DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 7/21/2017 The following deficiencies are a result of the recertification and licensure survey conduct on June 25th through June 28, 2017. See code 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by:	F 252		

QM, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaitlyn Devine	LNHA	7/21/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 Based on observation, record review, and interview, the facility failed to maintain a clean and sanitary environment for 10 of 12 rooms observed. The facility reported a census of 55 residents. Findings included: A 6/26/17 9:48 a.m. observation of Room C1 revealed a stand fan with a layer of thick dust on the blades and fan cover. A 6/27/17 9:33 a.m. observation of Room L10 revealed the following concerns: a. brown stains on the wallpaper with the wallpaper seams separating at the edges b. black scuffs on the floor c. scuffs and mars on the vanity A 6/27/17 10:45 a.m. observation of Room C1 revealed the following concerns: a. stickiness under foot b. a red and brown substance on a surge protector A 6/27/17 1:52 p.m. observation of Room C5 revealed brown and dingy baseboards . A 6/27/17 2:00 p.m. observation of Room L1 revealed brown and dingy baseboards. The undated facility policy entitled "Pull and Deep Cleaning" directed staff to clean mop boards, buff or wax, clean fans, and check wallpaper. During an interview on 6/28/17 at 7:30 a.m., the Administrator stated the facility was short of	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 2 housekeeping staff and stated she would speak to the Maintenance Director regarding a solution to the baseboards. 2. On 06/27/2017 observations of the following rooms revealed: a. In C 15 at 09:30 A.M. observations of the edges of the room where the baseboard meets the floor displayed brown grime with fine pieces of lose dirt and built up old wax. Under bed 1 and bed 2, the floor contained pieces of peanut/chocolate candy. b. In C 13 at 09:35 A.M. the floor by bed 1 contained pieces of black rubber or sponge pieces (1/2 inch). A surge protector had dust build up, and the edges of the room at the baseboard showed brown grime and lose dirt. c. In C 3 at 09:45 A.M., the edges of the room at baseboard level displayed the brown grime and wax build up noted in other rooms. d. In C 1 and C 9 at 09:50 A.M., the room edges at the baseboard level also displayed the brown grime, lose dirt, and old wax build up. e. In R 1 at 09:58 A. M, displayed the same issues as C 15, 13, 3, and 1. At 10:00 A. M. on 06/27/2017 Staff C (Housekeeper) agreed the room edges/baseboard contained wax build up and brown grime. She stated the baseboards cleaning schedule directed staff to clean monthly but it had been awhile since last completed. On June 28, 2017 at 10:00 A.M., Staff F (Housekeeper) reported her inability to locate any completed cleaning sheets for the rooms and baseboards. She commented staff for housekeeping for some time now only consisted	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 3 of 2 persons.	F 252		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the resident environment remained as free from accident hazards as possible for 2 of 12 residents sampled (Residents #3 and #7). Specifically, the facility failed to implement a system to ensure gaps in side rails were not large enough to create the risk	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 for entrapment for Residents #3 and #7. The failure to ensure the side rails did not have a large gap which the resident could become entrapped put Residents #3 and #7 at risk of serious injury, impairment, or death due to entrapment within the gap, placing the residents in immediate jeopardy. The facility reported a census of 55 residents. Findings include: 1. Review of the Food and Drug Administration's (FDA) Hospital Bed Safety Workgroup article, "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", dated April 2003, indicated, in pertinent part,"...Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patient's mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment(beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items...should be ongoing..." According to the FDA's Guidance for Industry and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..." An undated facility document entitled "Bed Rails" listed the following guidelines: 1. All residents will be evaluated for the appropriateness for use of bed rails prior to initiation on admission. 2. Ongoing use of bed rails will be evaluated quarterly, change in condition, and with change of equipment. 3. Evaluations will include risk of entrapment. 4. Risks and benefits of bed rail usage will be discussed with resident and family representative	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 and informed consent will be obtained prior to usage. 5. Care Plan will address bed rail usage and reason for device. 6. Assure that the bed's dimensions are appropriate for the resident's size and weight. 7. Follow the manufacturer recommendations and specifications for installing and maintaining bed rails. The MDS(Minimum Data Set) assessment tool, dated 6/6/17, listed diagnoses for Resident #3 included cerebrovascular accident(stroke) and hemiplegia(one sided paralysis). The MDS stated the resident required supervision and setup assistance for eating, limited assistance of 1 staff for bed mobility, and extensive assistance of 1 staff for transfers, walking, dressing, toilet use, personal hygiene, and bathing. The MDS stated the resident did not utilize a bed rail and listed the resident's BIMS(Brief Interview for Mental Status) as 8 out of 15, indicating moderately impaired cognition. The MDS stated the resident had 1 fall without injury since the previous assessment. A care plan entry, dated 3/2/17, stated the resident had 2 1/2 side rails up to promote independence with bed mobility. The care plan stated the resident had falls on 3/8/17 and 3/15/17 and had difficulty walking and weakness. The resident's "Side Rail Rationale Screen", dated 3/2/17, stated the resident: a. had an alteration in safety awareness related to cognitive decline b. had a history of falls c. had difficulty with balance or poor trunk control	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 e. took medication that would require increased safety precautions f. expressed a desire to have the side rails up while in bed to promote independence An observation on 6/25/17 at 3:08 p.m. revealed the resident lying on the back in bed resting on his/her elbows. One side of the bed was against the wall and both sides of the bed had side rails up covering 3/4 of the length of the bed. An observation on 6/25/17 at 3:42 p.m. revealed the resident remained in bed with both side rails up. An observation on 6/25/17 at 3:53 p.m. revealed Staff E CNA(Certified Nursing Assistant) assisted the resident out of the bed. During an observation on 6/26/17 at 2:45 p.m., the surveyor was able to place her head completely through 2 vertical bars of the side rails in between the top bar of the side rail and the top of the mattress of the resident's bed. During an observation on 6/27/17 at 9:00 a.m., Resident #3's bed was outside with no mattress. The vertical slats of the bed measured 8 inches. The Maintenance Supervisor was present and concurred with the surveyor approximately how high a mattress would reach. The space between where the top of the mattress would be and the top rail measured 9 inches. A 1/25/17 facility document entitled "Bed Evaluation" revealed staff initials on the following dates: 3/15/17, 4/25/17, 5/25/17, and 6/9/17. The form did not describe what the bed evaluation entailed.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 A facility document entitled "Physical Plan Preventative Maintenance" dated 1/25/17, stated the facility must conduct regular inspection of all bed frames, mattresses and bed rails, if any, as part of regular maintenance program to identify areas of possible entrapment. A facility "Quality Improvement Project Plan", dated 6/26/17, stated all resident's beds would be assessed to ensure the side rail measurements were within the regulatory standards of 4 3/4 inches and the facility would replace all beds with more than the allotted spacing. During an interview during initial tour on 6/25/17 at 1:45 p.m., the DON(Director of Nursing) stated the resident did not speak and was not interviewable. During an interview on 6/26/17 at 2:49 p.m., the DON stated she thought the gap between side rails should be no greater than 8 inches. She stated the facility did not have a physician's order for side rails for the resident. During an interview on 6/26/17 at approximately 3:30 p.m., the Nurse Consultant stated the facility removed the resident's bed. During an interview on 6/27/17 at 10:47 a.m., Staff H CNA(Certified Nursing Assistant) stated she saw the resident scoot down in bed to the end but did not see the resident attempt to crawl over the side rails. During an interview on 6/27/17 at 10:51 a.m., Staff G CNA stated she saw the resident sit up in bed but did not see him/her attempt to get out of	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 bed. During an interview on 6/28/17 at 9:57 a.m., the Maintenance Supervisor stated he thought the requirements for the bed rail measurements were to be no greater than 8 inches between bars. He stated he started measuring the bed rails around the beginning of the year and was using 8 inches as the guideline. 2. The Quarterly Minimum Data Set (MDS- a federally mandated resident assessment tool) with an assessment reference date of 03/21/2017 revealed a BIMS (Brief Interview of Mental Status) of 3 which indicated severe long and short term memory deficits. Resident # 7 required extensive assistance from 2 staff for bed mobility, transfers, dressing, personal hygiene, and toilet use. The MDS documented complete incontinency of both bowel and bladder. The resident only understood verbal communications and could reply appropriately on a limited basis. The assessment documented height and weight as 4 foot 8 inches and 122 pounds. Active diagnoses included Alzheimer's Disease, a seizure disorder, Downs Syndrome, and had experienced at least 1 fall prior to admission to the facility. The plan of care with a problem onset date of 12/14/2016 directed facility staff to supply the resident with a pressure reduction mattress and 2 half side rails to promote independence and bed mobility. Resident # 7 became a Hospice patient for comfort cares on 06/23/2017. The facility's Side Rail Rational Screen with an assessment date of 03/21/2017 indicated side	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

rails would provide safety and promote independence of movement for the resident. Resident # 7's poor visual acuity and decreased hearing complicated communication and understanding. A fracture to the right ankle and decline in overall function increased the risk of falls. The plan of care documented only 1 staff person needed to assist with transfers and personal cares.

The Fall Risk Assessment completed on 03/31/2017 revealed a score of 16. A score of 10 or above indicated a high risk for falls.

An observation on 06/26/2017 at 12:10 P.M., found Resident # 7 in bed with the head of the bed elevated approximately 30 degrees. The resident laid on the left side. A Hospice representative sat in a chair by the head of the bed. A tan overlay air pad could be seen over the mattress on the bed.

On 06/26/2017 at 12:25 P.M., Staff I and Staff J (certified Nursing Assistants) provided cares for Resident # 7 and positioned the resident on the right side with a body pillow behind, and the head of the bed up approximately 30 degrees.

At 1:05 P.M. on 06/27/2017, Staff J repositioned the resident higher in bed (slid down) on his/her back and rolled the bed up to the 60 degree range. This placed the resident's head 18 to 20 inches from the top of the mattress.
Around 1:10 P.M., as Staff J attempted to give the resident nourishment, this Surveyor sat on the right side of the bed by the upper side rail. Resident # 7's eyes unfocused and calling for mom and dad. The upper half bed rail measured approximately 2 foot horizontally and 1 foot 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 inches vertically with the upper bars 4 inches apart and the lower bar to the mattress/frame 7.5 inches. A tan overlay air pad laid on top of the mattress and raised the resident approximately 1/2 to 1 inch. The head of the bed touched the wall and the sides extended out into the room. Observations of the dark blue/black mattress at the half way point between the upper and lower rail from top of the bed to the bottom displayed a worn and frayed area brown in color and approximately 8 inches wide. The raised upper half rail angled higher at the center point of the bed where the mattress bends when the head of the bed is raised. When the head of the bed is raised, the blue/black mattress crushed down to around a half inch in depth. The area where the mattress met the bend of the bed when raised to the 60 degree range left a gap under the lowest bed rail bar to the mattress of 7.5 inches by 10 inches from the end of the bed rail (toward the center of the bed) to the mattress angles upward to form a "V" shape opening. A review of the medical record nursing notes of 06/26/17 and 6/27/2017 revealed: 06/26/2017 at 12:10 P.M., Resident # 7's bed in high fowler position (60 to 90 degrees for the head of the bed). The resident's wrists and hands twitching. 06/26/2017 at 1:30 P.M. The bed still is the high fowler position. 06/27/2017 at 08:30 A.M., the resident repositioned and the head of the bed left in a high fowler position. 06/27/2017 at 11:30 A.M., Resident # 7 yelling and restless. The restlessness continued through 12:30 P.M.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 A more recent Safe Bed Environment Evaluation form dated 06/26/2017 (due to a bed change) provided an assessment of factors including the resident being non-ambulatory, consciousness fluctuation, a history of falls, poor bed mobility and balance, effects of medications, and a diagnosis of a seizure disorder. The screen failed to identify the resident's compromised visual acuity along with a decrease in cognitive ability and safety awareness. Interventions included bed positioning devices, body pillows, wedges, and one way slides for beds. Hospice would deliver bed half rails appropriate to this particular bed. (Delivered on 06/27/2017). On 06/27/2017 the facility contacted the resident's representative by phone concerning the Bed Rails Informed Consent and Release form and documented an agreement to utilize side rails on the bed. Observation of Resident # 7 in the bed supplied by Hospice on 06/27/2017 at 11:40 A.M. found the bed and rails to fit together without gaps or possible entrapment issues. The facility Administrator and Director of Nursing were informed of the Immediate Jeopardy on 06/28/2017 at 11:00 A.M., due to the risk of entrapment for Resident # 3 by the use of a full bed rail which did not meet the requirement of only 4.75 inches between rails; and Resident #7's side rail gap of 7.5 by 10 inches when the head of the bed was in the raised position. The facility failed to identify the potential for side rail entrapment. The Immediate Jeopardy was abated on 6/28/17	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 at 1:30 pm and lowered to a D level scope and severity by implementation of the following actions: On 6/28/17 the facility educated and demonstrated to staff side rail assessments and measurements according to FDA guidelines. The facility informed staff all residents have been evaluated to ensure their safety and to relay concerns to the Administrator and or DON. The facility developed a process for monitoring residents bed dimensions based on zones [according to the FDA's Guidance for Hospital Bed System Dimensional] ; and mattress conditions (including overlay mattress and or pressure relieving mattress that can compress and make a gap between side rails and bed rails larger). Staff were informed to let the Administrator and the DON know if they had any concerns with bed rails safety for residents. The Maintenance Supervisor was provided education of safe measurements for side rails gaps and increase risk of entrapment for residents. The facility determined monthly checks will be completed and reviewed at safety meetings. Staff not present at the 6/28/17 in-service were required to review Side Rail Regulations instruction sheet and complete demonstration prior to beginning their shift. The facility's bed rails guidelines was updated to include : a). All residents will be evaluated for the appropriateness for bed rails prior to initiation on admission. b). Ongoing use of bed rails be evaluated quarterly, change in condition and with the change of equipment.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 c). Evaluations will included risk for entrapment. d). Risk and benefits of bed rail usage will be discussed with resident and family representative and informed consent will be obtained prior to usage. e. Care plan will address bed rail usage and reason for device. f. Assure that the bed's dimensions are appropriate for the resident's size and weight. g. Follow the manufacture's recommendations and specifications for installing and maintaining bed rails. Staff will document bed rail evaluations.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 15 visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews, the dietary staff failed to handle and serve food under sanitary conditions in order to reduce the risk of contamination and food-borne illness. The facility identified a census of 55 residents. Findings include: 1. Observation on 6/26/17, from 7:40 a.m. to 8:30 a.m., revealed Staff A, AM Cook, assigned to serve the breakfast meal. Staff A wore a glove on the left hand, which was used to pick up the biscuits to slice and plate. In addition to touching the biscuits, with the gloved hand, Staff A touched a variety of other surfaces including, but not limited to, plates, bowls, knife, serving utensils, dish dolly, serving cart, steamtable and uniform top. During the observation period, Staff A removed the glove and on 2 occasions rolled a cart of plates to the dining room and served residents. While in the dining room, Staff A handled resident select menus, a glass that fell to the floor and pencils used by residents to make menu selections. On each occasion, Staff A returned to the kitchen and donned a clean glove but failed to wash her hands first. On 2 occasions, Staff A removed her glove and obtained supplies from the storeroom. Staff A donned a clean glove prior to resuming handling biscuits but failed to wash her hands first. Staff A's meal service practice resulted in the use of contaminated gloves to handle biscuits served to 43 residents.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 16 2. Observation on 6/27/17, from 7:30 a.m. to 8:00 a.m., revealed Staff B, Dietary Aide, assigned to serve the breakfast meal. Staff B had donned gloves prior to initiating meal service. Staff B touched a variety of surfaces including, but not limited to plates, bowls, dish dolly, knife, serving utensils, steamtable, storage rack and uniform top and handled toast, with the contaminated gloves, served to 20 residents. During an interview on 6/27/17, at 10:45 a.m., Staff A reported she washes her hands frequently and acknowledged the importance of frequent handwashing. Staff A confirmed hands should be washed prior to donning and removing gloves. During an interview on 6/27/17, at 11:05 a.m., the Dietary Manager acknowledged she had not completed any training with the dietary, staff as she just began her employment at the facility approximately 1 month ago, but confirmed dietary staff should wash their hands prior to donning and removing gloves and encourages the use of utensils for meal service versus using hands to serve food items like toast and biscuits. Review of a policy titled "Bare Hand Contact With Food And Use of Gloves", dated February 2016, revealed in part "Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Hands are to be washed when entering the kitchen and before putting on the gloves ... Wash hands after removing the gloves."	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 17 The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry requires food employees to wash their hands immediately before engaging in food preparation, including before donning gloves for working with food in order to prevent cross contamination when changing tasks. Single-use gloves are to be used for only one task, such as working with ready-to-eat food and used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.	F 371		
F 461 SS=D	Various sections in 483.10,483.25,483.90 BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET 483.10 (l)(4) Private closet space in each resident room, as specified in §483.90(e)(2)(iv); 483.25 (n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. 483.90 (c)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. (e)(1)(vi) - Resident Rooms	F 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 18 Bedrooms must -- (vi) - Have at least one window to the outside; and (vii) Have a floor at or above grade level. (e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct regular thorough and appropriate inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. The facility reported a census of 55. Findings include: 1. An undated facility document entitled "Bed Rails" listed the following guidelines: 1. All residents will be evaluated for the appropriateness for use of bed rails prior to initiation on admission. 2. Ongoing use of bed rails will be evaluated quarterly, change in condition, and with change of	F 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 19 equipment. 3. Evaluations will include risk of entrapment. 4. Risks and benefits of bed rail usage will be discussed with resident and family representative and informed consent will be obtained prior to usage. 5. Care Plan will address bed rail usage and reason for device. 6. Assure that the bed's dimensions are appropriate for the resident's size and weight. 7. Follow the manufacturer recommendations and specifications for installing and maintaining bed rails. According to the MDS (Minimum Data Set) assessment tool, dated 6/6/17, Resident #3 had diagnoses that included cerebrovascular accident (stroke) and hemiplegia (one sided paralysis). The MDS documented the resident required supervision and setup assistance for eating, limited assistance of 1 staff for bed mobility, and extensive assistance of 1 staff for transfers, walking, dressing, toilet use, personal hygiene, and bathing. The MDS documented the resident did not utilize a bed rail and listed the resident's BIMS (Brief Interview for Mental Status) as 8 out of 15, indicating moderately impaired cognition. The MDS documented the resident had 1 fall without injury since the previous assessment. A care plan entry, dated 3/2/17, documented the resident had 2 1/2 side rails up to promote independence with bed mobility. The care plan documented the resident had falls on 3/8/17 and 3/15/17 and had difficulty walking and weakness. The resident's "Side Rail Rationale Screen," dated 3/2/17, stated the resident: a. had an alteration in safety awareness related	F 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 20 to cognitive decline b. had a history of falls c. had difficulty with balance or poor trunk control e. took medication that would require increased safety precautions f. expressed a desire to have the side rails up while in bed to promote independence An observation on 6/25/17 at 3:08 p.m. revealed the resident lying on their back in bed resting on his/her elbows. One side of the bed was against the wall and both sides of the bed had side rails up covering 3/4 of the length of the bed. An observation on 6/25/17 at 3:42 p.m. revealed the resident remained in bed with both side rails up. An observation on 6/25/17 at 3:53 p.m. revealed Staff E CNA(Certified Nursing Assistant) assisted the resident out of the bed. During an observation on 6/26/17 at 2:45 p.m., the surveyor was able to place her head completely through 2 vertical bars of the side rails in between the top bar of the side rail and the top of the mattress of the resident's bed. During an observation on 6/27/17 at 9:00 a.m., the resident's bed was outside with no mattress. The vertical slats of the bed measured 8 inches. The Maintenance Supervisor was present and concurred with the surveyor approximately how high a mattress would reach. The space between where the top of the mattress would be and the top rail measured 9 inches. A 1/25/17 facility document entitled "Bed Evaluation" revealed staff initials on the following	F 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 21 dates: 3/15/17, 4/25/17, 5/25/17, and 6/9/17. The form did not describe what the bed evaluation entailed. A facility document entitled "Physical Plan Preventative Maintenance" dated 1/25/17, stated the facility must conduct regular inspection of all bed frames, mattresses and bed rails, if any, as part of regular maintenance program to identify areas of possible entrapment. A facility "Quality Improvement Project Plan", dated 6/26/17, stated all resident's beds would be assessed to ensure the side rail measurements were within the regulatory standards of 4 3/4 inches and the facility would replace all beds with more than the allotted spacing. During an interview during initial tour on 6/25/17 at 1:45 p.m., the DON (Director of Nursing) stated the resident did not speak and was not interviewable. During an interview on 6/26/17 at 2:49 p.m., the DON stated she thought the gap between side rails should be no greater than 8 inches. She stated the facility did not have a physician's order for side rails for the resident. During an interview on 6/26/17 at approximately 3:30 p.m., the Nurse Consultant stated the facility removed the resident's bed. During an interview on 6/27/17 at 10:47 a.m., Staff H CNA (Certified Nursing Assistant) stated she saw the resident scoot down in bed to the end but did not see the resident attempt to crawl over the side rails.	F 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 461	Continued From page 22 During an interview on 6/27/17 at 10:51 a.m., Staff G CNA stated she saw the resident sit up in bed but did not see him/her attempt to get out of bed. During an interview on 6/28/17 at 9:57 a.m., the Maintenance Supervisor stated he thought the requirements for the bed rail measurements were to be no greater than 8 inches between bars. He stated he started measuring the bed rails around the beginning of the year and was using 8 inches as the guideline.	F 461		
F 496 SS=D	483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING d)(4) Registry verification Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. (d)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)	F 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 496	Continued From page 23 (2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. (d)(6) Required retraining If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel record review, staff interview and facility policy review, the facility failed to perform a follow-up check nurse aide registry verification for 1 of 1 certified nursing assistants (CNA) selected for review, hired prior to completion of a training program (Staff D). The facility identified a census of 55. Findings include: The facility identified a hire date of 11/1/16 for Staff D, Certified Nursing Assistant. Staff D's personnel file contained a document titled "Single Contact License & Background Check:, dated 10/4/16, which revealed the nurse aide registry check showed Staff D had not been found in the Iowa Nurse-Aide Registry and ineligible to work. The personnel file contained a copy of the passing results of Staff D's CNA skills test and a copy of her Direct Care Worker Registry card but lacked documentation to show the facility checked the Iowa Nurse-Aide Registry again to ensure she was eligible to work. The facility obtained nurse aide registry verification on	F 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD SPECIALTY CARE	1977 ALBIA ROAD OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 496	Continued From page 24 6/26/17, which showed work eligibility as of 11/11/16. During an interview on 6/26/17, at 11:05 a.m., the Business Office Manager reported she thought a copy of Staff D's card was sufficient, since she was a new CNA, to confirm completion of the course requirements and did not think she would need to check the nurse aide registry again.. Review of the facility's dependent adult abuse protocols, revised May 2017, revealed a protocol titled "Abuse Prevention Employee Screening Prior to Employment/New Conviction Criminal Record History" identified the facility will check with the appropriate registries, as part of the screening process for potential employees.	F 496		

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and/or state law.

This plan of correction constitutes our credible allegation of compliance. F 323 was corrected on 6/28/17. F 252, 371, 461, and 496 were corrected on the 21st of July 2017.

F 252 It continues to be the policy of Ridgewood Specialty Care to provide a safe/clean/comfortable/homelike environment.

The environmental concerns identified in rooms C 1, 3 ,5, 13, & 15, L 1 & 10 and R 1 and been corrected: baseboards and floors cleaned, wall paper repaired, vanity repaired, and fan cleaned. All other resident rooms have had baseboards cleaned, wall paper repaired as needed.

A revised cleaning schedule has been implemented to ensure that cleanliness will be maintained. Staff were educated verbally on 6/29/17 and re-educated on 7/19/2017.

Monitoring of compliance will be a part of the facility QA process.

F 323 It continues to be the policy of Ridgewood Specialty Care that the resident's environment will remain as free from accident hazards as possible.

On 6/26/17, the bed that resident #3 was using was replaced with a bed that provided a safe environment, and the mattress and side rails were replaced on the bed that resident # 7 was using. All other beds in the facility were measured according to FDA guidelines, and were determined to provide a safe bed environment for all other residents on 6/28/17.

On 6/29/17, resident #7 safe bed environment evaluation was updated to identify compromised visual acuity and cognitive deficit.

Re-education was provided to all staff related to the requirements for safe bed environment on 6/28/17. Safe bed environment screening was completed on 7/19 on all residents to determine what devices may be needed to provide a safe bed environment for each resident.

A schedule was established to routinely check each resident bed to ensure there are no safety concerns. Any new bed brought into the facility will be assessed before it is given to a resident to ensure it meets the safety standards. If an air overlay mattress is determined to be appropriate for a resident, and evaluation will be made to ensure the bed continues to meet the safety standards.

Monitoring of compliance will be a part of the facility QA process.

F 371 It continues to be the policy of Ridgewood Specialty Care to store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Re-education was provided to all dietary staff on 7/19/17 related to food service safety including hand washing and glove use. In addition, audits were completed with all dietary staff to ensure understanding and competency in food distribution and service.

Monitoring will continue with the facilities Dietary QA Checklist rounds.

F 461 It continues to be the policy of Ridgewood Specialty Care to follow the manufactures' recommendations and specifications for installing and maintaining bed rails.

The bed for resident # 3 was removed and replace with a bed that was assessed to meet the safety standards on 6/26/17 In addition, all other beds in the facility were evaluated and determined to meet the safety standards on 6/28/17.

On 6/28/17, all staff were provided with education regarding the safety requirements for resident beds.

The facility will conduct regular thorough and appropriate inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify possible areas of entrapment.

On 7/17/17, the facility maintenance program was updated to include measurements of the zones to be done monthly.

On 7/13/17, a schedule for bed inspections was established for all beds that are in the facility. In addition, any new bed that would be delivered to the facility will be inspected before it is put into use to ensure it meets the safety requirements.

Monitoring of compliance will be a part of the facility's QA process.

F 496 It continues to be the policy of Ridgewood Specialty Care to complete registry verification for all employees who are hired as certified nursing assistants.

The registry check for staff D was completed on 6/26/17, and was found that staff D was currently on the registry and eligible to work as of 11/11/16.

On 7/5/17, a 100% audit of all current certified nurse aides in the facility was completed, and all had registry verification completed before hire.

On 7/17/17, re-education was provided to Business Office Manager related to the need to check registry for any nurse aide who completes training after being hired by the facility. A log was implemented to track for new hires, to include non-certified nurse aides, for follow up on registry checks.

Monitoring will be a part of the facility's QA process.