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	12/22/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to ensure 2 of 10 residents on a mechanical soft diet received the correct texture (Residents #44 and #64). The facility reported a census of 55 residents.Findings included: Review of the facility policy Therapeutic Diets, revised October 2017, revealed the provider prescribed therapeutic diets in accordance with the resident's goals and preferences. Therapeutic diets were part of a treatment plan and included alterations to texture. Review of the document, Diet Type Report listed Residents #44 and #64 with a diet order for mechanical soft. Review of a document titled, [name of corporation redacted] FW25 Traditional SUN No Alts Diet Spreadsheet for lunch on 12/17/25 indicated the menu item of Buttered Corn mechanical Soft as 1 each corn PU (pureed). During an observation on the noon meal service on 12/17/25 starting at 12:15 PM, Staff A, [NAME] served Resident #44 corn vs the mechanical soft pureed corn. Staff A caught the mistake before Resident #44 consumed the corn. Staff A stated kitchen prepared another tray for the resident. At 1:12 PM, Staff A, [NAME] prepared room trays for staff to deliver.At 1:32 p.m., Resident #64 had a lunch plate in her room. The resident finished with her lunch, with a few kernels of regular corn remaining on the plate. The resident stated she ate the corn without problems.During an interview on 2/17/25 at 2:01 PM, the Dietary Manager stated the meal tickets staff referred to when they served meals directed diet texture orders for residents. During an interview on 12/17/25 at 2:05 PM, Staff A, [NAME] stated she had a feeling she gave Resident #44 the wrong diet so she asked Staff B, an Administrator of a sister facility to check.During an interview on 12/17/25 at 2:10 PM, Staff B stated Staff A, [NAME] asked her to check Resident #44's plate and her plate contained regular corn.

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of facility Quality Assurance and Performance Improvement (QAPI) meeting documentation, Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies, facility policy review, and staff interview, the facility failed to carry out Quality Assurance (QA) activities to prevent the reoccurrence of a deficient practice related to meal textures serviced to residents. The facility reported a census of 55 residents.Findings include:Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) Pro-gram-Governance and Leadership, revised March 2020, revealed a Policy Interpretation and Implementation section, which directed, in part:a. The governing body is responsible for ensuring the QAPI program is implemented and maintained to address identified priorities. b. The responsibilities of the QSPI Committee are to collect and analyze performance indicator data and other information; and establish benchmarks and goals by which to measure performance improvement.Review of the Centers for Medicare and Medicaid Services(CMS) Statement of Deficiencies, dated 10/31/24, listed, in part, a deficiency for F803 - Menus Meet Resident Needs/Prepared in Advance/Followed. The current survey, conducted 12/15/25-12/22/25 identified concerns related to staff serving incorrect textures to residents (F803).On 12/22/25 at 3:28 PM, the Administrator provided a binder which included documentation of facility QA activities since the last recertification. Review of the binder revealed no documentation of QA activities which focused on staff providing the correct diet textures to residents. The Administrator stated she had no additional QA documentation other than what the binder containedDuring an interview on 12/22/25 at 3:53 p.m., the Administrator stated that most of the QA activities were focused on nursing but stated she asked for test trays of different textures to sample. She acknowledged that this would not evaluate whether or not staff provided the correct diet textures to residents. On 12/22/25 at 4:28 p.m., via email, the Administrator provided the following additional documents: Certificates of Completion for staff related to modified diets; Meal Observation Audits conducted 11/6/24-12/13/24; Diet and Fluid Consistency Audits, conducted 10/29/24-12/8/24. The facility lacked further, more recent, documentation of QAPI/QA program activities related to residents receiving the correct diet texture. The facility lacked evidence of an ongoing QAPI program related to this focus area including a process of addressing how the committee would conduct the activities necessary to identify and correct the deficient practice. The facility lacked documentation of monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revision as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review and staff interviews, the facility failed to utilize infection control practices during the draining of a surgical wound for 1 of 3 (Resident #3) reviewed for infection control. The facility reported a census of 55 residents. Findings include: Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #63 list of diagnoses included an abscess of a limb, unspecified. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Review of the Care Plan for Resident #63, dated 12/15/25, revealed a Focus area to address I have a JP (Jackson Pratt - a surgical device with a tube and a suction bulb that removes excess blood and fluid from a surgical site to prevent buildup, infection and swelling, promote healing) to my right thigh. Interventions included:a. Monitor drain output every shift. Date Initiated: 12/15/25,b. Monitor JP drain site every shift. Notify physician if dislodged, purulent drainage, bleeding, or pain to site. Date Initiated: 12/15/25.c. Perform treatment and flush as needed. Date Initiated: 12/15/25.Review of a document titled, Medicine Progress Note, dated 11/20/25 for Resident #63 revealed, in part: admit date : [DATE]. Assessment/Plan:.Right thigh abscess. Pseudomonas bacteremic 10/29/25 and cleared on 10/30/25 S/P (status post) IR (interventional radiology) placement of drain in his infected hematoma in the right thigh on 11/13[2025]Review of the December 2025 Treatment Administration Record (TAR) revealed: a. On 12/17/25 day shift, 50 milliliters (ml) output of JP drain, signed by Staff C, Licensed Practical Nurse (LPN).b. On 12/17/25 am shift, flush the drain to the right posterior thigh with 10 ml of normal saline three times a day. The drain had a 3-way center port with a tap. Reposition tab to open towards the abscess, flush 5 ml then reposition and flush 5 ml towards the bulb. Reposition tap to the closed position and compress the bulb for suction. Clean the port with alcohol and apply the disinfecting cap to the port. Signed by Staff C, LPN.c. On 12/13/25 and 12/14/25 Staff C, LPN signed off completion of night time flush of drain to right posterior thigh drain with 10 ml normal saline. During an observation on 12/16/2025 at 3:41 pm, Resident #63 had a sign on his door that read contact isolation precautions and an isolation cart that contained gloves and yellow gowns. Resident #63 with an intact dressing with a drainage tube that came from the back of the right calf that led up his pants, out the back of his pants to a bulb attached to his outside pant leg secured with a safety pin. The drainage bulb contained serosanguinous (bloody drainage).During an interview on 12/16/25 at 3:42 pm, Staff F, Registered Nurse (RN) stated Resident #63 had a bacterial infection inside his leg so the contact precautions to be used when the staff are touching him. During an observation on 12/17/2025 at 10:12 am, Staff C, LPN entered Resident #63's room. Staff C completed hand hygiene, donned gloves and a gown. Staff C placed the 10 ml syringe of normal saline, and a clean cup onto Resident #63's bedside table. Staff C did not wipe down the table or place down a barrier. Staff C applied a gait belt around Resident 63's waist and assisted him to stand from the wheelchair to his walker. Staff C then removed the safety pen, which secured the JP drain bulb from Resident #63's pants. The drain contained bloody drainage. Staff C then opened the spout to the bulb. Staff C emptied the drainage into the clean cup and placed the cup back on to the bedside table. Staff C replaced the cap to the drainage bulb and secured it with a safety pen to the residents' pants. Without a change of gloves or completing hand hygiene, Staff C, LPN removed the cap to the 3-way stop-cock on the drain tubing and swabbed it. Staff C picked up the syringe from the bedside stand and connected it to the 3-way stop-cock, turned the dial to open and injected the 10 ml's of saline into the drain tubing. Staff C turned the stop-cock dial to drain into the bulb, removed the syringe, placed it onto the bedside stand next to the cup with the drainage and picked up the cap to replace it on the stop cock. Staff C assisted Resident #63 to sit into the wheelchair, picked the syringe and cup off the bedside stand and failed to clean the bedside stand. Staff C placed the cup with contaminated bloody drainage on to the sink counter and stated the drainage was less than 50 ml's. Staff C emptied the drainage into the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toilet. Staff C dropped the contaminated cup, gloves and gown into the trash with a clear bag. A red contamination bag not utilized for disposal. Without completing hand hygiene, Staff C propelled the resident out of the room to the main living room. Staff C did not sanitize the bedside table, or the sink counter prior to exiting the room. During an interview on 12/17/2025 at 10:35 am, Staff D, Housekeeper stated she had been employed for 4 months but was aware the red bags were for contaminated items. She stated they are placed in the large red bag container in the dirty utility room then transferred into the garage for a company to pick them up. Staff D stated the clear trash bags are placed into the main trash and transferred into the outside trash. Staff D stated there are 2 residents in contact isolation. She stated Resident #63 had the isolation sign and isolation cart outside his room but did not have red bags nor isolation barrels in the room so the clear trash bags were discarded into the main trash. During an interview on 12/17/2025 at 10:44 am, Staff E, Housekeeping Supervisor stated there were two residents in the facility on contact isolation. Staff E stated Resident #63 arrived on 12/12/25 and was placed onto contact isolation but was unaware of why. Staff E stated when she became aware Resident #63 was in isolation precautions on 12/15/25, she asked the Assistant Director of Nursing (ADON) about the contact isolation, the ADON responded that she will ask the corporate nurse. Staff E stated the ADON had not responded to her nor asked for isolation barrels for that room. During an interview on 12/17/25 at 10:58 am, the ADON/Infection Preventionist (IP) stated Resident #63 arrived on 12/12/25 and was to be on contact isolation precautions so she had placed the sign on the door with an isolation cart for the staff. The ADON stated she was aware of why Resident #63 needed the Enhanced Barrier Precautions (EBP) due to the wounds and treatment but was not aware of the reason for the contact isolation, the diagnosis of Pseudomonas. The ADON stated she felt badly as she was the infection control nurse. The ADON stated the isolation barrels and red bags were being placed in the room immediately. During an interview on 12/22/25 at 1 pm, Staff C, LPN stated the observation on 12/17/25 was the first time he had provided care for Resident #63 and he did not think about having a red biobag for the discarded items that would have been contaminated with bodily fluids from the drain device when emptied. Staff C stated he was aware of placing contaminated items on the bedside stand and sink counter and that the house keeping clean his room daily so he was not concerned. During an interview on 12/22/2025 at 11:46 am, the Director of Nursing (DON) stated she was the infection preventionist for three years at this facility before accepting the position of DON and the expectation of nursing staff would be for them to utilize a barrier, hand hygiene before, after and during care, utilize red biobags for the bodily fluids and items contaminated with bodily fluids. The DON stated she accepted the referral for Resident #63, was aware of the Pseudomonas and directed the ADON/IP to place him on contact isolation which included the sign, a Personal Protective Equipment (PPE) cart outside of the room and isolation barrels. The DON stated she informed the ADON/IP of the diagnosis and the contact isolation for Resident #63. The DON stated she had asked Staff C, LPN why he did not take a red bag with him if he was dealing with bodily fluids and he replied that he didn't think about doing that. The DON stated her expectation was that the nurses understand isolation precautions and how to handle bodily fluids properly. The policy titled Infection Control Regulations Governing Implementation revealed written standards, policies and procedures which must include standard and transmission-based precautions to be followed to prevent spread of infections and when isolation should be used for a resident.