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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38253 Based on observation, record review, and interview, the facility did not treat residents with dignity when administering insulin for 2 (R33 and R55) of 2 residents observed receiving insulin. Licensed Practical Nurse (LPN)-G administered insulin to R33 in the hallway by the nurses' station with other residents present. LPN-G checked R55's blood sugar and then administered insulin to R55 in the TV room with another resident present. No privacy was provided to R33 or R55. Findings include: The facility policy and procedure entitled Timely Administration of Insulin dated 1/2024 states: Policy Explanation and Compliance Guidelines: . 5. d. Explain procedure and provide privacy. On 5/1/2024 at 8:22 AM, Surveyor observed LPN-G standing at the medication cart next to the nurses' station. LPN-G dialed up the dose on the insulin pen for R33. R33 was in a wheelchair in the middle of the hallway next to the medication cart. Other residents were in the hallway and dining room getting ready for breakfast. The dining room was located across from the nurses' station. LPN-G administered R33's insulin in the right arm. LPN-G did not offer to take R33 to a private area to administer the insulin. LPN-G went into the TV room across from the nurses' station and next to the dining room and tested R55's blood sugar by drawing blood from the finger. R55 was sitting at a table with another resident. LPN-G then administered insulin to R55 in the left arm. LPN-G did not offer to take R55 to a private area to check the blood sugar or administer the insulin. Surveyor reviewed Resident Council minutes from 2/7/2023. A concern was identified at that meeting by residents. The concern was that insulin was being given to residents in the dining room. The recommendation/solution per the minutes was that staff would be educated on giving insulin in the dining room. On 5/1/2024 at 9:48 AM, Surveyor shared with Director of Nursing (DON)-B the observations of LPN-G taking R55's blood sugar in the TV room with another residents present and administering insulin to R33 and R55 in a public space. DON-B stated LPN-G had contacted DON-B after Surveyor had left the unit LPN-G worked on and informed DON-B of the observations. DON-B stated LPN-G was aware blood sugars and insulin should not be obtained or provided to residents in public spaces. No further information was provided at that time.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for assessing non-pressure wounds for 2 (R188 and R190) of 2 residents reviewed with non-pressure injuries. R188's non-pressure injuries were not comprehensively assessed on admission. R190's non-pressure injuries were not comprehensively assessed on admission. Findings include: The facility policy and procedure entitled Skin assessment dated ,d+[DATE] states: Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. document if resident refused assessment and why. f. Document other information as indicated or appropriate. 1.) R188 was admitted to the facility on [DATE] with diagnoses of pneumonitis due to inhalation of food and vomit, bacteremia, malnutrition, leukemoid reaction, anemia, anxiety, depression, and epilepsy. R188 had not been a resident of the facility long enough to have a comprehensive Minimum Data Set (MDS) assessment completed. R188 had an activated Power of Attorney (POA). R188's Activities of Daily Living Care Plan was initiated on 4/26/2024 and indicated R188 needed staff assistance of one for bathing/showering, bed mobility, dressing, personal hygiene, and toilet use and staff assistance of two for transferring using a mechanical lift. The Infectious Disease Physician Progress Note dated 4/26/2024 documented R188 had wounds on the dorsal aspect of the left foot and fifth metatarsal (toe) that measured approximately 2 cm x 2 cm and multiple small wounds scattered on bilateral legs and arms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R188's hospital Discharge Summary dated 4/26/2024 indicated no wound care was needed. On 4/26/2024, Registered Nurse (RN)-D completed R188's Admit/Readmit Assessment form and Skin & Wound Evaluation forms for the following open areas: -Left flank area skin tear measured 3.2 cm x 1.7 cm (on the Admit/Readmit Assessment form) and left iliac crest abrasion with the same measurements (on the Skin & Wound Evaluation form) with 100% granulation. Surveyor noted no depth of the wound was measured. -Left fourth toe Unstageable pressure injury measured 1.5 cm x 1.5 cm. Surveyor noted no depth was measured and no wound characteristics were documented. Surveyor noted the picture attached to the assessment showed the wound to be on the fifth toe and not the fourth toe. Surveyor noted no wound was documented to the left dorsal foot as noted on the Infections Disease Physician Progress Note dated 4/26/2024. R188's Skin Impairment Care Plan was initiated on 4/26/2024 with the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Encourage to elevate heels. -Encourage/assist with reposition as needed. -Use barrier cream to prevent skin impairment issues, as needed. R188's Skin Impairment Care Plan was revised on 4/27/2024 with the following interventions: -Encourage to offload heels. -Heel boots on when in bed. -R188 needs an air mattress to protect the skin while in bed. -R188 needs pressure relieving/reducing cushions to protect the skin while up in a chair. On 5/1/2024, Licensed Practical Nurse (LPN)-P completed a Skin & Wound assessment form for the following open area: -Left iliac crest abrasion measured 3.0 cm x 1.9 cm x not applicable. No tissue type was documented for the wound bed and the wound was stable with no other characteristics. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/2024 at 11:09 AM, Surveyor accompanied Wound Physician-I and RN Unit Manager (UM)-E to assess R188's pressure injuries. RN UM-E stated R188 had a skin tear to the left flank. Wound Physician-I stated the wound to the left fifth toe was due to trauma and not a pressure injury. Surveyor clarified with Wound Physician-I that the wound was on the fifth toe and not the fourth toe as initially documented. Wound Physician-I agreed the wound was on the fifth toe. Surveyor observed a scabbed area to the left dorsal foot. Wound Physician-I stated that wound was caused by trauma. Surveyor observed an open area on the left iliac crest. Wound Physician-I stated the wound to the left iliac crest was possibly due to pulling on the sheets when R188 was repositioned in bed. Surveyor requested a copy of Wound Physician-I's wound assessments. Wound Physician-I's documentation of R188's non-pressure areas on 5/2/2024 had the following assessments: -Left fifth toe trauma measured 1.24 cm x 1.0 cm x 0.1 cm with eschar. -Left dorsal foot trauma measured 1.08 x 1.01 x 0.1 with eschar. -Right posterior superior iliac crest trauma measured 1.88 cm x 1.89 cm x 0.1 cm with 1-25% granulation and 51-75% slough. Surveyor noted the wound was located on the left iliac crest and not the right iliac crest. This was the first comprehensive assessment of the non-pressure areas, six days since admission. In an interview on 5/2/2024 at 3:22 PM, Surveyor asked RN-D what the facility process was when a new resident was admitted to the facility. RN-D stated the nurse on the floor does the initial skin assessment which includes looking at the resident's skin from top to bottom and documenting anything like a scab, bruising, scratches, checking under the breasts and folds for redness or excoriation, and any open areas or Deep Tissue Injuries (DTI) caused by pressure. RN-D stated for any open areas or DTIs, you put a sticker next to the wound and take a picture with the phone; that is connected to the electronic charting system, and it measures the length and width of the wound. RN-D stated the picture is sent to Wound Physician-I or to RN UM-E with the resident's name and what the wound is so they can get a treatment order. RN-D stated the wounds are monitored and they are evaluated weekly on Wednesday. RN-D stated if a treatment needs to be done right away, RN-D will do that and then make sure everything is charted. RN-D stated if the resident has mushy heels, RN-D will get heel boots or pillows if the resident hates the boots. Surveyor asked RN-D if pictures were taken of all skin impairments. RN-D stated scabs, bruises, and blanchable redness just get written into the assessment, but if it is an open area, then they get a picture on the phone. RN-D clarified an open area on the coccyx or anything that gets a deeper assessment will get a picture so Wound Physician-I can get a treatment in place. RN-D stated Wound Physician-I is available every day and answers quickly. RN-D stated RN UM-E and Assistant Director of Nursing (ADON)-C are really good with wounds, so they help with assessments. Surveyor noted the phone picture assessment does not measure depth. Surveyor asked RN-D if any wounds get depth measurements. RN-D stated it depends on the wound if a depth is measured. RN-D stated with a flap off, like a skin tear, the depth is estimated and if it something deeper, then they would take a cotton swab to measure the depth. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/2024 at 9:31 AM, Surveyor shared with DON-B the concern R188's non-pressure areas were not comprehensively assessed until 5/2/2024, six days after admission, when Wound Physician-I assessed R188's wounds. Surveyor shared with DON-B R188 had a wound to the left fifth toe that was documented as the left fourth toe and determined to be caused by trauma when Wound Physician-I assessed the wound, the left iliac crest wound did not have a depth measurement on admission, and the left dorsal foot wound was not documented on admission. 2.) R190 was admitted to the facility on [DATE] with diagnoses of diabetes, osteomyelitis of the right ankle and foot, chronic obstructive pulmonary disease, cholecystitis, congestive heart failure, diabetic polyneuropathy, coronary artery disease, and anemia. R190 had not been a resident of the facility long enough to have a comprehensive Minimum Data Set (MDS) assessment completed. R190 did not have an activated Power of Attorney. R190's Hospital Wound Care Note dated 4/17/2024 indicated the following non-pressure wounds: -Right lateral foot incision wound from a diabetic ulcer measured 9.9 cm x 3.5 cm x 2 cm with 10% epithelialization, 70% granulation, and 20% slough. -Right distal posterior Achilles leg venous ulcer measured 0.7 cm x 0.8 cm x 0.6 cm with 15% epithelialization, 80% granulation, and 5% slough. -Right foot dorsum incision wound measured 2 cm x 1.6 cm x 0.9 cm with 10% granulation and 90% slough. -Right plantar foot originally a blister measured 0.8 cm x 3 cm x 0.2 cm with 5% epithelialization, 25% slough and 70% eschar. -Bilateral buttocks Suspected Deep Tissue Injury (DTI) with the right buttock DTI measured 0.3 cm x 0.5 cm and the left buttock DTI measured 0.5 cm x 0.5 cm. -Right anterior lower leg Stage 2 pressure injury measured 3 cm x 9 cm with 5% epithelialization. Treatments were ordered for each area including a wound vac to the right lateral foot wound. The Hospital Discharge Summary dated 4/18/2024 documented R190 was hospitalized for cholecystitis with elevated liver enzymes. R190 had continuation of a previously treated diabetic foot infection with osteomyelitis of the metatarsal and was placed on intravenous antibiotics. R190's Skin Impairment Care Plan was initiated on 4/18/2024 with the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Encourage to elevate heels. -Encourage/assist with reposition as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure pressure relieving cushion is used in dialysis chair when resident is in chair for dialysis session. Document if resident refuses to use cushion. (Surveyor noted R190 does not attend dialysis.) -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. -R190 needs pressure relieving/reducing cushions to protect the skin while up in chair. -R190 needs pressure relieving/reducing mattress, pillows to protect the skin while in bed. -Use barrier cream to prevent skin impairment issues, as needed. On 4/18/2024 on the Admit/Readmit Assessment form and on the Skin & Wound Evaluation form, Licensed Practical Nurse (LPN)-J documented R190 had the following skin integrity concerns: -Left lateral foot vascular wound measured 10.0 cm x 4.0 cm x 1.7 cm. (Surveyor noted the hospital documentation showed the wound to be on the right foot and not the left foot.) -Bottom of right foot diabetic ulcer measured 1.0 cm x 4.0 cm x 0.2 cm. No wound descriptors were documented. -Right dorsum foot vascular ulcer measured 1.0 cm x 4.0 cm x 0.2 cm. No wound descriptors were documented. -Left buttock Moisture Associated Skin Damage (MASD) measured 0.5 cm x 0.5 cm. No depth or wound descriptors were documented. -Right middle shin venous ulcer measured 4.25 cm x 2.14 cm with 100% granulation. No depth was documented. (Surveyor noted the hospital paperwork indicated this was a pressure area.) -Right medial calf venous ulcer measured 1.58 cm x 1.03 cm with 20% epithelialization and 20% slough. No depth was documented, and the wound descriptors did not equal 100%. -Right medial calf diabetic ulcer measured 1.99 cm x 0.94 cm with 20% granulation and 80% slough. No depth was documented. -Intergluteal cleft MASD measured 0.77 cm x 0.52 cm with 100% granulation. No depth was documented. (Surveyor was unable to determine if the intergluteal cleft MASD was the same area as the left buttock MASD though they did not have the same measurements. Surveyor noted the hospital paperwork indicated this was a pressure area.) -Right lateral midfoot surgical wound measured 9.46 cm x 3.84 cm with 80% granulation and 20% slough. No depth was documented. (Surveyor noted the area was now labeled right instead of left and the length and width measurements were similar.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/2024 R190 was seen for the initial visit by Wound Physician-I. Wound Physician-I documented the following wounds: -Right lateral foot surgical wound measured 7.76 cm x 3.19 cm x 1.4 cm with early/partial granulation with the wound bed color descriptions denoted by centimeters squared: red, black, yellow, pink, and other. The tissue types were not documented nor the percentage of wound bed coverage. -Right dorsal foot venous ulcer measured 1.59 cm x 1.2 cm x 0.6 cm with 1-25% granulation and 51-75% slough. -Right plantar foot diabetic ulcer measured 1.49 cm x 2.98 cm x 0.1 cm with 76-100% slough before debridement and 1.25 cm x 2.93 cm x 1.6 cm with 1-25% granulation and 51-75% slough. -Right shin venous ulcer measured 4.63 cm x 2.69 cm x 0.1 cm with 26-50% granulation and 26-50% slough. -Right calf venous ulcer measured 0.87 cm x 1.1 cm x 0.1 cm fully granulated. On 4/25/2024 at 2:40 PM in the progress notes, Registered Nurse Unit Manager (RN UM)-E charted R190's left buttock had healed. On 5/2/2024 at 10:47 AM, Surveyor observed Wound Physician-I along with RN UM-E assess R190's wounds. RN UM-E stated R190's coccyx area had healed since admission and currently has wounds to the lower right leg. Surveyor observed R190's right foot with a Kerlix dressing wrapped around the foot. Yellow drainage had seeped through the bandage on the bottom of the foot. The wound to the bottom of the right foot was macerated. The right lateral foot wound had a wound vac connected which was removed for the assessment. Surveyor observed wounds to the right shin, the right dorsum of the foot, and the right Achilles. Wound Physician-I stated the right Achilles wound had hyper-granulation because of possible tendon involvement. R190 stated R190 had cellulitis to the right foot and because of neuropathy to R190's hands, R190 was unable to change the dressings while at home. R190 stated R190 left the dressing to the right foot on for two weeks and then was in a really bad state and ended up in the hospital. Surveyor requested a copy of Wound Physician-I's wound assessments for that day. Wound Physician-I's documentation of R190's non-pressure areas on 5/2/2024 had the following assessments: -Right lateral foot measured 6.84 cm x 3.11 cm x 0.5 cm with early/partial granulation with the wound bed color descriptions denoted by centimeters squared: red, black, yellow, pink, and other. The tissue types were not documented nor the percentage of wound bed coverage. -Right dorsal foot venous ulcer measured 1.63 cm x 1.12 cm x 0.5 cm with 1-25% granulation and 51=75% slough. -Right plantar foot diabetic ulcer measured 0.76 cm x 5.64 cm x 0.6 cm with 76-100% slough. -Right shin venous ulcer measured 1.03 cm x 0.84 cm x 0.1 cm with 76-100% granulation. -Right calf venous ulcer measured 1.54 cm x 1.57 cm x 0.1 cm with full granulation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/2/2024 at 3:33 PM, Surveyor asked LPN-J what the facility procedure was for a newly admitted resident. LPN-J stated the majority of new admissions come on second shift, so the floor nurse does the assessment and admission note. LPN-J stated the Unit Manager or the unit secretary may help with orders and getting appointments into the computer system. LPN-J stated the floor nurse has to do the admission in addition to their normal duties and if there are multiple new admissions, then the two floor nurses will split up the admissions so it is an even workload. LPN-J stated the nurse has to get vital signs, do a skin assessment, an admission assessment, and write the admission note. LPN-J stated if the regular nurses are working when there are a lot of new admissions, it is not too bad, but if a nurse does not normally work on that unit, it can be very stressful. Surveyor asked LPN-J to explain what is meant by doing a skin assessment. LPN-J stated the nurse checks for bruising from IVs, open areas, redness, scars, tattoos, or anything else on the skin. LPN-J stated they normally know what they are looking at from the report that is given from the hospital. LPN-J stated the nurse gets measurements of the wounds and takes a picture of the wound that also gets measurements. LPN-J stated the Wound Physician will officially stage any pressure injuries. Surveyor asked LPN-J if the phone picture gets a depth measurement of the wound. LPN-J stated the phone gets a slight depth, but that is where the Wound Physician fills in. LPN-J stated LPN-J does not usually get a depth measurement but knows to use a disposable paper ruler to measure the depth. Surveyor asked LPN-J if LPN-J remembered doing the admission skin assessment for R190. LPN-J stated LPN-J was told to change the dressings that LPN-J could and that R190 was going to have a wound vac to one of the wounds and LPN-J was not going to do the wound vac. LPN-J did not remember getting a depth of the right lateral foot wound. LPN-J stated pictures are taken of the open wounds so the progression of healing can be seen. Surveyor asked LPN-J if any other areas of the skin would have pictures taken. LPN-J stated a picture of a large area of maceration on the buttocks was taken of R190. LPN-J stated LPN-J waits to have someone else look at the wound, so LPN-J does not describe the tissue. LPN-J stated after a picture is taken, the computer gives you option to specify the tissue type and other descriptors, so LPN-J clicks on whatever was seen. LPN-J stated the wound assessment is followed up by RN UM-E. On 5/6/2024 at 9:38 AM, Surveyor shared with Director of Nursing (DON)-B the concerns that R190's wounds on admission were very hard to follow with the documentation; either the wounds did not have a depth measurement, they did not have any description of the tissue type, or they labeled the same areas different names. DON-B stated on the Admit/Readmit Assessment form nurses are not able to add notes such as descriptions of the tissue type. Surveyor stated not all the wounds had Skin & Wound Evaluation forms completed which would allow the nurse to document more descriptors. DON-B stated Wound Physician-I comes after a resident has been in the facility for a few days and Wound Physician-I labels the wound to be at a different location than what the facility picked for the wound, so the facility has to take a new picture or relabel the wound and that makes it look like the wound is a new wound when really it is the same wound just relabeled with the location picked by Wound Physician-I. Surveyor shared the concern most wounds on admission did not have a depth measurement. DON-B stated the nurses will use the depth measurement from Wound Physician-I so they do not have a depth until then. No further information was provided at that time.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure residents with pressure injuries received care consistent with professional standards of practice to promote healing for 4 (R188, R62, R14, and R12) of 5 residents reviewed with pressure injuries. *R188 was admitted to the facility with pressure injuries that were not comprehensively assessed on admission and the air mattress was observed to be not set according to R188's weight. *R62, R14, and R12 had pressure injuries and observations were made of their air mattresses not to be set according to their weight. Findings include: The facility policy and procedure entitled Pressure Injury Prevention and Management dated 10/2023 states: Policy Explanation and Compliance Guidelines: . 3. Assessment of Pressure Injury Risk . c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. 4. Interventions for Prevention and to Promote Healing . c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: . iii. Provide appropriate, pressure-redistributing, support surfaces. The facility policy and procedure entitled Skin assessment dated ,d+[DATE] states: Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. document if resident refused assessment and why. f. Document other information as indicated or appropriate. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R188 was admitted to the facility on [DATE] with diagnoses of pneumonitis due to inhalation of food and vomit, bacteremia, malnutrition, leukemoid reaction, anemia, anxiety, depression, and epilepsy. R188 had not been a resident of the facility long enough to have a comprehensive Minimum Data Set (MDS) assessment completed. R188 had an activated Power of Attorney (POA). R188's Activities of Daily Living Care Plan was initiated on 4/26/2024 and indicated R188 needed staff assistance of one for bathing/showering, bed mobility, dressing, personal hygiene, and toilet use and staff assistance of two for transferring using a mechanical lift. The Infectious Disease Physician Progress Note dated 4/26/2024 documented R188 had wounds on the dorsal aspect of the left foot and fifth metatarsal (toe) that measured approximately 2 cm x 2 cm and multiple small wounds scattered on bilateral legs and arms. R188's hospital Discharge Summary dated 4/26/2024 indicated no wound care was needed. On 4/26/2024, Registered Nurse (RN)-D completed R188's Admit/Readmit Assessment form and Skin & Wound Evaluation forms for the following pressure injuries: -Coccyx/Sacrum Stage 3 pressure injury measured 8.1 cm x 6 cm x 0.2 cm with 20% granulation and 80% slough. An additional Skin & Wound Evaluation form was completed for the sacrum Stage 3 pressure injury measured 3.8 cm x 1.4 cm with no depth measurement with 20% granulation and 80% sough. The photos attached to the sacrum assessments revealed three open areas and measurements were for two areas with no description of what was being assessed. The location of the pressure injury was labeled coccyx on the Admit/Readmit Assessment form and was labeled sacrum on the Skin and Wound Evaluation form. -Left heel Unstageable pressure injury measured 2.9 cm x 1.9 cm with 100% eschar. -Left fourth toe Unstageable pressure injury measured 1.5 cm x 1.5 cm. Surveyor noted no depth was measured and no wound characteristics were documented. Surveyor noted the picture attached to the assessment showed the wound to be on the fifth toe and not the fourth toe. R188's Skin Impairment Care Plan was initiated on 4/26/2024 with the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Encourage to elevate heels. -Encourage/assist with reposition as needed. -Use barrier cream to prevent skin impairment issues, as needed. R188's Skin Impairment Care Plan was revised on 4/27/2024 with the following interventions: -Encourage to offload heels. -Heel boots on when in bed. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R188 needs an air mattress to protect the skin while in bed. -R188 needs pressure relieving/reducing cushions to protect the skin while up in a chair. On 4/27/2024 on the Treatment Administration Record (TAR), R188 had an order to check the function of the low airloss mattress every shift. On 5/1/2024, Licensed Practical Nurse (LPN)-P completed a Skin & Wound assessment form for the following pressure injuries: -Sacrum Unstageable pressure injury measured 6.5 cm x 3.3 cm with 90% slough and 10% eschar. Surveyor noted no depth was measured and the photo attached to the assessment showed two open areas. -Sacrum Stage 3 pressure injury had no measurements and no wound description other than the wound was stable. The photo attached to the assessment showed three open areas and had measurements of 0 cm x 0 cm. Surveyor noted the sacrum had open areas and was unable to determine what was being assessed. On 5/2/2024 at 11:09 AM, Surveyor accompanied Wound Physician-I and RN Unit Manager (UM)-E to assess R188's pressure injuries. RN UM-E stated R188 had pressure injuries to the left fourth toe, the left heel and the sacrum. RN UM-E stated R188 had three areas on the sacrum that the picture documentation counted as one area. Surveyor observed R188 in bed on an air mattress. The air mattress setting was at 360 pounds. Surveyor shared the observation of the air mattress setting with Wound Physician-I. Wound Physician-I asked R188 how much R188 weighed. R188 stated R188 weighed 172 pounds the last time R188 was weighed. Wound Physician-I turned the setting on the air mattress down to R188's weight. RN UM-E stated they would reset that air mattress. R188 had bilateral heel boots on. Wound Physician-I stated the wound to the left fifth toe was due to trauma and not a pressure injury. Surveyor clarified with Wound Physician-I that the wound was on the fifth toe and not the fourth toe as initially documented. Wound Physician-I agreed the wound was on the fifth toe. Surveyor observed three open areas on the sacrum and one open area on the left iliac crest. Wound Physician-I stated the sacrum wounds were measured as one area because the tissue surrounding two of the open areas was darkened and had damage below the skin making it one wound with two open areas. Surveyor noted the third open area on the sacrum was not measured or assessed. Wound Physician-I debrided necrotic tissue from the middle and right open areas of the sacral wound. The left heel pressure injury had an eschar cap over the wound. Surveyor requested a copy of Wound Physician-I's wound assessments. Wound Physician-I's documentation of R188's pressure areas on 5/2/2024 had the following assessments: -Sacrum Unstageable pressure injury measured 5.4 cm x 4.51 cm x 0.2 cm with 1-25% granulation and 51-75% slough before debridement and measured 3.97 cm x 5.28 cm x 1.1 cm with 1-25% granulation and 51-75% slough after debridement. Surveyor noted the measurement included two open areas. Surveyor noted the third open area on the sacrum was not assessed. -Left heel Unstageable pressure injury measured 2.16 cm x 1.84 cm x 0.1 cm with eschar. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/2/2024 at 3:22 PM, Surveyor asked RN-D what the facility process was when a new resident was admitted to the facility. RN-D stated the nurse on the floor does the initial skin assessment which includes looking at the resident's skin from top to bottom and documenting anything like a scab, bruising, scratches, checking under the breasts and folds for redness or excoriation, and any open areas or Deep Tissue Injuries (DTI) caused by pressure. RN-D stated for any open areas or DTIs, you put a sticker next to the wound and take a picture with the phone; that is connected to the electronic charting system, and it measures the length and width of the wound. RN-D stated the picture is sent to Wound Physician-I or to RN UM-E with the resident's name and what the wound is so they can get a treatment order. RN-D stated the wounds are monitored and they are evaluated weekly on Wednesday. RN-D stated if a treatment needs to be done right away, RN-D will do that and then make sure everything is charted. RN-D stated if the resident has mushy heels, RN-D will get heel boots or pillows if the resident hates the boots. Surveyor asked RN-D if pictures were taken of all skin impairments. RN-D stated scabs, bruises, and blanchable redness just get written into the assessment, but if it is an open area, then they get a picture on the phone. RN-D clarified an open area on the coccyx or anything that gets a deeper assessment will get a picture so Wound Physician-I can get a treatment in place. RN-D stated Wound Physician-I is available every day and answers quickly. RN-D stated RN UM-E and Assistant Director of Nursing (ADON)-C are really good with wounds, so they help with assessments. Surveyor noted the phone picture assessment does not measure depth. Surveyor asked RN-D if any wounds get depth measurements. RN-D stated it depends on the wound if a depth is measured. RN-D stated with a flap off, like a skin tear, the depth is estimated and if it something deeper, then they would take a cotton swab to measure the depth. Surveyor asked RN-D how air mattresses were set for the amount of pressure. RN-D stated maintenance usually sets that up but was not sure how they determined the amount of pressure. RN-D stated you can tell who needs a mattress, like if the resident has a wound to the back or is frail skin and bones. Surveyor clarified with RN-D who set the pressure on the air mattress. RN-D stated maintenance sets the pressure; nurses never set the pressure. On 5/6/2024 at 8:55 AM, Surveyor observed R188 lying in bed. The air mattress was set to the correct weight and a sticker had been added to the control panel that listed R188's weight as 166.5 pounds. Surveyor reviewed R188's TAR and R188 had an order to check the function of the low airloss mattress every shift. Weight settings: 166.5 had been added on 5/4/2024 to the original order on the TAR. On 5/6/2024 at 9:31 AM, Surveyor shared with DON-B the concern R188's pressure areas were not comprehensively assessed until 5/2/2024, six days after admission, when Wound Physician-I assessed R188's pressure injuries. Surveyor shared with DON-B R188 had three pressure areas on the sacrum and only two open areas were assessed, and those areas were measured as one area even though they were two separate open areas. DON-B stated Wound Physician-I measured those two open areas together because it gets one treatment. Surveyor shared the third open area was never assessed. Surveyor shared with DON-B R188's left heel did not have a depth measurement until 5/2/2024 when Wound Physician-I assessed the left heel. Surveyor shared with DON-B that R188's air mattress was set to 360 pounds when R188 weighed 166.5 pounds. DON-B provided a table that was obtained from the air mattress distributor that gave pound to kilogram conversions for settings on an air mattress, but the settings did not correlate with the air mattress in place on R188's bed. DON-B stated the bed should be set to the resident's weight and the resident's comfort. Surveyor was unable to find any documentation in R188's medical record that a conversation was had about the setting on the air mattress and R188's comfort level. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20025 2.) R12 was admitted to the facility on [DATE] with diagnoses of dementia, type 2 diabetes and CVA (cerebral vascular accident). The significant change MDS (minimum data set) dated 3/22/24 indicates R12 has cognitive impairments and is dependent for hygiene, bed mobility and toileting. R12 has a stage 3 pressure injury to the sacral area. The physician order dated 4/27/22 indicating a low air loss mattress (settings by weight). On 4/22/24 R12 weight was 114 lbs. On 4/30/24 at 9:09 a.m. Surveyor observed R12 in bed and the low air loss mattress was set at 180 lbs. On 5/1/24 at 8:33 a.m. Surveyor observed R12 was in bed and the low air loss mattress was set at 180 lbs . On 5/2/24 at 11:48 a.m. Surveyor observed R12 receive pressure injury treatment and the low air loss mattress was set at 180 lbs. R12's low air loss mattress device is called Proactive. The operating instructions for the Proactive mattress indicates determine the patient's weight and set the control knob to that weight setting on the control unit. On 5/2/24 at 3:00 p.m. during the daily exit meeting with DON (director of nursing)-B and NHA(nursing home administrator)-A, Surveyor explained the concern R12 was observed to be on the low air loss mattress set at 180 lbs when R12 weighs 114 lbs. On 5/6/24 at 10:07 a.m. Regional Consultant-Q stated the mattress representative explained to her that the mattress should be set at the weight and/or resident's comfort level. Surveyor explained what the mattress should be set at is not documented in the medical record. There is no indication an assessment was completed to determine if R12's mattress setting should be set differently from R12's weight. 3.) R14 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, dementia, paraplegia and anxiety disorder. Significant change MDS dated [DATE] indicate R14 has cognitive impairments and is incontinent of bowel and bladder. R14 has a healing stage 3 pressure injury to the right buttock. The care plan indicates R14 has a low air loss mattress. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observations, interview and record review, the facility did not ensure that 1 (R29) of 1 Residents reviewed with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. R29 has limitations in range of motion to R29's left upper extremity. The facility did not apply R29's left hand splint as per R29's Care Plan. Findings include: The Facility policy, entitled Prevention of Decline in Range of Motion, dated 2/2023, states, in part: Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning and preventative care . 3. Appropriate Care planning. A. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. B. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: . Appropriate equipment (braces or splints) . C. Care plan interventions will be developed and delivered . D. Interventions will be documented on the resident's person-centered care plan . E. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record . R29 was admitted to the facility on [DATE] and has diagnoses that include Hemiplegia (paralysis of one side of the body) and Spastic Hemiparesis (an abnormal level of muscle stiffness on one side of the body) affecting the left side following a Stroke, Muscle Weakness, and Mild cognitive impairment. R29's Minimum Data Set (MDS) assessment, dated 3/27/24, indicated that R15 is cognitively intact and that R15 has a functional limitation in range of motion impairment to both upper and lower extremities affecting one side. R15 is dependent on staff for upper body and lower body dressing, toileting, and personal hygiene. R15 does not exhibit any rejection of care. R29's Care Plan, dated 5/19/2020 states: Impaired Physical Mobility; actual Related to residual effects of disease process-[Stroke] with [Left sided residual deficits] Intervention, with a revision date of 4/23/24, include: Apply [Left] hand splint when up for 6-8 hours at night. Provide hand hygiene and monitor skin. Surveyor reviewed R29's Medical Doctor (MD) orders with a start date of 1/9/2024 [Left] hand splint-ON for 6-8 [hours] off PM shift; Complete hand hygiene prior to putting on in the morning AND every evening shift. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R29's Medication Administration Record (MAR). According to the MAR, the splint is to be placed on R29 at 8 AM, kept on for 6 to 8 hours, and taken off on the PM shift. For the month of February 2024, staff documented that the splint was ON a total of 8 out of 29 days. For the month of March 2024, staff documented that the splint was ON a total of zero out of 31 days. For the month of April 2024, staff documented that the splint was ON a total of one out of 30 days. From May 1st through May 3rd, 2024, staff documented that the splint was ON a total of zero out of 3 days. On 4/30/24 at 10:00 AM Surveyor observed R29 sitting in a wheelchair in R29's room. R29 does not have a splint on R29's left hand. On 5/1/24 at 8:11 AM, Surveyor observed R29 sitting in a wheelchair. R29 does not have a splint on R29's left hand. On 5/1/24 at 2:05 PM, Surveyor observed R29 sitting in a wheelchair in a common area. R29 does not have a splint on R29's left hand. On 5/2/24 at 8:08 AM, Surveyor observed R29 sitting in a wheelchair in the hallway. R29 does not have a splint on R29's left hand. On 5/2/24 at 8:23 AM, Surveyor interviewed Registered Nurse (RN)-H. Surveyor asked RN-H about R29's splint. RN-H indicated that R29 had a recent room change and came from another unit with the splint. RN-H stated that R29 will only wear the splint a couple hours and then will ask for it to be taken off. RN-H stated that R29 does not like the splint. Surveyor asked if Occupational Therapy was aware of R29's dislike of the splint. RN-H indicated that RN-H would have to look into that and would have to follow up with therapy. On 5/2/24 at 8:39 AM, Surveyor interviewed RN-F who is the unit manager on R29's unit. RN-F indicated that R29 does refuse to wear the splint at times. Surveyor asked what staff should do if a resident is refusing to wear a splint. RN-F stated that if a resident refuses 2 or 3 times, a nurse should chart that in a note and notify the physician and/or therapist. On 5/2/24 at 1:21 PM, Surveyor interviewed Occupational Therapist (OT)-N. Surveyor asked how R29 does with R29's splint. OT-N stated that R29 is pretty good about wearing his splint. Surveyor asked if OT-N had noticed any decline in R29's left upper extremity. OT-N stated that R29 is receiving Botox injections to help with R29's contracture and stated that OT-N has not seen any decline. Surveyor asked what could happen if R29 did not wear R29's splint. OT-N stated that R29's contracture could worsen. Surveyor asked if OT-N was aware that R29 had worn the splint a total of 9 days from February 2024 to April 2024. OT-N stated, No. Surveyor asked what staff should do if R29 is not wearing R29's splint. OT-N stated that OT-N would request that staff let OT-N know if R29 is not wearing R29's splint or refusing to wear the splint. On 5/2/24 at 1:39 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what steps staff should take if a resident is not wearing or refusing to wear a splint. DON-B indicated that if a resident is refusing on a daily basis, staff should be notifying the doctor and/or therapist. On 5/2/24 at 3:05 PM, Surveyor shared the following concern to the Nursing Home Administrator (NHA)-A and DON-B: R29 had worn R29's splint a total of 9 times from February 2024 to April 2024 and OT-N was not aware. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided at that time.

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review the facility did not ensure the accurate administration of all drugs and biologicals to meet the needs of each resident for 1 (R15) of 5 residents reviewed for medications. R15 has a Medical Doctor (MD) order for a daily Lantus injection (Lantus is a long-acting insulin used to control blood sugar). Registered Nurse (RN)-K did not follow the MD order on 4/10/24, 4/18/24 and 4/24/24 and the Lantus injection was not given by RN-K. Findings include: The facility policy, entitled Medication Administration, dated April 2024, states, in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . R15 was admitted to the facility on [DATE] and has diagnoses that include: Type 2 Diabetes Mellitus. R15's Minimum Data Set (MDS) assessment, dated 2/24/24, indicates that R15 is cognitively intact and that R15 receives insulin injections daily. Surveyor reviewed R15's MD order with a start date of 2/18/24 documents: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine). Inject 12 units subcutaneously one time a day for [Diabetes Mellitus]. Surveyor reviewed R15's MAR (Medication Administration Record). The MAR indicates on 4/10/24, 4/18/24 and 4/24/24 Lantus was not given by RN-K as ordered. (continued on next page)

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

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 1:15 PM, Surveyor interviewed RN-K who stated that RN-K was responsible for administering medications to R15 on 4/10/24, 4/18/24 and 4/24/24. Surveyor asked if RN-K would hold Lantus for any reason. RN-K stated that if R15's blood sugar was too low, RN-K would hold the Lantus. Surveyor asked if RN-K would hold the Lantus insulin if there was no direction to do so in the MD order. RN-K stated that RN-K would still hold it even if it wasn't in the MD order and RN-K would use her best judgement. Surveyor asked RN-K to explain why R15's Lantus was held on 4/10/24. RN-K looked in the Electronic Health Record (EHR). RN-K could not locate a nurses note. RN-K stated that RN-K would put a note within the MAR. RN-K looked for the documentation within the MAR. RN-K stated that on 4/10/24, RN-K documented that R15's blood sugar was 62. RN-K gave juice to R15 and documented that RN-K would re-check the blood sugar in 30 minutes. RN-K stated that R15 did not want to eat breakfast that morning. Surveyor asked why R15's Lantus was held on 4/18/24. RN-K stated that on 4/18/24 RN-K documented that R15's blood sugar was 68. RN-K stated that juice was given to R15 and that R15 was eating breakfast. RN-K indicated that RN-K would recheck the blood sugar in 30 minutes. Surveyor asked why R15's Lantus was held on 4/24/24. RN-K stated that R15's blood sugar was 56. RN-K gave juice and stated that R15 was eating breakfast. RN-K indicated that RN-K re-checked R15's blood sugar again and it was at 135. Surveyor asked if RN-K would notify the Physician before not giving the Lantus injection. RN-K stated, I would notify the Physician only if [R15] was symptomatic. Surveyor asked if R15 showed symptoms of low blood sugar on 4/10/24, 4/18/24 and 4/24/24. RN-K stated No. On 5/2/24 at 1:29 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the protocol is for administering Lantus. DON-B indicated that nurses should follow the MD order. Surveyor asked if Lantus should be held for any reason. DON-B explained that if a resident did not eat or there were concerns about giving the Lantus, the nurse should notify the Physician and follow the Physician direction. Surveyor asked if DON-B could identify any additional direction within R15's Lantus MD order indicating that Lantus should be held based on a blood sugar result. DON-B stated that there was nothing in the active order indicating that Lantus would be held based on a blood sugar result. DON-B stated that maybe [the nurse] got a verbal order. DON-B continued and stated that a nurse would need to have an order to hold the Lantus insulin. Surveyor reviewed R15's discontinued and completed MD orders. Surveyor did not locate a completed order for the Lantus to be held on 4/10/24, 4/18/24 or 4/24/24. On 5/2/24 at 3:05 PM, Surveyor shared the concern that R15's Lantus was held without an MD order to the Nursing Home Administrator (NHA)-A and DON-B. No further information was provided at that time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38253 Based on observation, record review, and interview, the facility did not ensure a sanitary environment to help prevent the development and transmission of communicable diseases and infections. Medical equipment was not sanitized between resident use potentially affecting 3 (R36, R15, and R86) of 3 residents reviewed for monitoring of blood sugars and the handling of dirty laundry was not kept separate from the clean laundry potentially affecting all 92 residents in the facility. *An observation was made of Registered Nurse (RN)-K wiping off an EvenCare glucometer with an alcohol wipe. RN-K did not use a disinfectant wipe to clean the glucometer. RN-K had checked blood sugars on R36, R15, and R86 without disinfecting the glucometer between residents potentially exposing those residents to blood borne pathogens. *Observations were made of Laundry Aide-M handling dirty laundry while wearing a gown. The gown was not removed before Laundry Aide-M handled clean linen from the dryer. Findings include: 1.) The facility policy and procedure entitled Blood Glucose Monitoring dated 1/2024 states: Procedure: . 18. Clean and disinfect the glucometer as per manufacturer's instructions. The EvenCare Blood Glucose Monitoring System User's Guide dated 2023 states: Intended Use: . It is indicated to be used for multiple patients in a clinical setting by healthcare professionals, as an aid to monitoring levels in Diabetes Mellitus. Cleaning and Disinfecting Procedures for the Meter: The EvenCare G3 Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. Materials needed: EvenCare G3 Meter, Gloves, A validated disinfecting wipe . Step 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. On 5/1/2024 at 7:46 AM, Surveyor observed Registered Nurse (RN)-K clean off the glucometer with an alcohol pad. Surveyor asked RN-K if residents had their own glucometer or if they shared a glucometer. RN-K stated residents do not have their own individual glucometer's and RN-K uses one glucometer for the residents on that hallway. Surveyor asked RN-K how many residents had their blood sugar checked that morning. RN-K stated three residents, R36, R15, and R86, had their blood sugars checked that morning by RN-K. Surveyor asked RN-K how the glucometer was cleaned between residents. RN-K stated with an alcohol wipe. RN-K stated Surveyor had just watched RN-K clean the glucometer. Surveyor reviewed R36, R15, and R86 diagnosis lists and confirmed none of the affected residents had blood borne pathogens. On 5/1/2024 at 9:48 AM, Surveyor shared with Director of Nursing (DON)-B the observation of RN-K clean the glucometer with an alcohol wipe and not a disinfectant wipe. DON-B stated RN-K should have cleaned the glucometer with the disinfectant wipe. No further information was provided at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	25490 2.) Review of the facility's Standard Precautions: For Infection Control, sign posted on the entrance door of the laundry room revealed, .Handwashing, wash hands after touching body fluids .wear gloves before touching body fluids .Gown, wear gown during procedures that may cause splashes .handle linen soiled with body fluids to prevent personal contamination and transfer to other patients . Review of the document provided by the facility titled Attention Housekeeping and Laundry Staff, dated 09/25/19 indicated .LAUNDRY: 1. Wear gown, gloves, mask and goggles when sorting and loading machines .Wash your hands with soap and water. Review of the facility's Laundry Policy dated 01/2023 revealed, .The facility launders linens and clothing under current CDC guidelines to prevent transmission of pathogens .soiled laundry shall be kept separate from clean laundry at all times. During an observation on 05/02/24 at 8:59 AM with the Director of Housekeeping/Laundry (DHL)-L revealed Laundry Aide (LA)-M placed soiled laundry into a washing machine. LA-M was wearing PPE of a yellow gown and gloves. After LA-M placed the soiled clothes in the washer, DHL-L verbally reminded LA-M to remove her PPE before she went to the dryer to retrieve clean linen. LA-M spoke very little English, and DHL-L gestured to LA-M to remove her soiled PPE. Even though LA-M was reminded to remove her PPE, she walked to the dryer and removed the clean linen with the soiled PPE still on. During an interview on 05/02/24 at 9:03 AM, DHL-L stated LA-M did not follow proper PPE procedures related to preventing cross contamination. DHL-L stated it was her expectation LA-M should have removed her soiled gown and gloves before handling the clean laundry. DHL-L also stated it was her expectation LA-M would have followed proper hand hygiene per facility policies. DHL-L further stated that he expected all staff to follow facility policies to eliminate the spread of infections. During an interview on 05/02/24 at 9:41 AM, Administrator (NHA)-A revealed it was his expectation the facility's staff would have followed the facility's policies and procedures for the proper donning and doffing of PPE to prevent the spread of infectious diseases.