

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2024
NAME OF PROVIDER OR SUPPLIER Ridgewood Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 624 Pinewood Avenue Seward, NE 68434	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12.006.05(21)</p> <p>Based on observation, interview, and record review, the facility failed to ensure secretions (a substance discharged from the body) were controlled to maintain the dignity of 1 (Resident 4) of 1 sampled resident. The facility census was 60.</p> <p>Findings are:</p> <p>A record review of Resident 4's Admission Record dated 02/12/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 4's Medical Diagnosis dated 02/12/2024 revealed the resident had diagnoses of Cerebral Palsy, Unspecified (disorders that affect a person's ability to move and maintain balance and posture), Dysphagia, Oropharyngeal Phase (swallowing difficulties due to items get stuck in the back of the mouth), Neonatal Aspiration of Amniotic Fluid and Mucus with Respiratory Symptoms (inhaled fluids during birth), Acquired Deformity of the Chest and Ribs, Other Disorders of the Lung, and Muscle Wasting and Atrophy (loss of muscle tissue).</p> <p>A record review of Resident 4's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 12/01/2023 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 99 which indicated the resident was unable to complete the interview. The resident was dependent on staff for all activities of daily living including oral and personal hygiene (cleaning). The MDS did not reveal the resident had a suction machine.</p> <p>A record review of Resident 4's Care Plan with an admitted [DATE] revealed the resident had Focus areas of potential risk for infection related to dependance for personal care, tube feeding, swallowing issues/aspiration risk, and potential for complications related to presence of enteral nutrition feeding tube and Dysphasia and an intervention was head of bed elevated at least 30 degrees as tolerated to reduce the risk of aspiration.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation from the hallway on 02/07/2024 at 9:02 AM revealed Resident 4 was sitting in a wheelchair in the resident's room with a long, thick strand of secretions coming from the Resident's mouth and extended to the Resident's lap and Resident 4 had a weak cough and audible rhonchi (congested sounds heard without a stethoscope). Resident 4 had a towel that covered the chest and abdomen (stomach area) that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>An observation from the hallway on 02/07/2024 at 11:21 AM revealed Resident 4 was sitting in a wheelchair at the nurse station with a long, thick strand of secretions coming from the Resident's mouth and extended to the Resident's lap. Resident 4 had a towel that covered the chest and abdomen that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>An observation from the hallway on 02/08/2024 at 7:22 AM revealed Resident 4 was sitting in a wheelchair in [gender]'s room with a long, thick strand of secretions coming from Resident 4's mouth and extended to the Resident's lap. Resident 4 had a towel that covered the chest and abdomen that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>An observation from the hallway on 02/08/2024 at 11:35 AM revealed Resident 4 was sitting in a wheelchair at the nurse station with a long, thick strand of secretions coming from the Resident's mouth and extended to the Resident's lap. Resident 4 had a towel that covered the chest and abdomen that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>An observation from the hallway on 02/12/2024 at 11:21 AM revealed Resident 4 was sitting in a wheelchair at the nurse station with a long, thick strand of secretions coming from the resident's mouth and extended to the resident's lap. Resident 4 had a towel that covered the chest and abdomen that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>A record review of Resident 4's Clinical Physician Orders dated 02/12/2024 revealed Resident 4 had an order of: May suction orally as needed (PRN) for secretions every 1 hours as needed.</p> <p>An observation from the hallway on 02/12/2024 at 11:21 AM revealed Resident 4 was sitting in a wheelchair at the nurse station with a long, thick strand of secretions coming from the resident's mouth and extended to the resident's lap. Audible rhonchi could be heard, and Resident 4 had a towel that covered the chest and abdomen that was held by a cable around the neck with clips on both sides. Resident 4 had a suction machine in the room that did not have the canister or tubing set up on it.</p> <p>In an interview on 02/12/2024 at 12:47 PM, Registered Nurse (RN)-A confirmed there were Yankauer oral suction tips (a tool used to suction oropharyngeal secretions to prevent aspiration) in the room, but there was not a suction canister or tubing to make the machine usable. RN-A confirmed Resident 4 had an order to suction orally every hour if needed for secretions, but they do not do that. They only do that when Resident 4 choked during oral care. RN-A confirmed the thick secretions from the mouth to the lap was common for Resident 4 and that was why the staff kept the towel on the Resident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 02/13/2024 at 8:58 AM of Resident 4's morning cares revealed the resident had a large amount of thick oral secretions the extended to the lap and the resident had a suction machine in the room with the supplies on the bottom shelf and not hooked up to the suction machine. RN-B completed oral cares and wiped the resident's mouth with a towel but did not orally suction the Resident and [gender] still had audible rhonchi.</p> <p>In an interview on 02/13/2024 at 8:58 AM, RN-B confirmed Resident 4 had a large amount of thick oral secretions. RN-B confirmed that was normal for the Resident and the Resident has always just had the towel on the chest and abdomen. The family was aware, and the family provided the towel clips that go around the neck to protect the resident's clothing. RN-B confirmed the suction equipment and supplies were available and needed put together, but the staff only suctioned the Resident when [gender] choked during oral cares. RN-B confirmed that Resident 4 would not refuse oral suctioning while in the Resident's room.</p> <p>In an interview on 02/12/2024 at 4:07 PM, the Assistant Director of Nursing (ADON) confirmed the ADON observed Resident 4 in a wheelchair at the nurse's station with thick secretions from the mouth to the lap. The ADON confirmed that was normal for Resident 4 and the staff did not orally suction unless the Resident was choking. The ADON confirmed it could be a dignity issue, but it was normal for Resident 4. The ADON confirmed the suction equipment was not set up and ready to go if Resident 4 had an emergency or the staff wanted to suction the Resident's secretions.</p> <p>In an interview on 02/13/2024 at 11:37 AM, the Administrator confirmed the excessive thick secretions for Resident 4 was normal for the resident and the staff had not attempted to orally suction the resident throughout the day to see if it would decrease the secretions that escaped from the mouth. The administrator confirmed it could be considered a dignity issue and the facility did not know how the resident actually felt about the excessive secretions and the clothing protector.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12.006.11E</p> <p>Based on observation, interview, and record review, the facility failed to ensure items stored in the facility's refrigerators and freezers were labeled and dated, ensure kitchen staff performed handwashing for at least 20 seconds, ensure floors in the dry storage and walk-in refrigerator and freezer were clean, and failed to test the sanitizing solution in the sanitizing bucket to prevent potential foodborne illness. This had the potential to affect 59 of the facility's 60 residents that consumed food from the kitchen. The total facility census was 60.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility's undated Labeling and Dating Foods (Date Marking) revealed in the dry storage, individual items would be marked with the date the item was received into the facility. Refrigerated and freezer storage items would be re-dated with a use by date once opened. Prepared food items should be discarded if it doesn't have a specific manufacturer date and has been refrigerated for 7 days, leftover for more than 72 hours, or expired.</p> <p>An observation on [DATE] at 7:52 AM kitchen revealed:</p> <ul style="list-style-type: none"> -1 opened white plastic container of chicken base on the prep table shelf not dated -1 opened bag of mozzarella cheese in the reach-in refrigerator un-dated -1 opened bag of dry mashed potatoes closed with tape on the dry shelf next to the reach-in refrigerator not dated <p>-Walk-In Refrigerator:</p> <ul style="list-style-type: none"> -1 each 18-quart clear container with lid had an orange substance in in not labeled or dated -1 opened and taped closed bag of shredded lettuce not labeled or dated -1 opened and taped shut bag of cabbage not labeled or dated -1 opened and taped shut bag of shredded carrots not labeled or dated -1 opened bag of Sysco Reliance Whipped Topping not dated -2 opened containers Resers Deli Salads not dated -1 opened container Len's Classic [NAME] not dated <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Locked Dry Storage:</p> <p>-1 opened bag and closed with tape Pasta La [NAME] Enriched Noodle Product not dated</p> <p>-1 opened bag and closed with tape Pasta La [NAME] Macaroni Product not dated</p> <p>An observation on [DATE] at 8:42 AM with the facility's cook revealed the all the items list above were not labeled or dated.</p> <p>In an interview on [DATE] at 8:42 AM, the facility's cook confirmed the above listed items had been opened and not been labeled or dated.</p> <p>In an interview on [DATE] at 12:01 PM, The facility's Registered Dietician (RD) confirmed all the items listed above should have been labeled or dated after being opened.</p> <p>B.</p> <p>A record review of undated Visitor Food policy revealed food stored for the residents needed to be labeled and dated and stored safely in the designated area.</p> <p>A record review of the facility's undated, unnamed sign located on the front of the side-by-side refrigerator/freezer revealed: All items in the freezer and refrigerator must be in a covered container and have a name and date. No metal cans are allowed. All open food/leftovers will be thrown away after 3 days or after the expiration date on the container.</p> <p>An observation on [DATE] at 9:56 AM revealed the side-by-side refrigerator/freezer in the North dining room of the Cardinal unit contained:</p> <p>-a bowl covered with plastic wrap labeled with a resident's name and room number was not dated</p> <p>-1 green cup with a white lid did not reveal a name or date</p> <p>-1 opened pop bottle labeled Fanta Orange had a sticky note with a resident's 1st name but no date</p> <p>-1 ice cream cake labeled with a resident's 1st name; last initial was dated ,d+[DATE]</p> <p>-1 cup of a frozen orange frozen substance was not labeled or dated</p> <p>In an interview on [DATE] at 10:16 AM, the RD confirmed the RD observed the items in the side-by-side refrigerator/freezer and the items where not labeled and dated correctly and should have been.</p> <p>C.</p> <p>A record review of the facility's undated Handwashing Techniques revealed the staff should wet hands, apply soap, and scrub hands and arms vigorously for 20 seconds, then rinse. Food handlers must wash hands before start work and after, after using the restroom, when handling raw food, and after touching hair, face, or body, etc. Food handlers should change their gloves before beginning a different task and after handling ready to eat food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A record review of the Handwashing Competency dated ,d+[DATE] revealed the facility staff should have wet hands, apply soap and lather, and rubbed hands together for a full 20 seconds. Staff should have performed handwashing after handling contaminated items and before applying and after removing gloves.</p> <p>An observation on [DATE] at 10:30 AM revealed the facility's Cook tested the temperature (temped) the chicken breast, wiped the thermometer (temp) probe, performed handwashing for 12 seconds and applied gloves. The Cook then performed mechanical process of the chicken, covered with foil, labeled, removed gloves and placed the pan on the steam table prior to preparing chicken broth without handwashing. The Cook then applied gloves, did not perform handwashing, and pureed the chicken breast. The Cook disassembled the blender and ran the blender parts through the dish sanitizer, removed the parts and applied gloves without handwashing, and re-assembled the blender. The Cook then pureed the cauliflower and dumped in a steam pan, covered with foil, labeled and dated, placed in the warmer, got the stuffing, temped the stuffing, got a steam pan from the dishwashing room, went a got food from the walk-in refrigerator, applied gloves, and dumped the stuffing in the blender, all without handwashing. Pureed the stuffing and dumped the blender of stuffing in the steam pan, removed gloves, cover the steam pan with foil, labeled and dated, and put the steam pan in the warmer, without handwashing.</p> <p>In an observation of food preparation on [DATE] at 9:00 AM revealed the Cook changed gloves 5 times during the food preparation process without handwashing.</p> <p>In an interview on [DATE] at 11:20 AM, the RD confirmed the Cook should have applied soap and lathered for at least 20 seconds during food temping and preparation and before and after glove changes.</p> <p>D.</p> <p>An observation on [DATE] at 7:52 AM revealed the floor in the walk-in refrigerator had a gray coating and multiple 2-[NAME] cart tracks through the gray fuzzy substance. The walk-in freezer floor had a gray fuzzy substance on it with scattered frozen French fries and drippings from the meat. The floors in the locked dry storage room had a gray fuzzy substance on them and multiple 2-[NAME] cart tracks from the door to the can racks.</p> <p>In and interview with the Cook on [DATE] at 8:42 AM, the Cook confirmed the Cook observed the floors in the walk-in refrigerator, walk-in freezer, and locked dry storage floors were dirty and should have been clean.</p> <p>In an interview on [DATE] at 11:20 AM, the RD confirmed the floors in the walk-in refrigerator, walk-in freezer, and locked dry storage floors were dirty and should have been clean.</p> <p>E.</p> <p>A record review of the undated EcoLab's Sink and (&) Surface Cleaner Sanitizer Test Strips How-to Guide revealed the Dodecyl Benzene Sulfonic Acid (DDBSA)(a sanitizing chemical) of the Sink & Surface Cleaner Sanitizer should have been between 272 and 700 parts per million (PPM).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on [DATE] at 8:27 AM revealed the Cook took a rag from the sanitizing bucket and wiped the prep table but did not reveal the Cook tested the sanitizing buckets for the active range of DDBSA.</p> <p>A record reveal of the kitchen's logbooks with multiple dates, did not reveal a log for the testing of the sanitizing bucket.</p> <p>In an interview on [DATE] at 8:27 AM, the Cook confirmed she had wiped the food preparation table with a rag from the sanitizing bucket. The cook confirmed the Cook does not test the dilution of the sanitizing bucket and has not tested since re-hired in [DATE] and should have tested the dilution of the bucket to ensure the sanitizer was effective.</p> <p>In an interview on [DATE] at 11:20 AM, the RD confirmed the kitchen sanitizing bucket should have been tested twice a day and was not.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12.006.17B</p> <p>Based on observation, interview, and record review, the facility failed to ensure the oxygen concentrator's (a machine used to deliver purified oxygen) cabinet filters were present and clean for 4 residents (Residents 2, 4, 31, and 60) of 5 sampled residents, ensure 2 residents (Residents 2 and 60) of 2 sampled resident's positive airway pressure device (PAP) masks were cleaned daily, and ensure 1 resident (Resident 20) of 2 sampled resident's PAP filter was clean. The total facility census was 60.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the undated Platinum Series XL, 5, 10 Operators Manual revealed there were cabinet filters on both sides of the unit that should have been removed and cleaned at least once a week. https://www.invacare.com/product_files/1106664.pdf</p> <p>A record review of Resident 2's Order Summary Report dated 02/13/2024 revealed orders of: BiPAP (a machine used to treat sleep apnea) at night with oxygen at 2 liters per minute (l/m) and External Filter: Rinse weekly (Saturdays), let dry and Replace every evening shift Sat.</p> <p>A record review of Resident 2's Treatment Administration Record (TAR) dated [DATE], [DATE], and [DATE] revealed the order of: External Filter: Rinse weekly (Saturdays), let dry Replace every evening shift Sat was marked completed every Saturday, and was last marked completed Saturday 02/10/2024. The TAR revealed Resident 2 used the oxygen every night the resident was at the facility.</p> <p>An observation on 02/07/2024 at 9:24 AM revealed Resident 2 had an Invacare Platinum XL oxygen concentrator in the room that was connected to the PAP and the cabinet filters on each side of the unit were missing.</p> <p>An observation on 02/07/2024 at 1:36 PM revealed Resident 2 had an Invacare Platinum XL oxygen concentrator in the room that was connected to the PAP and the cabinet filters on each side of the unit were missing.</p> <p>In an interview on 02/07/2024 at 1:36 PM, Resident 2 confirmed the oxygen concentrator and PAP was used every night.</p> <p>An observation on 02/08/2024 at 1:27 PM revealed Resident 2 had an Invacare Platinum XL oxygen concentrator in the room that was connected to the PAP and the cabinet filters on each side of the unit were missing.</p> <p>An observation on 02/12/2024 at 7:16 AM revealed the Invacare Platinum XL oxygen concentrator was in the hall by Resident 2's door and the cabinet filters on the unit were missing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 02/07/2024 at 9:42 AM revealed Resident 4 had an Invacare Platinum XL oxygen concentrator in the room that had a nasal cannula (NC)(a tube used to deliver oxygen to the nose) and the cabinet filters on each side of the unit were missing.</p> <p>An observation on 02/08/2024 at 7:22 AM revealed Resident 4 had an Invacare Platinum XL oxygen concentrator in the room that had a NC and the cabinet filters on each side of the unit were missing.</p> <p>In an interview on 02/08/2024 at 01:27 PM, RN-B confirmed the staff cleaned the filters on the oxygen concentrators every Saturday on the night shift.</p> <p>In an interview on 02/12/2024 at 12:47 PM, Registered Nurse (RN-A) confirmed Resident 4's Invacare Platinum XL oxygen concentrator did not have the cabinet filters.</p> <p>In an interview on 02/12/2024 at 1:34 PM, the Assistant Director of Nursing (ADON) confirmed the Invacare Platinum XL oxygen concentrator was in Resident 4's room and it did not have the external cabinet filters and should have. The ADON confirmed the external cabinet filters should have been cleaned and replaced every week. The ADON confirmed the internal filter was very gray and fuzzy and should not have been.</p> <p>C.</p> <p>A record review of Resident 31's Order Summary Report dated 02/08/2024 revealed orders of: Apply oxygen at 1-3 liters per minute as needed and External Filter: Rinse weekly (Saturdays), let dry Replace every evening shift Sat.</p> <p>A record review of Resident 31's Treatment Administration Record (TAR) dated [DATE] and [DATE] revealed the order of: External Filter: Rinse weekly (Saturdays), let dry Replace every evening shift Sat was marked completed every Saturday, and was last marked completed Saturday 02/10/2024. The TAR did not reveal the resident was using oxygen.</p> <p>An observation on 02/07/2024 at 9:24 AM revealed Resident 31 had an oxygen concentrator was on and the Resident had the NC in the nose. The oxygen concentrator was set at 1 l/m. The cabinet filter on left side of the unit was missing.</p> <p>In an interview on 02/07/2024 at 10:32 AM, Resident 31 confirmed [gender] used the oxygen most days when the [gender] felt it was needed.</p> <p>An observation on 02/08/2024 at 7:50 AM revealed Resident 31 had an oxygen concentrator was on and the Resident had the NC in the nose. The oxygen concentrator was set at 1 l/m. The cabinet filter on left side of the unit was missing.</p> <p>In an interview on 02/08/2024 at 01:27 PM, RN-B confirmed the staff cleaned the filters on the oxygen concentrators every Saturday on the night shift.</p> <p>In an interview on 02/12/2024 at 12:47 PM, Registered Nurse (RN-A) confirmed Resident 31's oxygen concentrator did not have the cabinet filter.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2024
NAME OF PROVIDER OR SUPPLIER Ridgewood Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 624 Pinewood Avenue Seward, NE 68434	

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/12/2024 at 1:34 PM, the Assistant Director of Nursing (ADON) confirmed Resident 31's oxygen concentrator was being used by Resident 31, and it did not have the external cabinet filter and should have. The ADON confirmed the external cabinet filters should have been cleaned and replaced every week.</p> <p>D.</p> <p>A record review of the undated Invacare Perfecto2 V Oxygen Concentrator manual revealed there were cabinet filters on both sides of the unit that should have been removed and cleaned at least once a week. https://www.invacare.com/product_files/1106664.pdf</p> <p>A record review of Resident 60's Clinical Census dated 02/08/2024 revealed the Resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 60's Order Summary Report dated 02/08/2024 revealed orders of: 4 l/m of oxygen bled into CPAP every HS and did not reveal an order to clean and replace the oxygen concentrator filter.</p> <p>A record review of Resident 60's TAR dated [DATE] revealed the Resident's oxygen was applied every night 02/06/2024 - 02/12/2024.</p> <p>An observation on 02/07/2024 at 12:31 PM revealed Resident 60 had an Invacare Perfecto2 V oxygen concentrator in the room that was connected to the PAP and the cabinet filter was coated with a gray fuzzy substance.</p> <p>An observation on 02/08/2024 at 7:25 AM revealed Resident 60 had an Invacare Perfecto2 V oxygen concentrator in the room that was connected to the PAP and the cabinet filter was coated with a gray fuzzy substance.</p> <p>In an interview on 02/08/2024 at 7:25 AM, Resident 60 confirmed the oxygen and PAP were used nightly.</p> <p>In an interview on 02/08/2024 at 1:27 PM, RN-B confirmed the staff cleaned the filters on the oxygen concentrators every Saturday on the night shift.</p> <p>In an interview on 02/12/2024 at 12:47 PM, Registered Nurse (RN-A) confirmed Resident 31's oxygen concentrator's cabinet filter was observed and had a gray fuzzy substance on it</p> <p>In an interview on 02/12/2024 at 1:34 PM, the Assistant Director of Nursing (ADON) confirmed Resident 60's oxygen concentrator was being used by the Resident, and the external cabinet filter had a gray fuzzy substance on it and it should have been cleaned. The ADON confirmed the external cabinet filters should have been cleaned and replaced every Saturday night.</p> <p>E.</p> <p>A record review of the facility's undated Your Continuous Positive Airway Pressure (CPAP)/Bi-Level Unit (machines used to treat sleep apnea) policy revealed the portion of the mask that comes in contact with the skin should have been wiped daily with a cloth to remove skin oils from the mask.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident 2's Order Summary Report dated 02/13/2024 did not reveal orders to clean the PAP or supplies.</p> <p>An observation on 02/07/2024 at 9:24 AM revealed Resident 2's PAP mask was laying on the sheets in the bed and had an only film on the mask seal (the part of the mask that comes in contact with the skin).</p> <p>An observation on 02/07/2024 at 1:36 PM revealed Resident 2's PAP mask was draped over the bedside table and there was an oily film on the mask seal.</p> <p>In an interview on 02/07/2024 at 1:36 PM, Resident 2 confirmed the [gender] was wearing the PAP every night, was not sure what it was supposed to be set at, and the staff cleans the mask weekly, but not wiped off daily.</p> <p>An observation on 02/08/2024 at 7:47 AM revealed Resident 2's PAP mask was in the black infection control bag and had an oily film on the mask seal.</p> <p>An observation on 02/12/2024 at 7:16 AM revealed Resident 2's PAP mask was draped over the bedside table and had an oily film on the mask seal.</p> <p>In an interview on 02/08/2024 at 01:27 PM, RN-B confirmed the staff only cleaned the PAP masks weekly on the day shift and it was not completed every day.</p> <p>In an interview on 02/13/2024 at 11:31 AM, the ADON confirmed the staff only cleaned PAP supplies weekly and the mask was not being wiped off daily and should have been per the policy.</p> <p>F.</p> <p>A record review of the facility's undated Your Continuous Positive Airway Pressure (CPAP)/Bi-Level Unit (machines used to treat sleep apnea) policy revealed the portion of the mask that comes in contact with the skin should have been wiped daily with a cloth to remove skin oils from the mask.</p> <p>A record review of Resident 60's Clinical Census dated 02/08/2024 revealed the Resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 60's Order Summary Report dated 02/08/2024 did not reveal orders to clean the PAP or supplies.</p> <p>An observation on 02/07/2024 at 12:32 PM revealed Resident 60's PAP mask was draped over the bedside table with an oily film on the mask seal.</p> <p>An observation on 02/08/2024 at 7:35 AM revealed Resident 60's PAP mask was draped over the bedside table with an oily film on the mask seal.</p> <p>In an interview on 02/08/2024 at 7:35 AM, Resident 60 confirmed the facility's staff had not cleaned the mask or wiped off the seal since the Resident was admitted .</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Ridgewood Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 624 Pinewood Avenue Seward, NE 68434	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/08/2024 at 01:27 PM, RN-B confirmed the staff only cleaned the PAP masks weekly on the day shift and it was not completed every day.</p> <p>In an interview on 02/13/2024 at 11:31 AM, the ADON confirmed the staff only cleaned PAP supplies weekly and the mask was not being wiped off daily and should have been per the policy.</p> <p>G.</p> <p>A record review of the facility's undated Your Continuous Positive Airway Pressure (CPAP)/Bi-Level Unit (machines used to treat sleep apnea) policy revealed that the filter maintenance would depend on the model the resident had, and it would be specific to the manufacturer's recommendations.</p> <p>A record review of the undated ResMed AirSense 10 User Guide revealed the air filter should have been checked and replaced at least every 6 months and the air filter was not washable or reusable. https://document.resmed.com/documents/products/machine/airsense-series/user-guide/airsense-10-device-with-humidifier_user-guide_amer_eng.pdf</p> <p>A record review of Resident 2's Order Summary Report dated 02/13/2024 revealed orders of: BiPAP (a machine used to treat sleep apnea) at night with oxygen at 2 liters per minute (l/m) and External Filter: Rinse weekly (Saturdays), let dry Replace every evening shift Sat.</p> <p>A record review of Resident 2's Treatment Administration Record (TAR) dated [DATE], [DATE], and [DATE] revealed the order of: External Filter: Rinse weekly (Saturdays), let dry Replace every evening shift Sat was marked completed every Saturday, and was last marked completed Saturday 02/10/2024. The TAR revealed Resident 2 used the BiPAP every night the resident was at the facility.</p> <p>An observation on 02/07/2024 at 9:24 AM revealed Resident 2's PAP filter had a gray fuzzy substance on it.</p> <p>An observation on 02/07/2024 at 1:36 PM revealed Resident 2's PAP filter had a gray fuzzy substance on it.</p> <p>In an interview on 02/07/2024 at 1:36 PM, Resident 2 confirmed [gender] was wearing the PAP every night, was not sure what it was supposed to be set at and was not sure that the staff had ever changed the filter.</p> <p>An observation on 02/08/2024 at 7:47 AM revealed Resident 2's PAP filter had a gray fuzzy substance on it.</p> <p>An observation on 02/12/2024 at 7:16 AM revealed Resident 2's PAP filter had a gray fuzzy substance on it.</p> <p>In an interview on 02/08/2024 at 01:27 PM, RN-B confirmed the staff were to clean filters and change the tubing weekly, every Saturday night.</p> <p>In an interview on 02/12/2024 at 1:50 PM, the ADON that the ADON observed the PAP filter and it had a gray fuzzy substance on it and that it should have been cleaned and changed, but had not been.</p>		