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 _____	C 09/07/2022

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 ok/CP	INITIAL COMMENTS Correction date: 10/05/2022 The following deficiencies resulted from investigation of complaints #105652-C, #105758-C, and #106446-C and facility reported incidents #106435-I and #106448-I conducted August 15, 2022 to September 7, 2022. Complaints #105652-C, #105758-C, and #106446-C were substantiated. Facility reported incident #106448-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Ridgewood Specialty Care** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550	F550 Resident Rights/Exercise of Rights Residents at Ridgewood Specialty Care will have the right to a dignified existence, self-determination inside and outside the facility. Each resident will be treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of their quality of life. The facility will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. The facility will maintain practices regarding transfer, discharge and the provision of services. Each resident has the right to exercise his or her rights and exercise those rights in a manner without interference, coercion, discrimination, or reprisal. Residents #1 was provided dignity and respect.	10/03/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaitlyn Fein — TITLE: LNHA — (X6) DATE: 10/5/2022

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.

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, CNA job description, and observation, the facility failed to speak to and treat residents in a dignified manner for 3 of 7 residents reviewed (Residents #1, #2, and #3). The facility reported a census of 54 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated 7/19/22 listed dementia and psychotic disorder as diagnoses for Resident #3. The resident's Brief Interview for Mental Status (BIMS) scored 1, which indicated severe cognitive impairment. The Care Plan, dated 8/8/19 stated Resident #3	F 550	Residents #2 was provided dignity and respect. Residents #3 was provided dignity and respect. Current residents have the potential to be affected. Staff education completed regarding treating residents with dignity and respect. Administrator/designee will monitor respect and dignity audits to ensure residents are being treated with dignity, respect and self-determination. Administrator/Designee will interview 3 residents per week for 4 weeks on treatment with dignity, respect and self-determination. Random audits thereafter. Concerns identified will be addressed in QAPI.	

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F 550	Continued From page 2	F 550		

had impaired cognitive function or thought process and had difficulty expressing herself so needed plenty of time to get words out and reassurance and support if upset.

An observation on 8/15/22 at 12:00 p.m. revealed the resident in a wheelchair eating independently. The resident did not respond to any questions.

A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, Certified Nurse Aide (CNA) reported that on 7/22/22 around 11:30 pm, Resident #3 began yelling out "Mommy". Staff A heard Staff B, CNA, respond to the resident by screaming, "Just shut up. Shut the fuck up."

2. The Quarterly MDS assessment dated 8/4/22 listed dementia and difficulty in walking as diagnoses for Resident #1. The resident's Brief Interview for BIMS scored 5, which indicated severe cognitive impairment.

The Care Plan, dated 7/21/22 stated Resident #1 had impaired cognition function or thought process and needed consistent, simple, directive sentences. The resident needed assistance of one staff with a walker for walking.

An observation on 8/15/22 at 12:05 p.m. revealed Resident #1 seated in her recliner, wheelchair and walker nearby. Resident #1 could not appropriately answer questions due to confusion.

A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, CNA reported hearing Staff B, CNA, gasp loudly as if she had been startled seeing Resident #1 ambulating toward the dining hall. Staff A witnessed Staff B roughly grab the resident's arm and start pushing the resident

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F 550	Continued From page 3 towards her room yelling loudly, "Go to your room!" 3. The Quarterly MDS assessment dated 7/19/22 listed non-traumatic brain dysfunction as a diagnosis for Resident #2. The resident's Brief Interview for BIMS scored 1, which indicated severe cognitive impairment. The Care Plan, dated 10/27/21, stated Resident #2 needed assistance with personal hygiene. An observation on 8/15/22 at 11:00 a.m. revealed resident walking independently up and down the halls and not acknowledging any comments or questions. A facility Incident Report dated 7/24/22 at 1:23 p.m. stated a Staff B, CNA, reported during cares that her fingernails scratched the front of Resident #2's right shoulder. Another CNA present stated the CNA's nails, noted to be long and sharp, had scratched the resident's shoulder. On 8/22/22 at 12:35 p.m., Staff A, CNA, stated on 7/22/22 a little before midnight, Resident #3 began moaning "Mommy" and continued this for over an hour. Staff B, CNA, then went into the resident's room and yelled, "Just shut up. Shut the fuck up." A couple of hours later, around 1:30 a.m., Staff A reported she heard Staff B gasp she saw Resident #1 walking unassisted in the hall. Staff A then observed Staff B grab Resident #1's upper arm roughly, and pulling her towards her room, loudly say, "Go back to your room right now." On 8/23/22 at 12:00 p.m., Staff C, CNA, stated she reported concerns to her charge nurse that	F 550		

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F 550	Continued From page 4 Resident #2 had what appeared to be new scratch marks on him. Staff C noted these marks when she went into Resident #2's room the beginning of the day shift, approximately 10-15 minutes after Staff B, CNA, had left the room on 7/23/22. A Job Description for Certified Nursing Assistant signed by Staff B on 12/6/21 stated functions: a. respond to inappropriate or maladaptive behaviors exhibited by residents in a manner consistent with the care plan or established procedures, and which safeguards resident rights. b. follow residents' rights policies at all times. c. control emotions and behavior so as to protect residents' rights and to respond professional with respect and dignity.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609	F609 Reporting of Alleged Violations Residents at Ridgewood Specialty Care will have the right to be free of abuse, neglect, exploitation, injuries of unknown origins, and misappropriation. All alleged violations regarding abuse, neglect, exploitation or mistreatment will be reported immediately but no later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not cause abuse or result in serious bodily injury. The allegation will be reported to facility administrator and officials according to state law. Residents #1 allegations was reported timely.	10/03/22

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

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F 609	Continued From page 5 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, policy review, and observation, two facility staff failed to immediately, no later than two hours, report alleged violations of abuse to administration for 3 of 3 residents reviewed (Residents #1, #2, and #3). The facility reported a census of 54 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated 7/19/22 listed dementia and psychotic disorder as diagnoses for Resident #3. The resident's Brief Interview for Mental Status (BIMS) scored 1, which indicated severe cognitive impairment. The Care Plan, dated 8/8/19 stated Resident #3 had impaired cognitive function or thought process and had difficulty expressing herself so needed plenty of time to get words out and reassurance and support if upset. An observation on 8/15/22 at 12:00 p.m. revealed the resident in a wheelchair, eating lunch in the dining room. The resident did not respond to any	F 609	Residents #2 allegations was reported timely. Residents #3 allegations was reported timely. Current residents have the potential to be affected. Staff education completed regarding reporting allegations of abuse timely. DON/designee will monitor timely reporting audits to ensure residents are having allegations of abuse reported timely. DON/Designee will interview 3 staff per week for 4 weeks on timely reporting. Random audits thereafter. Concerns identified will be addressed in QAPI.	

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F 609	Continued From page 6 questions. A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, Certified Nurse Aide (CNA) reported that on 7/22/22 around 11:30 pm, Resident #3 began yelling out "Mommy". Staff A heard Staff B, CNA, respond to the resident by screaming, "Just shut up. Shut the fuck up." 2. The Quarterly MDS assessment dated 8/4/22 listed dementia and difficulty in walking as diagnoses for Resident #1. The resident's Brief Interview for BIMS scored 5, which indicated severe cognitive impairment. The Care Plan, dated 7/21/22 stated Resident #1 had impaired cognition function or thought process and needed consistent, simple, directive sentences. The resident needed assistance of one staff with a walker for walking. An observation on 8/15/22 at 12:05 p.m. revealed Resident #1 seated in her recliner, wheelchair and walker nearby. Resident #1 could not appropriately answer questions due to confusion. A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, CNA reported hearing Staff B, CNA, gasp loudly as if she had been startled seeing Resident #1 ambulating toward the dining hall. Staff A witnessed Staff B roughly grab the resident's arm and start pushing the resident towards her room yelling loudly, "Go to your room!" 3. The Quarterly MDS assessment dated 7/19/22 listed non-traumatic brain dysfunction as a diagnosis for Resident #2. The resident's Brief Interview for BIMS scored 1, which indicated	F 609		

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F 609	Continued From page 7	F 609		

severe cognitive impairment.

The Care Plan, dated 10/27/21, stated Resident #2 needed assistance with personal hygiene.

An observation on 8/15/22 at 11:00 a.m. revealed resident walking independently up and down the halls and not acknowledging any comments or questions.

A facility Incident Report dated 7/24/22 at 1:23 p.m. stated Staff B, CNA, reported during cares that her fingernails scratched the front of Resident #2's right shoulder. Another CNA present stated the CNA's nails, noted to be long and sharp, had scratched the resident's shoulder.

On 8/22/22 at 12:35 p.m., Staff A, CNA, stated on 7/22/22 a little before midnight, Resident #3 began moaning "Mommy" and continued this for over an hour. Staff B, CNA, then went into the resident's room and yelled, "Just shut up. Shut the fuck up." A couple of hours later, around 1:30 a.m., Staff A reported she heard Staff B gasp she saw Resident #1 walking unassisted in the hall. Staff A then observed Staff B grab Resident #1's upper arm roughly, and pulling her towards her room, loudly say, "Go back to your room right now."

Staff A said she reported her concerns to the Director of Nursing (DON) when working her next shift on 7/23/22 around 8:30 p.m. Staff A stated she held off notifying anyone of her concerns because nurses had not followed-up on concerns in the past, and she did not know if her concerns were abuse.

On 8/23/22 at 12:00 p.m., Staff C, CNA, stated

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F 609	Continued From page 8	F 609		

she reported concerns to Staff E, Registered Nurse (RN) that Resident #2 had what appeared to be new scratch marks on him. Staff C noted these marks when she went into Resident #2's room the beginning of the day shift, approximately 10-15 minutes after Staff B, CNA, had left the room on 7/23/22.

On 8/23/22 at 2:00 p.m., Staff D, Licensed Practical Nurse (LPN), stated that on the afternoon of 7/24/22, the DON asked her to assess and document Resident #2's scratch marks. Staff D reported the incident had occurred the day prior but had not been documented at that time.

On 8/24/22 at 4:50 p.m., the Administrator stated Staff A failed to report the concern for abuse from the night shift until the following evening shift when she spoke to the DON. On the afternoon of 7/24/22, Staff C, CNA, reported she told Staff E, RN, the morning of 7/23/22, about concerns that Staff B, CNA had scratched Resident #2. The facility had no documentation completed or verbal report by Staff E showing the concern. Administration immediately submitted a report to the Department of Inspections and Appeals (DIA) and investigated the concerns once aware of them. .

On 8/24/22 at 7:48 p.m., Staff E, RN, reported Staff C, CNA, reported scratches on Resident #2. Staff E stated the way Staff C presented the concern, she did not feel it to be an allegation of abuse.

The facility's Dependent Adult Abuse Protocols dated November 2019 documented all allegations or resident abuse, neglect, exploitation,

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F 609	Continued From page 9 mistreatment, injuries of unknown origin, and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.	F 609		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on facility record review, clinical record review, and staff and physician interviews, the facility failed to provide ongoing assessments after observing signs of poor circulation in a foot for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 54 residents. Findings include: The Admission Minimum Data Set (MDS) assessment tool dated 10/21/21 showed Resident #5 had diagnoses including stroke, hemiplegia, dementia, and diabetes. The resident required extensive assistance of staff for transferring, dressing, and hygiene. The Brief Interview for Mental Status (BIMS) scored "4" indicating severely impaired cognition.	F 684	F684 Quality of Care Residents at Ridgewood Specialty Care will receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. Resident #5 no longer resides at Ridgewood Specialty Care. Current residents have the potential to be affected. Staff education completed regarding change in condition and physician notification. DON/designee will monitor skin observation/circulation and change in condition evaluations to ensure residents are receiving ongoing assessments. DON/Designee will audit 3 skin observation/circulation checks x4 weeks. Random audits thereafter. DON/Designee will audit 3 change in condition evaluations x4 weeks. Random audits thereafter. Concerns identified will be addressed in QAPI.	9/29/22

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F 684	Continued From page 10	F 684		

The Care Plan, dated 12/27/21, documented the resident had an alteration in musculoskeletal status related to right foot drop and needed a right AFO brace (a brace to support the resident's foot in a natural position) placed prior to all transfers.

On 12/28/21, a Physical Therapy Treatment Encounter Note revealed Resident #5 cried out in pain when the PTA (Physical Therapist Assistant) scooted the resident's right foot back for proper foot placement. The PTA removed the resident's sock and shoe and observed her right foot to be purplish in color with the foot, ankle, and calf swelling (a potential sign of tissue injury, including blocked arteries). Therapy notified Staff F, Licensed Practical Nurse (LPN).

On 12/28/21 at 3:59 p.m., A Progress Note by Staff F, LPN, documented Resident #5 had 2 toes with a blue hue and poor circulation (a potential sign that Resident #5 had blocked arteries in their leg). The note indicated that Staff F added the concern about Resident #5's toes to a list of concerns for the physician to review the next time the physician came to the facility to provide care to residents. Staff F also encouraged Resident #5 to move their right leg.

On 12/31/21, a Physical Therapy Treatment Encounter Note recorded the PTA assessed Resident #5's feet and legs when Resident #5 grimaced while the PTA assisted Resident #5 with the placement and removal of the AFO brace and shoes. The nursing staff was aware that Resident #5 had 2 toes which were dark in color (a sign Resident #5 potentially had blocked arteries in their leg).

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F 684	Continued From page 11 Review of Resident #5's medical record, from 12/28/21 through 1/3/22, revealed the medical record lacked any nursing documentation regarding Resident #5's right foot, especially regarding the appearance or assessment of Resident #5's right foot. Review of the Physical Therapy Treatment Encounter Notes revealed therapy staff did not work with the resident on 1/1/22 or 1/2/22. On 1/3/22, a Physical Therapy Treatment Encounter Note documented Resident #5 complained of pain when therapy staff moved Resident #5's right foot and Resident #5 did not want to bear weight on their right foot. The PTA removed the resident's right sock and shoe and observed the plantar/dorsal (bottom/top) areas of Resident #5's right foot discolored a dark purple. The second and third toes appeared purplish/black (late signs of possible arterial blockage), and the underside of Resident #5's foot contained blisters. On 1/3/22 at 11:42 a.m., a Progress Note by Staff E, Registered Nurse (RN), described Resident #5's right foot as extremely blue, cold, and without palpable pedal pulses (emergent signs of arterial blockage, indicating the foot was not receiving blood flow). The facility staff transferred Resident #5 to the Emergency Department (ED) for further evaluation of Resident #5's right foot. On 1/3/22, the ED Physician Record noted Resident #5 had several black toes with ulcerations and redness noted to the right leg. A Computed Tomography Angiography (CTA-a CT scan with injection of dye), showed complete blockage of the right iliac, femoral, and popliteal	F 684		

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F 684	Continued From page 12	F 684		

arteries (the major arteries in Resident #5's right leg). The ED Physician's clinical impression included gangrene (death of body tissue due to a lack of blood flow). The ED staff transferred Resident #5 to a second hospital so that a vascular surgeon specialized in treating blocked arteries could evaluate Resident #5 and determine if they could save Resident #5's toes.

The hospital Discharge Summaries, dated 1/7/22, listed the reason for admission as critical limb ischemia (blocked blood flow to Resident #5's right leg) and the principal diagnosis as thrombosis (blood clot) of arteries of lower extremity. The vascular surgeon's note indicated that the damage to Resident #5's right foot was likely irreversible. The vascular surgeon discussed the possibility of amputating parts of Resident #5's right foot, but Resident 5's family declined surgery and instead opted to place Resident #5 in hospice care.

On 8/24/22 at 3:40 p.m., Staff D, LPN, stated when nursing monitored concerns, they triggered hot charting in the Progress Notes (additional focused charting kept separate so the nursing staff will document more frequently). Staff D did not recall receiving any information about Resident #5's discolored toes, either through nurse-to-nurse report or a staff member reporting a concern to Staff D. If the patients expressed pain to the therapy staff, the therapy staff would notify the nursing staff.

On 8/24/22 at 3:42 p.m., Staff G, Certified Nurse Aide (CNA) could not recall any circulation concerns or discolored toes on Resident #5.

On 8/24/22 at 3:53 p.m., Staff H, RN, did not

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F 684	Continued From page 13	F 684		

recall hearing anything about Resident #5's discolored toes in nurse-to-nurse report prior to the nursing staff sending Resident #5 to the hospital.

On 8/24/22 at 5:15 p.m., Staff I, CNA, reported seeing a purple area on the top of Resident #5's foot that had not been there the day prior. Staff I recalled telling the nurse but did not work with the resident after that day.

On 8/24/22 at 7:48 p.m., Staff E, RN, felt the poor circulation documented on 1/3/22 came on abruptly. She could not recall hearing anything in shift-to-shift report.

On 8/25/22 at 8:38 a.m., Staff J, CNA, could not recall the resident or any discolored feet/toes.

On 8/25/22 at 8:56 a.m., Staff K, CNA, described the resident as being cold a lot and but could not recall seeing or hearing about any foot discoloration. The resident wore gripper socks and usually slept in the gripper socks.

On 9/6/22 at 9:25 a.m., the Director of Nursing indicated they expected that if the nursing staff received a report of discolored toes or discovered a resident with discolored toes, the nursing staff should check the resident's discolored toes every shift and that the physician would follow-up on any concerns. The nurse practitioner or physician rounded 3 days a week and so they should have seen Resident #5 within a couple of days of the nursing staff writing the progress note on 12/28/21.

On 9/7/22 at 8:30 a.m., Resident #5's Primary Care Physician (PCP reported being in the facility

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F 684	Continued From page 14 on 12/30/21 (2 days after the therapy and nursing staff identified possible concerns with the circulation in Resident #5's foot), but Resident #5's PCP did not see Resident #5 on 12/30/21. Neither Resident #5's PCP, nor Resident #5's PCP's Nurse Practitioner, saw or documented any notes regarding Resident #5's right foot during the 12/30/21 visit. Resident #5's PCP did not believe the nursing staff informed Resident #5's PCP about the concerns regarding Resident #5's foot discoloration. Given Resident #5's history of poor blood flow to their feet and dark, purplish appearing skin on Resident #5's feet, Resident #5's PCP would not have paid much attention to a report of Resident #5 experiencing skin discoloration, unless the resident experienced pain (Resident #5 had pain in their feet, starting on 12/28/21) or the development of sores (Resident #5 developed blisters, a potential start of a sore, on 1/3/22). Resident #5's PCP expected the nursing staff to continue to monitor Resident #5's right foot if they identified concerns and notify Resident #5's PCP of any changes (such as Resident #5 developing blisters on 1/3/22). The facility's Charting and Documentation Policy, revised July 2017, indicated that any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	F880 Infection Prevention & Control	10/05/22

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F 880	Continued From page 15 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	Ridgewood Specialty Care has established an infection prevention and control program that includes preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers and visitors. Standard and Transmission based precautions will be followed to prevent spread of infections. Infection prevention and control procedures will be followed on when to isolate a resident to include but not limited to the type and duration depending upon the infectious agent or organism. The isolation requirement should be least restrictive as possible. Hand hygiene procedures will be followed by staff involved in direct resident contact. Linens will be handled, stored, processed and transported to prevent the spread of infection. The facility will conduct an annual review of the IPCP and update as necessary. Staff A educated on screening in prior to shift on 9/30/2022. Staff A educated regarding new QSO-20-39-NH Guidance for screening on 10/4/22. Current residents have the potential to be affected. Staff education including agency staff on screening in prior to shift on 9/30/2022. Staff education including agency staff completed regarding new QSO-20-39-NH Guidance for screening on 10/4/22.	

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F 880	Continued From page 16 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on Centers for Disease Control and Prevention (CDC) guidance, facility report review, observation, and staff interviews, the facility failed to ensure staff screened in with temperature, symptoms, and COVID-19 exposure prior to the start of their shifts for 1 of 3 staff reviewed (Staff A, CNA). The facility reported a census of 54 residents. Findings include: The CDC's Interim Infection Prevention and Control Recommendations for Healthcare	F 880	Administrator/designee will monitor staff for Covid Symptoms. Administrator/Designee will audit staff for covid symptoms 3x/week x4 weeks. Random audits thereafter. Concerns identified will be addressed in QAPI.	

Kaitlyn M. Lewis (Ridgewood)

From: Gina Anderson <ganderson@telligen.com>
Sent: Tuesday, September 13, 2022 12:13 PM
To: Gina Anderson
Subject: Thank you for attending Telligen's RCA Training
Attachments: TQIC blank catagories Fishbone Worksheet_4.pdf; Five-Whys-Worksheet-v.2-4-18.pdf; RCA Training-rehosp_ED_ADE-9_13_2022.pdf

Importance: High

Hello!

Thank you for meeting with me this morning to review resources that will help you in your improvement processes and allowing me to provide you with training on the root cause analysis (RCA).

It is important for us to learn from your feedback about our trainings. We appreciate you taking a few seconds to provide your feedback on this RCA Training. Please go **HERE** to take this two-question evaluation.

Below are additional resources to support along with the attached power point for the RCA training and resources covered in the presentation (note: information has been added to reflect your participation in the exercise with side notes). I know I shared a lot, but just take one resource at a time to see if it is useable for your needs at the organization and will benefit you in further training more staff on the RCA process and ultimately an improvement project. Let me know if you need further support.

Take action, join in on our Plan-Do-Study-Act (PDSA) Training

- **PDSA Training is offered every other Wednesday at 11:00am CT/10am MT**
  Register HERE to select a Wednesday you would like to attend!
  Once your perform a RCA, the next step is planning, doing, studying and acting. Please join Telligen to learn the principles of the Plan-Do-Study-Act (PDSA) cycle! The PDSA cycle is an action-oriented learning process. It is designed to be a quick test of a new or different practice in the real work environment and is structured to help you make an informed decision! This learning event will orient you on the PDSA four-step process (Planning, Trying, Observing, and Acting) and identify methods for implementing PDSA cycles into your organizational practices. For all provider types.

Telligen events and resources:

- Explore **Telligen's event line up here** for more opportunities.
- Investigate **Telligen's resources and support options** here.
- For exclusive access to data collection and reporting, events, resources and networking, sign into the **Telligen QI Connect™ portal**. Not sure how to gain access, refer to the Portal Help? link.

Recognition opportunity:

- The ***Blue Ribbon in COVID-19 Vigilance*** Award for Telligen QI Connect™ participants was created to recognize the efforts nursing homes have made to prevent the spread of COVID-19. If you represent a nursing home that is prepared for COVID-19, we want to make it easy for you to share your

achievements with your stakeholders, partners, residents and their families. Continue reading here to learn how you can receive the Blue Ribbon in COVID-19 Vigilance. We are asking all nursing homes to Complete the COVID-19 Preparedness Assessment attesting that you are committed to have policies, processes and ongoing staff education to prevent the spread of COVID-19. Each quarter Telligen will update those nursing homes who have achieved this recognition, if you are one of those homes you can use the exclusive marketing toolkit to "shout out" your hard efforts.

Spotlight Resource:

- **Emergency Preparedness Plan – Nursing homes are you ready for an emergency?**
  Quickly evaluate your readiness with Telligen's digital Emergency Preparedness Assessment (EPP)! Use this alongside your current EPP to gain insight and resources to address identified gaps and improve your plan! Use this comprehensive checklist to evaluate critical required elements important to your nursing home's safety. This assessment will assist you in updating, revising, or developing your EPP.

Thank you so much for partnering with Telligen QI Connect™ so we can continue to provide this type of assistance at no cost. Now that you attended this training take action, you are on the right path for stronger systems in your organization.

Let me know if you have further questions or in need of support in your QI process!

Gina Anderson, RN, BSN
Senior Quality Improvement Facilitator | Telligen QI Connect™
515-223-2127 | ganderson@telligen.com

Nursing homes, evaluate your readiness with Telligen's Emergency Preparedness Assessment! Gain insight and resources to address identified gaps and improve your plan!