitor resident frequently when in his/her room; staff to attempt to keep resident in group areas during times of confusion; (cognitively impaired) resident educated to lock wheelchair when he/she stops and call for assistance to change his/her footwear; staff to monitor frequently for needs; wheelchair cushion fashioned with Velcro to ensure it remains in place; non-skid socks applied to resident feet and updated to Task List in computer; attempt to dress resident as he/she wishes at all times; bring to monitored areas as needed; foot wear reviewed for safety to notify responsible party to remove footwear with backs out, for safety; spouse encourage to increase frequency of visits during waking hours; clip belt to wheelchair to deter self-transfers; staff to remind/encourage spouse to call for assist with |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 5)<br>resident toileting; staff to keep resident in view during times of agitation/anxiety and waking hours; Occupational Therapy (OT) and Physical Therapy (PT) evaluation and treat three (3) times a week for four (4) weeks; staff will assist with activities of daily living (ADLs) as needed and encourage resident to participate as appropriate; and staff will ensure call light is within reach and functioning properly. Review of the Fall Risk Assessments scoring revealed a score of ten (10) or above represented the resident at a high fall risk. Review of the assessments completed quarterly from 3/14/19 to 8/24/20 scored the resident from 15 to 18, indicating the resident was a high fall risk. Review of the Investigation Reports and the Care Plan revealed the following 28 falls and the interventions since 2/24/19: -2/24/19 at 6:39 a.m. - staff found the resident with knees on floor and body across roommate's bed -2/26/19 at 5:00 p.m. - a visitor found the resident on the floor, with the interventions for staff to assist with activities of daily living (ADLs) as needed and encourage resident to participate as appropriate -2/27/19 at 2:24 p.m. - found on floor in front of recliner -2/27/19 at 10:30 p.m. - found sitting on the floor with the intervention for a clip belt when in the wheelchair with a Pommel cushion -2/28/19 at 5:12 p.m. - another resident told staff the resident was on the floor; staff were educated on proper use of clip belt and the Pommel cushion was ordered -2/28/19 at 7:30 p.m. - found on floor next to bathroom -3/3/19 at 12:03 p.m. - found on floor by nurses' desk, safety precautions reinforced -3/4/19 at 7:35 a.m. - slid out from under clip belt at nurses' desk, the resident requires frequent rounding -3/4/19 at 7:45 a.m. - found on floor in room, had removed clip belt -3/4/19 at 7:55 a.m. - found on floor in room, had removed clip belt, with the intervention for a Geriatric chair with soft waist restraint to deter self-transfers with falls. -4/22/19 at 9:24 a.m. - spouse assisted resident to bathroom and resident found on floor, (spouse) was instructed to call staff for assist. Quarter side rail times one (1) for positioning and safety and bed against wall on left side initiated. -6/9/19 at 12:18 p.m. - found on floor in room in front of recliner, reminders given to (cognitively impaired) resident to call for assistance, staff to keep well- lit lighting and room free of clutter -6/28/19 at 7:10 p.m. - found on floor after being placed in bed for the night. Resident transferred to the hospital and the computer tomography (CT) revealed fractures to the anterior and posterior walls of the left maxillary sinus, left lateral orbital wall and left orbital floor, hemorrhage filled the left maxillary sinus and a left cheek/periorbital hematoma. -7/19/19 at 10:00 a.m. - found on floor, was previously in bed. -8/2/19 at 8:19 a.m. - found on floor in room, resident had disconnected the bed alarm -10/11/19 at 4:00 p.m. - found on floor, transferred to hospital for complaint of pain. No fracture sustained and therapy screen requested -2/2/2020 at 10:07 p.m. - found on floor in bathroom -4/8/2020 at 9:37 p.m. - found on floor in room, (cognitively impaired) resident instructed to call for assistance and staff to make sure bed alarm is in place and functioning and respond to bed alarm quickly. Skin tears to left elbow sustained. -4/9/2020 at 2:26 p.m. - found resident on floor in room -4/19/2020 at 12:12 p.m. - found the resident had slid under the waist restraint and was sitting on the floor in his/her room. A skin tear was noted to the right arm -5/12/2020 at 2:17 p.m. - found resident on floor in room beside the bathroom with his/her pants around his/her ankles. -5/16/2020 at 9:59 p.m. - found sitting on floor in doorway, staff instructed to keep bed alarm box out of resident's reach -5/30/2020 at 1:07 p.m. - found on floor beside bed after responding to bed alarm, staff instructed to make sure shoes or non-skid socks are on when resident is out of bed -7/1/2020 at 10:10 a.m. - found on floor next to his/her chair with the alarm going off, resident sustained [REDACTED]. sure bed alarm is intact and check resident upon rising, after meals and at bedtime for toileting -7/19/2020 at 8:26 a.m. - found on floor in front of bathroom, bed alarm going off Review of the 28 falls revealed 27 of the falls were unwitnessed by staff and all of those 27 falls occurred in the resident's room. Further review of the falls revealed, while the resident received physical therapy from 10/10/19 to 2/27/2020, the resident only had two (2) falls. Review of the facility's Fall Investigations lacked this track and trending of the falls, what was occurring prior to the falls and the root cause analysis of the falls. There was a lack of evidence the facility analyzed the falls to determine if there were any patterns to the falls. There was a lack of evidence the facility developed interventions based on the root cause analysis of the falls. The care plan lacked individualized and effective interventions for the prevention of falls. Furthermore, the risk of the lap belt restraint was not evaluated as an accident hazard even though the resident sustained [REDACTED]. Review of the Physical Therapy (PT) Discharge Summary revealed the resident received therapy from 10/10/19 to 2/27/2020. Upon discharge the resident was able to ambulate 150 feet with a front wheeled walker and minimum assist. The resident had excellent prognosis to maintain clinical level of function. Observation on 8/23/2020 at 5:06 p.m. revealed the resident sat in a wheelchair with a waist restraint tied to the lower bars on the back of the wheelchair. The resident wheeled him/herself up and down the hall. Observation on 8/24/2020 at 10:03 a.m. revealed the resident sat in his/her room in a wheelchair with the tied waist restraint on. Observation on 8/24/2020 at 11:58 a.m. revealed the resident sat in a wheelchair in his/her room. The resident slid partially down in the wheelchair and the tied waist restraint was positioned under her armpits. The room was slightly dark and the room lights were not on and it was rainy and cloudy outside. Staff came and repositioned the resident. Observation on 8/25/2020 at 10:40 a.m. revealed the resident lying in bed on his/her left side and the bed pressure alarm in place. Observation on 8/25/2020 at 12:46 p.m. revealed the resident sat in the wheelchair with the tied waist restraint on. The resident was eating his/her lunch. Observation on 8/26/2020 at 5:25 p.m. revealed the resident sat in the wheelchair with the tied waist restraint on. The resident was eating his/her dinner and staff were sitting with him/her. Interview with Certified Nurse Aide (CNA) #1 on 8/25/2020 at 10:40 a.m. revealed the fall interventions for Resident #4 consisted of a bed alarm and a belt around the waist when in the wheelchair. Interview with the Occupational Therapist (OT) on 8/26/2020 at 3:45 p.m. revealed he/she 8/26/2020 reviewed the falls every morning and evaluate to see if it warrants an evaluation. For Resident #4 we have tried a bed alarm and a clip belt. Interview with Licensed Practical Nurse (LPN) #1 on 8/26/2020 at 2:01 p.m. revealed Resident #4 gets up unassisted and falls. The facility tried a chair alarm but with the waist restraint it was considered a double restraint so we removed the chair alarm. LPN #1 further stated the resident had a bed alarm and staff allow the resident to wheel in the halls, help him/her do a puzzle or offered the resident a snack. Staff sometimes will walk him/her to the bathroom but the resident in not on a restorative program or a set ambulation schedule. Further interview with CNA #1 at on 8/26/2020 at 2:37 p.m. revealed the resident had the restraint because of all the falls. He/she further stated that therapy or the restorative aide would walk with the residents. The CNAs did not walk Resident #4. Interview with the Director of Nursing (DON) on 8/26/2020 at 2:51 p.m. revealed the department heads met every week and review the falls since the last meeting and decide what interventions were needed. The DON stated that sometimes the staff walked Resident #4 to the bathroom but did not walk with him/her any other time. The DON stated sometimes the staff sat with the resident for a few minutes but could not sit with him/her for an hour or so. Review of the undated Fall Prevention Policy included the intervention for staff to provide assistance with transfers, mobility and toileting as needed and the Interdisciplinary Team will review falls weekly and make recommendations for individual fall prevention. The facility failed to provide effective, timely and individualized interventions for this resident with 28 falls and who had sustained several fractures. 2. Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 8/6/2020 revealed bed rails had not been utilized on the bed for Resident #2 during the review period. A Restraint/Positioning Device Quarterly Assessment was completed on 8/6/2020. Although the resident was assessed to not utilize siderails on the bed during the review period, it was determined they would be used to assist the resident with positioning during times when the resident became agitated. The assessment indicated Resident #2's responsible party (RP) had been notified of the decision. Review of physician's orders [REDACTED].#2 to utilize one full length siderail for bed positioning and define parameters, every shift, for safety. Resident #2 was observed on 8/23/2020 at 3:30 p.m. to be lying in bed with her entire body covered, including head, with a blanket. A full length siderail was observed to be up on the left side of the bed. The bed was in a low position and a fall mat was on the floor beside the bed on the side where the siderail was noted. Resident #2 was observed on 8/24/2020 at 10:39 a.m. to be lying in bed with a full length siderail up on the left side of the bed. The resident was noted to have her back to the siderail and was facing the wall. The bed continued to be in a low position and a fall mat was positioned on the floor. Resident #2 was observed on 8/25/2020 at 12:03 p.m. to be lying in bed on her right side. A full length siderail was observed to be up and the resident's back was facing the siderail. The siderail was observed to have detached from the bed and there was a gap of approximately 6 to 9 inches between the mattress and the siderail. CNA #3 had been observed exiting the resident's room approximately 10 minutes before the observation of a safety hazard regarding the siderail being detached and the safety risk for entrapment for Resident #2 was observed at 12:03 p.m. Interview was conducted with the Registered Nurse (RN) Supervisor on 8/25/2020 at 12:25 p.m. who was requested by the surveyor to accompany her to the room of Resident #2. The RN Supervisor stated she had not been made aware of the siderail being detached, creating an entrapment space between the mattress and siderail. The RN Supervisor agreed the placement of the siderail created an increased risk for an accident for |

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|---|---|---|---|
| | 425132 | A. BUILDING _____ B. WING _____ | 08/26/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| RIDGELAND NURSING CENTER INC | 1516 GRAYS HIGHWAY RIDGELAND, SC 29936 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 6)<br>Resident #2. CNA #3 was already in the room setting up a meal tray when the RN Supervisor was requested to enter the resident's room. Interview was conducted with CNA #3 on 8/25/2020 at 12:30 p.m. The CNA indicated she had not noticed the siderail being detached. The CNA stated Resident #2 had been walked by therapy earlier and afterwards had become agitated. CNA #3 stated she had assisted Resident #2 earlier with getting in the bed and had put the siderail up. The CNA indicated he/she was preparing to get the resident up into a bedside chair to assist him/her with eating lunch. A request was made on 8/25/2020 at 12:35 p.m. for the Administrator to go to the room of Resident #2. The Administrator, after noting the siderail was detached, confirmed the resident was at an increased danger of an entrapment accident. The Administrator indicated the Maintenance Director would be notified immediately. Staff were to remain with the resident until the equipment could be repaired or the bed replaced. |
| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observation, interview and policy review, it was determined the facility failed to maintain the freezer at the appropriate temperature to maintain safe and operating conditions. Three (3) of the four (4) days of the survey the freezer was not maintaining zero (0) degrees Fahrenheit. The facility also failed to follow their policy for storing and disposing of leftover foods. On the first day of the survey there were six (6) items not dated or stored properly. This failed practice had the potential to affect all residents eating meals out of the kitchen. Findings include: On 8/23/2020 at 4:00 p.m. during the initial kitchen tour, it was observed that the walk-in freezer temperature was registering at 10 degrees Fahrenheit. The Cook#1, who was in charge of the kitchen that day, stated, We have a leak. There was an ice buildup in the back of the freezer and the ice cream wasn't frozen. The facility form, Refrigerator/Freezer Temperature Log Form revealed the freezer temperatures were not recorded since August 17, 2020. There was no documentation that the freezer reached zero (0) degrees Fahrenheit in the past seven days. The form documented the freezer temperature should register at negative 10 to zero (0) degrees Fahrenheit. The Administrator was made aware of the freezer situation. The following was observed in the reach in cooler. All items were stored in non NSF (National Safety Foundation) approved containers: Tuna salad was dated 8/2/2020, A undated, unlabeled non NSF approved container had an unknown substance in it. Cook #1 stated it was peanut butter and jelly. Another container had documented on it Pimento spread, it was dated 6/29/2020, Tropical fruit was dated 7/5/2020, Peaches were dated 8/13/2020. There were also two empty containers chicken salad and egg salad that did not have dates of when they were opened. Cook#1 stated, It's not a good idea to reuse the containers, the lids get mixed up. We are supposed to date the containers the day we open them. There was no internal thermometer in the reach in cooler. Cook#1 stated, I don't know where there are extra thermometers. The Foodservice Supervisor has them somewhere. On 8/23/2020 at 5:00 p.m., the Maintenance Director stated, Someone came out a while ago to look at the drip, I guess it needs to be looked at again. This is the first I've heard about the freezer not working. On 8/23/2020 at 5:30 p.m., the Administrator stated that Hobart (the company that maintenances the freezer)was called, and they were coming in later to look at the freezer. On 8/24/2020 at 10:00 a.m., the freezer was registering 20 degrees Fahrenheit. The Foodservice Supervisor confirmed that the last freezer temperature was documented on August 16, 2020 and that the temperatures should be recorded daily. The Foodservice Supervisor also indicated that the Hobart representative came in on the evening of 8/23/20. She agreed the freezer temperatures and storage containers were a concern. At 2:30 p.m., the freezer was registering 30 degrees Fahrenheit. At 2:45 p.m., the Administrator stated the Hobart repair representative was going to come out again to fix it. In an interview with the Consultant Dietitian on the phone at 3:00 p.m., she stated she would come to the facility tomorrow to help with disposing of any food and making menu changes. She acknowledged the freezer temperatures were a concern. On 8/25/2020 at 10:30 a.m., the freezer was registering 10 degrees Fahrenheit. The FSD stated she had already called Hobart to come back out. At 12:10 p.m., the freezer was still registering 10 degrees Fahrenheit. At 2:15 p.m., the Administrator stated, If he (Hobart) can't fix it today we will order a frozen food truck to put the food in. He is supposed to come in later to try and fix it today. On 8/26/2020 at 10:30 a.m., the Field Representative from Hobart was in the freezer fixing it. He said he came out because the freezer was registering five (5) degrees Fahrenheit at 7:00 a.m., instead of zero (0). At 2:00 p.m., the freezer was registering zero (0) degrees Fahrenheit. Review of the facility policy, Refrigerators and Freezers, undated, documented Acceptable temperatures should be less than zero (0) degrees Fahrenheit for freezers. Monthly tracking sheets will include time, temperature, initials and action taken. The last column will be completed only if temperatures are not acceptable. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. Review of the policy Leftover Food Items, undated, documented, Leftovers may be kept in the refrigerator for 3-4 days or frozen for 3-4 months. In an interview with the Foodservice Supervisor on 8/26/2020 at 11:00 a.m., she stated new NSF food containers were ordered to store the leftover food properly. |
| F 0908<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Keep all essential equipment working safely.**<br><br>Based on observation, interview and policy review, it was determined the facility failed to maintain essential equipment in proper working condition. For three (3) of the four (4) days of the survey the walk-in freezer was not maintaining 0 degrees Fahrenheit. All meal were served out of this kitchen. This failed practice had the potential to affect all residents. The census on the first day of the survey was 54. Findings include: On 8/23/2020 at 4:00 p.m. during the initial kitchen tour, it was observed that the walk-in freezer temperature registered 10 degrees Fahrenheit. There was an ice buildup in the back of the freezer which covered two shelves containing boxes of food. The Refrigerator/Freezer Temperature Log Form revealed the freezer temperatures had not been recorded since 8/17/2020. There was no documentation that the freezer reached 0 degrees Fahrenheit in the past seven days. The form indicated the freezer temperature should register between negative 10 degrees Fahrenheit (F) to 0 degrees F. On 8/23/2020 at 5:00 p.m., the Maintenance Director stated, Someone came out a while ago to look at the drip, I guess it needs to be looked at again. This is the first I've heard about the freezer not working. The Maintenance Director was not aware of the elevated temperatures in the freezer. On 8/24/2020 at 10:00 a.m., the freezer registered 20 degrees F. The Foodservice Supervisor confirmed the last freezer temperature was taken on 8/16/2020; the temperatures should be recorded daily. On 8/24/2020 at 2:30 p.m., the freezer registered 30 degrees F. On 8/24/2020 at 2:45 p.m., the Administrator stated the Hobart repair representative was going to come out again to fix it. On 8/25/2020 at 10:30 a.m., the freezer registered 10 degrees F. The Food Service Director stated he/she had already called Hobart to come back out. On 8/25/2020 at 12:10 p.m., the freezer registered 10 degrees Fahrenheit. On 8/25/2020 at 2:15 p.m., the Administrator stated, If (he/she) (Hobart) can't fix it today we will order a frozen food truck to put the food in. (He/she) is supposed to come in later to try and fix it today. On 8/26/2020 at 10:30 a.m., the Hobart Field Representative was in the freezer fixing it. He/she said he/she came out because the freezer was registering 5 degrees F at 7:00 a.m., instead of 0 F. On 8/26/2020 at 2:00 p.m., the freezer registered 0 degrees F. Review of the facility policy, Refrigerators and Freezers undated, documented Acceptable temperatures should be less than 0 degrees Fahrenheit for freezers. Monthly tracking sheets will include time, temperature, initials and action taken. The last column will be completed only if temperatures are not acceptable. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. Review of a policy titled Preventative Maintenance Program (Implemented January 2018) revealed a policy statement A preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public . The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. The procedures for implementation revealed the Maintenance Director would asses all aspects of the physical plant to determine if preventative maintenance was required. If preventative maintenance was required, the Maintenance Director would decide what tasks need to be completed and how often to complete them. The Maintenance Director would obtain assistance with keeping track of all tasks by having yellow maintenance request slips dated in the computer. All repair requests were to be made in writing, using the maintenance requisition forms. Work orders would be completed according to the nature of the problem. Interview was conducted on 8/26/2020 at 2:40 p.m. with the Maintenance Director while the environmental tour was being conducted. The Maintenance Director indicated that in accordance with facility policy, nursing and other staff members were required to complete a yellow maintenance request slip when they identify any concerns with the environment. At 3:00 p.m. the |

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| F 0908<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 7)<br>Maintenance Director stated he/she thought the freezer was working until this past Sunday (8/23/2020) until it was brought to his attention by the surveyor during the initial kitchen tour. He stated he did not receive any repair requests. The facility failed to follow their policy to maintain equipment in working order. |