

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Ridgewood Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879</b></p> <p>Based on record reviews, interviews, and facility policy review, the facility failed to ensure one of nine sample residents (Resident (R) 6) had her preferences honored.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Accommodation of Needs, provided by the facility, with a revised date of 02/24, revealed The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The policy further revealed Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and well being to the extent possible.</p> <p>Review of R6's admission Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) revealed R6 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated her cognition was intact. The MDS further revealed R6 was admitted to the facility on [DATE].</p> <p>Review of R6's diagnoses under the Diagnosis tab of the EMR revealed R6 had diabetes and chronic kidney disease stage four.</p> <p>Review of R6's comprehensive Care Plan, dated 08/27/24 and located in the Care Plan tab of the EMR revealed a problem for an activity of daily living (ADL) self-care deficit. Review of the interventions for 08/29/24 included for bathing and showering R6 was totally dependent on one member of staff to provide bathing and showering weekly and as needed. The intervention included no male Certified Nursing Assistants (CNA) was to perform care. Review of the dressing intervention revealed R6 required assistance of one staff and no male CNAs for care. Review of the personal hygiene intervention revealed R6 was totally dependent on staff, but it did not reflect no male CNA to render care. Review of the toilet use intervention revised on 09/09/24 revealed R6 required assistance of two staff but did not specify no male CNA. Review of the problem for functional bladder incontinence revealed peri care was to be completed after each incontinent episode but did not include no male CNA. Review of the care plan with a revised date of 10/10/24 revealed R6 was to not have any male CNAs for any care.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 3:00 PM, CNA3 revealed he had taken care of R6 previously but only to pass her tray and water to her. CNA3 stated he had introduced himself to R6 and her family when she was admitted to the facility. CNA3 stated he was her CNA on 10/10/24 during the night and he had gone into her room around midnight to just check her brief to see if it was yellow or blue and if she needed to be changed, he would go get the female CNA on the other hall, but R6 was dry. CNA3 revealed he went back into R6's room around 4:00 AM to check if R6 was wet. CNA3 revealed R6 was awake, and he pulled the cover back and looked to see if the line on the brief was blue and it was yellow which meant she was still dry. CNA3 stated he knew R6 did not want a male CNA to do certain care. but that was for peri care, and he did not do peri care. CNA3 stated he was just checking R6 for wetness. CNA3 stated he did not go back into the room after Registered Nurse (RN) 2 told him not to.</p> <p>During an interview on 10/22/24 at 6:30 PM, R6 revealed she did not want any male to take care of her because men should not be in a profession where they wiped residents' butts. R6 revealed a male CNA, who she had never seen before, came into her room twice on 10/10/24 and she told the CNA to get out.</p> <p>During an interview on 10/22/24 at 7:15 PM, RN2 revealed she was not aware R6 was not to have a male aid taking care of her. RN2 stated she reviewed the care plan after R6 informed her she did not want a male taking care of her and saw where it was listed to not have a male CNA for peri care and bathing. RN2 stated Unit Manager (UM) 1 scheduled CNA3 to work that shift and she knew about R6 preferring to not have a male CNA.</p> <p>During an interview on 10/23/24 at 9:47 AM, the UM1 revealed CNA3 had taken care of R6 before but only passed water and meal trays to her and did not do peri care or bathing. UM1 stated the son had informed them on admission that R6 preferences was to not have any male CNAs to bathe or do peri care for R6. UM1 revealed she did the scheduling but the nurse on the unit could do the hall assignments. UM1 stated checking the brief was a part of peri care.</p> <p>During an interview on 10/23/24 at 2:09 PM, the Director of Nursing (DON) revealed R6 was care planned to not have a male CNA for bathing and peri care. The DON stated checking the brief for a yellow or blue mark was not a part of peri care. The DON stated CNA3 was just looking at the brief to see if R6 needed care. The DON revealed she had talked to R6, and the resident did not have an issue with a man passing water or a meal tray but did not want a male CNA seeing her nude. The DON stated RN2 should have known that R6 preferred to not have a male CNA because it was on her care plan and the care list.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15879</p> <p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure one comprehensive care plan for enhanced barrier precautions (EBP) was implemented for one of nine sample residents (Resident (R) 4) reviewed for care plans. This failure had the potential to put R4 and other residents at risk for infections.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plans provided by the facility with a revised date of 02/24, revealed It was the policy of this facility to develop and implement a comprehensive person-center care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Resident specific interventions that reflect the resident's needs and preferences.</p> <p>Review of R4's admission Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 10/02/24 revealed R4 was admitted to the facility on [DATE] with diagnoses of Parkinsons, diabetes with a foot ulcer, hypertension, and cerebral vascular accident (CVA). The MDS revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition.</p> <p>Review of the comprehensive care plan located in the Care Plan tab of the EMR, initiated 09/27/24, revealed a problem listed for infection control with an intervention that R4 had to be on enhanced barrier precautions. The care plan revealed a gown and gloves should be worn. A problem was identified for impaired skin integrity.</p> <p>Review of the Physicians Orders located under the Orders tab of the EMR, dated 10/16/24, revealed an order for enhanced barrier precautions due to wounds.</p> <p>A wound care treatment observation for R4, on 10/22/24 at 10:04 AM, with Licensed Practical Nurse (LPN) 2, revealed the nurse entered R4's room and did not wash or sanitize his hands before entering the room which had enhanced barrier precautions posted visibly on the door which was opened.</p> <p>During the entire observation on 10/22/24 at 10:15 AM, LPN2 did not wear a gown during the wound treatments to the left heel and buttock. Observation of the signage on the door for R4 revealed enhanced barrier precautions should be used which included hands were to be washed or sanitized before and after entering the room. The signage further revealed the staff must wear gloves and a gown when wound care was done that required a dressing.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 12:38 PM, the MDS Coordinator (MDSC) revealed if the care plan had enhanced barrier precautions on it then enhanced barrier precautions should have been utilized. The MDSC further revealed staff should have worn gloves and a gown if they did any kind of patient care such as wound care treatments. The MDSC stated enhanced barrier precautions helped to prevent transmission of germs to the next patient.</p> <p>During an interview on 10/23/24 at 12:45 PM the Administrator revealed care plans should have been followed and modified as needed.</p> <p>During an interview on 10/23/24 at 1:00 PM, the Director of Nursing (DON) revealed care plans should have been followed to meet the needs of the residents. DON stated the care plan for enhanced barrier precautions should have been implemented.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879</b></p> <p>Based on observations, record review, interviews, and review of the facility policy, the facility failed to follow enhanced barrier precautions (EBP) and infection control for one of nine sample residents (Resident (R) 4) reviewed for infection control precautions. The failure had the potential to put the residents at risk for the spread of an infection.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Clean Dressing Change, provided by the facility, with an implemented date of 11/23 and reviewed/ revised on 09/24, revealed It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physicians' orders will specify type of dressing and frequency of changes. The policy further revealed to set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: a. If the table is soiled, wipe clean. b. Place a disposable cloth or linen saver on the overbed table. c. Place only the supplies to be used per wound on the clean field at one time (include wound cleanser, gauze for cleansing, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings, tape) .e. Use no-touch techniques to remove ointments and creams from their containers (i.e. use tongue blade or applicator) .Wash hands and put on clean gloves .Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites. Loosen the tape and remove the existing dressing .Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. Wash hands and put on clean gloves .Cleanse the wound as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound (i.e., clean outward from the center of the wound). Pat dry with gauze .Wash hands and put on clean gloves. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant. Secure dressing. [NAME] with initials and date. Discard disposable items and gloves into appropriate trash receptacle and wash hands.</p> <p>Review of R4's admission Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 10/02/24 revealed R4 was admitted to the facility on [DATE] with diagnoses of Parkinson's, diabetes with a foot ulcer, hypertension, and cerebral vascular accident (CVA). The MDS revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition.</p> <p>Review of the comprehensive Care Plan located in the Care Plan tab of the EMR, initiated 09/27/24, revealed a problem listed for infection control with an intervention that R4 had to be on enhanced barrier precautions. A problem was identified for impaired skin integrity.</p> <p>Review of the Physicians Orders located under the Orders tab of the EMR, review date 10/16/24, revealed an order, dated 10/17/24, for enhanced barrier precautions due to wounds. The physician orders further revealed Santyl External Ointment 250 unit/grams was to be applied to the sacrum, dated 10/17/24. Another physician order revealed clean the sacrum with 1/2 Dakin's. Apply skin prep to the peri wound, apply Santyl to the wound base and it was to be followed up with a bordered gauze daily, dated 10/17/24. Another physician's order further revealed the left heel was to be cleansed with saline and skin prep was to be applied, dated 10/17/24.</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 - Few</p>	<p>A wound care sacral treatment observation for R4, on 10/22/24 at 10:04 AM, with Licensed Practical Nurse (LPN) 2, revealed he gathered Dakin's Solution (an antiseptic used to treat and prevent infections in wounds), Santyl (an ointment used for debriding ulcers), skin prep, two gauze pads and a bordered gauze and took them into R4's room without washing or sanitizing his hands before entering the room which had a sign visibly posted on the door for enhanced barrier precautions which included washing or sanitizing the hands before going into the room and wearing a gown and gloves when doing care. During the entire observation LPN2 did not wear a gown while doing the wound treatments.</p> <p>During observation on 10/22/24 at 10:04 AM in R4's room, LPN2 did not clean the overbed table before putting the supplies on it and did not put a barrier on the table. Observation further revealed the overbed table had candy bars, Kleenex, a cup, a remote control, and a cell phone lying on it. Observation further revealed LPN2 put gloves on and removed the pillows from behind the resident and under his knees. LPN2 used the lift pad to turn the resident over to his left side and went to remove the brief when he realized R4 had a bowel movement. LPN2 provided appropriate peri care. Observation revealed R4 was not double briefed. The pad and the brief were folded under R4. The dirty washcloth was placed on the side of the garbage can that had a plastic bag in it. Observation revealed LPN2 did not change gloves or wash his hands before he removed the old bandage for the sacral wound. Observation of LPN2 revealed he removed his gloves and applied new gloves but did not wash or sanitize his hands. LPN2 wet the gauze with the Dakin's Solution and cleaned the wound. LPN2 applied Santyl to the wound with the same gloved finger that he had just cleaned the wound with. LPN2 removed the gloves, new gloves were put on, then he applied skin prep around the edges of the wound and applied the border dressing. LPN2 took a pen out of his pocket, signed the dressing, and put the pen back in his pocket.</p> <p>During observation on 10/22/24 at 10:30 AM, LPN2 removed the soiled brief and put it in the garbage can. Peri care to the groin area was completed and a new brief was put on R4. LPN2 removed the pad that was under R4 and placed it on the floor beside the bed and put the dirty washcloth in it. Observation revealed LPN2 removed his gloves and did not wash or sanitize his hands in the room. Observation further revealed LPN2 went down to the small dining room and washed his hands there.</p> <p>During the wound care left heel treatment observation on 10/22/24 at 10:30 AM in R4's room, LPN2 gathered supplies for the left heel wound treatment that consisted of skin prep, normal saline, and a gauze sponge. LPN2 went into R4's room and did not put a gown on. LPN2 placed the supplies on R4's bed. Observation revealed LPN2 removed the old bandage on the foot which did not have any drainage or blood noted. LPN2 placed the old bandage on the bed and did not change gloves. LPN2 cleaned the wound with normal saline and placed that gauze on the bed, put skin prep on the area and placed a sock on the foot. LPN2 removed his gloves but did not wash his hands before he left the room. LPN2 went to the dining area and washed his hands there.</p> <p>During an interview on 10/22/24 at 10:45 AM, LPN2 stated he had training on infection control but just missed it and did not notice that R4 was on enhanced barrier precautions. LPN2 read the enhanced barrier precautions on the door and stated he should have worn a mask, gown, and gloves which he did wear gloves. LPN2 stated he had never been told he had to clean the table off or put a barrier on the table before putting the supplies on the table. LPN2 stated he should not have put the pad on the floor, however he did put the dirty washcloth inside the pad, so it did not touch the floor. During the interview, LPN2 revealed he did change gloves, but he did not wash or sanitize his hands during the wound treatment. LPN2 revealed infection control was to prevent infection from being passed to someone else.</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 - Few</p>	<p>During an interview on 10/22/24 at 1:00 PM, the Director of Nursing (DON) revealed for enhanced barrier precautions and doing a wound treatment the nurse should wear gowns and gloves when going into the room. The DON further revealed the surface should be cleaned off and the supplies should be opened there and laid out. The DON stated the old dressing should be removed and put in the garbage can. DON stated the nurses should remove their gloves, clean their hands, put on new gloves, and apply the new dressing after cleaning the wound. The DON stated the gown, and gloves should be removed and placed in garbage bags in the rooms and disposed of. The DON revealed staff should sanitize their hands before going into the room that had enhanced barrier precautions and when leaving the room. The DON revealed the overbed table should be cleaned and all items should be removed from the table. The DON stated the pad that had been under R4 should not have been put on the floor. The DON stated that anytime a staff member removed their gloves they should wash or sanitize their hands. The interview further revealed it was not appropriate for the dirty bandages to be placed on the bed and the bandages should be placed in the garbage.</p> <p>During the interview on 10/22/24 at 1:30 PM, the DON revealed they had a yearly skills fair and they went over enhanced barrier precautions. The DON stated staff were trained in enhanced barrier precautions for wound care, gastrostomy tube (G-tube) care, foley catheter care which consisted of donning a gown and gloves. The DON revealed infection control was utilized to prevent spreading infections. The DON stated the Santyl should have been applied with a Q-Tip and not the gloved finger of the nurse. The DON revealed they have not had any outbreak of infections.</p>		