

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

PRINTED: 04/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD OWINGSVILLE, KY 40360	

(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
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 03/18/14 and concluded on 03/20/14 with deficiencies cited at the highest Scope and Severity of an "E".

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the facility's policies and review of the Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as was possible.

Observations revealed a clean utility closet door unlocked on Unit 2 with chemicals and oxygen cannisters stored within; and a clean utility closet door on Unit 1 unlocked and ajar with chemicals and oxygen cannisters also stored in it.

The findings include:

Review of the facility's policy titled, "Storage Areas, Maintenance" dated 08/01/13, revealed materials including chemicals that could pose a safety hazard to vulnerable residents were to be

F 000

F323

F 323

It is and was on the day of survey the policy of Ridgway Nursing and Rehabilitation to ensure the resident's environment remains as free of accident hazards as is possible. The surveyor questioned the Administrator concerning the clean utility room on unit 2. It was explained that the room was open when there was someone present in the nurse's station to ensure no resident entered this area. In the case of any emergency the door is locked. On 03-20-14 at 8:20am it should be noted that it was reported that a hinge spring failed on the clean utility room door on Unit 1. This was immediately repaired by the maintenance supervisor.

1. No resident were affected by the clean utility room door being unlocked.

2. All residents are routinely monitored especially those who are identified as wandering residents.

3. An inservice was conducted with all employees by the Director of Nursing on 03-28-14 specifically addressing the need to maintain an accident free environment for the residents. The two clean utility rooms are being kept locked and all staff has been instructed to ensure the door latches before walking away from the area.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Billy Batts

(X6) DATE

Administrator 04-11-14

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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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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F 323 Continued From page 1
monitored and/or stored safely. Further review revealed storage areas were to be maintained in a safe manner.

Observation, during initial tour of the facility on Unit 2, on 03/18/14 at 5:28 AM and 5:26 AM, revealed a clean utility storage closet door unlocked and the contents accessible to residents. Observation of the storage closet are revealed: two (2) containers of bleach wipes; forty-seven (47) containers of hand sanitizer; twelve (12) containers of mouth wash; eight (8) bottles of hydrogen peroxide; six (6) boxes of one hundred (100) count per box Povidone-Iodine (antimicrobial) Prep Pads; twenty-one (21) oxygen cylinders; eleven (11) containers of Ultra Secure antiperspirant; ten (10) packs of ten (10) disposable razors, one (1) box of one hundred (100) count disposable razors and sixteen (16) loose disposable razors.

Observation on 03/20/14 at 8:20 AM, revealed a clean utility closet door on Unit 1 was ajar and easily accessible to residents. Observation of the door revealed despite having a push button locking mechanism, the door would not automatically close all the way upon exit unless it was physically pulled closed. Observation of the clean utility room area revealed: fourteen (14) oxygen cylinders; a container of Dispatch Hospital Cleaner Disinfectant Towels with Bleach; thirteen (13) bottles of hydrogen peroxide; seven (7) cans of Freshcent Aerosol Shave Cream; twenty-two (22) containers of Dermatech Hand Sanitizer with Aloe; three (3) boxes each containing ninety (90) tablets of Fresh Mint Denture Cleanser; fourteen (14) containers of DermaRite Antiperspirant Spray; one (1) container of DermaSarra Anti-Itch Lotion; six (6) ten (10) packs of disposable

F 323 4. As part of the facility's ongoing Quality Assurance Program, the Director of Nursing will daily for one month audit for any chemicals which are not properly stored and then monthly the safety committee will audit for chemicals which are not properly stored. These audits will be incorporated in the facility's Quality Assurance meetings monthly. In addition, the safety committee (monthly) will conduct environmental audits to ensure the facility is free of accident hazards as possible. This practice will be on-going.

04-08-14

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F 323	<p>Continued From page 2</p> <p>razors, two (2) open packs containing a total of nine (9) disposable razors; and two boxes of wooden cuticle sticks.</p> <p>Review of the facility's MSDS for Dispatch Hospital Cleaner Disinfectant Towels with Bleach revealed the product could cause eye irritation if gotten in the eyes, which could require medical attention if the condition persisted more than five minutes. Further review revealed the product could cause gastrointestinal irritation.</p> <p>Review of the facility's MSDS for Hydrogen Peroxide revealed if exposed to eyes they were to be rinsed and a Physician called. Further review revealed if ingested vomiting should be induced followed by a call to a Physician.</p> <p>Review of the facility's MSDS for Freshscent Aerosol Shave Cream revealed the product could cause eye irritation, and eyes were to be flushed with water for at least fifteen (15) minutes, with a Physician contacted if irritation persisted beyond fifteen (15) minutes. Further review revealed if ingested the product could cause nausea, vomiting, and diarrhea, medical attention would be required.</p> <p>Review of the facility's MSDS for Dermatech Hand Sanitizer with Aloe revealed the product could cause eye irritation if it came in contact with eyes. Further review revealed it could cause nausea or upset stomach if ingested, and a Physician or poison control center should be called.</p> <p>Review of the facility's MSDS for Fresh Mint Denture Cleanser revealed the product could cause eye irritation if it came in contact with eyes.</p>	F 323		

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F 323	Continued From page 3 requiring flushing with water and a call to a Physician if irritation remained. Further review revealed if ingested water and milk were to be ingested to dilute the product, and a poison control center was to be contacted. Review of the facility's MSDS for DermaRite Antiperspirant Spray revealed eyes were to be washed immediately with large amounts of water for a minimum of fifteen (15) minutes and medical attention sought if contact made with eyes. Further review revealed if ingested medical attention was required. Review of the Safety Data Sheet (SDS) for DermaSarra Anti-Itch Lotion revealed the product could be an eye irritant if contact was made, and eyes should be flushed with water for fifteen (15) minutes. Further review revealed if ingested large amounts of water were to be consumed and a Physician called. Review of the facility's list of resident's at risk for wandering revealed three (3) total residents, with one (1) resident, Unsampled Resident #A, residing on Unit 1 and Unsampled Resident B on Unit 2. Interview with Certified Nursing Assistant (CNA) #5 on 03/20/14 at 10:58 AM, revealed Unsampled Resident #A wandered in the hallways on Unit 1, and he had not witnessed him/her wandering in other residents' rooms or rooms with closed doors. CNA #5 revealed Resident #B, although he/she resided on Unit 2, occasionally wandered onto Unit 1, but again had not been observed to try to get into areas with closed doors. CAN #5 revealed he had never observed the clean utility room to be open. He stated he always pulled the	F 323			

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F 323	<p>Continued From page 4</p> <p>door closed behind him. The CNA stated there were "things" stored in the clean utility closet which he wouldn't want residents "to get into". He indicated these "things" would be potentially harmful to residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 03/20/14 at 1:58 PM, revealed the clean utility storage closet to Unit 2 was generally left open if someone was present at the nurse's station to monitor the door. LPN #7 stated in case of an emergency staff would lock the door to the clean utility storage closet. Further interview revealed the chemicals and sharps stored in clean utility storage closet could be a hazard to some of the facility's residents.</p> <p>Interview with Registered Nurse (RN) #1 on 03/20/14 at 12:40 PM, revealed she was unaware of any instance in which wandering residents had wandered into other rooms. RN #1 stated, however the clean utility storage closets contained items that could potentially be harmful for residents. She stated that was why these areas were to be kept secured.</p> <p>Interview with the Administrator on 03/20/14 at 12:47 PM, revealed the clean utility storage closets were kept secured so no residents could just wander in and potentially be lost and the facility unable to locate them. The Administrator stated "as a general rule", she would not want products, such as, bleach wipes or razors to be left with confused residents. She indicated, however she did not feel the door to the clean utility storage closets not being secured posed a risk to residents beyond risks they faced on a day-to-day basis. She stated in the case of Unit 1's clean utility storage closet door it had been a</p>	F 323		

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F 323	Continued From page 5	F 323		
F 514	483.75(l)(1) RES SS-D RECORDS COMPLETE/ACCURATE/ACCESSIBLE	F 514	F514	
	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to maintain each resident's medical record in accordance with accepted professional standards and practices to ensure the medical record was accurate, complete and organized for one (1) of nineteen (19) sampled residents (Resident #18).</p> <p>Review of Resident #18's closed medical record revealed the resident had been pronounced deceased by a Hospice Nurse. Review of the Provisional Report of Death form revealed it had</p>		<p>It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain clinical records on each resident in accordance with accepted professional standards and practices. Long Term Care Facilities are exempt from the requirements of reporting all death to the KODA program. This was confirmed with the KODA Coordinator during the survey. Her name and phone number was provided to the surveyor. The question related to whether blood and body fluids precautions were advised was not answered however, as a medical professional; it is a standard of practice that <u>All</u> blood and body fluids are treated with precautions. The facility did document in the resident's nurse's notes that the funeral home picked up the body and that the facility released the remains.</p> <p>1. Resident #18 died on 01-18-14.</p>	

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F 514	Continued From page 6 not been completely filled out to indicate: the location of death, whether the Kentucky Organ Donor Affiliates (KODA) had been notified; and no documentation to indicate who the facility released the resident's remains to. The findings include: Review of the facility's, "Hospice Agreement" undated revealed under the "Compilation of Records" section the Hospice was to prepare and maintain complete and detailed medical records concerning each Hospice patient receiving Hospice Services under the Agreement in accordance as required by applicable federal and state law and regulations and applicable Medicare and Medicaid program guidelines. Review of the facility's policy titled, "Documenting Death of a Resident", revised 08/01/13, revealed the person removing the deceased resident's body from the facility was to sign the release for the body, and the release was to be filed in the resident's medical record. Further review revealed all records were to be completed and forwarded to the facility's Medical Records department for disposition. Review of Resident #18's medical record revealed the resident had admitted to Hospice after being diagnosed with a terminal illness. Continued review revealed Resident #18 was pronounced deceased on 01/08/14 and the remains had been released to the Funeral Home personnel. Review of the Provisional Report of Death form, located in Resident #18's medical record, however revealed all areas of the form had not been completed, such as, the location of the resident's death and the area indicating who	F 514			

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F 514 Continued From page 7
had granted release of the resident's remains to the Funeral Home personnel. Continued review of the form revealed the KODA area had not been completed and the question regarding whether blood and body fluid precautions were advised had not been answered.

Interview with Medical Records Staff #1 and Medical Records Staff #2 on 03/20/14 at 1:58 PM, revealed the Provisional Report of Death form's sections A, B and C were incomplete. Medical Records Staff #1 stated the Charge Nurse, present when Resident #18 was pronounced deceased, should have indicating the facility's name for location of the of the death in Section A and in Section B for granting release of the body to the Funeral Home personnel. According to Medical Records Staff #1 facility staff should have had the Funeral Home personnel complete Section C when they were ready to transport the deceased resident's remains. Medical Records Staff #1 stated the nurses had the opportunity to ensure the document was completed before the Funeral Home personnel arrived to transport the resident's body. Medical Records Staff #2 stated she agreed the Provisional Report of Death form was incomplete and indicated, therefore Resident #18's medical record was incomplete.

Interview with Registered Nurse (RN) #2 on 03/20/14 at 2:35 PM, revealed the Provisional Report of Death form was incomplete and should have been completed. She stated the Sections A and B should have been completed. RN #2 also stated Section C was incomplete because the Funeral Home personnel had not signed the document when they picked up the deceased resident's body from the facility. She stated it

F 514

2. All records of residents who died in the past three months have been reviewed by medical records to ensure the provisional death certificate has been completed properly. Medical records of all residents have been audited by Medical Records staff to ensure the clinical record is maintained in accordance with accepted professional standards and practice that is complete.

3. An in-service was conducted by the Director of Nursing and Administrator with licensed staff on 03-28-14 concerning the need to maintain complete, accurate medical records. The Provisional Death Certificate was specifically reviewed and instructions given on the required sections to be completed.

4. As part of the facility's ongoing Quality Assurance Program the Director of Nursing will review the clinical record of each resident who dies in the facility to ensure it is complete specifically the Provisional Death Certificate. The clinical record of residents of the facility will be audited for completeness quarterly by the Director of Nursing. This audit will be conducted during the resident's care plan meeting. This practice will be on-going. The results of these audits will be reviewed and action plan developed by the Administrator.

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F 514	Continued From page 8 was the responsibility of the facility's nurses to ensure the form was entirely completed before submission to Medical Records. Interview with the facility's Administrator on 03/20/14 at 3:40 PM, revealed it was her expectation for the Provisional Report of Death form to be entirely completed before it was filed in a resident's medical record. The Administrator indicated it was the responsibility of the facility to ensure the document was completed and the medical record complete. She further stated the facility was ultimately responsible for the Hospice Nurse's failure to accurately complete the Provisional Report of Death form before it was submitted to medical records.	F 514	04-09-14		
F 520 SS-E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	F520	It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain an active Quality Assurance Program. The facility's Quality Assurance Committee meets monthly and the facility's Medical Director attends these meetings. The facility implemented a plan of correction related to the previously cited deficiency and continued those audits for the specified time with periodic audits after the time frame expired. The deficiency cited on this survey was related to failure of a door spring which was immediately corrected. The previous citation related to the resident not having an adaptive piece of equipment to maintain safety.	

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F 520	<p>Continued From page 9 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by a repeated deficiency related to the facility's failure to ensure the residents' environment remained as free of accident hazards as was possible.</p> <p>The findings include: Review of the facility's Plan of Correction (POC) with a compliance date of 06/01/13, revealed staff were educated on proper storage of chemicals and biologicals. Continued review of the POC revealed Department Supervisors were to conduct safety audits monthly specifically looking for accident hazards. Those audits were to have been conducted for three (3) months and if no issues were noted the audits would be conducted on a random basis and were to be incorporated into the facility's QA Program Committee.</p> <p>Observations during the current survey revealed unsecured clean utility storage closets which contained chemicals and sharps, such as, razors and cuticle sticks. Observation of the Unit 2</p>	F 520	<ol style="list-style-type: none"> No residents were affected. All residents are monitored routinely especially those identified as wandering residents. An inservice was conducted with all employees by the Director of Nursing on 03-28-14 specifically addressing the need to maintain an accident free environment for the residents. The two clean utility rooms are being kept locked and all staff has been instructed to ensure the door latches before walking away from the area. Daily audits will be conducted by the Director of Nursing, Monday-Friday, and administrative staff person on weekend call, Saturday and Sunday, to ensure all chemicals are properly stored. These daily audits will continue for one month and their results will be reported to the Quality Assurance Committee. If there are no further problems with chemical storage noted these audits will be moved to a monthly basis. In addition, the safety committee (monthly) will conduct environmental audits to ensure the facility is free of accident hazards as possible. This practice will be on-going. 	04-08-14	

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F 520 Continued From page 10

clean utility storage closet revealed it to be unlocked and observation of the Unit 1 clean utility storage closet revealed the door did to be ajar and not close unless pulled closed by staff.

Interview with the Housekeeping Supervisor on 03/20/13 at 2:09 PM, revealed she and her staff routinely monitored resident care areas for items which might be hazardous and needed to be secured. The Housekeeping Supervisor stated if she or her staff were to discover a door open, such as, the clean utility storage closet door they would secure it immediately for resident safety as there were oxygen tanks and razors in the closets. According to the Housekeeping Supervisor, she and her staff audited resident care areas as part of the POC for the 05/01/13 through 05/03/13 Statement of Deficiencies (SOD). She indicated, however the facility had no documented evidence of the audits performed by herself and her staff.

Interview with the Administrator on 03/20/13 at 2:35 PM, revealed she thought the current survey observations were a "totally different situation" than last year's survey findings as a family member had brought in Hydrogen Peroxide for a resident and staff had been unaware of it during last year's survey. She indicated she saw the unsecured clean utility storage closet on Unit 1 as a "failure of a piece of equipment", not as though staff had left potentially harmful items accessible to residents. However, the Administrator stated as a "general rule" the facility would not want products, such as, bleach wipes and razors to be accessible to a confused resident. Further interview revealed the unlocked door on Unit 2 was monitored by staff at the nursing station or it would have been locked as staff knew they were

F 520

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

PRINTED: 04/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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)	(X5) COMPLETION DATE
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F 520 Continued From page 11 to check doors.

F 520

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

PRINTED: 04/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

(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
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 Edition)

Plan approval: 1978

Facility type: SNF/INF

Type of structure: Type III unprotected

Smoke Compartments: Three

Fire Alarm: Fire alarm installed in 1978
Smoke detectors in corridors
Heat detectors in kitchen/attic

Sprinkler System: Complete sprinkler system (dry) installed 1978

Generator: Natural gas installed 2005

A standard Life Safety Code survey was conducted on 03/10/14. Ridgway Nursing and Rehabilitation Facility (Existing construction) was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety-one (91). The facility is licensed for ninety-nine (99) beds.

K 000 Ridgway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.

Ridgway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal disputes resolution, legal appeal proceedings or any administrative or legal proceeding. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance of self critical examination privileges which Ridgway Nursing and Rehabilitation does not waive, and reserve the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Ridgway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sally Baxter RN

TITLE
Administrators

(X6) DATE
04-11-14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW EDITION B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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)	(X5) COMPLETION DATE
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K 000: INITIAL COMMENTS

- CFR: 42 CFR 483.70(a)
- Building: 02
- Plan Approval: 03/06/2012
- Survey under: NFPA 101 (2000 edition)
- Facility type: SNF/NF
- Type of structure: Type (111)
- Smoke Compartment: One (1)
- Fire Alarm: Complete fire alarm (New)
- Sprinkler System: Complete sprinkler system (New)
- Generator: Type II (New)

A standard Life Safety Code survey was conducted on 03/19/14. Ridgeway Nursing and Rehabilitation Facility (New Construction Wing) was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety-one (91). The facility is licensed for ninety-nine (99) beds. The highest Scope and Severity identified was at a "D" level.

K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress hardware had signage of the proper height, according to National Fire Protection Association (NFPA)

K 000:

K038

It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to clearly identify all exits as required by NFPA 101. The facility added 39 beds to the facility in 2013 and received approval by all state agencies before occupancy.

1. The exit doors will be identified with 1 inch letters and non-exits are identified with 2" lettering for the word NO in accordance with NFPA.
2. All exits are clearly marked and non-exits are identified in accordance with NFPA standards.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Sally Buxton

TITLE

Administrator

DATE

04-11-14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW EDITION B. WING	(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

(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
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)
Building: 02
Plan Approval: 03/06/2012
Survey under: NFPA 101 (2000 edition)
Facility type: SNF/NF
Type of structure: Type (111)
Smoke Compartment: One (1)
Fire Alarm: Complete fire alarm (New)
Sprinkler System: Complete sprinkler system (New)
Generator: Type II (New)

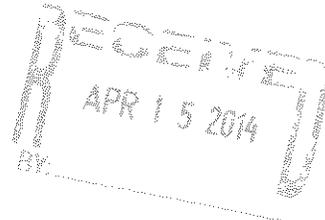
A standard Life Safety Code survey was conducted on 03/19/14. Ridgeway Nursing and Rehabilitation Facility (New Construction Wing) was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety-one (91). The facility is licensed for ninety-nine (99) beds. The highest Scope and Severity identified was at a "D" level.

K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress hardware had signage of the proper height, according to National Fire Protection Association (NFPA)

K 000:



K038

It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to clearly identify all exits as required by NFPA 101. The facility added 39 beds to the facility in 2013 and received approval by all state agencies before occupancy.

1. The exit doors will be identified with 1 inch letters and non-exits are identified with 2" lettering for the word NO in accordance with NFPA.

2. All exits are clearly marked and non-exits are identified in accordance with NFPA standards.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ DATE _____

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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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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)	(X5) COMPLETION DATE
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K 038 Continued From page 1
standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, thirty six (36) residents, staff, and visitors.

The findings include:

Observation on 03/19/14 at 3:03 PM, revealed the exterior exit door equipped with delayed egress located at the Laundry Hall Area had signage indicating the proper door operation with letters less than one (1) inch in height. Additional observation revealed the same was found for the exterior exits from the 100 Hall, 200 Hall, and 300 Hall. The observations were confirmed with the Maintenance Director. Doors having delayed egress hardware must have signage meeting height and brush stroke width requirements.

Interview, on 03/19/14 at 10:40 AM, with the Regional Maintenance Director revealed the facility had relied upon the construction contractor to ensure the new construction area met the National Fire Protection Association Codes.

The findings were confirmed with the Administrator during the exit conference on 03/19/14.

Reference: NFPA 101 (2000 Edition).

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42,

K 038

3. An inservice will conducted by the administrator on 04-04-14 with all Maintenance Staff to review NFPA standards on signage requirements.

4. As part of the facility's ongoing Quality Assurance Program the Maintenance Supervisor will check all exits doors quarterly to ensure the NFPA standard is met.

04-23-14

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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K 038	<p>Continued From page 2 provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a</p>	K 038		
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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD OWINGSVILLE, KY 40360
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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)	(X5) COMPLETION DATE
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K 038 Continued From page 3
sign that reads as follows:
NO
EXIT
Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

K 038

K 056 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.

K 056

K056
It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain an automatic sprinkler system in accordance with NFPA 13. This area was newly constructed and certified in 2013.

1. The lights will be moved on or before 4-24-14 to allow sprinkler coverage in the basement.
2. All sprinklers have been assessed to ensure there are no other obstructions to the sprinkler coverage.
3. An inservice was conducted on 04-04-14 by the Administrator with the Maintenance Supervisor discussing the NFPA 13 Standard.
4. As part of the facility's ongoing Quality Assurance Program, quarterly the sprinkler heads will be assessed to ensure they are no obstructions.

This STANDARD is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure sprinkler coverage was not obstructed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments and Maintenance staff working in the basement.

The findings include:

04-14-14

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

(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
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K 056 : Continued From page 4

K 056:

Observations on 03/19/2014 at 2:55 PM, with the Maintenance Director present, revealed four (4) sets of fluorescent lights which obstructed four (4) sprinkler heads located in the basement area. The lights were located between five (5) and eight (8) inches from the sprinkler heads. The sprinkler heads did not project below the fluorescent lights. Obstructions to sprinkler heads can prevent the sprinkler heads from activating during a fire. The findings were confirmed with the Maintenance Director.

Interview, on 03/19/2014 at 2:55 PM, with the Maintenance Director revealed the fluorescent lights were installed with the new construction and the facility had relied on the electrical contractors and the sprinkler installation contractors to ensure the sprinkler heads and fluorescent lights followed the NFPA standards.

The findings were acknowledged with the Administrator during the exit conference.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Maximum Allowable Distance

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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K 056 Continued From page 5
Distance from Sprinklers to Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B)
Less than 1 ft
0
1 ft to less than 1 ft 6 in.
2 1/2
1 ft 6 in. to less than 2 ft
3 1/2
2 ft to less than 2 ft 6 in.
5 1/2
2 ft 6 in. to less than 3 ft
7 1/2
3 ft to less than 3 ft 6 in.
9 1/2
3 ft 6 in. to less than 4 ft
12
4 ft to less than 4 ft 6 in.
14
4 ft 6 in. to less than 5 ft
16 1/2
5 ft and greater
18

K 056

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-8.5.1.2(a).