

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2011
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431
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(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)	(X6) COMPLETION DATE
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K 000 K 069 SS=D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Life Safety Code Survey, investigating ARO #KY00016477 was initiated on 05/19/2011 and concluded on 05/20/2011. ARO # KY00016477 was substantiated with a deficiency cited.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 98</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the kitchen area was maintained according to NFPA standards. The deficiency had the potential to affect staff in the kitchen area.</p> <p>The findings include:</p> <p>Observation on 05/20/2011 at 9:54 AM, revealed the fire extinguisher in the kitchen area did not have the required signage. The observation was confirmed with the Maintenance Director and the Dietary Manager</p> <p>Interview on 05/20/2011 at 9:54 AM, with the Maintenance Director and the Dietary Manager, revealed they were unaware of a sign ever being near the fire extinguisher.</p> <p>Reference: NFPA 96 (1999 edition) 7-2.1.1 A placard identifying the use of the</p>	K 000 K 069	<p>DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Ridgewood Terrace Health & Rehabilitation Center agrees with the allegations and citations listed on the pages of Statement of Deficiencies. Ridgewood Terrace Health & Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates Ridgewood Terrace Health & Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.</p> <p style="text-align: right;">RECEIVED JUL 29 2011 BY: _____</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian Kelly</i>	TITLE <i>Administrator</i>	(X8) DATE <i>06/10/11</i>
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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.

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

PRINTED: 05/20/11
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(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
K 069	Continued From page 1 extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.	K 069	K069: 1. Placards were placed above the fire extinguishers in the kitchen on 06/09/11 stating the following: "Warning! In case of appliance fire, use this extinguisher after fixed suppression system has been activated." 2. On 06/10/11 the Maintenance Director confirmed placement of the placards above the fire extinguishers in the dietary department to the Safety Committee consisting of: The Administrator, Director of Nursing, Dietary Manager, Unit Nursing Managers, Medical Records Director, Minimum Data Set Coordinators, RN Corporate Compliance Officer, Maintenance Director, Housekeeping Director, Therapy Director, Activities	

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

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FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431		
(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)	(X6) COMPLETION DATE

Director, Business Office
Manager and Social
Services Director.

3. The Maintenance Director scheduled an in-service training for dietary personnel on the use of the extinguisher as a secondary backup means to the automatic fire suppression system for appliance fires on 06/13/11.
4. The Maintenance Director will orient all new dietary employees in the proper method of responding to a fire involving appliances beginning 06/10/11.
5. Completion date:
06/13/11