STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Health Campus	181 Campus Dr Lawrenceburg, IN 47025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 50498 Based on interview and record review, the facility failed to provide the scheduled Activities of Daily Living care related to bathing for 1 of 3 residents reviewed. (Resident 64) Findings include: During an interview on 07/22/24 at 2:13 P.M., Resident 64 indicated she was lucky to get a shower once a week. At home she showered every other day. The resident's clinical record was reviewed on 07/24/24 at 10:02 A.M. An admission MDS (Minimum Data Set) assessment, dated 06/29/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, a right hip fracture, Clostridioides difficile (C-diff, a bacteria that causes watery Diarrhea), and urinary tract infection. The resident tested positive for C-diff Toxins on 07/03/24. The Electronic Health Record History and the Shower Sheets indicated the resident had the following showers or complete bed baths from admission to the facility from 06/26/24 to 07/26/24: - On 07/04/24 the resident refused a shower. - On 07/08/24 the resident received a complete bed bath. - On 07/15/24 the resident received a shower. - On 07/18/24 the resident refused a shower. - On 07/22/24 the resident received a complete bed bath. The resident had only five documented showers, complete bed baths, or refusals since admission. The resident should have had 11 documented showers in the time frame reviewed. During an interview on 07/25/24 at 1:34 P.M., QMA (Qualified Medication Aide) 4 indicated residents were to be offered showers at least twice a week but could be more if requested. Bathing was to be documented in the electronic record and on a shower sheet. If there was a refusal, they would need to fill out a refusal form with the nurse. (continued on next page)

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.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/24 at 10:01 A.M., RN (Registered Nurse) 6 indicated the resident's scheduled shower days were Monday and Thursday evenings. If a resident refused to take a shower two different CNA's (Certified Nurse Aide) would attempt to offer the resident a shower and then the nurse would try. If they continued to refuse, then family was notified, and a refusal form was filled out and signed. The current facility policy, titled Guidelines for Bathing Preference with a review date of 12/31/22, was provided by the DON on 07/26/24 at 2:28 P.M. The policy indicated, .Bathing shall occur at least twice a week unless resident preference states otherwise . 3.1-38(a)(2)(A)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34232 Based on observation, record review, and interview, the facility failed to follow appropriate infection control guidelines while providing indwelling urinary catheter care for residents with a history of UTIs (Urinary Tract Infections) for 2 of 3 residents reviewed for UTIs. (Residents 62 and 26) Findings include: 1. Indwelling urinary catheter care was observed for Resident 62 on 07/25/24 at 2:15 P.M., with CNA (Certified Nurse Aide) 2 and CNA 3. The staff donned gowns from the cart that was just inside the resident's room door due to the resident being in Enhanced Barrier Precautions and placed a plastic bag containing clean linens on the foot of the resident's bed. The staff donned gloves. CNA 2 prepared water in a basin in the bathroom for the procedure. CNA 3, wearing her gloves, proceeded to shut the window blind, turned on the light over the bed, and adjusted the resident's bed using the bed controls. CNA 2 brought the pan of water out and placed it on the over the bed table. The two staff members pulled the resident's pants down and rolled the resident side to side, placing a towel under their buttocks. CNA 3 put a clean towel in the tub of water then cleaned around the entry point of the catheter tubing at the head of the penis, turning the towel, pulling away from the body with each wipe, and detached and reattached the tubing from the anchor on the resident's left upper thigh. She cleaned the skin folds and leg creases turning the towel. The CNAs took the resident's boots off, sat them on the bed, took off the resident's pants, put on a new brief, put the resident's pants and shoes back on, and removed the towel from underneath the resident wearing the same gloves the entire time. The CNAs bagged the dirty linens, removed gowns and gloves, and washed their hands with soap and water. The clinical record for Resident 62 was reviewed on 07/24/24 at 10:10 A.M. A Scheduled 5-day MDS (Minimum Data Set) assessment, dated 07/02/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, UTI, sepsis, stroke, dementia, diverticulosis, partial intestinal obstruction, hemiplegia, and cirrhosis of the liver. The resident had an indwelling urinary catheter and was frequently incontinent of bowel An Infection Tracking Surveillance Log was provided by the Corporate Clinical Support on 07/29/24 at 10:45 A.M. The record indicated the resident was treated for a UTI from 07/12/24 to 07/18/24 with the antibiotic Macrobid. 38239 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 07/25/24 at 3:17 P.M., CNA 3 was observed as she provided suprapubic urinary catheter (an indwelling catheter placed through the skin, just above the pubic bone and into the bladder) care for Resident 26. CNA 3 washed her hands and donned gloves. With her gloved hands she moved papers and a remote control from the resident's overbed table. Supplies were placed on the overbed table and at the foot of the bed. She turned on the light, adjusted the window blinds, and repositioned the overbed table. She grabbed the bed controller and adjusted the position of the bed. She pulled the resident's blankets down. She took the basin with water over to the resident and let her feel the water to check the water temperature. She placed the basin back on the table, placed a washcloth in the basin, grabbed the roll of trash bags, opened a bag, and placed it at the foot of the bed. She exposed the resident's skin and the catheter insertion site, took the washcloth from the basin, applied a cleanser to it, and began cleaning the resident's urinary catheter. During an interview on 07/25/24 at 3:33 P.M., CNA 3 indicated after she adjusted the blinds and moved the resident's items around, she normally would have washed her hands and put on new gloves before performing the actual catheter care. The resident's clinical record was reviewed on 07/26/24 at 10:04 A.M. A Quarterly MDS assessment, dated 05/20/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, multiple sclerosis, cancer, stroke, neurogenic bladder, chronic myeloid leukemia, dementia, and depression. An Infection Tracking Surveillance Log was provided by the Corporate Clinical Support on 07/29/24 at 10:45 A.M. The record indicated the resident was treated for a UTI from 06/15/24 to 06/24/24 with the antibiotic Bactrim. The current facility policy, titled Urinary Catheter Care, reviewed on 12/31/23, was provided by the DON (Director of Nursing) on 07/29/24 at 11:30 A.M. The policy indicated, .Prior to the beginning of the procedure . close drapes/lower shades/close blinds .place the clean equipment on the bedside stand or overbed table . Arrange supplies .Wash and dry hands thoroughly .put on gloves .wash the resident's genitalia and perineum thoroughly .remove gloves .wash and dry your hands .put on clean gloves .cleanse and rinse the catheter from insertion site .Remove gloves .Wash and dry hands thoroughly .Reposition the bed covers .Make the resident comfortable .Wash and dry hands thoroughly . 3.1-41(a)(2)