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	04/11/2024

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 22506 Based on clinical record review and staff interviews, the facility failed to revise a Care Plan to address the need for supervised visits, following an allegation of abuse perpetrated by a family member. (Resident #1) The facility reported census was 58. Findings include: According to a Minimum Data Set (MDS) with a reference date of 1/9/24, Resident #1 had a Brief Mental Status (BIMS) score of 15 indicating an intact cognitive status. Resident #1 required dependent assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Cerebrovascular accident (stroke), left hemiplegia, atrial fibrillation and gastroesophageal reflux disease. In an interview on 4/8/24 at 1:37 p.m. the Director of Nursing (DON) stated on the evening of 1/7/24 he received a call from his overnight nurse (Staff A) reporting an allegation made by Resident #1, that bruising discovered on her right arm that evening was caused by her spouse grabbing her that day and telling her she was costing him too much money. Resident #1 stated her spouse can be mean. The DON stated he notified the police, the Department of Health and Human Services (DHS) and made a self report to the Department of Inspections, Appeals and Licensing (DIAL). The DON stated he then notified the spouse and informed him of the allegation and that he would be unable to visit. The DON stated the spouse stated Resident #1 was upset because he wouldn't take her home and stated she had made similar allegations when she was in the hospital. The DON stated the next day he called the hospital and spoke with a case manager, who confirmed Resident #1 had made an allegation of abuse by her spouse, but noted it was not substantiated. The DON stated they initiated supervised visits in which either a nurse or social worker would provide line of sight supervision while Resident #1 and her spouse visited in the dining room. The DON stated the intervention was in the care plan. The reviewed Nursing Assignment sheets dated 1/15/24 to 2/23/24 documented that the spouse and Resident#1 had supervised visits. In a follow up interview on 4/8/24 at 4:45 p.m. the DON stated following further review of the events, line of site supervision during visits was provided throughout the remainder of Resident #1's stay. The DON stated the supervision interventions were not added to the care plan or Kardex. (continued on next page)

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care Plan found no interventions to address the need for supervised visitations following an allegation of abuse perpetrated by a family member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. 22506 Based on observation, clinical record review and resident and staff interviews, the facility failed to provide catheter cares, grooming and personal hygiene needs for 1 of 3 residents reviewed. (Resident #3) The facility census was 58. Findings include: The Admission Minimum Data Set (MDS) with a reference date of 3/17/24, documented Resident #3 had a Brief Mental Status (BIMS) score of 15 which indicated an intact cognitive status. Resident #3 required dependent assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #3's diagnosis included congestive heart failure, atrial fibrillation, renal insufficiency, arthritis and morbid obesity. The MDS documented that the resident had always been incontinent of urine and bowel. Resident #3 had a Foley catheter. During observations on 4/11/24 from 7:40 a.m. through 1:50 p.m. Resident #3 was not provided catheter care, grooming or personal hygiene services. Observation on 4/11/24 at 8:40 a.m. found Resident #3 sitting up in bed with her room tray on bedside table. Resident #3 stated staff assisted her up in bed this morning, but did not provide any peri cares or catheter cares. Resident #3 stated she was not feeling well and felt ignored. Resident #3 stated she requests bed baths because of her perineal sores and the Hoyer sling irritating them when transferred, but states she does not get them regularly and does not refuse baths. During an observation on 4/11/24 at 10:30 a.m. Resident #3 stated there has been no one this morning checking or cleaning her catheter or providing her peri cares, oral cares, grooming or change of clothes. Observation on 4/11/24 at 11:00 a.m. noted Resident #3 was receiving therapy at this time in her room. Was transferred from her bed into her recliner. Pleasant affect. Resident #3 stated she was wearing the same gown as she has for the past few days. Observation on 4/11/24 at 1:50 p.m. Resident #3 was transferred from her recliner back into bed by therapy staff. Resident #3 stated therapy staff are the only ones that can transfer her. Resident #3's catheter bag was emptied by aide. Resident #3 stated no one has cleaned her catheter tubing today or provided basic grooming needs like a wet cloth to wash her face or hands. Resident #3 stated she is still wearing her original brief that was put on her last night. In an interview on 4/15/24 at 8:53 a.m. the Director of Nursing (DON) stated staff are to provide activity of daily living cares, oral hygiene, dressing, grooming and preferably catheter cares in the morning of each day and as needed throughout their shift. Catheter care includes cleaning the tubing at least once a shift and as needed if it becomes visibly soiled. Cares should include offering a wash cloth to wash the resident's upper torso, face and hands, perineal care and a change into a fresh brief and clothing.