STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525608	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Care Ctr	3205 Wood Rd Racine, WI 53406

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure residents with pressure injuries received care consistent with professional standards of practice to promote healing for 4 (R188, R62, R14, and R12) of 5 residents reviewed with pressure injuries. *R188 was admitted to the facility with pressure injuries that were not comprehensively assessed on admission and the air mattress was observed to be not set according to R188's weight. *R62, R14, and R12 had pressure injuries and observations were made of their air mattresses not to be set according to their weight. Findings include: The facility policy and procedure entitled Pressure Injury Prevention and Management dated 10/2023 states: Policy Explanation and Compliance Guidelines: . 3. Assessment of Pressure Injury Risk . c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. 4. Interventions for Prevention and to Promote Healing . c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: . iii. Provide appropriate, pressure-redistributing, support surfaces. The facility policy and procedure entitled Skin assessment dated ,d+[DATE] states: Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. document if resident refused assessment and why. f. Document other information as indicated or appropriate. 1.) R188 was admitted to the facility on [DATE] with diagnoses of pneumonitis due to inhalation of food and vomit, bacteremia, malnutrition, leukemoid reaction, anemia, anxiety, depression, and epilepsy. R188 had not been a resident of the facility long enough to have a comprehensive Minimum Data Set (MDS) assessment completed. R188 had an activated Power of Attorney (POA). R188's Activities of Daily Living Care Plan was initiated on 4/26/2024 and indicated R188 needed staff assistance of one for bathing/showering, bed mobility, dressing, personal hygiene, and toilet use and staff assistance of two for transferring using a mechanical lift. The Infectious Disease Physician Progress Note dated 4/26/2024 documented R188 had wounds on the dorsal aspect of the left foot and fifth metatarsal (toe) that measured approximately 2 cm x 2 cm and multiple small wounds scattered on bilateral legs and arms. R188's hospital Discharge Summary dated 4/26/2024 indicated no wound care was needed. On 4/26/2024, Registered Nurse (RN)-D completed R188's Admit/Readmit Assessment form and Skin & Wound Evaluation forms for the following pressure injuries: -Coccyx/Sacrum Stage 3 pressure injury measured 8.1 cm x 6 cm x 0.2 cm with 20% granulation and 80% slough. An additional Skin & Wound Evaluation form was completed for the sacrum Stage 3 pressure injury measured 3.8 cm x 1.4 cm with no depth measurement with 20% granulation and 80% sough. The photos attached to the sacrum assessments revealed three open areas and measurements were for two areas with no description of what was being assessed. The location of the pressure injury was labeled coccyx on the Admit/Readmit Assessment form and was labeled sacrum on the Skin and Wound Evaluation form. -Left heel Unstageable pressure injury measured 2.9 cm x 1.9 cm with 100% eschar. -Left fourth toe Unstageable pressure injury measured 1.5 cm x 1.5 cm. Surveyor noted no depth was measured and no wound characteristics were documented. Surveyor noted the picture attached to the assessment showed the wound to be on the fifth toe and not the fourth toe. R188's Skin Impairment Care Plan was initiated on 4/26/2024 with the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Encourage to elevate heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage/assist with reposition as needed. -Use barrier cream to prevent skin impairment issues, as needed. R188's Skin Impairment Care Plan was revised on 4/27/2024 with the following interventions: -Encourage to offload heels. -Heel boots on when in bed. -R188 needs an air mattress to protect the skin while in bed. -R188 needs pressure relieving/reducing cushions to protect the skin while up in a chair. On 4/27/2024 on the Treatment Administration Record (TAR), R188 had an order to check the function of the low airloss mattress every shift. On 5/1/2024, Licensed Practical Nurse (LPN)-P completed a Skin & Wound assessment form for the following pressure injuries: -Sacrum Unstageable pressure injury measured 6.5 cm x 3.3 cm with 90% slough and 10% eschar. Surveyor noted no depth was measured and the photo attached to the assessment showed two open areas. -Sacrum Stage 3 pressure injury had no measurements and no wound description other than the wound was stable. The photo attached to the assessment showed three open areas and had measurements of 0 cm x 0 cm. Surveyor noted the sacrum had open areas and was unable to determine what was being assessed. On 5/2/2024 at 11:09 AM, Surveyor accompanied Wound Physician-I and RN Unit Manager (UM)-E to assess R188's pressure injuries. RN UM-E stated R188 had pressure injuries to the left fourth toe, the left heel and the sacrum. RN UM-E stated R188 had three areas on the sacrum that the picture documentation counted as one area. Surveyor observed R188 in bed on an air mattress. The air mattress setting was at 360 pounds. Surveyor shared the observation of the air mattress setting with Wound Physician-I. Wound Physician-I asked R188 how much R188 weighed. R188 stated R188 weighed 172 pounds the last time R188 was weighed. Wound Physician-I turned the setting on the air mattress down to R188's weight. RN UM-E stated they would reset that air mattress. R188 had bilateral heel boots on. Wound Physician-I stated the wound to the left fifth toe was due to trauma and not a pressure injury. Surveyor clarified with Wound Physician-I that the wound was on the fifth toe and not the fourth toe as initially documented. Wound Physician-I agreed the wound was on the fifth toe. Surveyor observed three open areas on the sacrum and one open area on the left iliac crest. Wound Physician-I stated the sacrum wounds were measured as one area because the tissue surrounding two of the open areas was darkened and had damage below the skin making it one wound with two open areas. Surveyor noted the third open area on the sacrum was not measured or assessed. Wound Physician-I debrided necrotic tissue from the middle and right open areas of the sacral wound. The left heel pressure injury had an eschar cap over the wound. Surveyor requested a copy of Wound Physician-I's wound assessments. Wound Physician-I's documentation of R188's pressure areas on 5/2/2024 had the following assessments: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sacrum Unstageable pressure injury measured 5.4 cm x 4.51 cm x 0.2 cm with 1-25% granulation and 51-75% slough before debridement and measured 3.97 cm x 5.28 cm x 1.1 cm with 1-25% granulation and 51-75% slough after debridement. Surveyor noted the measurement included two open areas. Surveyor noted the third open area on the sacrum was not assessed. -Left heel Unstageable pressure injury measured 2.16 cm x 1.84 cm x 0.1 cm with eschar. In an interview on 5/2/2024 at 3:22 PM, Surveyor asked RN-D what the facility process was when a new resident was admitted to the facility. RN-D stated the nurse on the floor does the initial skin assessment which includes looking at the resident's skin from top to bottom and documenting anything like a scab, bruising, scratches, checking under the breasts and folds for redness or excoriation, and any open areas or Deep Tissue Injuries (DTI) caused by pressure. RN-D stated for any open areas or DTIs, you put a sticker next to the wound and take a picture with the phone; that is connected to the electronic charting system, and it measures the length and width of the wound. RN-D stated the picture is sent to Wound Physician-I or to RN UM-E with the resident's name and what the wound is so they can get a treatment order. RN-D stated the wounds are monitored and they are evaluated weekly on Wednesday. RN-D stated if a treatment needs to be done right away, RN-D will do that and then make sure everything is charted. RN-D stated if the resident has mushy heels, RN-D will get heel boots or pillows if the resident hates the boots. Surveyor asked RN-D if pictures were taken of all skin impairments. RN-D stated scabs, bruises, and blanchable redness just get written into the assessment, but if it is an open area, then they get a picture on the phone. RN-D clarified an open area on the coccyx or anything that gets a deeper assessment will get a picture so Wound Physician-I can get a treatment in place. RN-D stated Wound Physician-I is available every day and answers quickly. RN-D stated RN UM-E and Assistant Director of Nursing (ADON)-C are really good with wounds, so they help with assessments. Surveyor noted the phone picture assessment does not measure depth. Surveyor asked RN-D if any wounds get depth measurements. RN-D stated it depends on the wound if a depth is measured. RN-D stated with a flap off, like a skin tear, the depth is estimated and if it something deeper, then they would take a cotton swab to measure the depth. Surveyor asked RN-D how air mattresses were set for the amount of pressure. RN-D stated maintenance usually sets that up but was not sure how they determined the amount of pressure. RN-D stated you can tell who needs a mattress, like if the resident has a wound to the back or is frail skin and bones. Surveyor clarified with RN-D who set the pressure on the air mattress. RN-D stated maintenance sets the pressure; nurses never set the pressure. On 5/6/2024 at 8:55 AM, Surveyor observed R188 lying in bed. The air mattress was set to the correct weight and a sticker had been added to the control panel that listed R188's weight as 166.5 pounds. Surveyor reviewed R188's TAR and R188 had an order to check the function of the low airloss mattress every shift. Weight settings: 166.5 had been added on 5/4/2024 to the original order on the TAR. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/2024 at 9:31 AM, Surveyor shared with DON-B the concern R188's pressure areas were not comprehensively assessed until 5/2/2024, six days after admission, when Wound Physician-I assessed R188's pressure injuries. Surveyor shared with DON-B R188 had three pressure areas on the sacrum and only two open areas were assessed, and those areas were measured as one area even though they were two separate open areas. DON-B stated Wound Physician-I measured those two open areas together because it gets one treatment. Surveyor shared the third open area was never assessed. Surveyor shared with DON-B R188's left heel did not have a depth measurement until 5/2/2024 when Wound Physician-I assessed the left heel. Surveyor shared with DON-B that R188's air mattress was set to 360 pounds when R188 weighed 166.5 pounds. DON-B provided a table that was obtained from the air mattress distributor that gave pound to kilogram conversions for settings on an air mattress, but the settings did not correlate with the air mattress in place on R188's bed. DON-B stated the bed should be set to the resident's weight and the resident's comfort. Surveyor was unable to find any documentation in R188's medical record that a conversation was had about the setting on the air mattress and R188's comfort level. 20025 2.) R12 was admitted to the facility on [DATE] with diagnoses of dementia, type 2 diabetes and CVA (cerebral vascular accident). The significant change MDS (minimum data set) dated 3/22/24 indicates R12 has cognitive impairments and is dependent for hygiene, bed mobility and toileting. R12 has a stage 3 pressure injury to the sacral area. The physician order dated 4/27/22 indicating a low air loss mattress (settings by weight). On 4/22/24 R12 weight was 114 lbs. On 4/30/24 at 9:09 a.m. Surveyor observed R12 in bed and the low air loss mattress was set at 180 lbs. On 5/1/24 at 8:33 a.m. Surveyor observed R12 was in bed and the low air loss mattress was set at 180 lbs . On 5/2/24 at 11:48 a.m. Surveyor observed R12 receive pressure injury treatment and the low air loss mattress was set at 180 lbs. R12's low air loss mattress device is called Proactive. The operating instructions for the Proactive mattress indicates determine the patient's weight and set the control knob to that weight setting on the control unit. On 5/2/24 at 3:00 p.m. during the daily exit meeting with DON (director of nursing)-B and NHA(nursing home administrator)-A, Surveyor explained the concern R12 was observed to be on the low air loss mattress set at 180 lbs when R12 weighs 114 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 10:07 a.m. Regional Consultant-Q stated the mattress representative explained to her that the mattress should be set at the weight and/or resident's comfort level. Surveyor explained what the mattress should be set at is not documented in the medical record. There is no indication an assessment was completed to determine if R12's mattress setting should be set differently from R12's weight. 3.) R14 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, dementia, paraplegia and anxiety disorder. Significant change MDS dated [DATE] indicate R14 has cognitive impairments and is incontinent of bowel and bladder. R14 has a healing stage 3 pressure injury to the right buttock. The care plan indicates R14 has a low air loss mattress. On 5/2/24 at 12:22 p.m. Surveyor observed R14's pressure injury treatment and the mattress was set at 320 lbs. The mattress is a Proactive device. The operating instructions for the Proactive mattress indicates determine the patient's eight and set the control knob to that weight setting on the control unit. On 4/3/24 R14 weight was 163.5 lbs. On 5/2/24 at 3:00 p.m. during the daily exit meeting with DON (director of nursing)-B and NHA(nursing home administrator)-A, Surveyor explained the concern R14 was observed to be on the low air loss mattress set at 320 lbs when R14 weighs 163.5 lbs. On 5/6/24 at 10:07a.m. Regional Consultant-Q stated the mattress representative explained to her that the mattress should be set at the weight and/or resident's comfort level. Surveyor explained what the mattress should be set at is not documented in the medical record. There is no indication an assessment was completed to determine if R14's mattress setting should be set differently from R14's weight. 4.) R62 was admitted to the facility on [DATE] with diagnoses of dementia, type 2 diabetes and major depression. On 4/30/24 at 9:25 a.m. Surveyor observed R62 in bed and the low air loss mattress was set at 280 lbs. On 5/2/24 at 12:36 p.m. Surveyor observed R62's pressure injury treatment and observed the mattress set between 240 and 280 lbs. On 4/27/24 R62 weighed 190.5 lbs. On 5/2/24 at 3:00 p.m. during the daily exit meeting with DON (director of nursing)-B and NHA(nursing home administrator)-A, Surveyor explained the concern R62 was observed to be on the low air loss mattress set at 240-280 lbs when R62 weighs 190.5 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24 at 10:07 a.m. Regional Consultant-Q stated the mattress representative explained to her that the mattress should be set at the weight and/or resident's comfort level. Surveyor explained what the mattress should be set at is not documented in the medical record. There is no indication an assessment was completed to determine if R62's mattress setting should be set differently from R62's weight.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview and record review the facility did not ensure 1 (R75) of 6 residents reviewed for weight received the necessary services to assist with nutritional maintenance. * R75 had a significant weight loss of 23 pounds (LBS) or 10.7% in 8 days which was not addressed by the Dietician or notification given to R75's physician. Findings include: On 5/6/24 the facility's policy titled, Weight Monitoring dated 1/24 was reviewed and read: A significant change in weight is defined as a 5% change in weight in 1 month (30 days). The physician should be informed of a significant weight change. The Registered Dietician should be consulted to assist with intervention: actions are recorded in the nutrition progress notes. R75 was admitted to the facility on [DATE] with diagnoses that included Diabetes Type 2, Dysphasia and Dementia. R75's quarterly Minimum Data Set (MDS) dated [DATE] indicated R75 did not have significant weight loss or gain during the assessment reference period. On 5/5/24 R75's physician orders were reviewed and indicated R75 received tube feeding and nothing by mouth from admission on 8/22/23 through 10/30/23 when she started a mechanical soft diet along with the tube feeding. On 11/28/23 R75's tube feeding order was changed to receive the tube feeding if she consumes less then 50% of her meal and at the time of the survey was the current order. Daily weights were ordered on 11/29/23 and at the time of the survey was the current order. On 5/5/24 R75's weights were reviewed and were recorded as follows: 5/1/2024 200.0 Lbs Mechanical Lift, 6.98% loss from 4/14/24 4/30/2024 192.0 Lbs Wheelchair 4/29/2024 192.5 Lbs Wheelchair 4/28/2024 192.0 Lbs Wheelchair 4/25/2024 192.0 Lbs Mechanical Lift 4/24/2024 192.0 Lbs Wheelchair 4/23/2024 192.0 Lbs Wheelchair 4/22/2024 192.0 Lbs Wheelchair, 10.7% loss from 4/14/24 4/20/2024 197.2 Lbs Mechanical Lift, 8.28% loss from 4/14/24 4/19/2024 210 Lbs Wheelchair (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/14/2024 215.0 Lbs Wheelchair On 5/5/24 R75's progress notes were reviewed and no notification to R75's physician could be found. R75's last visit from the physician was 4/19/24 and her weight was stable at that time. On 5/6/24 at 10:30 AM Dietician-O was interviewed and indicated R75 had a significant weight loss but this was addressed with the supplemental feeding that was ordered. The Surveyor indicated that the order for supplemental feedings was started on 11/28/23 and R75's significant weight loss was 4/20/24. Dietician-O indicated he would ask for a reweigh for that big of a weight loss but could not find where that was done. Dietician-O indicated he did not assess the new weight loss and the last nutritional assessment for R75 was 3/21/24 and at that time her weight was stable. Dietician-O also indicated the problem could be using 2 different types of scales, (R75 had the same weight using the different scales from 4/20/24 to 4/30/24 and this was never addressed). Dietician-O indicated R75's physician should be called with a significant weight loss. On 5/5/24 R75's nutritional care plan dated 3/21/24 was reviewed and read: at risk for malnutrition goal weight maintenance. The last change to the care plan was 4/19/24 before any significant weight loss as was the goal of will show no nutritional deficits with current diet. Interventions included monitor weight trends which was initiated 8/28/23. On 5/5/24 at 12:15 PM R75 was observed to eat 75% of her lunch meal. The above findings were shared with Administrator-A and Director of Nurses-B on 5/6/24 at 1:00 PM. Additional information was requested if available.