STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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 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** 35033 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on medical record review, staff interviews and policy review, the facility failed to ensure new admission wound care orders were timely clarified and completed per physician orders. This affected one (#52) of three residents reviewed for wound care. The facility census was 51. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included malignant neoplasm of the bladder, hematuria, chronic kidney disease, acute kidney failure, diabetes mellitus type two, end stage renal disease and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #52 had intact cognition. Further review of the MDS revealed the resident had surgical wounds and received surgical wound care. Review of hospital documentation dated 09/15/24 revealed Resident #52 had laparoscopic port sites and extraction incision to the anterior of the abdomen. The dressing assessment noted left open to air. The dressing status assessment noted the dressing as clean, dry, and intact. Review of the admission nursing assessment dated [DATE] revealed Resident #52 had a surgical incision in the general abdomen area. Review of Resident #52's physician orders dated 09/17/24 revealed on each dayshift to cleanse surgical wounds to abdomen with normal saline, cover with abdominal pad, and secure with tape as needed if dressing becomes soiled or removed. Review of the treatment administration record (TAR) dated 09/16/24 through 10/01/24 revealed there were no dressing changes completed on 09/21/24 and 09/23/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/09/24 at 1:09 P.M., Corporate Complaint Registered Nurse (CCRN) #500 revealed the facility compliance hotline was notified of concerns regarding Resident #52's care. CCRN #500 revealed the caller alleged Resident #52 had not received wound care for two to three days after his admission. CCRN #500 revealed Resident #52 had no wound care orders in place on admission and the following morning the Director of Nursing (DON) obtained wound care orders after Resident #52's family voiced concerns about the resident's wound dressings not being changed. CCRN #500 also revealed there was no documentation Resident #52's abdominal wound dressings were changed on 09/21/24 and 09/23/24. CCRN #500 revealed on 09/23/24 the nurse was confident she had changed the dressing and forgot to document the dressing change. CCRN #500 revealed the nurse was provided education. CCRN #500 revealed on 09/21/24 an agency nurse had not documented the wound treatment and this nurse was put on the do not return to the facility list. Review of the policy Wound Care, revised 10/2010, revealed to verify physician orders for wound care and document the date and time wound care was given. The deficient practice was corrected on 10/07/24, when the facility implemented the following corrective actions: On 10/01/24 through 10/03/24, skin checks were completed on all residents with no new physician orders. On 10/03/24, CCRN #500 educated the nursing management team including the DON, Assistant Director of Nursing (ADON) #216, ADON #218, and MDS Coordinator #220 on expectations to audit all new admissions using the triple check admissions process, whiteboard clinical meeting process and skin assessments on new admissions. On 10/03/24, Scheduler #222 provided education to nurses regarding admission and weekly skin check expectations/protocol. Scheduler #222 was provided the educational information by CCRN #500 On 10/03/24, CCRN #500 educated Registered Nurse (RN) #228 on completing dressing changes and proper documentation regarding missing wound care documentation on the treatment administration record. On 10/07/24, CCRN #500 educated the DON and ADON #218 on skin check responsibilities to ensure all new admissions have a second Registered Nurse skin check. The DON/designee will complete a weekly audit for four weeks of all new admissions for the week prior to ensure admission triple check audits completed. Any concern identified from the audit and clinical meetings would be addressed immediately and would be reviewed by the Quality Assurance Performance Improvement team monthly to determine if current interventions adequate or additional action needed to be completed to ensure substantial compliance. Interviews on 10/09/24 and 10/10/24 with Licensed Practical Nurse (LPN) #252, ADON #216, ADON #218, MDS Coordinator #220, LPN #200, and the DON revealed they had received education regarding wound care orders, wound care dressing changes, and new admission skin checks and new admission orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound treatment administration records (TAR's) from 10/01/24 through 10/09/24 for ten residents (#8, #17, #19, #23, #33, #34, #36, #37, #39 and #48) revealed wound care was completed per physician orders. This deficiency represents noncompliance investigated under Complaint Number OH00158444.

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on medical record review, review of hospital documentation, staff and resident interviews and policy review, the facility failed to ensure Resident #17, who had an indwelling suprapubic catheter, received timely treatment for a symptomatic urinary tract infection (UTI). This resulted in Actual Harm on 10/05/24 when Resident #17's symptomatic UTI was not treated at the facility and the resident was subsequently transported to the hospital and admitted . Resident #17 required intravenous (IV) antibiotic at the hospital to treat the UTI and sepsis. Additionally, the facility failed to provide indwelling urinary catheter care for Resident #52 for a period of eight days, from admission on 09/16/24 to 09/24/24, placing the resident at risk for the potential for more than minimal harm, at which time the urinary catheter was removed. This affected two (#17 and #52) of three residents reviewed for urinary catheters. The facility census was 51. Findings include: 1) Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included quadriplegia, neuromuscular dysfunction of bladder, pressure ulcer stage four of the sacral region, chronic pain, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition. Resident #17 had an indwelling catheter and ostomy. Resident #17 was dependent on staff for toileting hygiene. Review of the plan of care initiated on 06/14/20 and last revised on 01/24/23 revealed Resident #17 had a suprapubic catheter related to a neurogenic bladder and was at risk for infection. Interventions included to check tubing for kinks throughout each shift, monitor for signs and symptoms of discomfort on urination and frequency, monitor and document for pain/discomfort due to catheter, and monitor/record/report to physician for signs and symptoms of a UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increase temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Review of the medical record revealed Resident #17 had a history of UTI and sepsis. Resident #17 was treated for a UTI with IV antibiotics from 09/02/24 through 09/09/24. Review of a physician progress note dated 09/27/24 revealed Resident #17 had dysuria with a plan to obtain a urinalysis with culture and sensitivity. The physician noted Resident #17 had a history of UTI's with multidrug-resistant organisms and if the urinalysis was positive then the physician would consider broad-spectrum antibiotic therapy. Further review of the progress note revealed Resident #17 complained of urinary symptoms such as mild burning and increased urine sediment over the past several days. Resident #17 denied fever and chills but admits to some mild intermittent fatigue. The physician noted Resident #17 would like to have a urinalysis along with culture and sensitivity. Review of a physician order dated 09/29/24 revealed Resident #17 was ordered a urinalysis with culture and sensitivity. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a preliminary laboratory result report dated 10/01/24 revealed Resident #17 had dark yellow turbid urine with leukocytes, white blood cells and bacteria present. The physician was notified and awaiting the culture results. Review of the final laboratory result report dated 10/03/24 revealed Resident #17 had a UTI with greater than 100,000 colony forming unit (cfu) per milliliter (ml) of the bacteria Providencia stuartii. There was no documentation the physician was notified of the results and no new orders were received to treat Resident #17's UTI. Review of the nurse's notes from 09/27/24 through 10/04/24 revealed no documentation of Resident #17's signs and symptoms of a UTI. Review of nurse's note dated 10/05/24 at 6:13 A.M. revealed Resident #17 was screaming and yelling out in pain. Resident #17 was requesting to go out to the hospital. Emergency Medical Services (EMS) transported Resident #17 to the hospital. The physician was notified. Resident #17's blood pressure was 145/76, with a pulse of 100 beats per minute and a temperature of 100.3 degrees Fahrenheit (F). Review of a change in condition evaluation dated 10/05/24 at 4:54 P.M. revealed Resident #17 had abdominal pain, uncontrolled pain that started in the afternoon on 10/04/24. Resident #17 complained of lower abdominal/back pain related to a UTI. Resident #17 was also noted with groin pain. Resident #17 was sent to the emergency room for evaluation. Review of the treatment administration record (TAR) from 09/01/24 through 10/09/24 revealed Resident #17 had received suprapubic catheter care twice daily with no refusals noted. Review of hospital documentation dated 10/05/24 at 6:13 A.M. revealed Resident #17 was treated in the emergency room and admitted to the hospital for principal problem of sepsis due to gram negative UTI. Further review of the hospital documentation revealed Resident #17 had a history of drug-resistant infections and potential for colonization. A urinalysis with culture and sensitivity and blood cultures were ordered. Continued review of the hospital documentation revealed Resident #17 had an abnormal urinalysis. Blood cultures were negative on day four. No urine culture and sensitivity results were documented with several documented notes stating, culture not sent. Resident #17 was treated with the IV antibiotic Zosyn for three days. Resident #17 returned to the facility on [DATE] with new orders for oxycodone extended release 20 milligrams every six hours for pain related to sepsis due to gram-negative UTI. Resident #17 also received orders for pregabalin 150 milligram capsule by mouth three times daily for sepsis due to unspecified organism. Interview on 10/09/24 at 10:57 A.M., Resident #17 revealed on 10/04/24 he was having abdominal pain and signs of a UTI and told the Director of Nursing (DON). Resident #17 revealed the facility had not notified the physician and the following day he had to go to the hospital. Resident #17 revealed he had a UTI and was septic. Resident #17 revealed he was treated with IV antibiotics in the hospital and then returned to the facility. Interview on 10/09/24 at 11:04 A.M., the DON revealed Resident #17 had reported abdominal pain on 10/04/24. The DON revealed she told Resident #17's nurse to have the physician see the resident when he came into the building. The DON revealed the physician never came to the building. The DON revealed there was no documentation that the resident's nurse had contacted the physician about the resident's abdominal pain on 10/04/24. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 10/10/24 at 8:06 A.M., the DON revealed there was no documentation Resident #17's physician was notified of the resident's urinalysis culture and sensitivity results on 10/03/24 and no new orders had been received. The DON revealed an agency nurse was working when the results would have been received and was not returning calls to the facility. The DON confirmed Resident #17 was admitted to the hospital on 10/05/24 for UTI and sepsis. Interview on 10/10/24 at 9:45 A.M., Licensed Practical Nurse (LPN) #200 revealed on 10/04/24 the day shift nurse had not reported Resident #17 was having abdominal pain. LPN #200 revealed Resident #17 had not reported pain until the following morning 10/05/24 and was sent to the hospital. LPN #200 revealed Resident #17 had a urinalysis with culture and sensitivity previously ordered on 09/28/24 and she sent it to the laboratory on 09/30/24. LPN #200 revealed Resident #17 had complained of urine odor and sediment in his suprapubic catheter. Interview on 10/10/24 at 12:30 P.M., Regional Director of Clinical Services (RDCS) #400 revealed Resident #17 had been sent out to the hospital five times this year for UTI and had been treated monthly for chronic UTI's. RDCS #400 revealed Resident #17 was noncompliant with suprapubic catheter care and wound care. RDCS #400 revealed Resident #17 had stage four pressure ulcers and stays up in his chair for up to 22 hours per day. RDCS #400 also revealed Resident #17 had refused suprapubic catheter care and wound care in the hospital. Further interview with RDCS #400 revealed the hospital had a history of not completing urine cultures on Resident #17 and just treating him for sepsis. 2) Review of the medical record for Resident #52 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included malignant neoplasm of the bladder, hematuria, chronic kidney disease, acute kidney failure, diabetes mellitus type two, end stage renal disease and chronic obstructive pulmonary disease. Review of the admission MDS dated [DATE] revealed Resident #52 had intact cognition. The resident had an indwelling urinary catheter and required partial moderate assistance with toileting hygiene. Review of the admission nursing assessment dated [DATE] revealed Resident #52 had an indwelling urinary catheter. Review of the admission physician orders dated 09/16/24 revealed no orders for an indwelling urinary catheter or catheter care. Review of the treatment administration record from 09/16/24 through 09/24/24 revealed no documentation Resident #52 had received catheter care. Interview on 10/01/24 at 1:09 P.M., Corporate Compliance Registered Nurse (CCRN) #500 revealed Resident #52 had no orders for catheter care. CCRN #500 revealed she had some statements from some staff stating they had completed catheter care for Resident #52 but there was no documentation in the medical record that catheter care had been completed. CCRN #500 revealed Resident #52's catheter had been removed on 09/24/24 with no signs of infection. Review of the policy Change in a Resident's Condition or Status, revised 02/2021, revealed the nurse would notify the resident's attending physician or physician on call when there was a significant change in the resident's condition. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the policy Urinary Continence and Incontinence - Assessment and Management, revised 08/2022, revealed the physician and staff would provide appropriate services and treatment to prevent UTI to the extent possible. If an indwelling catheter was needed, staff would monitor for and report complications such as evidence of a symptomatic infection. Review of the policy Prevention and Screening - Clinical Protocol, revised 03/2018, revealed the physician would order laboratory screening tests relevant to monitoring the individual's treatment regimen or identifying modifiable risks and complications. Further review of the policy revealed no guidelines for reporting laboratory results to the physician. Review of the policy Catheter Care, Urinary revised 08/2022, revealed to observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately including signs and symptoms of UTI. Further review of the policy revealed catheter care would be documented in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00158444.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35033 Based on observations, staff interviews, and policy review, the facility failed to ensure the kitchen was kept in a sanitary manner. This had the potential to affect all 51 residents residing in the facility. The facility census was 51. Findings include: Observation on 10/09/24 beginning at 8:20 A.M. of the facility kitchen revealed there were several areas of broken floor tile trim leading into the dishwasher room. There was heavy dust buildup on the walls near the kitchen entrance. Further observations revealed there was a buildup up of food debris in the three grease traps underneath the cook top stove. Continued observations revealed there was a buildup of debris on the floor on the side and behind the cook top stove. Interview on 10/09/24 at 8:28 A.M., Dietary Manager (DM) #122 stated stated the kitchen was deep cleaned every six months. DM #122 verified the broken kitchen tiles, dust build up on the walls, the buildup of debris on the floor next to the cook top stove. DM #122 also verified the buildup of food debris in the grease traps and stated the grease traps were cleaned out weekly. The facility confirmed all 51 residents receive their meals from the kitchen. Review of the undated policy Kitchen Sanitation, revealed the Registered Dietician and/or Director of Food and Nutrition Services would conduct a monthly cleaning schedule for employees. Review of the cleaning schedule revealed grease drip trays would be cleaned out at the end of each day. Floors would be mopped after lunch, at the end of the day and after breakfast if needed. Walls would be cleaned when assigned. There were no guidelines for replacing the broken tiles. This deficiency represents noncompliance investigated under Complaint Number OH00158481.