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	02/19/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review the facility did not ensure 1 (R2) of 5 residents needing assistance with bathing received the necessary services for cares. R2 was admitted to the facility on [DATE] and discharged on [DATE]. R2 went from 1/25/25 until 2/7/25 without receiving a shower/bath. R2 should have received a shower/bath on 1/31/25 according to the plan of care. Findings include: R2 is a [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses of sepsis, Myasthenia [NAME], subdural hemorrhage, epilepsy, abnormal posture, and colostomy. R2's Admission Minimum Data Set (MDS) completed on 1/20/25 documents that R2 is dependent with toileting, showering, dressing and transfers. R2 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating that R2 has severe cognitive impairment. Surveyor reviewed R2's bathing documentation which documents R2 was to receive showers every Friday on the evening shift. The documentation indicates a shower was not completed for R2 on 1/31/25. Surveyor reviewed R2's nursing notes which documents R2 received a shower on 1/17/25, 1/20/25, 1/24/25, and 2/7/25. Surveyor notes R2 did not receive his scheduled shower on 1/31/25, making it two weeks without receiving a shower/bath per the plan of care. Surveyor interviewed Registered Nurse (RN) Unit Manager- D on 2/18/25, at 11:21 AM, who reviewed R2's shower records and indicated R2 did not receive a shower on 1/31/25. RN Unit Manager- D stated documentation looks like R2 missed his 1/31/25 shower. Surveyor notified RN Unit Manager- D of concerns with R2 missing his 1/31/25 shower and going two weeks without a shower. On 2/19/25, at 11:48 AM, Surveyor notified interim Director of Nursing (DON)- B of concerns with R2 going two weeks without a shower and missing his 1/31/25 shower. Interim DON- B acknowledged these concerns. No additional information was provided.

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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(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** 48391 Based on observation, interview, and record review the facility did not ensure 2 (R6 and R7) of 3 residents reviewed with pressure injuries had the necessary care and treatment to prevent and heal the pressure injuries. * R6 was admitted to the facility on [DATE]. Upon admission, R6 had no open wounds or Pressure Injuries (PI). R6 was assessed to be at risk for pressure injuries and to need assistance with bed mobility upon admission. On 2/7/25, R6 developed a facility acquired Deep Tissue Injury (DTI) to his left heel. On 2/9/25, R6 developed a PI to his sacrum. The facility did not complete a comprehensive assessment of his wounds when discovered. R6 was transferred to the hospital on 2/13/25, with a change in condition and noted to have an unstageable sacral wound. * R7 developed an unstageable PI to the right calf on 10/24/2024. R7 did not have a comprehensive assessment of the wound when discovered, the weekly measurements did not include the measurement of depth, and the wound bed was never documented so staff could not determine if the wound was improving or declining. The unstageable PI has not ever been comprehensively assessed with all the components of a comprehensive assessment: stage, measurements of length, width, and depth, and a complete description of the wound bed. Registered Dietician (RD)-H was not aware of the pressure injury when it was discovered. Findings include: The facility's policy titled, Pressure Injury Prevention and Management, dated 2023, last reviewed/revised 04/2024, documents: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure injury, prevent infection and the development of additional pressure injuries. Avoidable means, that the resident developed a pressure injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Unavoidable means, the resident developed a pressure injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. Licensed nurses will conduct a pressure injury risk assessment, using the Braden risk assessment, on all residents upon admission. The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include but are not limited to: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired/decreased mobility and decreased functional ability. Cognitive impairment. Exposure of skin to urinary and fecal incontinence. Under nutrition, malnutrition, and hydration deficits. The presence of a previously healed pressure injury. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse. The staging of pressure injuries will be clearly identified to ensure correct coding on the Minimum Data Set (MDS). Monitoring: The Registered Nurse (RN) unit manager will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly. 1.) R6 is an [AGE] year-old resident who was admitted to the facility on [DATE]. R6's diagnoses include bilateral osteoarthritis of the knee and left shoulder, pain in the left shoulder, Chronic Obstructive Pulmonary Disease (COPD), contusion of the left eyelid, difficulty walking, abnormalities of gait and mobility, lack of coordination, abnormal posture, cognitive communication deficit, and glaucoma. R6's Admission MDS completed on 2/3/25, documents R6 is dependent with toileting hygiene, dressing, and requires substantial/maximal assistance with showering and rolling left to right. R6 was documented as having a Brief Interview for Mental Status (BIMS) score of 8, indicating R6 has moderate cognitive impairment. The MDS assesses R6 as not demonstrating the behavior of refusing cares. R6's MDS documents no unhealed pressure injuries and is at risk for developing PI's. R6's Care Area Assessment (CAA) for PI documents, R6 has frequent bowel incontinence, is at risk for developing PI's, and requires assistance with Activities of Daily Living (ADL) for movement in bed. R6 requires assistance from rolling left to right. R6 requires assistance from sitting on the side of the bed to lying flat on the bed. R6 requires assistance to safely move from lying on his back to sitting on the side of the bed with feet flat on the floor, and with no back support. R6's CAA documents R6 does not have any pressure ulcers. R6 was admitted to the skilled nursing facility (SNF) after an inpatient stay, treatment for rib pain after a fall at home, and requires assistance with ADL's, including transfers. R6 is frequently incontinent of bowel. R6's care plan, dated 1/28/25, documents: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R6) has actual impairment to skin integrity of the face, hematoma below the left eye with a scab, scattered bruising to extremities related to fall prior to admission, 2/7/25 left heel ruptured blister, now appears unstageable, 2/9/25 moisture acquired skin damage (MASD) now appears unstageable, (dated 1/28/25 with revisions on 1/29/25, 2/8/25, 2/10/25 and 2/13/25). Interventions include: Encourage good nutrition and hydration in order to promote healthier skin (dated 1/28/25). Encourage (R6) to elevate heels (dated 1/28/25). Encourage/assist (R6) with reposition as needed (dated 1/28/25). Low air loss mattress to protect the skin while in bed (dated 1/29/25). (R6's) skin will be assessed on a weekly basis on his scheduled bath day and document findings on a weekly skin assessment (dated 1/28/25). Pressure relieving/reducing cushions to protect the skin while up in chair (dated 1/29/25). Report any skin redness/impaired integrity areas to my nurse (dated 1/28/25). Use barrier cream to prevent skin impairment issues, as needed (dated 1/28/25). Heel lift boots when in bed (dated 2/8/25). Bed rest per wound medical director (MD) (dated 2/13/25). Surveyor noted R6's care plan was not individualized to R6 until 2/13/25 when bedrest, specific to R6, was ordered by the wound MD-L. Surveyor reviewed R6's medical record which documents a Braden Score performed on 2/7/25 and documents a score of 19, indicating R6 is not at risk for pressure injuries. Surveyor notes R6 was assessed rarely being moist on his 2/7/25 Braden Score indicating skin is usually dry and linen only requires changing at routine intervals. R6's medical record documents a progress note on 2/7/25, at 8:56 PM, indicating R6's Certified Nursing Assistant (CNA) notified nursing staff of a ruptured blister on his left heel. There was no drainage, pain, swelling, or erythema noted, and nursing staff notified R6's Medical Director (MD) and facility nurse manager. Treatment orders were obtained and R6 was placed on the 24-hour board for monitoring. Surveyor reviewed R6's Treatment Administration Record (TAR) which documents an order placed on 2/7/25 to apply betadine to the left heel twice daily and apply heel boots when R6 is in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's medical record documents a Head-to-Toe Assessment completed on 2/7/25, that documents a ruptured blister to the left heel measuring 3 cm x 3 cm x 0 cm. Staging is documented as Not Applicable (N/A) and no further wound description or details are documented. Surveyor notes there is no comprehensive assessment to include staging, wound bed description or, surrounding skin assessment performed. R6's medical record documents a Pressure Ulcer/Skin Breakdown Unavoidable Investigation/Review completed on 2/7/25, by Registered Nurse (RN) Unit Manager (UM)- D documenting the ruptured blister to R6's heel as unavoidable. Documentation includes primary risk factors being immobility and urine and bowel incontinence. Clinical interventions in place on the care plan include daily skin observation, weekly skin observation, frequent turning and repositioning, heel/elbow protectors, protein supplements, pain management, wound MD consult. Comments on the investigation/review form document (R6) is at risk for skin breakdown due to decreased mobility from rib pain and knee pain status post fall prior to admission. The Root Cause portion of the form was blank. Surveyor noted information documented on the unavoidable investigation as clinical interventions in place such as frequent turning and repositioning, heel/elbow protectors were not included on R6's care plan as interventions specific to R6's assessed needs prior to the development of the pressure injuries. Primary risk factors identified to include immobility, and urine and bowel incontinence were not reflected as being addressed individually for R6's potential needs as the care plan, generically, stated encourage/assist with reposition as needed. R6's Braden assessment dated [DATE] did not identify wet/moist skin and linen (which is possible with urine incontinence) as a risk factor for R6. On 2/19/25, at 9:37 AM, Surveyor left a message on RN- I's voicemail to contact Surveyor to discuss the Head-to-Toe Assessment completed on 2/7/25. RN- I did not return the call to Surveyor. R6's medical record documents a Head-to-Toe Assessment completed on 2/9/25, that documents an open area on R6's coccyx measuring 1cm x 1 cm. Surveyor notes there are no descriptive details regarding the open area including possible measurement of depth, staging, wound bed description or surrounding skin description. This was completed by Licensed Practical Nurse (LPN)-N. Surveyor reviewed R6's Medication Administration Record (MAR) which documents an order placed on 2/9/25, that now identifies the open area as Moisture Associated Skin Damage (MASD) on coccyx to be cleansed with Normal Saline (NS) and apply border foam every shift on every Monday, Wednesday, and Friday. Surveyor reviewed R6's medical record which documents a Braden Score performed on 2/9/25 and documents a score of 20, indicating R6 is not at risk for pressure injuries. Surveyor notes R6 was documented as having slightly limited mobility and makes frequent though slight changes in body or extremity position independently, potential problem for friction and shear, moves freely or requires minimum assistance, skin probably slides to some extent against sheets during a move, maintains relatively good position in his chair or bed most of the time but occasionally slides down. Surveyor notes R6's MDS assesses R6 as requiring substantial/maximal assistance with rolling left to right and being dependent with toileting hygiene and dressing. R6's diagnoses include abnormalities of gait and mobility, abnormal posture, and lack of coordination. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interdisciplinary team (IDT) note written by RN UM-D on 2/10/25 at 18:06 (6:06 pm) documents: IDT note concerning MASD to sacral area measuring approx.1.0 cm x 1.0 cm with surrounding blanchable redness. Resident was not aware of new skin breakdown and denied pain. (Name of) physician notified, new tx (treatment) orders received for bordered foam 3x (times)/week. Resident has hx (history) of morbid obesity, COPD (chronic obstructive pulmonary disease) and osteoarthritis and bowel and bladder incontinence which predisposes him to skin breakdown. Resident requires assist of 1 for bathing, dressing, toileting, and incontinence cares. The IDT recommends a low air loss mattress to prevent further skin breakdown . Surveyor noted R6's care plan indicates a low air loss mattress was identified as an intervention that was to be in place for R6 going back to 1/29/25. R6's medical record includes a Weekly Skin Review performed on 2/12/25, which documents R6's alteration in skin condition to redness that is not checked to indicate if it is pre-existing or new. A bruise that is not checked whether it is pre-existing or new. Surveyor noted there is nothing checked or indicating R6 has an open area on the assessment. Under other it is documented: (R6) admitted with hematoma and scab below left eye and scattered bruising to extremities, new bruise on right side of face, redness and wound to buttocks noted, (R6) denies pain at the time of skin check, and dressing on buttocks replaced per treatment orders. Surveyor noted this was completed by LPN-O and there is no RN assessment despite the documented presence of a wound on R6's buttock. Surveyor notes there is no comprehensive assessment to R6's buttocks wound or left heel to include staging, wound bed description, or surrounding skin assessment. On 2/19/25, at 11:19 AM, Surveyor interviewed Licensed Practical Nurse (LPN)- J to discuss wound care treatments provided to R6 on 2/12/25. LPN- J states she does not recall R6 and works as a travel/agency nurse and typically works at the facility once every 2-3 months. On 2/19/25, at 2:32 PM, Surveyor interviewed Registered Dietitian (RD)- H who states she was notified that R6 developed a new PI after admission. RD- H does not recall how she was notified of R6 having a PI however, RD- H states she attends morning stand up meetings and may have been told at that time. RD- H indicates she reviews wound care documentation that is performed by Wound Physician (MD)- L on Thursdays. RD- H indicates Prostat supplement was ordered for R6 on 2/14/25 after she reviewed wound care documentation from MD- L. On 2/13/25, MD- L performed wound assessment and treatments which document the following: * Unstageable Sacrum Pressure Ulcer with attached edges, 1-25% slough, 51-75% eschar, small serous drainage, normal odor, and excoriated periwound measuring 5.23 x 3.47 x 0.10 cm, with a total area of 12.54 cm. Treatment orders include: Complete Blood Count (CBC) on 2/13/25 and 2/19/25, bed rest, protect periwound with skin prep, apply Santyl to wound bed, change daily, cleanse with 1/2 strength Dakin's solution, change as needed (PRN) for soiling and/or saturation, cover wound with bordered gauze, and discussed nutrition and its impact on wound healing. * Suspected DTI left heel Pressure Ulcer with attached edges, purple wound bed, no drainage, normal odor, and periwound is clean, dry, and intact measuring 4.76 x 2.59 x 0.10 with a total area of 7.57 cm. Treatment orders include: change PRN for soiling and/or saturation, discussed nutrition and its impact on wound healing. Surveyor notes this is the first comprehensive assessment completed for R6's left heel wound discovered on 2/7/25 and sacral wound discovered on 2/9/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25, at 3:10 PM, Surveyor notes documentation from RN UM- D indicating MD- L was in house and saw (R6's) left heel and sacrum, both wounds have declined since initial finding, and both now present as unstable. (R6) remains on low air loss mattress, (MD- L) gave new treatment orders and bed rest as intervention. (R6) made aware. Call placed to daughter to update; she will update (R6's) wife. Care plan update, chart updated to reflect new orders. R6's medical record documents a Pressure Ulcer/Skin Breakdown Unavoidable Investigation/Review completed on 2/13/25 by RN UM- D documenting R6's heel wound as unavoidable. Documentation includes primary risk factors being immobility, urine and bowel incontinence and head of bed elevated most of the day. The unavoidable investigation/review documents as clinical interventions in place on the care plan include daily skin observation, weekly skin observation, frequent turning and repositioning, moisture barrier, heel/elbow protectors, pressure relieving chair cushion, protein supplements, pain management, and wound MD consult. Comments include (R6) is at risk for skin breakdown due to decreased mobility from rib pain and knee pain status post call prior to admission, recent diagnosis of COVID. The Root Cause portion of the form was blank. Surveyor noted R6's care plan for pressure still had not been updated by 2/13/25 to include frequent turning and repositioning or a frequency specifically assessed for R6's needs. The risk factors for possible skin breakdown when sick with COVID were not assessed or addressed with interventions on R6's care plan for skin concerns. On 2/13/25, at 5:00 PM, R6 was documented as having a change in condition related to a recent diagnosis of COVID and was sent out to the hospital for evaluation. R6's hospital documentation indicates post admission to the hospital, R6 arrived in the emergency room (ER) on 2/13/25, at 5:16 PM with generalized weakness, increased confusion, and positive COVID 3 days ago. R6's [NAME] Blood Cells (WBC) were documented as WBC 6.9 (normal) on 2/13/25, at 6:15 PM. The records indicate R6 was noted to have a suspected DTI to the sacrum measuring 6 x 4 cm with 100% slough. R6 was admitted to the inpatient floor. The hospital records do indicate a delay in treating R6 in the ER and admission to the floor post arrival. The records indicate R6's sacral wound was debrided in general surgery and R6 was started on Intravenous (IV) Antibiotics. On 2/18/25, at 3:01 PM, Surveyor interviewed Interim DON- B and RN UM- D who indicate wound care rounds are performed by MD- L weekly on Thursdays. RN UM- D stated floor nursing staff complete wound measurements and wound care evaluations with MD- L. RN UM- D attends wound care rounds with MD- L weekly on Thursdays. Surveyor asked what a Head-to-Toe Assessment is compared to the Weekly Skin Assessments in resident records. Interim DON- B and RN UM- D indicate the weekly skin assessments are more comprehensive than the Head-to-toe Assessments. Head-to-Toe Assessments are generated when risk management prompts a change in condition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25, at 3:02 PM, Surveyor interviewed RN UM- D who stated the floor nurse will complete wound measurements upon discovery of a new wound, notify the MD, get treatment orders, notify family, update the care plan, and contact maintenance for an air mattress if they don't already have one. Head to Toe Assessments are triggered and performed by the floor nurse and reviewed by the unit manager if a Licensed Practical Nurse (LPN) is completing the Head-to-Toe Assessment. Surveyor asked RN UM- D about the Pressure Injury Unavoidable forms and RN UM- D stated MD- L notifies staff to fill out the unavoidable form. RN UM- D stated R6 qualified as unavoidable because he has 2 or more risk factors, is non-compliant with turning and repositioning, pain from his previous fall at home, and immobile due to his pain after falling at home. Surveyor asked where documentation was of R6 being non-compliant with turning and repositioning. RN UM- D stated staff tell her, and she is not sure this is documented. RN UM- D stated the facility had things in place such as an air mattress, turning, incontinence care, toileting every two to three hours, prior to prevent skin breakdown and it still broke down. RN UM- D stated if all those things are happening and there's still breakdown then it's determined as being unavoidable. RN UM- D indicated the facility started using the pressure ulcer unavoidable investigation form around August or September of 2024. Surveyor notified RN UM- D of concerns with R6 developing an unstageable pressure injury to his sacrum and the suspected DTI to the left heel with no comprehensive assessment completed until MD- L saw R6 on 2/13/25. On 2/19/25, at 3:42 PM, Interim Director of Nursing (DON)- B requested to speak with Surveyor. Interim DON- B stated the facility completes daily skin monitoring for R6 which is documented on the TAR. Interim DON- B stated the comprehensive assessment is completed in the interdisciplinary team (IDT) note. Surveyor notified Interim DON- B there is no comprehensive assessment completed for R6's left heel DTI and unstageable sacral wound to include staging, wound bed description, and surrounding skin in the IDT notes. Interim DON- B acknowledged these concerns. On 2/25/25, at 10:49 AM, Surveyor interviewed MD- L who stated he recalls conversing with R6 at the time of his wound care assessment on 2/13/25. MD- L stated R6's wounds looked significantly worse than what the facility had initially notified him. MD- L stated he ordered bed rest for at least a week, blood work to rule out infection, and planned to follow up with another set of labs because the wound had progressed so much. MD- L indicated he ordered lab work to include a CBC to rule out a bacterial infection due to the worsening wounds. MD- L stated he would have started IV antibiotics right away if he was contacted with a positive CBC. MD- L stated he reviewed R6's hospital documentation and notes R6 did not have an elevated white blood cell count until 2/17/25. MD- L then stated R6's CBC was slightly elevated at 11.3 on 2/17/25 which is just out of range. MD- L stated he thinks this case was due to R6 being elderly, immunocompromised because of his age and very fragile due to COVID. MD- L indicated you have to look at it clinically because labs don't show everything or worsening infection, there's nothing we can go by, so I believe it was due to skin failure that was taken over with opportunistic bacteria that grew in an infected wound and that's why it had gotten so big so fast. MD- L indicated he could feel healthy tissue about 0.5 cm behind R6's sacral wound on 2/13/25, which is why he chose not to debride it. MD- L indicated he saw some excoriation that was kind of red around the area. MD- L notified staff to let him know if the sacral wound gets boggy and he would come by the facility. MD- L indicated there was no fluid leaking to the open area on R6's left heel at the time of the wound assessment on 2/13/25 which is why he chose to leave the blister alone. On 2/20/25 the facility submitted information provided to the Surveyor during the survey for additional review and consideration regarding R6. 38253 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R7 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, gastro-esophageal reflux disease with esophagitis with bleeding, protein-calorie malnutrition with a gastrostomy tube for all nutrition, anemia, and chronic embolism and thrombosis of deep veins. R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 and had impairment to both arms and legs requiring maximum to total assistance with all activities of daily living and bed mobility. The MDS documented R7 received all nutrition through the gastrostomy tube. The MDS documented R7 had a Deep Tissue Injury that was present upon admission and had a pressure reducing device for the chair and bed and received pressure ulcer care. R7's Skin Impairment Care Plan dated 6/26/2024 documented R7 had deep tissue injuries to the five toes on the left foot. R7's Quarterly MDS assessment dated [DATE] documented R7 did not have any pressure injuries. R7 had an activated Power of Attorney (POA). R7's Skin Impairment Care Plan, initiated 6/25/2024, had the following interventions in place on 10/24/2024: -Apply zinc barrier cream every shift and as needed with incontinence cares. -Encourage good nutrition and hydration in order to promote healthier skin. (Surveyor noted R7 did receive any nutrition orally.) -Encourage to elevate heels. -Encourage/assist with reposition as needed. -Keep linen dry, clean, and free of wrinkles. -Skin will be assessed on a weekly basis on scheduled bath day and document findings on a weekly skin assessment. -Report any skin redness/impaired integrity areas to the nurse. -Use barrier cream to prevent skin impairment issues as needed. R7 was receiving enteral nutrition through a gastrostomy tube. R7 had an order for Osmolyte 1.2 at 75ml/hr from 2:00 PM to 10:00 AM, a total of 20 hours. On 10/24/2024 at 10:24 AM in the progress notes, a Licensed Practical Nurse (LPN) documented a Certified Nursing Assistant (CNA) was giving (R7) a bed bath and noticed (R7) had a scabbed area on the right leg. The LPN documented the area is a dry, scabbed pressure area that measured 1.0 cm x 1.2 cm. The LPN documented the physician, POA, Unit Manager, and the Wound Physician were notified. The LPN documented the area was cleaned with normal saline and was awaiting orders from the wound physician. On 10/24/2024 on the Head to Toe Skin Check form, the LPN documented R7 had a new Unstageable pressure injury to the back of the right lower extremity that measured 1.0 cm x 1.2 cm. (continued on next page)

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Ridgewood Care Ctr	3205 Wood Rd Racine, WI 53406

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 10:33 AM in the progress notes, Registered Nurse Unit Manager (RN UM)-C documented R7 had a pressure injury to the right calf and R7 was unaware of the breakdown. RN UM-C documented R7 requires extensive assist for bed mobility, total assist for incontinence cares, and total assist of two for Hoyer transfer. RN UM-C documented R7 had a history of cerebral palsy, dysphagia, protein calorie malnutrition, and unilateral osteoarthritis of the right hip. RN UM-C documented R7 would be seen in house by the Wound Physician during wound rounds. RN UM-C documented R7's legs were elevated at the knee to avoid pressure to the site. The POA was updated, and the Care Plan was updated. RN UM-C documented previous intervention in place included heel boots. Surveyor noted heel boots when in bed were on the Treatment Administration Record to be signed off every shift initiated on 6/25/2024. On 10/24/2024 on the Weekly Skin Review, RN UM-C documented R7 had a scabbed area to the right calf, the Wound Physician had been notified, and a treatment order was received. The form was signed by RN UM-C on 10/25/2024. A treatment order for the right calf was to cleanse the wound with normal saline and apply betadine daily. On 10/24/2024 on the Pressure Ulcer/Skin Breakdown Unavoidable Investigation/Review form, RN UM-C documented R7 developed on 10/24/2024 to the right calf, skin breakdown. Primary risk factors include immobility and failure to thrive. No treatments were indicated. No recent lab values were indicated. Clinical signs that increased risk were gradual weight loss, immobility, and total dependence. No non-compliant behavior risk factors were indicated. clinical intervention in place and on the care plan included weekly skin observation, moisture barrier, heel/elbow protectors, and tube feeding. Monitoring included vital signs and weight changes. Education was provided to the POA. The form indicated based on the above clinical findings the pressure ulcer was determined to be unavoidable. The Root Cause portion of the form was blank. Surveyor noted with the information documented on the form, the pressure injury was not unavoidable. R7's Skin Impairment Care Plan was revised on 10/24/2024 with the interventions: -Educate (R7)/family/caregivers of causative factors and measures to prevent skin injury. -Elevate knees with pillow to avoid pressure to calves. Surveyor noted R7 was not seen by the Wound Physician as indicated. On 10/30/2024 on the Head to Toe Skin Check form, RN UM-C documented R7 had an Unstageable pressure injury to the right lower leg (rear) that measured 1.0 cm x 1.2 cm. On 10/30/2024 on the Weekly Skin Review form, an LPN documented R7 had a scabbed area to the right calf. On 10/31/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 2.0 cm x 2.0 cm with no drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type or percentages were documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 2.0 cm x 2.5 cm with no drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type or percentages were documented. On 11/14/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 2.0 cm x 2.0 cm with no drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type or percentages were documented. On 11/21/2024, R7 was admitted to the hospital due to a large brown emesis indicating a gastrointestinal bleed. R7 was readmitted to the facility on [DATE]. On 11/22/2024 on the Admit/Readmit Assessment form, an RN completed the Skin Integrity portion of the assessment and documented R7 had a pre-existing open wound to the back of the right lower leg (rear) that measured 1.5 cm x 1.5 cm x 0.2 cm with slough present. Surveyor noted this was the first measurement of depth and description of the tissue in the wound bed. No staging of the pressure injury was documented, and the percentage of slough was not documented. The treatment was changed to cleanse with normal saline, apply betadine, and cover with a foam dressing daily. On 11/27/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 1.4 cm x 1.0 cm with light serous drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type were documented. On 12/5/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 1.6 cm x 1.0 cm with light serous drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type were documented. RN UM-C documented the Wound Physician would be updated if the condition declines or changes. On 12/12/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 1.3 cm x 1.0 cm with light serous drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type were documented. RN UM-C documented the Wound Physician would be updated if the condition declines or changes. On 12/19/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 1.3 cm x 1.0 cm with light serous drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type were documented. RN UM-C documented the Wound Physician would be updated if the condition declines or changes. On 12/26/2024 on the Skin and Wound Evaluation form, RN UM-C documented R7 had an Unstageable pressure injury to the right calf that measured 1.6 cm x 1.3 cm with light serous drainage. RN UM-C documented the pressure injury was Unstageable due to slough and/or eschar. No depth or description of the wound bed tissue type were documented. RN UM-C documented the treatment was changed to manuka honey to the wound bed daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/26/2024, R7 was admitted to the hospital due to shortness of breath. R7 was readmitted to the facility on [DATE]. On 12/30/2024 on the Admit/Readmit Assessment form, an LPN completed the Skin Integrity portion of the assessment and documented R7 had a wound to the posterior right lower leg. No staging, measurements, or description of the wound was documented. The hospital nutrition orders were for Osmolyte 1.2 at 75ml/hr from 2:00 PM to 12:00 Noon, a total of 22 hours, which is the order continued on readmission to the facility. On 12/30/2024 on the Nutrition Initial/Quarterly/Annual Assessment form, Registered Dietitian (RD)-H documented R7 was a nutritional risk related to past me [T

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 (R4 and R2) of 3 residents reviewed for falls. *R4 had unwitnessed falls on 1/17/2025, 1/19/2025, 2/4/2025, and 2/13/2025. The facility did not thoroughly investigate the falls to determine a root cause of each fall and develop personalized interventions to prevent future falls. *R2 had two unwitnessed falls on 1/17/2025 and 2/7/2025. The facility did not thoroughly investigate these falls. There is no evidence of a comprehensive assessment to determine when R2 was last observed, when R2 was provided toileting cares, staff statements, whether R2's call light was within reach at the time of the fall, and a thorough investigation to determine a root cause to determine necessary preventative interventions. Findings include: The facility policy and procedure titled Fall Prevention Program dated 4/2024 documents: Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 5. When any resident experiences a fall, the facility will: a. Assess the resident. b. complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments. 1.) R4 was admitted to the facility on [DATE] with diagnoses of urinary tract infection, chronic kidney disease, diabetes, polymyalgia rheumatica, dementia, depression, difficulty in walking, lack of coordination, and communication deficit. R4's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R4 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 9, wore glasses, was always incontinent of bladder, frequently incontinent of bowel, needed maximal assistance with toileting hygiene, and needed moderate assistance with transfers. R4's Fall Care Area Assessment with this MDS documented R4 had not had any recent falls, depends on staff to assist with activities of daily living including transfers, has dementia, and becomes confused at times and needs reorientation. R4 was taking psychotropic medication, insulin, and a diuretic which may increase the risk for falls due to side effects. R4 was at risk for falls due to impaired mobility and side effects of medication. R4 did not have an activated Power of Attorney. R4's At Risk for Falls Care Plan was initiated on 1/3/2025 with the intervention: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Be sure (R4's) call light is within reach and encourage (R4) to use it for assistance as needed; (R4) needs prompt response to all requests for assistance. R4 had a Bowel Incontinence Care Plan and a Bladder Incontinence Care Plan initiated on 1/3/2025. No toileting schedule or check and change protocol was initiated. On 1/17/2025 at 7:29 PM in the progress notes, a Registered Nurse (RN) documented a Certified Nursing Assistant (CNA) entered R4's room at 6:05 PM to pick up the dinner tray and found R4 laying on the floor next to the bed. R4 reported R4 had slipped off from the bed while trying to get self into bed. The call light was not activated. R4 did not hit the head. Range of motion was within normal limits, neuro checks were negative, and R4 did not have any injury. R4's spouse, PM supervisor, and physician were notified. The Fall Risk Management form was completed by the RN and documented R4 was oriented to person, place, and situation, predisposing physiological factors were confusion, incontinence, gait imbalance, and weakness/fainted, and predisposing situation factors were using a wheelchair. R4 had intermittent confusion. The Post Fall Assessment form was completed by the RN and documented the fall occurred on 1/17/2025 at 6:05 PM in R4's room. R4 had been up in a wheelchair prior to the fall. R4 did not have a history of falls. R4 had diabetes and unsteady gait. R4 took a diuretic and recently had a new medication of Kevzara injections (used to treat rheumatoid arthritis). R4's functional status included receiving rehab therapy, incontinent of bladder and bowel, unable to toilet self, and can use call light independently. The review of post fall findings documented R4 was attempting to self-transfer from the wheelchair to the bed and slipped off. A referral was made to therapy and the root cause was unsteady gait and did not use the call light. R4's At Risk for Falls Care Plan was revised on 1/17/2025 with the intervention to anticipate and meet R4's needs. R4's Actual Fall Care Plan was initiated on 1/17/2025 with the interventions: -Complete Post Fall Assessment. -Complete Risk Management in PCC (computer charting system). -Initiate neuro checks per facility protocol. -Initiate pain monitoring per facility protocol. -Update physician, nurse practitioner, and responsible party. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/19/2025 at 11:20 PM in the progress notes, a Licensed Practical Nurse (LPN) documented R4 had an unwitnessed fall at 9:30 PM. The CNA called the nurse into the room. R4 was found halfway on the bed with the torso bent forward and R4 kneeling on the floor. The wheelchair was unlocked and away from R4 about 3 feet. R4 stated R4 thought R4 locked the wheelchair and then leaned forward towards the bed to reach for the call light but the wheelchair slipped out from under R4 and R4 fell forward onto the bed. R4 stated R4 was there for 5 minutes before R4 was found. The charge nurse was called. Vital signs and neuro checks were obtained and normal. R4 did not have any injuries. R4 was transferred to bed. the physician was notified and R4 declined for emergency contact to be called. Education was provided about locking the wheelchair and process of how post-fall works. The Fall Risk Management form was completed by the LPN and documented R4 had predisposing physiological factors of incontinence, gait imbalance, and medication, and predisposing situation factors of using a wheelchair, on a diuretic, unlocked wheelchair, and lack of coordination. The Post Fall Assessment form was completed by the LPN and documented the fall occurred on 1/19/2025 at 9:30 PM in R4's room when R4 was reaching to get the call light off the bed and thought R4 had locked the wheelchair. Fall interventions in use at the time of the fall were lock wheelchair, call light in reach, and education to R4 about locking the wheelchair and use of the call light for assistance. R4 had 1-3 falls in the past three months. R4 had underlying diseases or conditions of psychiatric or cognitive conditions such as dementia, lack of coordination, and abnormal posture. R4 took hypoglycemic's and diuretics. R4's functional status included problems with mobility, standing and sitting balance, use of assistive/adaptive devices, receiving rehab therapy, incontinent of bowel and bladder, unable to toilet self, and can use call light independently. The new fall prevention intervention to be implemented as a result of the assessment was call light in reach, education about locked wheelchair, and call for assistance if they need to transfer to bed or to wheelchair. The root cause was unlocked wheelchair. On 1/20/2025 at 9:07 AM in the progress notes, RN Unit Manager (RN UM)-C documented the interdisciplinary team (IDT) met to review R4's fall on 1/17/2025 at 6:05 PM and determined R4 would benefit from a Call Don't Fall sign placed in R4's room. Surveyor noted the IDT met three days after the fall and the intervention was implemented after R4 had another fall. On 1/20/2025 at 10:08 AM, RN UM-C documented the IDT met to review R4's fall on 1/19/2025 at 9:30 PM and determined R4 would benefit from staff to ensure call light is within reach prior to leaving R4's room each time. Surveyor noted that intervention was in R4's initial At Risk for Falls Care Plan. R4's At Risk for Falls Care Plan was revised on 1/21/2025 with the intervention Call Don't Fall sign placed in R4's room. R4's At Risk for Falls Care Plan was revised on 1/22/2025 with the intervention to reeducate R4 on locking wheelchair prior to transfers with return demonstration. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2025 at 11:17 AM in the progress notes, an LPN documented they heard someone screaming for help from the hallway. The LPN and two CNAs did a walk through and found R4 sitting up on the bathroom floor. R4 verbalized R4 needed to use the toilet and felt weak and out of balance during the self-transfer to the toilet. R4 was assessed for injury and R4 had minimal redness to the buttocks. The unit manager and physician were updated with no new orders. Therapy was updated. R4 was responsible to self. The Fall Risk Management form was completed by the LPN and documented R4 was oriented to person, place, and situation. Predisposing physiological factors were gait imbalance and impaired memory. Predisposing situation factors were improper footwear. The LPN documented R4 self-transferred without grip socks on. The Post Fall Assessment was completed by the LPN and documented the fall occurred on 2/4/2025 at 7:25 AM in R4's bathroom due to a self-transfer. The call light was within reach and the bed was in the lowest position. R4 had a history of 1-3 falls in the last three months. R4 took diuretics. R4's functional status included use of assistive/adaptive devices, receiving rehab therapy, incontinent of bowel and bladder, unable to toilet self, and can use call light independently. The new fall prevention intervention to be implemented as a result of the assessment was to check R4 often, call light within reach, and education provided to R4 about waiting for assistance to arrive prior to transferring self. The root cause was unsteady gait, not utilizing call light for assistance. Surveyor noted the documentation of the fall was unclear as to how R4 got to the bathroom, whether in a wheelchair or ambulating independently. Surveyor noted the fall risk management form does not document follow up or investigation into what type of footwear R4 should have on and whether it was included on the care plan or ask why R4 did not have on gripper socks as identified as a contributing factor in the fall. On 2/5/2025 at 9:56 AM in the progress notes, RN UM-C documented the IDT met to review R4's fall on 2/4/2025 at 7:25 AM and determined R4 would benefit from offering R4 to get up after blood glucose monitoring is completed. Review of the fall shows R4 was attempting to get out of bed unassisted in the early morning after being woken for glucose monitoring. R4's At Risk for Falls Care Plan was revised on 2/5/2025 with the intervention R4 to be offered to get up in the morning after blood glucose monitoring is completed. Surveyor noted R4's toileting care plan was not revised to address R4 needing to use the toilet at the time of the fall and the lack of proper footwear was not addressed. On 2/13/2025 at 12:15 AM in the progress notes, an RN documented the RN heard R4 yelling and found R4 on the floor sitting with no incontinent product on and with R4's walker nearby. R4 had taken the incontinent product off and it was lying on the bed. R4 stated R4 thought it was time to get up so R4 got up to go to the bathroom and slid down. R4 did not have any injuries. The physician and spouse were notified. The Fall Risk Management form was completed by the RN and documented R4 was confused and had impaired memory. R4 was ambulating without assist and had improper footwear. R4 was using a walker. The Post Fall Assessment form was completed by the RN and documented the fall occurred on 2/13/2025 at 12:15 AM in R4's room. R4 had been in bed sleeping prior to the fall. The bed was in low position and the call light was within reach. R4 had 1-3 falls in the last three months. R4 was diabetic. R4 took hypoglycemic's and diuretics. R4's functional status included problems with mobility, standing and sitting balance, use of assistive/adaptive devices, incontinent of bowel, unable to toilet self, and can use call light independently. The new fall prevention intervention to be implemented as a result of the assessment was for R4 to have gripper socks on when in bed. The root cause was confusion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's At Risk for Falls Care Plan was revised on 2/13/2025 with the intervention to have bed in low position and gripper socks on when in bed. Surveyor noted R4 did not have appropriate footwear on when R4 fell on [DATE] and was not addressed as an intervention at that time. On 2/14/2025 at 11:57 AM in the progress notes, RN UM-C documented the IDT met to review R4's fall on 2/13/2025 at 12:15 AM and determined R4 would benefit from a night light kept on for assistance with orientation if waking up in the middle of the night. Surveyor noted R4's toileting schedule was not reviewed or revised with R4's need to use the bathroom. R4's At Risk for Falls Care Plan was revised on 2/14/2025 with the intervention night light to be on at night for assistance with orientation in the middle of the night. On 2/17/2025 at 1:21 PM, Surveyor observed R4's room. R4 was not in R4's room at the time. Surveyor observed a Call Don't Fall sign on R4's bulletin board across the room from R4's bed. Surveyor noted multiple items were on the bulletin board such as cards and pictures making the sign very difficult to see. As a fall intervention, the sign was not in R4's line of vision whether in bed or transferring into or out of bed. Surveyor noted R4 required glasses for clear vision and only one sign was observed in R4's room. The call light was attached to R4's pillowcase at the edge of the bed. A walker was up against the wall opposite of the bed. Surveyor asked CNA-M where R4 would be located at that time. CNA-M stated R4's spouse comes regularly to see R4 and wheels R4 downstairs for activities. CNA-M stated R4 does not spend much time in R4's room. Surveyor observed R4 in a wheelchair on the first floor attending the BINGO activity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/18/2025 at 1:31 PM, Surveyor asked RN UM-C what the facility fall protocol was. RN UM-C stated the CNA would let the nurse know if a resident had fallen and an RN must do the assessment before the resident is moved either to a chair or bed. RN UM-C stated the unit nurse does a skin assessment, a pain assessment, neurological checks, starts the 72-hour post fall follow ups, and does the post fall assessment. The unit nurse notifies the physician and the Power of Attorney or emergency contact. The fall is reported to the unit manager or shift supervisor or the on-call supervisor. RN UM-C stated falls are discussed in morning stand-up and at 1:30 PM stand-down. RN UM-C stated the floor nurse talks to all the staff to get details of the fall. RN UM-C stated if a fall happens on a weekend, therapy is here and can do an assessment at that time and then the IDT meets on Monday after the weekend to come up with interventions. RN UM-C stated the IDT has a group chat, so all are updated timely on any situations. RN UM-C stated for instance, R4 just decided to get out of bed and go to the other bed in the room. Surveyor noted that information was not in R4's fall investigation for the fall that occurred on 2/13/2025. Surveyor asked RN UM-C if the facility uses fall mats as an intervention because Surveyor had not noted any fall mats in use with residents. RN UM-C stated yes, they use fall mats. Surveyor reviewed with RN UM-C R4's four falls for clarification. Surveyor shared the concern with RN UM-C that the documentation does not always follow as to how the intervention is determined, such as the fall on 2/4/2025 did not have any information as to how R4 got into the bathroom, who had seen R4 last, and did R4 walk to the bathroom or was there a wheelchair in the vicinity of the fall. RN UM-C was unable to say how R4 got into the bathroom. Surveyor shared the concern with RN UM-C that R4 had fallen a few times trying to get to the bathroom and toileting was not addressed in any of the root cause evaluations. Surveyor shared with RN UM-C the intervention for R4's fall on 2/13/2025 was to have gripper socks on when in bed and improper footwear was listed in the fall on 2/4/2025 and not followed up on. Surveyor shared with RN UM-C the observation in R4's room of the Call Don't Fall sign; the sign was buried on the bulletin board and would not catch R4's eye to remind them to use the call light. Surveyor shared that Surveyor was actively looking for the sign as a fall intervention and it took a bit to find it. RN UM-C agreed that the interventions needed to be reviewed. On 2/19/2025 at 8:56 AM, Surveyor observed R4's room. R4 was not in the room at the time of the observation. The Call Don't Fall sign was still on the bulletin board covered with cards and pictures. A fall mat was on the floor next to R4's bed. The call light was on the bed under a pillow at the head of the bed. Surveyor noted R4, in a wheelchair, would not be able to get close to the bed to reach the call light to ask for assistance due to the fall mat being placed on the floor next to the bed. On 2/19/2025 at 9:23 AM, Surveyor shared with Director of Nursing (DON)-B the concerns with R4's falls not being thoroughly investigated to implement a personalized fall intervention based on the root cause analysis. Surveyor shared with DON-B the observations of R4's Call Don't Fall sign being buried on the bulletin board where R4 would not be able to see it as well as the need for R4 to have glasses on to see the sign, showing the intervention was not personalized to R4's needs. Surveyor shared with DON-B the observation that morning of a fall mat on R4's floor that was not assessed as a need or put on R4's At Risk for Falls Care Plan and the fact that the floor mat made it impossible for R4 to wheel up to the bed to reach the call light to ask for assistance. In an interview on 2/19/2025 at 10:24 AM, RN UM-C stated Nursing Home Administrator (NHA)-A had purchased fall mats and a nurse saw them and put one in R4's room. RN UM-C stated the fall mat should be put up off the floor when R4 is not in bed. RN UM-C stated RN UM-C added the fall mat to R4's care plan. RN UM-C agreed the Call Don't Fall sign was not placed well. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/19/2025 at 11:49 AM, DON-B agreed the Call Don't Fall sign should have been moved. DON-B stated a nurse on the floor saw the fall mats so put one in R4's room that morning. Surveyor shared with DON-B there was no assessment to show R4 needed a fall mat. DON-B stated the nurse saw it and thought it would be a good idea. DON-B stated the IDT meets and DON-B feels they do a very good job with falls. DON-B stated the sign would have been placed right away and there may not have been anything else on the bulletin board at that time. Surveyor shared with DON-B that interventions are not reviewed to see if they are still effective, such as the Call Don't Fall sign. DON-B agreed interventions need to be reevaluated. On 2/20/25 the facility submitted information provided to the Surveyor during the survey for additional review and consideration regarding R4. 48391 2.) R2 is a [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses of sepsis, Myasthenia [NAME], subdural hemorrhage, epilepsy, abnormal posture, and colostomy. R2's Admission Minimum Data Set (MDS) completed on 1/20/25 documents that R2 is dependent with toileting, showering, dressing and transfers. R2's MDS documents falls since admission to the facility on [DATE]. R2's MDS documents falls with injury in the last 2-6 months prior to admission. R2 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating that R2 has severe cognitive impairment. R2's care plan, dated 1/14/25, documents: (R2) is at risk for falls related to myasthenia gravis status post Cerebrovascular Accident (CVA) with right sided weakness (date initiated 1/14/25). Interventions include: Be sure (R2's) call light is within reach and encourage the resident to use it for assistance as needed. (R2) needs prompt response to all request for assistance (date initiated 1/14/25). Surveyor notes these are the only interventions for R2 who has a history of falls with injury, right sided weakness post CVA, and severe cognitive impairment prior to his fall on 1/17/25. R2 has an activities of daily living (ADL) self-performance deficit related to myasthenia gravis status post CVA with right sided weakness (date initiated 1/14/25) Interventions include: (R2) requires assistance by one staff with bathing as necessary (date initiated 1/15/25). (R2) requires assistance by one staff to turn and reposition in bed (date initiated 1/14/25). (R2) requires assistance by one staff to dress (date initiated 1/15/25). (R2) requires set up by one staff to eat (date initiated 1/14/25). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25, at 1:30 PM, R2 sustained an unwitnessed fall and was found by facility staff sitting on his buttocks on the floor with his back and head against the side of the bed. There is no evidence of a comprehensive assessment to determine when R2 was last observed, when R2 was provided toileting cares, staff statements, whether R2's call light was within reach at the time of the fall, and thorough investigation to determine a root cause. Surveyor reviewed the facility fall investigation dated 1/17/25 for R2 which documents the following: (R2) fell in his room on 1/17/25 at 1:30 PM and was sitting in his wheelchair prior to the fall. (R2) sustained a red linear line to the back of his neck, however skin was not broken. (R2's) family, and physician were notified of his fall on 1/17/25. Fall interventions currently in place prior to his fall were documented to keep (R2's) call light within reach. Neuro checks were completed without significant findings. R2's post fall assessment documents R2 having problems with cognition, judgment, memory, and/or safety awareness. (R2) is a new admission to the facility; is alert and oriented but does have decreased safety awareness. There are no environmental factors that may have contributed to R2's fall. (R2) is alert, oriented; did not activate his call light to ask for assistance; (R2) wanted to get into bed and attempted to self-transfer which resulted in a fall due to weakness. New fall prevention interventions included, encourage (R2) to use his call light to ask for assistance into bed from wheelchair and notify therapy. The post fall assessment documents the root cause as weakness and lack of safety awareness. The fall investigation included an incident description which states staff was notified R2 had fallen in his room. Staff entered R2's room and noted him to be sitting on his buttocks, with his back and head against the side of the bed. R2's wheelchair was to the right of him, brakes unlocked. R2's call light was not activated, but within reach. R2 had gripper socks on both feet. No environmental factors noted. R2 is unable to fully verbally state what happened, but did indicate he was trying to get himself into bed. R2 indicated to staff he did not hit his head during the fall. R2's fall investigation indicates a Registered Nurse (RN) assessment was completed. R2 was placed on the 24-hour report board for monitoring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes the Interdisciplinary Team (IDT) met on 1/20/25 which documents (R2) would benefit from a call don't fall visual aid on the wall in his room. The IDT team documents the root cause of the fall being R2 self-transferring. Surveyor notes the fall investigation does not include when R2 was last seen, last toileted, location of where R2 was sitting in his wheelchair prior to his fall, staff statements, and whether R2's call light was within reach at the time of the fall. Surveyor notes the fall investigation did not identify a thorough root cause analysis. R2's care plan was updated after R2's 1/17/25 fall to include: Call don't fall visual aid on the wall in my room (date initiated 1/17/25). Encourage (R2) to use his call light to ask for assistance with transferring to bed from wheelchair, and to wait for assistance (date initiated 1/17/25). Surveyor notes care plan interventions are not personalized interventions for (R2) who has severe cognitive impairment and a BIMS of 3. Fall occurred with no injury (date initiated 1/17/25) Interventions include: Complete a risk assessment in point click care (PCC) (date initiated 1/17/25). If no apparent acute injury, determine and address causative factors of the fall (date initiated 1/17/25). Initiate neuro checks per facility protocol (date initiated 1/17/25). Initiate pain monitoring per facility protocol (date initiated 1/17/25). Complete post fall assessment (date initiated 1/17/25). Complete risk management in PCC (date initiated 1/17/25). Continue interventions on the at risk for falls care plan (date initiated 1/17/25). Update nurse manager, Director of Nursing (DON), Assistant Director of Nursing (ADON) of a fall with significant injury requiring emergency room evaluation (date initiated 1/17/25). Update physician, nurse practitioner, and responsible party (date initiated 1/17/25). On 2/7/25, at 10:15 AM, R2 sustained an unwitnessed fall and was found by facility staff sitting on the floor next to his bed with his back against the side of the bed facing the door. There is no evidence of a comprehensive assessment to determine when R2 was last observed, when R2 was provided toileting cares, staff statements, whether R2's call light was within reach at the time of the fall, and thorough investigation to determine a root cause. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility fall investigation dated 2/7/25 which documents the following: (R2) fell in his room on 2/7/25 at 10:15 AM with no apparent injury. (R2) was sitting prior to his fall. (R2's) family and physician were notified of R2's fall on 2/7/25. Fall interventions currently in place prior to his fall were documented to keep (R2's) call light within reach. Underlying diseases or conditions were documented as R2 having prior CVA and seizures. (R2) was documented as recently starting a new medication or having a change in medications. (R2) functional status is documented as being incontinent of bowel and bladder. (R2) was documented as having concerns with cognition, judgment, memory and/or safety awareness. There are no environmental factors that may have contributed to R2's fall. Post fall findings document (R2) is alert, oriented, able to use his call light independently, has a history of falls, and weakness. New fall interventions included a sidewall mattress to (R2) bed, notify therapy. The post fall assessment documents R2's fall root cause being weakness. The fall of investigation included an incident description documenting, staff was walking down the hallway and heard (R2) yelling out. Staff noted (R2) to be sitting on the floor next to his bed with his back against the side of the bed. (R2's) call light was not activated. (R2) had gripper socks on his feet and no environmental factors were noted. R2 is alert, oriented, though somewhat aphasic, and did not indicate if he was attempting a transfer or if he slid off the bed. (R2) was assisted back to bed. Vital signs and neuro checks were obtained with no significant findings. No injuries were noted and (R2) denied pain or discomfort. R2's provider, family, and DON were notified. (R2) was placed on the 24-hour board for monitoring. Surveyor notes the IDT team met on 2/7/25 which documents R2 sustained an unwitnessed fall without injury on 2/7/25. The IDT team progress note documents R2 was sitting at bedside when he slid off his mattress onto the floor. Interventions post fall were to place a side wall mattress to aid into finding the perimeter of the mattress. R2's care plan was updated, and the IDT team progress note documents nursing staff will continue to monitor and implement the intervention and evaluate the effectiveness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted the fall investigation does not include when R2 was last seen, last toileted, location of where R2 was sitting prior to the fall, staff statements, whether the call light was within reach at the time of the fall, and further investigation into new medications recently started for R2. Surveyor noted the documentation related to R2's 1/17/25 and 2/7/25 post fall documentation includes documentation to notify therapy. It is unclear if therapy was involved in reviewing R2 for safety as the facility documentation references weakness as a factor in the falls but does not address through investigation to help identify effective interventions to prevent falls for R2. On 2/18/25, at 8:39 AM, Surveyor observed unit one east. Surveyor noted every resident on 1 East having a low bed in the low position. Surveyor observed no fall mats being used throughout 1 East at the time of the observation. On 2/18/25, at 10:14 AM, Surveyor interviewed RN Unit Manager- D who indicates every resident has a low bed. RN Unit Manager- D stated the nurse assigned to the resident starts a fall investigation when a resident falls. The assigned nurse will talk with staff, talk with the resident, obtain a location of where the resident was last seen and when the resident was last seen. RN Unit Manager- D stated statements are verbally given to the nurse and documented in the post fall evaluation. RN Unit Manager- D indicated R2 was very forgetful and would self-transfer. RN Unit Manager- D described R2 as impulsive and indicated R2 told staff he was trying to get into bed at the time of his fall on 1/17/25. RN Unit Manager- D stated this is documented in a nursing progress note. RN Unit Manager- D indicated R2's progress notes document where R2 was last seen, however RN Unit Manager- D was unable to state when R2 was last seen. RN Unit Manager- D indicated the IDT team meets daily in the mornings Monday through Friday and will discuss falls the same day or following day. RN Unit Manager- D stated the default intervention after a resident falls, is to place a call don't fall sign in their room. The IDT team will discuss the fall and unit managers will determine if other interventions are warranted. Surveyor asked RN Unit Manager- D how the facility follows up with interventions placed post fall. RN Unit Manager- D stated, interventions are discussed in the IDT team if another fall occurs. On 2/19/25, at 9:28 AM, Surveyor notified Interim DON- B of concerns discussed above with the fall investigations for R2's unwitnessed falls on 1/17/25 and 2/7/25. Surveyor notified Interim DON- B the facility fall investigations did not determine when R2 was last seen, last toileted, exact location of where R2 was last seen prior to his falls, staff statements, and completion of a thorough investigation to determine a root cause to establish effective interventions to prevent future falls. On 2/19/25, at 11:48 AM, Interim DON- B requested to speak with Surveyor. Interim DON- B reviewed with Surveyor R2's facility progress notes, IDT notes, and post fall investigation. Surveyor notified Interim DON- B of concerns with the facility not completing a thorough fall investigation for R2's falls on 1/17/25 and 2/7/25. Surveyor noted to Interim DON- B the fall investigations lacked a thorough investigation to determine why R2 was attempting to self-transfer or possible causes for R2's falls. On 2/20/25 the facility submitted information provided to the Surveyor during the survey for additional review and consideration regarding R2.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure a sanitary environment was maintained to help prevent the development and transmission of infections during wound care for 1 (R7) of 1 residents observed during wound care. *R7 had a treatment to the right calf pressure injury and hand hygiene was not performed between dirty and clean aspects of the treatment. Findings include: The facility policy and procedure titled Hand Hygiene dated 4/2024 documents: Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The attached Hand Hygiene Table included, in part, hand hygiene in the following situations: after handling contaminated objects, before performing invasive procedures, before applying and after removing personal protective equipment (PPE) including gloves, before and after handling clean or soiled dressings, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when during resident care moving from a contaminated body site to a clean body site, and when in doubt. R7 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, gastro-esophageal reflux disease with esophagitis with bleeding, protein-calorie malnutrition with a gastrostomy tube for all nutrition, anemia, and chronic embolism and thrombosis of deep veins. R7's Admission Minimum Data Set (MDS) assessment dated [DATE] documented R7 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 and had impairment to both arms and legs requiring maximum to total assistance with all activities of daily living and bed mobility. The MDS documented R7 received all nutrition through the gastrostomy tube. The MDS documented R7 had a Deep Tissue Injury that was present upon admission and had a pressure reducing device for the chair and bed and received pressure ulcer care. R7's Skin Impairment Care Plan dated 6/26/2024 documented R7 had deep tissue injuries to the five toes on the left foot. R7's Quarterly MDS assessment dated [DATE] documented R7 did not have any pressure injuries. R7 had an activated Power of Attorney (POA). On 10/24/2024 at 10:24 AM in the progress notes, a Licensed Practical Nurse (LPN) documented a Certified Nursing Assistant (CNA) was giving R7 a bed bath and noticed R7 had a scabbed area on the right leg. The LPN documented the area is a dry, scabbed pressure area that measured 1.0 cm x 1.2 cm. On 2/18/2025 at 1:17 PM, Surveyor observed R7 in bed on an air mattress. R7 stated R7 was comfortable and agreeable to have Surveyor observe wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/2025 at 3:57 PM, Surveyor observed LPN-F provide wound care to R7 with the assistance of CNA-G. R7 was observed in bed on an air mattress and to have heel boots on. LPN-F washed their hands in the bathroom with soap and water. LPN-F and CNA-G put on isolation gowns and gloves. LPN-F turned R7's feeding tube pump to hold. LPN-F moved the garbage can with gloved hands by grabbing the top edge of the garbage can with the fingertips inside the garbage can. LPN-F removed the lid and protective seal on a bottle of normal saline. LPN-F opened a 4x4 gauze, folded the gauze, and placed it over the open normal saline bottle. With two hands, LPN-F turned the bottle up-side-down so the gauze was on the bottom absorbing the normal saline and then placed the saline soaked gauze on the open gauze packet. LPN-F removed R7's heel boots. CNA-G held R7's right leg under the ankle and knee so LPN-F could access the wound site. LPN-F removed R7's dressing from the back of R7's calf and threw it in the garbage can. LPN-F picked up the saline soaked gauze and washed the wound bed with the gauze. LPN-F took a dry gauze and patted the wound dry. LPN-F removed the gloves and put on a new pair of gloves. LPN-F did not complete any hand hygiene between the use of gloves. LPN-F put manuka honey from a tube onto the middle of the foam gauze. LPN-F placed the foam gauze onto and covering the wound. LPN-F did not perform any hand hygiene after touching the garbage can and before putting normal saline on the gauze. LPN-F did not perform any hand hygiene after removing the heel boots and removing the old dressing. LPN-F did not perform any hand hygiene after removing the old dressing and cleansing the wound with normal saline. LPN-F did not perform any hand hygiene after removing gloves and putting on a new pair of gloves. LPN-F did not perform any hand hygiene after the wound care was completed. Surveyor asked LPN-F if LPN-F normally washes their hands while doing wound care. LPN-F stated LPN-F usually has hand gel (alcohol-based hand sanitizer) in their pocket but today LPN-F did not have any. Surveyor asked LPN-F when LPN-F would use the hand sanitizer. LPN-F stated LPN-F would use it between taking gloves off and putting gloves on. On 2/19/2025 at 7:57 AM, Surveyor shared with Director of Nursing (DON)-B the observation of R7's Unstageable pressure injury wound treatment completed by LPN-F on 2/18/2025. Surveyor shared the concerns with DON-B LPN-F did not perform hand hygiene at critical points throughout the treatment and touched multiple surfaces, such as the garbage can and R7's heel boots, without performing hand hygiene. DON-B agreed hand hygiene should have been performed throughout the wound treatment.