STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Specialty Care	1977 Albia Road Ottumwa, IA 52501

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure staff spoke to residents with respect and dignity for 1 of 2 residents reviewed for dignity (Resident #20). The facility reported a census of 56 residents. Findings: The Minimum Data Set(MDS) assessment tool, dated 8/27/24, listed diagnoses for Resident #20 included bipolar disorder (a disorder characterized by alternating periods of depression and mania), schizophrenia (a mental health illness that affected a person's thoughts, feelings, and behaviors), and obsessive-compulsive disorder. The MDS listed a Brief Interview for Mental Status(BIMS) score of 3 out of 15, indicating severely impaired cognition. The Care Plan, Revision On: 9/9/24, included a Focus area to address I have impaired cognitive function/dementia or impaired thought processes. An Intervention included, in part: COMMUNICATION: Face me when speaking and make eye contact, and Stop and return if I am agitated. Date Initiated: 4/15/24. During a phone interview on 10/28/24 at 12:46 PM, Staff O Registered Nurse (RN) stated Staff P Licensed Practical Nurse (LPN) told him he needed to go to Resident #20's room. He stated Staff Q Certified Nursing Assistant(CNA) was very angry and stated she could not tolerate this disrespect anymore while she pointed her finger at him. Staff O stated the resident could have had hallucinations and she should have been receptive to his behavior. Staff O stated the resident was not in all senses and she shouldn't be that angry. He stated after the interaction, Staff Q immediately went home. During a phone interview on 10/28/24 at 2:00 PM, Staff P stated Staff Q stood beside Resident #20's roommate and stated that he didn't get to talk to her that way, it was rude and disrespectful, and she wouldn't put up with that. Staff P stated Staff Q was disrespectful, demeaning, and spoke to him like he was a child. During an interview on 10/29/24 at 10:25 PM, Staff Q stated Resident #20 swore at her and called her a b----. She told him he didn't need to disrespect her that way and she would not be disrespected. She stated after this interaction, Staff O sent her [Staff Q] home. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident, Accident, Unusual Occurrence Note, dated 10/16/24 at 10:00 PM, revealed a CNA yelled at a resident in Room [number redacted] and stated he was not going to be rude and disrespectful to her and told the resident his behavior was unacceptable. The CNA explained that the resident was rude and threw his remote. The nurse asked the CNA to leave the room. On 10/30/24 at 10:02 PM, the Assistant Director of Nursing (ADON) stated staff should speak to residents in a kind and respectful manner and stated if the resident had behaviors, she expected staff to remain calm and continue to be kind and respectful. On 10/30/24 at 10:16 PM, the Administrator stated staff should speak to residents kindly and with an attitude of customer service. He stated Staff Q could have chosen her words better. The facility policy Dignity revised February 2021, directed staff to care for residents in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, clinical record review, and staff interviews, the facility failed to assist a resident with changing their clothing after food spilled on their pants and shirt during a meal (Resident #8) for 1 out of 3 residents reviewed. The facility reported a census of 56 residents. Findings include: The Minimum Data Set, dated dated [DATE], for Resident #14 revealed diagnoses of Huntington's disease, muscle wasting and anxiety disorder. The MDS identified the resident dependent on a wheelchair for mobility. The Care Plan, Date Initiated: 10/6/23, included a Focus area to address Activities for Daily Living (ADL's). Interventions included, in part; Eating - I am substantial assist x 1 (one staff), Upper Body Dressing - I am dependent assist x1, and Lower Body Dressing - I am dependent assist x 1 with a Date Initiated: 10/6/23. During an observation on 10/22/24 at 9:06 AM, Resident #14 assisted to his room by Staff S, Certified Nursing Assistant (CNA) after breakfast. Spilled food noted on Resident #14 shirt and pants. After exiting the room, Staff S stated staff assists Resident #14 to eat, and she provided pericare after assisting the resident to bed. Resident #14 dressed in same clothing after cares. During an observation on 10/22/24 at 1:10 PM, after lunch Resident #14 in bed. Resident wearing same shirt and pants, with additional food spilled from the noon meal. During an interview on 10/23/24 at 12:58 PM, Staff B, Certified Medication Aid, (CMA) stated staff should change a resident's clothes after a meal if it is dirty. During an interview on 10/23/24 at 2:53 PM, Staff F, CNA stated staff should change resident's clothes anytime they have food on them. I wouldn't want to walk around with food on my clothes and they shouldn't either. During an interview on 10/23/24 at 1:15 PM, the Director of Nursing (DON) stated her expectation was for the staff to change resident's clothes if dirty.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51573 Based on observation, staff interview, and clinical record review, the facility failed to provide continued assessment for Resident #23 after an episode of excessive coughing caused by taking medications with a thin liquid, instead of the physician ordered nectar consistency liquid. The facility reported a census of 56 residents. Findings Include: The Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #23 scored a 4 out of 15 on a Brief Interview for Mental Status (BIMS) test, indicating severely impaired cognition. The MDS listed diagnoses included: aphasia (inability to swallow), cerebrovascular accident (CVA-interruption of blood flow to the brain leading to neurological issues), transient ischemic attack (TIA-a brief blockage of blood flow to brain), or stroke, and dysphagia (swallowing difficulties). The MDS identified Resident #23's with a Mechanically altered diet - required change in texture of food or liquids (e.g., pureed food, thickened liquids). The Oral/Dental Status of the resident indicated No natural teeth or tooth fragment(s). A review of the Care Plan Diagnosis section, revealed, in part, PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT. A review of Physician Orders revealed an order, dated 4/27/23, for Regular/NAS (no salt added) diet. Level 4 Pureed texture, Level 2 Mildly Thick (Nectar) consistency. The Care Plan, updated on 10/22/2024, included a Focus area to address I am at increased nutritional risk d/t (due to) med dx (diagnosis) of severe protein-calorie malnutrition, dysphagia, underweight, HTN (high blood pressure), HLD (high cholesterol), GERD (gastroesophageal reflux disease, cause of heartburn). An Intervention included, in part: Regular diet, Puree texture, level 2 mildly thick Nectar thick liquids. Date Initiated: 10/27/23. Revision on: 7/8/24. During an observation on 10/23/24 at 8:02 AM, Staff A, Certified Medication Assistant (CMA) administered Resident #23's medications with regular, unmodified consistency water. After the administration, the resident began coughing significantly. Staff A retrieved nectar thickened water to assist Resident #23 with the coughing. Staff D, Licensed Practical Nurse(LPN), commented that Resident #23 was thickened liquids to which staff A replied I know. Staff D then commented she normally administered Resident #23's medications in pudding to prevent him from choking to which Staff A replied that she was not aware of that. Staff D then came over to Resident #23 and asked him if he was ok and wiped his nose and mouth with a tissue. Resident #23 continued to cough and had large amounts of drainage from his mouth and nose. Staff D observed Resident #23 at the nurse's station for approximately 3 minutes until he stopped coughing. The resident then continued down the hall to his room. During an interview on 10/23/24 at 8:13 AM, Staff A, CMA stated that she provided Resident #23 with non-thickened liquids. Staff A was aware that Resident #23 had a thickened liquid diet order but she was not aware that he normally received his pills with pudding. Staff A stated she normally mixed his Miralax (stool softener) with water to dissolve the Miralax and then added a thickened supplement to it afterwards but was running low on the supplement so she forgot to thicken the liquid. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 8:30 AM, Staff D, LPN stated that the pudding was just a personal preference for the resident and that she believed that the resident has had Speech Therapy change his liquid consistency several times. Staff D noted that there was an area on the electronic MAR that documented resident preferences that was put into place for agency staff. During an observation on 10/23/24 at 8:32 AM, Resident #23 while in his room, sat in his recliner. His face appeared bright red, and he had large amounts of secretions coming from his mouth and nose. When the State Agency (SA) asked the resident if he was ok, he shook his head no and pointed to his chest and stated he felt like something was stuck. The SA informed Staff D, LPN of the findings. Staff J, Director of Nursing (DON) and Staff K, Regional Director of Clinical Services (RDCS) accompanied Staff D into Resident #23's room. On 10/23/24 at 8:37 AM, Staff D, LPN brought in a basin and equipment for vital signs (thermometer, blood pressure cuff, pulse oximeter, stethoscope). Staff D listened to the resident's lung sounds on his back, and obtained a blood pressure, and temperature. The resident stated that he did not feel better. When Staff J, DON asked the resident if he felt short of breath, he shook his head no. On 10/23/24 at 8:42 AM., Staff J, DON asked the resident if he felt like he had something stuck in his throat and he responded yes. On 10/23/24 at 8:45 AM, the resident continued to have a cough and runny nose and stated he did not feel well. On 10/23/24 at 8:48 AM, Staff J, DON and Staff K, RDCS cleaned up the resident and asked him to take a deep breath and cough several times. At this time Staff J left the room and called the physician to notify him of the resident's status. On 10/23/24 at 8:53 AM, the resident took one drink of thickened liquids and began coughing. Staff K, RDCS stated to call the physician and Staff J, DON said that she had already called. The resident coughed up a large amount of secretions after he took one drink. On 10/23/24 at 8:54 AM, Staff D, LPN left the room for one minute and came back in with new orders from the physician for a two-view chest x-ray and orders for temperature and lung sounds every shift for the next three days. On 10/23/24 at 9:26 AM, via phone, Staff R Registered Dietician (RD) stated Resident #23 had an order for nectar thick liquid which was in place since April of 2023. She stated she would absolutely not be ok with him receiving thin liquids since he had dysphagia (difficulty swallowing) and could aspirate (inhale food or liquids into the lungs). On 10/23/24 at 9:53 AM, the resident sat in his recliner watching TV with no obvious signs of distress observed at this time. On 10/23/24 at 9:56 AM, the Certified Dietary Manager (CDM) stated Resident #23 had always received thickened liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 10:39 AM, the DON stated residents should receive the ordered liquid consistency and Resident #23's order was nectar thick. She stated (after a coughing episode) she expected the nurse to complete a full respiratory assessment to include vitals, an oxygen level, and a check for cyanosis (blue color to the skin). She stated she expected the nurse to notify the provider and check on them every 15-30 minutes. She stated she expected staff to stay with him if they thought something was stuck (in the throat). On 10/30/24 at 12:35 PM, Staff N, Speech Therapist stated that she believed that Resident #23 was a high risk for aspiration as that was why he was ordered for a mechanically altered diet. He did not have any teeth and she recommended that he be provided with nectar thickened liquids at all times. 35434 The facility policy, revised February 2021, titled Change in a Resident's Condition or Status, Policy Interpretation and Implantation section, directed staff, in part, to: 1. The nurse will notify the resident's attending physician or physician on call when there has been: a. accident or incident involving the resident; d. significant change in the resident/s physical/emotional/mental condition; 2. A significant change of condition is a major decline or improvement in the residents status that: a. requires interdisciplinary review and/or revision of the care plan; 3. Prior to notifying the physician or healthcare provider, the nurse will make a detailed observation and gather relevant and pertinent information for the provider, including information prompted by the SBAR (Situation, Background, Assessment, Recommendation) communication form. 9. If a significant change in the resident's physician or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA (Omnibus Budget Reconciliation Act) - federal law aimed to improve quality of care in long term care facilities) regulations governing resident assessments and as outlined in the MDS RAI (Resident Assessment Instrument) Instruction Manual.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, clinical record review and staff interviews, the facility failed to ensure safe wheelchair transport for 1 of 1 residents reviewed (Resident #12). The facility reported a census of 56 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The MDS indicated the resident utilized a wheelchair for mobility, and had not attempted to self propel due to medical condition or safety concerns. Review of the Care Plan for Resident #12 dated 6/13/22, revised 6/6/23 revealed, I am at risk for falls. The Intervention dated 5/26/23 revealed, Keep my w/c (wheelchair) pedals off due to my like to self propel. An observation on 10/22/24 at 3:18 PM revealed Staff A, Certified Medication Aide (CMA) pushed Resident #12 while the resident's feet were off of the pedals of the wheelchair, and were below the level of the wheelchair pedals. On 10/22/24 at 3:21 PM, Resident #12 observed pedaling herself in her wheelchair in the common area. On 10/22/24 at 3:43 PM, Staff B, CMA observed assisting Resident #12 to move while the resident was in their wheelchair. One of the resident's feet observed to drag on the floor at the time of the observation. During an observation on 10/22/24 at 4:14 PM. Staff C, CNA (Certified Nursing Assistant)/CMA assisted Resident #12 from dining room while Resident #12 present in their wheelchair. The resident's feet were not on the wheelchair pedals, and both feet slid across the floor while the staff member assisted the resident. On 10/22/24 at 4:19 PM, Staff C observed assisting the resident back into the dining room, and the resident's feet slid across the floor not on the foot pedals. During an interview on 10/23/24 at 2:18 PM, Staff E, CNA queried about where feet were to be when assisting resident in wheelchair, and acknowledged on pedals. During an interview on 10/23/24 at 2:58 PM, Staff F, CNA acknowledged resident's feet should be no the foot pedals when resident assisted in wheelchair. During an interview on 10/24/24 at 3:32 PM, the Director of Nursing (DON) explained she had been given misinformation from the previous DON that staff could be present on the side to assist for residents who could self propel, and explained not allowed to do anything without foot pedals.