

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
--	--	--	--

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
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS AMENDED A recertification survey was conducted in conjunction with the revisit to KY #17858 on 05/15/12 through 05/17/12 and a Life Safety Code survey was conducted on 05/15/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S being "G." A separate CMS 2567L will be issued for the complaint revisit (Event ID FVNM13), detailing the same tags at F225, F226, F241, F490 and F520. After the Centers for Medicare and Medicaid Services (CMS) review and consultation with the State Agency, actual harm was also determined to exist at F282 and F323 at a scope and severity of a "G".	F 000	Preparation and execution of this plan of Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	<u>F 225 (G) INVESTIGATE/REPORT/ALLEGATIONS</u> <i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 6/20/12

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: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2012
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
F 225	<p>Continued From page 1</p> <p>including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and review of the facility's Incident/Investigative Report, it was determined the facility failed to ensure all alleged violations were reported in accordance with State and Federal regulations; failed to provide evidence that an alleged violation was thoroughly investigated; and failed to prevent further potential abuse for one resident (#5), in the selected sample of 19 residents. The facility failed to follow their investigation and Abuse policy/procedure. Resident #5 reported an allegation of verbal abuse to Certified Medication Technician (CMT) #2, witnessed by CMT #3 (refer</p>	F 225	<p>witness to the reporting of Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 225. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to allegations of abuse.</p> <p><i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the revision of policies as they relate to investigation and reporting of allegations of abuse. A newly revised Abuse Prohibition and Control Manual was developed and implemented on June 1, 2012. The QAA Committee approved the</p>	

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLANO 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
F 226	<p>Continued From page 2 to F241) on 04/28/12. While the CMTs notified the Administrative nurse, the facility continued to allow the alleged perpetrator, Nurse Aide State Registered (NASR) #5, to give direct care to other residents to include bathing the victim, prior to removing the perpetrator for over an hour after the allegation was made. On 05/15/12, eighteen (18) days after the incident, Resident #5 was observed crying while describing the incident stating it embarrassed him/her and made him/her feel bad. The facility's investigation was not thorough as all witnesses, staff nor the victim were interviewed. Additionally, the facility failed to report the allegation to the State Agency.</p> <p>Findings include:</p> <p>A review of the facility's investigation policy/procedure, revised 02/25/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-interview the alleged resident or victim; interview witnesses to include the assigned caregiver, caregivers in the immediate area, remote or potential witnesses; and interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established.</p>	F 225	<p>revised policies for Abuse Prohibition and Control on May 31, 2012.</p> <p>The Administrator conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse Prohibition and Control Manual policies that includes what to do immediately following an allegation of abuse. A Post Test for employees was held on these same dates on how and when to report any allegations of abuse.</p> <p>Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns regarding the investigating and reporting of abuse allegations and to solicit dignity concerns. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding dignity, abuse investigation and reporting of allegations.</p> <p>Monitoring The Administrator will review all allegations of abuse with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that allegations of abuse are</p>	

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 3</p> <p>A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation and report the results of the investigation within five working days to the Division of Long-Term Care.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact.</p> <p>A review of the facility's Incident/Investigation Report, dated 04/28/12, revealed an allegation was made by Resident #5 to Certified Medication Tech (CMT) #2. CMT #2 reported the allegation to Licensed Practical Nurse (LPN) #8. Allegedly, Nurse Aide State Registered (NASR) #5 stated that the way the resident drank water reminded her of her "dog." According to the investigation, the comment was made on 04/27/12, during a meal. The investigation included a statement by NASR #5, dated 04/28/12, indicating, that on 04/27/12, she was feeding Resident #5 in the dining room. There were other residents and family members present at the table. She was talking to the resident about her "puppy" and she made a comment that the resident nodded his/her head like her "puppy." NASR #5 indicated in the statement, she did not mean to hurt the</p>	F 225	<p>investigated and reported immediately.</p> <p>The QAA Committee will meet weekly beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved. All allegations of Abuse will be submitted to the QAA Committee by the Social Services Director and reviewed by the QAA Committee to determine that all allegations of abuse are investigated and reported immediately to the Administrator, Social Services Director, Director of Nursing and all regulatory reporting agencies.</p>	6/20/12	

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

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 225	<p>Continued From page 4</p> <p>resident's feelings. There were no other written statements included in the investigation. The Administrator's Report (included in the investigation), dated 04/28/12, revealed NASR #5 was suspended after the report was made to LPN #8. It further revealed Resident #5 was "extremely sensitive" about the progression of his/her ALS and the resident was noted to cry at various times about his/her loss of function. The Administrator interviewed three other residents in the facility with no complaints, and indicated that Resident #5 was very sensitive about ALS and his/her health, but there was no crying noted during the Administrator's interview with the resident. That concluded the investigation. There was no evidence the facility substantiated/unsubstantiated the incident.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM and 05/16/12 at 2:10 PM, revealed he/she was fed by staff due to a recent decline related to the disease process of ALS. The resident revealed it was going to get worse and he/she was discouraged with the loss of independence. The resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during the resident interview, on 05/15/12 at 4:15</p>	F 225			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 225	<p>Continued From page 5</p> <p>PM, revealed Resident #5 was visibly upset and crying while discussing the comment made by NASR #5, on 04/27/12.</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to LPN #8. After reporting, LPN #8 made a phone call in her office, so he went to lunch with CMT #3. He did not know when NASR #5 was removed from resident care.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the resident's allegation reported to CMT #2. She revealed CMT #2 left the resident's room to report the allegation to LPN #8. CMT #3 left the resident's room shortly after, and went to LPN #8's office. She went to lunch with CMT #2 after the report was made. She revealed NASR #5 had been preparing to give the resident a shower, but she "assumed" it was not given by her, as this was an allegation of verbal abuse. She did not know when NASR #5 was removed from care. A review of the Timecard Report for CMT #2 and CMT #3, dated 04/28/12, revealed both employees clocked out for lunch at 10:31 AM.</p> <p>An interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she gave Resident #5 a shower and provided incontinent care for another resident, on 04/28/12, prior to her suspension. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM, at least one hour and fifteen minutes after the allegation was reported to LPN #8.</p>	F 225		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	PRVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 6</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed she was the Administrative Licensed Nurse in the facility, on 04/28/12. The allegation of verbal abuse was reported to her by CMT #2. She revealed when she went to find NASR #5, she was giving a resident a shower. She stated that everyone on the floor was "busy", so she reported to the charge nurse to send NASR #5 to her office when she was finished with the resident's shower. She did not know which resident was in the shower room with NASR #5. She admitted she should have removed NASR #5 from resident care immediately, per the facility policy. LPN #8 revealed she did not conduct a thorough investigation. She did not document a statement from Resident #5. She also revealed she should have obtained statements from CMT #2 and CMT #3. She did not verify who was sitting at the table when the comment was made to the resident, and did not try to contact any of them. She stated it was "very busy" that morning.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed LPN #8 contacted her at home, on 04/28/12, to report the allegation. She revealed LPN #8 was instructed to gather statements from anyone around the area, any resident that could have heard the comment, and any residents cared for by NASR #5. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately. She stated she did not speak to Resident #5 about the allegation.</p> <p>An interview with the Social Services Director, on 05/17/12 at 9:10 AM and 3:00 PM, revealed she</p>	F 225			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 225	<p>Continued From page 7</p> <p>was the facility's abuse coordinator; however, she was not aware of the allegation made by Resident #5.</p> <p>An interview with the Administrator, on 05/14/12 at 4:00 PM and 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the resident was not upset about the comment; however, she admitted she did not question the resident about what happened. The Administrator revealed the investigation did not have enough information to determine the findings of the allegation; however, it was discussed in the Quality Assurance (QA) committee meeting, on 04/28/12, with no concerns. She revealed the Social Services Director was responsible for ensuring a thorough investigation, with assistance from the DON and Administrator. She revealed the allegation was not reported to the State Agency, as it did not qualify as verbal abuse. NASR #5 was terminated due to the "questionable" incident.</p> <p>An interview with the Corporate Compliance Nurse, on 05/17/12 at 5:00 PM, revealed he did review the investigation in the QA committee meeting, on 04/30/12. The allegation was unsubstantiated due to the statement by NASR #5; however, he admitted it was not a thorough investigation to determine the findings of the allegation. He could not recall if he recommended a more thorough investigation after review, on 04/30/12. He revealed the facility did not report the allegation because the allegation was unsubstantiated. He stated that any allegation of abuse would be reported to the State Agency; however, he did not feel this was verbal abuse.</p>	F 225			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2012	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 226 SS=G	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to implement written policies and procedures that prohibit abuse of residents for one resident (#5), in the selected sample of 19 residents. The facility failed to implement the investigation and Abuse policy/procedure as evidenced by the failure to protect Resident #5 after an allegation of verbal abuse. Resident #5 reported an allegation of verbal abuse to Certified Medication Technician (CMT) #2, witnessed by CMT #3 (refer to F241) on 04/28/12. While the CMTs notified the Administrative nurse, the facility continued to allow the alleged perpetrator, Nurse Aide State Registered (NASR) #5, to give direct care to other residents to include bathing the victim, prior to removing the perpetrator for over an hour after the allegation was made. On 05/15/12, eighteen (18) days after the incident, Resident #5 was observed crying while describing the incident stating it embarrassed him/her and made him/her feel bad. The facility's investigation was not thorough as all witnesses, staff nor the victim were interviewed.</p> <p>Findings include: A review of the facility's Abuse, Neglect, and</p>	F 226	<p>F 226 (G) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p><i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a witness to the reporting of Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 226. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to allegations of abuse.</p>				

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 226	<p>Continued From page 9</p> <p>Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM and 05/16/12 at 2:10 PM, revealed he/she had to be fed by the staff due to a recent decline related to the disease process of ALS. The resident revealed it was going to get worse and he/she was discouraged with the loss of independence. The resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during the resident interview, on 05/15/12 at 4:15 PM, revealed Resident #5 was visibly upset and crying while discussing the comment made by NASR #5, on 04/27/12.</p>	F 226	<p>Systemic Changes</p> <p>An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the revision of policies as they relate to the prevention of mistreatment, neglect and abuse. A newly revised Abuse Prohibition and Control Manual was developed and implemented on June 1, 2012. The QAA Committee approved the revised policies for Abuse Prohibition and Control on May 31, 2012.</p> <p>The Administrator conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse Prohibition and Control Manual policies that includes policies related to mistreatment, neglect, and abuse. A Post Test for employees was held on these same dates on the prevention of mistreatment, neglect, and abuse.</p> <p>Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns regarding the mistreatment, neglect, and abuse policies. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any</p>	

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

PRINTED: 08/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 226	<p>Continued From page 10</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 was in his/her room, on 04/28/12, visibly upset and crying. He revealed the resident expressed a complaint about having to get a shower so late in the morning. During conversation with Resident #5 while providing care, the resident stated "they probably would not listen because apparently he/she looked like a dog." He revealed upon discussion with the resident, it was reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to Licensed Practical Nurse (LPN) #8 and left for lunch.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the resident's allegation reported to CMT #2. She stated that NASR #5 was in the room, but left to get towels for the resident's shower. She revealed the resident stated that he/she did not like NASR #5 because of the comment made, on 04/27/12. She revealed CMT #2 left the room to report the allegation to LPN #8. After the report was made, she left for lunch with CMT #2. She revealed NASR #5 was preparing to give the resident a shower, but she "assumed" it was not given by her. She did not know when NASR #5 was removed from resident care.</p> <p>An interview with NASR #6, on 05/17/12 at 11:45 PM, revealed NASR #5 gave Resident #5 a shower, on 04/28/12, prior to her suspension.</p> <p>An interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she gave Resident #5 a shower and provided incontinent care for another resident, on 04/28/12, prior to her suspension. A review of the Timecard Report for CMT #2 and CMT #3, dated</p>	F 226	<p>concerns regarding mistreatment, neglect, and abuse policies.</p> <p><i>Monitoring</i> The Administrator will review all allegations of abuse with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that the developed and implemented policies to prevent mistreatment, neglect, and abuse are being followed.</p> <p>All allegations of mistreatment, neglect and abuse will be submitted to the QAA Committee by the Social Services Director and reviewed by the QAA Committee to determine that these allegations are being treated according to the policies of the facility</p> <p>The QAA Committee will meet weekly to address policies relating to the prevention of mistreatment, neglect and abuse beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved.</p>	6/20/12	

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 226	<p>Continued From page 11</p> <p>04/28/12, revealed both employaes clocked out for lunch at 10:31 AM. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM, at least one hour and fifteen minutes after the allegation was reported to LPN #8.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2 (right before he left for lunch). She revealed she went to find NASR #5; however, she was giving a resident a shower. She stated that everyone on the floor was "busy", so she reported to the charge nurse to send NASR #5 to her office when she was finished with the shower. She did not know which resident was in the shower room with NASR #5. She admitted she should have removed NASR #5 from resident care immediately, per the facility's policy.</p> <p>An interview with LPN #3, on 05/16/12 at 10:05 AM, revealed she was the charge nurse, on 04/28/12, and was aware of the allegatton made against NASR #5. She stated that LPN #8 asked her to send NASR #5 to her office after completing care for a resident in the shower room. She admitted she was making "rounds" and providing care for other residents; therefore, she was not monitoring the shower room to ensure NASR #5 went to see LPN #8. She revealed NASR #5 should have been sent home immediately, but LPN #8 was in charge as the Administrative Licensed Nurse on duty.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed she was not aware NASR #5 continued to provide care for the</p>	F 226			

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 428 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(X4) IO 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 226	Continued From page 12 resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately, removing her from care of any residents. An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was not aware NASR #5 provided care to Resident #5, prior to her suspension. She expected LPN #8 to find another caregiver to take over for NASR #5.	F 226	<u>F 241 (G) DIGNITY AND RESPECT OF INDIVIDUALITY</u> <i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #8 who is a Licensed Practical Nurse was educated on the facility Dignity policy and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 241. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on June 5-6, 2012 to solicit any concerns relating to care and treatment that includes dignity. <i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the Administrator in the guidance of policy as it relates to Dignity.	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that enhanced each resident's dignity and respect for one resident (#5), in the selected sample of 19 residents. The facility failed to follow the Dignity/Respect policy. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 allegedly made a comment that the resident was drinking his/her water similar to her "dog." Resident #5 reported the comment to the staff, on 04/28/12; however, NASR #5 was allowed to continue providing care for Resident #5. An interview with Resident #5, on 05/15/12 at 4:15 PM, revealed the resident did not want NASR #5	F 241		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 241	<p>Continued From page 13</p> <p>providing his/her care. The resident revealed the comment was embarrassing and made him/her "feel bad." Resident #5 was visibly upset and crying during the interview with the surveyor, 18 days after the incident.</p> <p>Findings include:</p> <p>A review of the facility's Dignity/Respect policy, revised 10/04/11, revealed appropriate measures would be taken to assure the residents were treated in a courteous and dignified manner. The staff would promote independence and dignity in dining.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12, revealed the facility identified the resident as cognitively intact and able to eat independently with tray setup. A review of the Activities of Daily Living (ADL) Tracking record, dated March 2012 and April 2012, revealed a decline in the resident's eating abilities, requiring extensive to total assistance for eating after 03/27/12.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM, and on 05/16/12 at 2:10 PM, revealed he/she required assistance to be fed due to a recent decline related to the disease process of ALS. The resident revealed things were going to get worse and he/she was discouraged with the loss of independence. The resident stated, on 04/27/12, NASR #5 was feeding him/her. NASR #5 made a comment that "I drank my water like</p>	F 241	<p>The facility Dignity Policy was revised on May 31, 2012 and approved by the QAA Committee on that date. The policy was implemented on June 1, 2012, and educated to all staff by the Administrator on June 1-6, 2012.</p> <p>A new policy on "How to Converse With Residents" was developed on May 31, 2012 and approved by the QAA Committee on that date. The policy was implemented on June 1, 2012, and educated to all staff by the Administrator on June 1-6, 2012.</p> <p>Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns related to dignity. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding dignity.</p> <p>Monitoring All concerns from any source regarding dignity will be submitted to the Social Services Director. The Administrator will review all dignity concerns with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that the developed and implemented dignity policies are being followed.</p>	

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 241	<p>Continued From page 14</p> <p>her dog." The resident revealed the comment made by the NASR made him/her feel bad and was embarrassing, because there were other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident revealed he/she did not want NASR #5 to provide his/her care. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower. An observation during e resident interview, on 05/15/12 at 4:15 PM, revealed Resident #5 was visibly upset and crying while discussing a comment made by NASR #5, on 04/27/12, 18 days after the incident.</p> <p>An interview with CMT #2, on 05/16/12 at 9:32 AM, revealed Resident #5 was in his/her room, on 04/28/12, visibly upset and crying. He revealed the resident expressed a complaint about having to get a shower so late in the morning. He revealed the resident wanted to get up at 9:00 AM, and it was almost 11:00 AM. CMT #2 told the resident he would report it to the charge nurse; however, the resident stated "they probably would not listen because apparently he/she looked like a dog." He revealed upon discussion with the resident, it was reported that NASR #5 made the comment about the resident drinking water like her "dog." He reported the comment to Licensed Practical Nurse (LPN) #8.</p> <p>An interview with CMT #3, on 05/16/12 at 10:35 AM, revealed she was a witness to the allegation reported to CMT #2. She revealed the resident was upset and crying when she went into the room. She stated that NASR #5 was in the room, but left to get towels for the resident's shower. She revealed the resident stated that he/she did</p>	F 241	<p>The Administrator and Social Services Director will submit all dignity concerns to the QAA Committee.</p> <p>The QAA Committee will meet weekly to address policies relating to the prevention of mistreatment, neglect and abuse beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved.</p>	6/20/12	

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 241	<p>Continued From page 15</p> <p>not like NASR #5 because of the comment made, on 04/27/12. She revealed NASR #5 was preparing to give the resident a shower, but she "assumed" it was not given by her, as this was an allegation of verbal abuse.</p> <p>An interview with NASR #6, on 05/17/12 at 11:45 PM, revealed NASR #5 gave Resident #5 a shower, on 04/28/12. She revealed NASR #5 needed assistance with the resident after the shower, but she and another NASR took over while NASR #5 went to assist another resident. She revealed the resident began talking about the comment made by NASR #5 and appeared to be upset.</p> <p>An interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she was feeding Resident #5 in the dining room, on 04/27/12, and they were talking about her "puppy." She revealed the resident nodded his/her head to drink and the comment was made "that was how my puppy nods its head." NASR #5 admitted she gave the resident a shower, on 04/28/12, prior to her suspension.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, on 05/16/12 at 2:35 PM, and on 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2. She revealed she went to find NASR #5; however, she was giving a resident a shower. She stated that everyone on the floor was "busy", so she reported to the charge nurse to send NASR #5 to her office when she was finished with the resident's shower. She did not know which resident was in the shower room with NASR #5. LPN #8 revealed when questioning Resident #5 about the allegation, the resident was quiet and had "one tear" roll down</p>	F 241		

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

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	PROMOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 16 his/her face. An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed she did not speak to Resident #5 about the allegation. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. An interview with the Social Services Director, on 05/17/12 at 9:10 AM and 3:00 PM, revealed she was not aware of the allegation made by Resident #5. She revealed she spoke to the resident about his/her diagnosis of ALS and to see if there was any depression; however, she was not asked to speak to the resident about an allegation of abuse. She revealed she did not recall the discussion about the allegation in the QA meeting, held on 04/30/12. An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the resident was not upset about the comment; however, she admitted she did not question the resident about what happened or ask the resident how the comment made him/her feel.	F 241	F 281 (E) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS <i>Residents Found to Have Been Affected</i> Resident #7, #8, #11, #13, #20 and #22 are receiving medications as ordered by the physician. Resident #8, #11, and #20 are receiving their oxygen as ordered by the physician. On June 6, 2012 Licensed Practical Nurse #7 has been re-educated and counseled. <i>Identification of Other Residents with the Potential to be Affected</i> On June 10, 2012 a review of all medication orders and oxygen orders was completed for all residents to assure that they are receiving care according to physician orders. <i>Systemic Changes</i> On June 6, 7, 8, 10, 11, and 12, 2012 the Quality Assurance Nurse (RN) and Medical Records Director (LPN) inserviced all Certified Medication Technicians and Licensed Nurses on the Medication Administration policies and administered a Post Test after each education. All personnel receiving this education received 100% on their Post Test. This inservice included administering medication	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 281		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 281	<p>Continued From page 17</p> <p>and review of the facility's policy and procedure, it was determined the facility failed to ensure four (4) residents (#7, #8, #11, and #13), in the selected sample of 19 residents, and two (2) residents, (#20 and #22), not in the selected sample, received their medications in accordance with the physician's orders. Resident #7 was ordered Niacin 500 milligram (mg) to be given with food at 5:00 PM. An observation revealed Resident #7's medication was administered without food at 2:51 PM. For Resident #11, Oxygen (O2) was ordered at 4 Liters/minute continuously and observations revealed the resident was without his/her continuous O2. Resident #13 was ordered Metformin HCL 1000 mg with meals at 5:00 PM, and an observation revealed the medication was administered at 2:57 PM without food. Resident #22 was ordered Aricept 5 mg and Namenda 5 mg at 5:00 PM, and an observation revealed the medication was administered at 3:00 PM. Resident #20 was observed on 05/15/12, 05/16/12 and 05/17/12 with O2 at three liters per minute. The physician's order was for four liters per minute. Resident #8 was observed on 05/15/12 with O2 at two liters per minute, on 05/16/12 with O2 at two liters per minute, and on 05/17/12 with O2 at one and a half liters per minute. The physician's order was for O2 at two and a half liters per minute.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, "Medication Pass," dated 05/10/11, revealed the facility adheres to Nursing Standards for medication passes. Begin medication pass on time. It is permissible to give the medication one</p>	F 281	<p>per the physician orders that includes the time ordered.</p> <p>Beginning on June 1, 2012 medication administration skill validations will continue until all licensed nurses and medication technicians have been observed. Observations will be completed by the Medical Records Director, Director of Nursing, Unit Managers and Quality Assurance Nurse. These observations are completed on each shift daily for thirty days and compliance is sustained.</p> <p>Beginning on June 10, 2012 administration of oxygen observations will be completed and will continue until all licensed nurses have been observed. These observations insure that oxygen is administered per the physician order. Observations will be completed by the Medical Records Director, Director of Nursing, Unit Managers and Quality Assurance Nurse. These observations are completed on each shift daily for thirty days and compliance is sustained.</p> <p>Monitoring All reviews of medication administration and oxygen administration completed by the Quality Assurance Nurse and the</p>	

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 281	<p>Continued From page 18</p> <p>hour before it was ordered and up to one hour after it was ordered. (Excluding medicine dependent on food or other specific factors.)</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 7:23 PM, revealed the facility adhered to the standard of practice established by the American Medical Directors Association (AMDA) and Med-Pass, Inc. The DON was unable to provide evidence of the established practice guidelines by the AMDA.</p> <p>A review of the facility's policy and procedure, "Administering Oral Medications," dated 2001, revised September 2003, revealed the purpose of this procedure is to provide guidelines for the safe administration of oral medications. Always verify the "5 Rights" before administering medications: the right medication, the right dose, the right resident, the right route, and the right time. Administer medications within one (1) hour before or after their scheduled time.</p> <p>1. A record review revealed the facility admitted Resident #7 on 03/28/12 with diagnoses to include Acute Respiratory Failure, Diabetes Mellitus Type II, Hypertension, Chronic Kidney Disease and Depressive Disorder.</p> <p>Observation of a medication pass, on 05/16/12 at 2:51 PM, revealed Licensed Practical Nurse (LPN) #7 administered Niacin 500 milligrams (mg) capsule (medication to reduce the cholesterol and fatty substances in the blood) to Resident #7. Review of the physician's order, dated May 2012, and the Medication Administration Record (MAR), dated May 2012, revealed the medication should have been</p>	F 281	<p>Medical Records Director will be submitted to the Quality Assurance and Assessment team for recommendations and follow up.</p>	6/22/12

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 19</p> <p>administered at 5:00 PM and with the supper meal.</p> <p>2. A record review revealed the facility admitted Resident #13 on 07/08/11, and readmitted on 01/25/12, with diagnoses to include Glaucoma, Peripheral Vascular Disease (PVD), Hypertension, and Diabetes Mellitus Type II.</p> <p>Observation of a medication pass, on 05/16/12 at 2:57 PM, revealed LPN #7 administered Metformin HCL 1000 mg tablet with 30 milliliters (ml) of water. A review of the physician's order, dated May 2012, revealed an order for Metformin HCL 1000 mg tablet three times daily with meals for Diabetes.</p> <p>3. A record review revealed the facility admitted Resident #22 on 01/25/12 with diagnoses to include Psychosis, Chronic Kidney Disease, Hypertension, and Senile Dementia.</p> <p>Observation of a medication pass, on 05/16/12 at 3:00 PM, revealed LPN #7 administered Namenda 5 mg tablet and Aricept 5 mg table with 60 ml of water. A review of the physician's order, dated May 2012, revealed an order for Aricept 5 mg tablet once daily every day and Namenda 5 mg tablet twice daily with meals.</p> <p>An interview with LPN #7, on 05/16/12 at 3:25 PM, revealed she was instructed to "give up to the 5:00 PM medications" as soon as she could, because she was needed to assist with feeding in the dining room at supper. She revealed she could not recall who told her to pass medications in that manner. LPN #7 revealed she had one hour before or one hour after the scheduled time</p>	F 281			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORO 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	
F 281	<p>Continued From page 20</p> <p>to administer the medications, and realized she was administering medications too early; however, she stated she had to get the medications completed in order to assist with feeding the residents in the dining room. She revealed she administered the medications in that manner for a couple of months, and the medications were not being administered according to the physician's orders.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 7:23 PM, revealed the time frame for giving medications was an hour before or after the scheduled time for administration. Each hall had a set time for their medications. The earliest a nurse could administer scheduled 6:00 PM medications would be 5:00 PM. The medications could not be given before that time and the staff were expected to administer the medications as ordered by the physician.</p> <p>4. A review of the facility's policy and procedure for "Oxygen," dated 12/13/11, revealed the purpose of O2 is to supplement O2 supply when insufficient O2 is being carried by the blood to the tissues. The procedure is to check the physician's order for O2 liter flow and method of administration. The physician's order should include continuous or as needed (PRN) use.</p> <p>A record review revealed the facility admitted Resident #8 on 09/22/10 with diagnoses to include Dysphagia, Muscle Weakness, Dementia, Persistent Mental Disorder, Effusion of Lower Leg Joint, Adhesive Capsulitis of Shoulder and Urine Retention.</p> <p>A review of the resident's care plan, "Impaired</p>	F 281			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431		
(X4) IO 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 281	<p>Continued From page 21</p> <p>Gas Exchange,"dated 05/04/12, and last reviewed on 05/04/12, revealed O2 was to be administered at two and a half liters per minute.</p> <p>A review of a quarterly MDS assessment, dated 05/07/12, revealed the facility assessed Resident #8 as non-ambulatory and required extensive assistance with all activities of daily living.</p> <p>A review of a physician's order, dated 05/12, revealed the resident was to have O2 at two and a half liters per minute per nasal cannula continuously to keep O2 saturations above 92%.</p> <p>Observations, on 05/15/12 at 10:25 AM, 3:15 PM and 5:25 PM, revealed the resident had O2 per nasal cannula at two liters per minute.</p> <p>Observations, on 05/16/12 at 8:30 AM and 11:00 AM, revealed the resident was receiving O2 at two liters per minute. Observations, on 05/17/12 at 9:30 AM, 10:30 AM and 11:00 AM, revealed the resident with O2 per nasal cannula at one and a half liters per minute instead of the prescribed two and a half liters per minute.</p> <p>An interview with the DON, on 05/17/12 at 7:30 PM, revealed Resident #8 should have O2 at two and a half liters continuously according to the physician's order, and the nurses were ultimately responsible to ensure O2 was being administered according to the physician's order.</p> <p>5. A record review revealed the facility admitted Resident #11 on 12/15/11 with diagnoses to include Unspecified Heart Failure, Pneumonia, Organism Unspecified, and Acute Respiratory Failure.</p>	F 281			

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 281	<p>Continued From page 22</p> <p>A review of the quarterly MDS assessment, dated 03/01/12, revealed the facility assessed Resident #11 to be alert and oriented to person, place and time, independent with supervision, and required limited assistance with activities of daily living.</p> <p>A review of the Comprehensive Care Plan, dated 03/08/12, revealed an intervention for administration of O2 as ordered.</p> <p>A review of the physician's order, dated May 2012, revealed "O2 at four liters per nasal cannula continuous to maintain saturation. Check O2 saturation every shift every day and every night." A review of the Medication Administration Record (MAR), dated May 2012, revealed scheduled times of 6 AM - 6 PM and 6 PM - 6 AM.</p> <p>A review of the MAR, dated May 2012, revealed "O2 at four liters per nasal cannula continuous to maintain saturation, check O2 saturation every shift." Nursing staff initialed 05/01/12 thru 05/16/12 in the 6 AM - 6 PM and the 6 PM - 6 AM column that the resident had O2 at four liters per nasal cannula continuously to maintain O2 saturation.</p> <p>Observation, on 05/15/12 at 10:25 AM, revealed Resident #11 with O2 in use per nasal cannula, and the O2 concentrator was set on four liters per minute. Resident #11 stated "I can turn my oxygen on and off as needed."</p> <p>Observations, on 05/15/12 at 3:05 PM and 5:20 PM, on 05/16/12 at 9:25 AM and 12:35 PM, on 05/17/12 at 9:30 AM, 1:00 PM, 1:11 PM, 2:20 PM and 3:10 PM, revealed Resident #11 without</p>	F 281		

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 428 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
F 281	<p>Continued From page 23</p> <p>his/her O2 in use.</p> <p>An interview with Resident #11, on 05/16/12 at 12:35 PM, revealed "I use my oxygen all night, but during the day it's on and off." Further interview with Resident #11, on 05/17/12 at 4:00 PM, revealed "I got short of breath, I've been up walking around, and put it on. I use it part of the time and at night. They check my level once in the morning and night, they showed me how to turn it on and off. The nurses showed me, I know how to do it."</p> <p>An interview with the DON, on 05/17/12 at 7:30 PM, revealed Resident #11 should have O2 at four liters continuously according to the physician's order.</p> <p>6. A record review revealed the facility admitted Resident #20 on 09/24/09 with diagnoses to include Other Chronic Pulmonary Heart Disease, Late Effect Cerebrovascular Disease, Heart Failure, and Hypertension.</p> <p>A review of the comprehensive care plan, dated 04/02/12 revealed an intervention for administration of O2 as ordered.</p> <p>A review of the physician's order, dated May 2012, revealed "O2 at two liters per nasal cannula to maintain O2 saturation greater than 90%, check O2 saturation every shift each day and each night."</p> <p>Observation, on 05/15/12 at 10:27 AM, revealed Resident #20 with O2 in use per nasal cannula at three and a half liters per minute. Observation, on 05/16/12 at 3:50 PM and on 05/17/12 at 1:02</p>	F 281		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2012
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	
F 281	Continued From page 24 PM, revealed Resident #20 with O2 in use per nasal cannula at three liters per minute.	F 281	<p><u>F 282 (G) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p><i>Residents Found to Have Been Affected</i> Resident #1 was sent to the hospital for evaluation on March 29, 2012. The Certified Nursing Assistant was terminated on March 29, 2012.</p> <p>The Treatment Nurse completed a skin assessment for Resident #8 on May 15, 2012 and with no new areas identified.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 282. See Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p> <p><i>Systemic Changes</i> On June 5 through 19, 2012 all nursing assistants, medication technicians and licensed nurses have been educated on following resident care plans to include transfers and bed mobility. This training was provided by the Director of Nursing, Quality Assurance Nurse, Admissions Director (LPN), and Medical Records Director (LPN).</p>		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure two residents (#1 and #8), in the selected sample of 19 residents, were provided care in accordance with the plan of care. Resident #1 was care planned to have two staff for transfers. On 03/29/12, Nurse Aide (NA) #1 assisted Resident #1 to transfer from the toilet to the wheelchair alone. The resident fell which resulted in a laceration to his/her left eyebrow and abrasions to the resident's bilateral knees. Resident #1 was transferred to the local hospital and diagnosed with a small subdural hematoma. The resident was readmitted to the facility on 03/30/12. (Refer to F323) Resident #8 was care planned to be turned and repositioned every hour; however, observations, on 05/17/12 from 8:40 AM through 11:00 AM,	F 282			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 282	<p>Continued From page 25</p> <p>revealed the resident remained in the same position in bed without repositioning.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, "Nurse Aide Care Plan," dated 02/10/10, revealed the purpose of the form was to document how each resident's daily care needs were provided by the nursing staff as outlined in the Comprehensive Care Plan in accordance with guidelines of RAI process and in keeping with the Commonwealth of Kentucky Department of Medicaid Services Documentation Guidelines.</p> <p>1. A record review revealed the facility admitted Resident #1 on 09/04/09 with diagnoses to include Depressive Disorder, Osteoporosis, Hypertension, Generalized Muscle Weakness and Abnormality of Gait.</p> <p>A review of the comprehensive care plan, dated 01/11/12, for "Self Care Deficit related to required assistance with activities of daily living (ADLs) due to impaired cognition" revealed an intervention to "transfer with assistance of two and a gait belt."</p> <p>A review of the Fall Assessment Screening Tool (FAST), dated 02/20/12, revealed the resident was assessed as a high falls risk with a score of "95."</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 02/24/12, revealed the facility had assessed Resident #1 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of "5." The resident was assessed</p>	F 282	<p>Beginning June 12, 2012 an audit of each resident's Comprehensive Care Plan and the nursing assistant care plan was completed and compared to the direct observation of care delivery by the MDS/Care Planning Nurses.</p> <p><i>Monitoring</i> Care Plan rounds will be conducted daily by the Medical Records Director, Director of Nursing, Unit Managers and Quality Assurance Nurse to ensure resident care is provided in accordance with the Plan of Care. The care plan rounds will use the nursing assistant care plan that is based on the Comprehensive Care Plan to see that care is provided per the care plan.</p>	6/22/12	

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

PRINTED: 06/18/2012
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 _____ D. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 282	<p>Continued From page 26</p> <p>as requiring extensive assistance of two staff for transfers and totally dependent on two staff for toileting.</p> <p>A review of the Nurse Aide Care Plan, dated May 2012, revealed the resident required the assistance of two staff for toileting and the assistance of two staff plus a gait belt for transfers.</p> <p>A phone interview with NA #1, on 05/17/12 at 9:52 AM, revealed she assisted the resident to the bathroom and transferred him/her from the toilet to the wheelchair alone. She assisted Resident #1 to stand up, and he/she started shuffling his/her feet. The resident tripped over the aide's foot as they were trying to move back to the wheelchair. Resident #1 fell to the floor and hit his/her head as he/she fell to the floor. Resident #1 sustained a cut above his/her eye. She was unaware the resident was care planned for the assistance of two staff for transfers. She revealed the aides arrived to the facility 15 minutes prior to their shift to do a walking round and get a report from the previous shift's aides. There was no time to review the resident's care plan, but they were suppose to review the care plans before the shift started. NA #1 revealed she had not reviewed Resident #1's care plan before she transferred the resident.</p> <p>A phone interview with Registered Nurse (RN) #5, on 05/17/12 at 2:22 PM, revealed the resident was sitting up in the wheelchair when she walked in. She questioned the aide how the injuries occurred and the aide reported she transferred the resident alone. The aide reported the resident tripped over her foot and they went down</p>	F 282			

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 27</p> <p>to the floor together. The chair tilted over and bumped the resident's head. Later during the day, RN #5 educated the aide about lifting the resident, the use of the gait belt, and review of the care plan book to know many staff it required to assist the resident. RN #5 revealed she explained to the aide if she was unsure about how a resident was to be transferred, then she should not transfer him/her alone. The aides should review the care plans daily prior to the start of the shift. She was unaware if the aide reviewed Resident #1's care plan prior to provision of care.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 1:23 PM revealed she was notified about Resident #1's fall approximately 10 minutes after it occurred. She questioned RN #5 about who was involved and what happened. She was informed by RN #5 that the aide had transferred the resident alone in the bathroom, and the resident's feet got tangled up with the staff's feet, which resulted in the resident's fall and hitting his/her head. RN #5 checked the care plan and stated the resident was care planned for the assistance of two staff with transfers. The incident was investigated and NA #1 was sent home that day. The likelihood of the resident's fall would be less if there had been the right amount of people for the transfer. The staff were expected to read the care plans of the residents daily prior to starting their assignment. NA #1 was later terminated because it was determined she transferred the resident with the assistance of one and did not follow the resident's care plan.</p> <p>2. A record review revealed the facility admitted Resident #8 on 09/22/10 with diagnoses to</p>	F 282		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 282	<p>Continued From page 28</p> <p>Include Dysphagia, Muscle Weakness, Dementia, Persistent Mental Disorder, Effusion of Lower Leg Joint, Adhesive Capsulitis of Shoulder and Urine Retention.</p> <p>Observations, on 05/17/12 at 8:40 AM, 9:30 AM, 10:30 AM and 11:00 AM, revealed Resident #8 was in bed on his/her back with the head of the bed slightly raised. The resident's position in the bed remained unchanged during the observations.</p> <p>A review of the resident's comprehensive care plan, "At Risk for Skin Integrity" revealed an intervention, dated 03/26/12, for the resident to be turned and repositioned hourly.</p> <p>A review of a quarterly MDS assessment, dated 05/09/12, revealed the facility assessed Resident #8 as non-ambulatory and required extensive assistance with all activities of daily living and was assessed as high risk for pressure sores and required two staff for turning and repositioning.</p> <p>A review of the Nurse Alda Care Plan, dated 05/12, revealed turning and repositioning was to be provided by two staff and the resident was to be turned and repositioned every hour.</p> <p>An interview with CNA #1, on 05/17/12 at 11:30 AM, revealed she was responsible for Resident #8's care and was aware the resident needed to be turned and repositioned every hour due to fragile skin. CNA #1 stated she did not turn and reposition Resident #8 every hour because she had a hard time getting someone to assist her. CNA #1 did not inform the nurse she needed assistance with repositioning the resident hourly.</p>	F 282			

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 282	Continued From page 29	F 282	<u>F 315 (D) NO CATHETER, PREVENT UTI, RESTORE BLADDER</u>		
F 315 SS=D	<p>An interview with the DON, on 05/17/12 at 11:50 AM, revealed Resident #8 was to be turned hourly due to his/her fragile skin. The CNA was responsible to provide care according to the care plan and the nurse was ultimately responsible to ensure that it was completed.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one resident (#8), in the selected sample of 19 residents, was provided appropriate care and treatment related to an indwelling catheter. Observation on 05/17/12 revealed the resident's indwelling catheter was not properly secured to prevent accidental trauma to the resident's bladder.</p> <p>Findings include: A review of the facility's policy and procedure,</p>	F 315	<p><i>Residents Found to Have Been Affected</i> On May 17, 2012 the Director of Nursing coiled and secured the catheter tubing of Resident #8.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents with physician orders for a catheter have the potential to be affected by F 315. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p> <p><i>Systemic Changes</i> On June 6, 2012, the Quality Assurance Nurse completed a 100 per cent review of all residents with catheters to ensure that tubing was secured and coiled properly.</p> <p>On June 7, 2012 and inservice was held for all nursing staff regarding the procedures for proper catheter care to include catheter tubing.</p> <p>On June 12, 2012 daily reviews of catheter tubing will be conducted by the charge nurse and will continue until compliance is sustained. Results of these reviews will be submitted to the Quality</p>		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 315	<p>Continued From page 30</p> <p>"Foley Catheter Care," dated and revised 06/28/11, revealed procedure #8 as: "Make sure the catheter is secured properly. Coil and secure the tubing."</p> <p>A record review revealed the facility admitted Resident #8 on 09/22/10 with diagnoses to include Dysphagia, Muscle Weakness, Dementia, Persistent Mental Disorder, Effusion of Lower Leg Joint, Adhesive Capsulitis of Shoulder and Urine Retention.</p> <p>Observation of Resident #8, on 05/17/12 at 9:00 AM, during a skin assessment completed by Registered Nurse (RN) #4, revealed an indwelling catheter with the tubing draped across the resident's left leg and attached to a bedside drainage bag. The tubing was not secured to prevent trauma from accidental pulling against the resident's bladder.</p> <p>Observation, on 05/17/12 at 9:25 AM, during catheter care for Resident #8 revealed the indwelling catheter tubing was not secured to prevent trauma from accidental pulling against the resident's bladder. Certified Nurse Aide (CNA) #1, who was providing the catheter care, revealed she was not aware the catheter tubing was to be anchored.</p> <p>An interview with Licensed Practical Nurse (LPN) #8, on 05/17/12 at 8:30 PM, revealed leg straps with Velcro closures were available in central supply to secure catheter tubing to prevent accidental trauma to the bladder. Additionally, LPN #8 revealed all catheter tubing should be anchored to prevent trauma.</p>	F 315	<p>Assurance Nurse submitted daily to ensure catheters are properly secured.</p> <p><i>Monitoring</i> The Quality Assurance Nurse will review the results of the catheter tubing reviews at the daily CQI Meetings for recommendations and follow-up.</p>	6/22/12	

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 315	Continued From page 31 An interview with the Director of Nursing (DON), on 05/17/12 at 8:45 PM, revealed she expected the staff to ensure indwelling catheter tubing was properly anchored to prevent any accidental trauma to a resident's bladder, and the nurse was ultimately responsible.	F 315	<u>F 323 (G) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u> <i>Residents Found to Have Been Affected</i> Resident #1 was sent to the hospital for evaluation on March 29, 2012. The Certified Nursing Assistant was terminated on March 29, 2012. On May 16, 2012 the oxygen saturation rate of Resident #4 was checked upon return to the facility with a 98% saturation rate. On May 16, 2012 resident #8 was educated on the importance of complying with the diet by the Director of Nursing. On May 16, 2012 a telephonic care plan meeting was held by the Interdisciplinary Team with the POA for the resident. The POA was advised of the risks associated with supplying foods to the resident that is not allowed on a prescribed mechanical soft diet. The POA stated that they would not bring food to the resident not allowed on the resident's diet. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 323 regarding accident hazards and supervision. Systemic and Monitoring actions		
F 323 SS=G	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, and record review, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents and failed to ensure the residents' environment remained as free from accident hazards as is possible for three residents (#1, #4, and #8), in the selected sample of 19 residents. Resident #1 was care planned to have two staff for transfers. On 03/29/12, Nurse Aide (NA) #1 assisted Resident #1 to transfer from the toilet to the wheelchair alone. The resident fell which resulted in a laceration to his/her left eyebrow and abrasions to the resident's bilateral knees. Resident #1 was transferred to the local hospital and diagnosed with a small subdural hematoma. The resident was readmitted to the facility on 03/30/12.	F 323			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 323	<p>Continued From page 32</p> <p>Resident #4, who required constant oxygen (O2) therapy, was transported to a physician's appointment outside the facility without staff escort. The facility failed to ensure there was enough O2 to maintain the resident throughout the physician's appointment as well as the return trip back to the facility.</p> <p>Resident #8, who was prescribed a mechanical soft diet, was observed in bed on multiple occasions eating popcorn and peanuts.</p> <p>Findings include:</p> <p>1. A review of the policy entitled "Fall Prevention Policy" revised 10/21/10 revealed they identify residents at risk for falls and implement a fall prevention approach to reduce the risk of falls and possible injury. The Fall Prevention Approach is incorporated with the facility's Quality Improvement and Safety Committees. Every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, interventions and approaches for every resident who is identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment. Direct Care Providers will be instructed regarding approaches and goals for the management of the resident falls risk.</p> <p>A record review revealed the facility admitted Resident #1 on 09/04/09 with diagnoses to include Depressive Disorder, Osteoporosis, Hypertension, Generalized Muscle Weakness and Abnormality of Gait.</p>	F 323	<p>listed below will include all residents who have the potential to be affected.</p> <p>Systemic Changes On June 12, 13, 16, and 17, 2012 all nursing assistants, medication technicians and licensed nurses have been educated on following resident care plans to include transfers and bed mobility and diet orders.</p> <p>On June 5 through 19, 2012 all nursing assistants, medication technicians and licensed nurses have been educated on following resident care plans to include transfers, bed mobility and diet orders. This training was provided by the Director of Nursing, Quality Assurance Nurse, Admissions Director (LPN), and Medical Records Director (LPN).</p> <p>On June 12, 2012 the Interdisciplinary Team reviewed the policy and procedure on resident transfers. A new tool was developed to ensure appropriate resident condition on transfer. This new <i>Resident Condition on Transfer</i> tool was inserviced to the staff beginning June 13, 2012.</p> <p>Monitoring The Interdisciplinary Team will monitor the care plans and the</p>		

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 323	<p>Continued From page 33</p> <p>A review of the comprehensive care plan, dated 01/11/12, for "Self Care Deficit related to requires assistance with activities of daily living (ADLs) due to impaired cognition," revealed an intervention which stated "transfer with assistance of two and a gait belt."</p> <p>A review of the Fall Assessment Screening Tool (FAST), dated 02/20/12, revealed the resident was assessed as high falls risk with a score of "95."</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 02/24/12, revealed the facility assessed Resident #1 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of "5." The resident was assessed to require extensive assistance of two staff for transfers and totally dependent on two staff for toileting.</p> <p>A review of the nurse's notes, dated 03/29/12 at 7:15 AM, revealed documentation by Registered Nurse (RN) #5 which revealed an aide called for assistance and RN #5 entered the bathroom to find the resident sitting up in the wheelchair. NA #1 stated the resident fell and she assisted the resident onto the floor. The resident hit his/her head in the process and the resident had a laceration on his/her left brow and lateral eye, and abrasions to his/her bilateral knees. The resident complained of a headache and dizziness with no nodules noted on his/her head. He/she complained of blurred vision. Vitals signs were checked and an ice pack was applied to his/her left eye. Steri-strips were applied to his/her lateral left eye, a band-aid was applied to the left</p>	F 323	<p>Resident condition on Transfer tools at their daily meeting. The results of this monitoring will be submitted to the Quality Assurance Committee for recommendations and follow-up.</p>	6/22/12

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 323	<p>Continued From page 34</p> <p>brow and bilateral knees. The physician was notified with orders received to send the resident to the hospital for an evaluation. The family was notified about the resident's condition and he/she was to be sent to the emergency room for an evaluation.</p> <p>A review of the history and physical, from an acute care hospital, dated 03/29/12, revealed the resident sustained a small subdural hematoma. The resident was referred to a neuro surgeon and assessed, on 03/30/12, with no neurosurgical intervention indicated. Resident #1 was readmitted to the facility later on 03/30/12.</p> <p>A review of the Nurse Aide Care Plan, dated May 2012, revealed the resident required the assistance of two staff for toileting and the assistance of two staff plus a gait belt for transfers.</p> <p>An interview with NA #1, on 05/17/12 at 9:52 AM, revealed at the time of the incident she was not certified. She had assisted the resident to the bathroom and transferred him/her from the wheelchair to the toilet alone. The resident was on the toilet and she noticed the colostomy bag needed changing. The aide called for assistance. Nobody came and the resident was swaying like he/she was unbalanced on the toilet. Resident #1 was assisted to stand up, and he/she started shuffling his/her feet and he/she tripped over the aide's foot as they were trying to move back to the wheelchair. NA #1 moved in front of the resident to keep him/her from falling and they both fell to the floor. Resident #1 hit his/her head as he/she fell to the floor. The resident hit his/her head on the aide's shoulder as well as the wall,</p>	F 323			

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

PRINTED: 05/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 323	<p>Continued From page 35</p> <p>and the resident sustained a cut above his/her eye. They were on the floor and she called for assistance a second time for approximately 15 minutes. No other staff came to assist the resident or the staff. NA #1 wiggled out from under the resident and she saw the resident was bleeding from the above and beneath his/her eye. She continued to call out for assistance and picked the resident up from the floor and sat him/her in the wheelchair. The nurse finally came in the room and asked what happened. NA #1 explained and showed the nurse what happened. The nurse examined the resident and he/she was sent out to the emergency room for an evaluation later. NA #1 reported she did not know the resident was care planned for the assistance of two staff for transfers. She stated the aides arrived to the facility 15 minutes before shift to do a walking round and get report from the previous shift. There was no time to look at the resident's care plan, but they were suppose to look at the care plans before their shift started. She had not reviewed Resident #1's care plan prior to transferring the resident.</p> <p>An interview with RN #5, on 05/17/12 at 2:22 PM, revealed the resident was sitting up in the wheelchair when she arrived to the room. She checked the resident over and there was an injury above his/her brow, on the side of his/her eye and abrasions on his/her knees. She questioned the aide about the injuries, and the aide reported she transferred the resident alone. The aide stated the resident tripped over her foot and they went down to the floor together. The chair tilted over and bumped the resident's head. Later, during the day she educated the aide about lifting the resident, use of the gait belt, and reviewing the</p>	F 323			

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 323	<p>Continued From page 36</p> <p>care plan book to know how many staff it took to assist the resident.</p> <p>An interview with the DON, on 05/17/12 at 1:23 PM, revealed RN #5 notified her by phone about Resident #1's fall approximately 10 minutes after it happened. She questioned RN #5 about who was involved and what happened. She was informed the aide transferred the resident alone in the bathroom and the resident's feet got tangled up with the staff's feet which resulted in the resident's fall and hitting his/her head. RN #5 checked the care plan and reported the resident was care planned for the assistance of two staff with transfers. The incident was investigated and NA #1 was sent home that day. The likelihood of the resident's fall would be less if there were the right amount of people for the transfer. The staff were expected to read the care plans of the residents daily prior to the start of their shift. The aide was later terminated because it was determined she transferred the resident with the assistance of one, and did not follow the resident's care plan.</p> <p>2. On 05/17/12 at 1:00 PM, the Director of Nursing (DON) and the ADON provided a facility policy for Transporting Patients with Oxygen Out of the Facility. The DON revealed the policy was created, on 05/17/12, with direction from the facility's O2 therapy vendor representative.</p> <p>A record review revealed the facility admitted Resident #4 on 10/18/10, and re-admitted on 02/21/12, with diagnoses to include Chronic Obstructive Pulmonary Disease, Heart Failure, Gastrointestinal Hemorrhage, Leukocytosis, and</p>	F 323			

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 323	<p>Continued From page 37</p> <p>Generalized Muscle Weakness.</p> <p>A review of the physician's order, dated 04/15/11, revealed "oxygen (O2) therapy to be delivered at 5 liters per minute."</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 04/12/12, revealed a Brief Interview for Mental Status (BIMS) score of 15 and the Resident Mood Interview (PHQ-9) score of 4.</p> <p>A review of the nurse's notes, dated 05/16/12 at 2:10 PM, revealed an O2 saturation level of 97% on 5 liters of O2 per nasal canula.</p> <p>An observation, on 05/16/12 at 10:50 AM, revealed Resident #4 was not in his/her room. Upon questioning RN #2, she stated Resident #4 was transported to a physician's appointment by the local public transportation system. It was reported to RN #2, that an observation and an attempted interview by the surveyor at 9:30 AM, revealed the resident demonstrated confusion and the inability to answer questions. RN #2 stated the resident was very hard of hearing and questions should be asked by writing it down on paper to get a better response.</p> <p>Interview with CNA #2, on 05/17/12 at 1:45 PM, revealed that prior to the resident's transfer to a physician's appointment on 05/16/12, she observed LPN #2 place an O2 tank in the pouch attached to the wheelchair, connect the oxygen delivery tubing, set the regulator to match the number on the bedside concentrator, and then left the room. CNA #2 stated the resident returned to the facility at the end of the lunch pass, and she did not see anyone check the O2 tank</p>	F 323			

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 323	<p>Continued From page 38 setting.</p> <p>An interview with LPN #2, on 05/17/12 at 2:35 PM, revealed, on 05/16/12, Resident #4 was prepared for a physician's office visit outside the facility by the CNA staff and she got a full O2 tank and secured it to the back of the wheelchair. LPN #2 stated she tested the O2 tank by turning on the tank to the continuous delivery setting of 5 liters, and then turned the regulator back to zero (0) as the CNAs had not transferred Resident #4 into the wheelchair. LPN #2 immediately left the room and was unsure who set the regulator at 5 liters when the resident was in the wheelchair and ready to leave the building. She stated the charge nurse was responsible for documentation in the nurse's notes when a resident left and returned to the facility. LPN #2 stated she was at the nurse's station when Resident #4 returned to the facility, at approximately 12:30 PM. She reported the process for providing an escort was dependent on the resident's ability to communicate and the level of confusion. She stated the facility depended on the physician's office staff to notify the facility if an O2 tank ran low, and the facility would send a new O2 tank to the physician's office via a facility CNA or the Social Services Assistant.</p> <p>A phone interview, on 05/16/12 at 3:00 PM, with staff at the physician's office revealed the office staff did not look at Resident #4's O2 tank regulator during the time the resident was in the physician's office.</p> <p>A phone interview with the public transportation scheduler, on 05/17/12 at 9:30 AM, revealed the transportation driver picked up Resident #4 at</p>	F 323			

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 323	<p>Continued From page 39</p> <p>10:00 AM and returned the resident to the facility at 12:30 PM. The transportation company policy for transportation of persons with O2 was the transportation driver was not allowed to handle, monitor, or adjust the O2 tank or delivery settings.</p> <p>An observation, on 05/16/12 at 12:40 PM, revealed Resident #4 was in the room sitting in a wheelchair with O2 delivered by nasal cannula from a portable tank attached to the back of his/her wheelchair. The Social Services Assistant was conducting a regularly scheduled BIMS and PHQ-9 assessment. The Social Services Assistant stated he never had such difficulty completing the assessment in the past and saw a decline in the resident's responses. A review of the assessment, completed on 05/16/12 at 1:05 PM, revealed a BIMS score of 13 and the PHQ-9 score was 12. Further observation revealed the resident's O2 tank regulator showed the reading of "Refill," meaning the O2 tank was empty.</p> <p>An interview with the Social Services Assistant, on 05/16/12 at 4:15 PM, revealed he completed a reassessment of the BIMS and PHQ-9 for Resident #4 after learning of the empty O2 tank during the earlier assessment. The second BIMS score was 15 and the PHQ-9 score was 17.</p> <p>A phone interview with the Respiratory Therapist employed by the facility's O2 therapy vendor, on 05/17/12 at 10:15 AM, revealed the tank used by Resident #4 for transport outside the facility was an "E" tank and contained 680 liters. The respiratory therapist stated the tank would last 1.5 hours and might last up to 2 hours.</p> <p>Interview with CNA #3, on 05/16/12 at 1:25 PM,</p>	F 323		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 323	<p>Continued From page 40</p> <p>revealed the process for preparing a resident for transport to an appointment outside the facility began with the CNA's responsibility of bathing and grooming the resident and transferring to the wheelchair. It was the charge nurse's responsibility to attach and adjust the O2 for the resident.</p> <p>An interview with LPN #3, on 05/17/12 at 2:05 PM, revealed the process for residents on O2 therapy who left the facility on a trip were prepared by the CNA staff, and the licensed staff prepared the O2 by ensuring the O2 tank was full. If a resident had difficulty communicating, an escort was assigned to go with him/her. She stated, that on 05/16/12, O2 therapy preparation for Resident #4 was provided by the float nurse, LPN #2. LPN #3 stated she was not present when the O2 was hooked up. LPN #3 stated she expected a full O2 tank at the continuous delivery setting of 5 liters to last 2.5 hours to 3 hours related to the resident's breathing. She stated it was the responsibility of the licensed staff to document in the nurse's notes when a resident left and returned to the facility.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 05/17/12 at 9:55 AM, revealed the facility had no policy and procedure for transporting a resident requiring O2 therapy to an outside appointment. The ADON stated the facility's process for a resident, requiring O2 therapy, who left the facility was for the charge nurse to provide a new O2 tank and secure it to the wheelchair. In the case of Resident #4, a facility staff person would escort the resident to the appointment related to the resident being hard of hearing. The facility routinely sent a facility escort for any resident who was confused</p>	F 323			

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 323	<p>Continued From page 41</p> <p>or had difficulty with communication. Upon the resident's return to the facility, the charge nurse was to check the tank and ensure the tank still had O2 delivery. The ADON stated she expected an O2 tank to last two (2) to three (3) hours on the setting of 2.0 - 2.5 liters per minute. With Resident #4, the O2 delivery setting was 5 liters per minute and the ADON expected the tank to last one (1) hour to one and a half (1.5) hours.</p> <p>Interview with the Director of Nursing (DON) and the ADON, on 05/17/12 at 1:00 PM, was prompted by the provision of a facility policy for Transporting Patients with Oxygen Out of the Facility. The DON revealed the policy was created, on 05/17/12, with direction from the facility's O2 therapy vendor representative. The ADON stated the licensed nursing staff was responsible for documentation of a resident's departure and return to the facility, and the documentetion would be in the nurse's notes and on the 24-hour shift report. The DON stated information related to O2 therapy during the resident's time out of the facility would also be documented. The DON stated Resident #4 was not ambulatory, not always able to make needs known, and was very hard of hearing. She stated Resident #4 went to an appointment outside the facility on 05/15/12 and was escorted by facility staff. The facility escort could be anyone in the building and typically it was a CNA. The DON stated if the O2 tank malfunctioned or the O2 supply got low, the escort notified the facility for direction. Review of the facility provided CNA job description did not cover provision or adjustment of O2 therapy. The DON stated she expected a full O2 tank with the continuous delivery setting of 5 liters to last 1 hour to 1.5 hours.</p>	F 323		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 323	<p>Continued From page 42</p> <p>Further interview with the DON, on 05/17/12 at 3:00 PM, revealed the charge nurse was responsible for ensuring the resident was safely and adequately prepared to leave the facility for an outside appointment. The charge nurse could receive assistance from the float nurse, but the charge nurse was responsible for the resident. The DON reported the facility provided O2 education, and the presenter covered the number of hours of coverage expected from a full O2 tank according to the delivery setting.</p> <p>3. A review of the facility's sample menu for mechanical soft diet, no date, revealed appropriate snacks for mechanical soft diet to include graham crackers, vanilla wafers, ice cream, house supplement, applesauce, canned fruit, pimento cheese sandwich, meat salad and sugar cookies.</p> <p>A record review revealed the facility admitted Resident #8 on 09/22/10 with diagnoses to include Dysphagia, Muscle Weakness, Dementia, Persistent Mental Disorder, Effusion of Lower Leg Joint, Adhesive Capsulitis of Shoulder and Urine Retention.</p> <p>A review of a hospital admission History and Physical, dated 02/01/12, revealed the resident was admitted to the hospital with a diagnosis of Pneumonia, suspect aspiration and a Urinary Tract Infection. The resident was treated with antibiotics and placed on a pureed diet.</p> <p>A review of the comprehensive care plan, "At risk for weight loss, altered nutrition and dehydration" revealed interventions to include "Assist with</p>	F 323			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 428 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
F 323	<p>Continued From page 43</p> <p>feeding" and "Provide and serve diet as ordered," both were dated 02/15/12.</p> <p>A review of a physician's order, dated 05/12, revealed "No added salt, mechanical soft diet with pureed meat, may have regular diet once weekly and on holidays-texture modifications to remain the same."</p> <p>A review of the Nurse Aide Care Plan, dated 05/12, revealed the resident was to be totally fed by staff and was to have a mechanical soft diet with pureed meat.</p> <p>Observation, on 05/15/12 at 5:25 PM, revealed Resident #8 was in bed eating popcorn from a bag, with no staff present. Observation, on 05/16/12 at 8:30 AM, revealed the resident was asleep in bed and an opened bag of popcorn was on the overbed table. Observation, on 05/16/12 at 11:00 AM, revealed the resident in bed, no staff present, with a white bag that had peanuts in it. The resident was eating the peanuts and stated he/she did not know where the peanuts came from.</p> <p>An interview with the Registered Dietician (RD), on 05/16/12 at 4:10 PM, revealed Resident #8 was on a mechanically altered, pureed meat diet. The RD revealed appropriate snacks for mechanically soft diet with pureed meat included soft canned fruit, pudding or some other soft dessert, but peanuts or popcorn were not appropriate.</p> <p>On 05/16/12 at 5:45 PM, the DON verified the peanuts and popcorn on Resident #8's over bed table. The DON revealed peanuts and popcorn</p>	F 323		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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
F 323	Continued From page 44 were not appropriate for any resident on a mechanical soft diet and thought family might have brought these items to the resident. The DON stated the CNA should have noticed the inappropriate snacks and removed them and alerted nursing. Additionally, she stated the peanuts and popcorn were an increased risk for potential choking and aspiration for Resident #8.	F 323	<u>F 441 (E) INFECTION CONTROL, PREVENT SPREAD, LINENS</u>	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	<i>Residents Found to Have Been Affected</i> Residents #4, #23, 24, 25, and #26 were assessed by a licensed nurse and no negative outcomes were noted. Licensed Practical Nurse #7 has been counseled and re-educated. <i>Identification of Other Residents with the Potential to be Affected</i> Residents with orders for Accuchecks have the potential to be affected by F 441. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. <i>Systemic Changes</i> An in-service was conducted by the Quality Assurance Nurse for all nursing staff regarding infection control and prevention practices including the disinfecting and cleaning of glucometers according to manufacturer's guidelines. In-services occurred on May 15, 2012. Skill validations were completed with all licensed nurses on June 12, 13, 14, 15, and 16, 2012. On June 12, 2012 an instruction card was placed with the	

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

PRINTED: 06/18/2012
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 _____ B. WNO _____	(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MAOISONVILLE, 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
F 441	<p>Continued From page 45 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to maintain a safe environment to help prevent the development and transmission of disease and infection. Observation during a medication pass, on 05/15/12, revealed accuchecks were completed for one resident (#4), in the selected sample of 19 residents, and for four residents (#23, #24, #25 and #26), not in the selected sample; however, Licensed Practical Nurse (LPN) #7 was observed utilizing the same glucometer for each resident, and obtaining blood samples for testing blood glucose levels without disinfecting the glucometer between residents.</p> <p>Findings include: A review of the facility's policy and procedure, Infection Control, revealed the purpose of the guide was to "ensure that correct cleaning and disinfecting of the Assure Platinum Blood Glucose Monitoring System is followed to prevent the potential transmission of infectious organism. Both the Centers for Disease Control (CDC) and</p>	F 441	<p>Glucometer to assist licensed staff in maintaining compliance with glucometer cleaning and disinfecting.</p> <p>Monitoring The results of the skill validations will be submitted to the QAA Committee for their review, recommendations, and follow-up. Infection Control will be reviewed at every monthly QAA Committee Meeting.</p>	6/22/12

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 441	<p>Continued From page 46</p> <p>JCAHO recommend that precautions be taken during all procedures and in all circumstances where there is a possibility of exposure to blood or any body fluid." The policy indicated cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. To use a wipe, remove from container and follow product label instructions to disinfect the meter. Additionally, many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one to clean and a second wipe to disinfect."</p> <p>Observation of a medication pass, on 05/15/12 starting at 3:45 PM, revealed LPN #7 completing accuchecks for five residents (#4, #23, #24, #25, and #26) prior to the administration of insulin. LPN #7 used an alcohol prep to clean Resident #24's finger and then used a lancet to prick the resident's finger causing the site to bleed. LPN #7 held the glucometer with the test strip to the resident's finger to collect the blood for a blood glucose reading. The glucometer was used in the exact same manner for Residents #4, #23, #25, and #26. The glucometer was taken from room to room to obtain the blood samples without being cleaned or sanitized between each resident.</p> <p>An interview with LPN #7, on 05/15/12 at 4:10 PM, revealed she was a new nurse and was unaware of the facility's policy for cleaning and sanitizing the glucometer after each use. The LPN stated, since her employment in January 2012, she cleaned the glucometer at the end of the shift with an alcohol wipe and she did not clean it between residents because that was the way she was shown during orientation upon hire.</p>	F 441		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORO 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
F 441	Continued From page 47 An interview with the Assistant Director of Nursing (ADON), on 05/15/12 at 6:10 PM, revealed the facility practice was to clean the glucometer with a sanitizing wipe between each use and allow to dry. Two glucometers were located on the Medication Carts and while one glucometer was drying from cleaning, the nurse could continue to the next resident utilizing the second glucometer, already sanitized. The ADON revealed newly hired nurses followed a charge nurse for two weeks to learn facility policies and practices, and skills were checked off on a skills check-off sheet as the skill was observed to be completed successfully. An interview with the Corporate Educator, on 05/15/12 at 6:10 PM, revealed all licensed staff should have a check-off sheet from orientation, but a check-off sheet could not be located for LPN #7 for verification of check-off skills on accuchecks and glucometer sanitation. An interview with the Director of Nursing (DON), on 05/16/12 at 8:50 AM, revealed licensed staff were to clean glucometers with the appropriate sanitizing wipes after each use and allow to dry completely, and then were to use a second glucometer located on the cart while the first was drying from being cleaned. The DON revealed that currently new staff were orientated to facility policies and a check-off sheet was used to verify each area of skill. LPN #7 started working at the facility during a change of administrative staff, in January 2012, and may not have been oriented with a check-off sheet to verify skills.	F 441	F 490 (G) EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING <i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated by the Administrator and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #3 was a witness to the reporting of Resident #5 reporting the allegation to Employee #2 and acted appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012 by the Administrator. Additionally a formal counseling was completed with employee #8 on June 5, 2012 by the Administrator. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 490. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. The Administrator instructed nursing staff on second shift to complete	
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
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	
F 490	<p>Continued From page 48</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure, and review of the facility's Incident/Investigation Report, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one resident (#5), in the selected sample of 19 residents.</p> <p>The facility failed to follow the "Abuse, Neglect, and Exploitation" policy/procedure related to the protection of residents, investigation, and reporting of an allegation of abuse. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 made a comment that the resident was drinking his/her water similar to her "dog." Resident #5 reported the comment to the staff, on 04/28/12; however, the facility allowed NASR #5 to continue to provide care to Resident #5 and other residents for at least one hour and fifteen minutes, prior to suspension. An interview with Resident #5, on 05/15/12 at 4:15 PM, revealed the resident did not want NASR #5 providing his/her care. The resident revealed the comment was</p>	F 490	<p>interviews with all residents on June 5-6, 2012 to solicit any concerns relating to dignity, mistreatment, neglect and abuse.</p> <p>Systemic Changes On May 29, 2012 the Administrator contracted with an experienced skilled nursing facility consultant to re-educate the Administrator in the areas of Abuse Prohibition and Control that includes investigating and reporting of allegations, development and implementation of policies related to mistreatment, neglect and abuse; Dignity; and Quality Assessment and Assurance programming.</p> <p>The Administrator has inserviced all staff on Abuse Prohibition and Control that includes investigating and reporting of allegations, development and implementation of policies related to mistreatment, neglect and abuse; Dignity; (June 1-4, 2012) and Quality Assessment and Assurance programming (June 5-7, 2012).</p> <p>The Administrator initiated that Resident Council meetings will be held every week beginning June 1, 2012 to solicit any concerns regarding the investigating and reporting of abuse allegations, to solicit any concerns regarding mistreatment, neglect/abuse and to</p>		

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

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(X4) IO 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 490	<p>Continued From page 49</p> <p>embarrassing and made him/her "feel bad." Resident #5 was visibly upset and crying during the interview, 18 days after the incident (refer to F241). Licensed Practical Nurse (LPN) #8 failed to conduct a thorough investigation of the allegation and remove NASR #5 from resident care immediately.</p> <p>The allegation was discussed in the morning Quality Assurance (QA) committee meeting, on 04/30/12; however, these issues were not identified as a problem. Additionally, the Administrator failed to report the allegation of abuse to the State Agency (refer to F225 and F226).</p> <p>Findings include:</p> <p>A review of the facility's investigation policy/procedure, revised 02/25/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-interview the alleged resident or victim; interview witnesses to include the assigned caregiver, caregivers in the immediate area, remote or potential witnesses; and interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established.</p>	F 490	<p>solicit any concerns with dignity. These Resident Council weekly meetings will continue for eight weeks or longer if needed to resolve any concerns regarding abuse allegations, abuse policies and dignity.</p> <p>A newly created position was developed by the Administrator on May 29, 2012 that included a Job Description for a facility Quality Assurance (QA) Nurse. The QA Nurse will complete detailed reviews and adherence of policies in the facility of areas identified through the Continuous Quality Improvement Committee, the Administrator and other staff members.</p> <p>The Administrator initiated a review of the Quality Assurance and Assessment (QAA) Committee and the QAA policies that have been reviewed and revised on May 31, 2012 to better identify and address quality issues on a more immediate basis.</p> <p>The Interdisciplinary Team (IDT) was educated by the Administrator on June 5, 2012 on the newly developed Continuous Quality Improvement (CQI) Investigation system. The newly developed CQI Investigation system was implemented on June 7, 2012 by</p>	

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 490	<p>Continued From page 50</p> <p>A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation and report the results of the investigation within five working days to the Division of Long-Term Care.</p> <p>A record review revealed the facility admitted Resident #5 on 11/07/11 with diagnoses to include Amyotrophic Lateral Sclerosis (ALS), Anxiety, and Depressive Disorder.</p> <p>An interview with Resident #5, on 05/15/12 at 4:15 PM, and on 05/16/12 at 2:10 PM, revealed the resident stated that NASR #5 was feeding him/her on 04/27/12, and made a comment "I drank my water like her dog." The resident revealed the comment made him/her feel bad and was embarrassing, as other residents and guests were at the table. He/she revealed the comment was reported the next day, to Certified Medication Tech (CMT) #2, and the resident expressed he/she did not want NASR #5 providing care for him/her. After making the report, the resident revealed NASR #5 was allowed to give him/her a shower.</p> <p>Interviews with CMT #2 and CMT #3, on 05/16/12 at 9:32 AM and 10:35 AM, respectively, confirmed the resident's allegation and that it was reported to LPN #8 as an allegation of verbal abuse. CMT #3 revealed the resident was upset</p>	F 490	<p>the Administrator and all staff educated on this same date. The CQI investigation system is designed for the participation of all employees.</p> <p>The Administrator conducted training on June 5, 2012 to the IDT team and all other staff on June 8, 2012 to educate all staff on the QAA policies, committee structure, and how to involve themselves in the QAA process. A Post Test for QAA was administered to staff on June 8, 2012. The facility conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse and Dignity policies. A Post Test for Abuse and Dignity was conducted on these same dates.</p> <p>Monitoring The newly hired skilled nursing facility consultant will make routine visits to review sustained compliance with Abuse Prohibition and Control and Quality Assurance and Assessment programs for a minimum of three months.</p> <p>The Quality Assurance and Assessment Committee will review with the Administrator the submitted reports from the Quality Assurance Nurse and the Social Services Director for a minimum of</p>		

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

PRINTED: 06/18/2012
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2012
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
F 490	<p>Continued From page 51</p> <p>and crying. An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the resident was quiet and had "one tear" roll down his/her face.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, 05/16/12 at 2:35 PM, and 05/17/12 at 2:00 PM, revealed the allegation was reported to her, by CMT #2. NASR #5 was giving a resident a shower. She confirmed she did not remove NASR #5 from direct care immediately. She admitted she should have removed NASR #5 from resident care immediately, per the policy. LPN #8 further revealed she did not conduct a thorough investigation. She did not document a statement from Resident #5. She also revealed she should have obtained statements from CMT #2 and CMT #3. She did not verify who was sitting at the table when the comment was made to the resident, and did not try and contact any of them. She also indicated that the investigation was turned over to the Administrator and reviewed in the QA committee meeting; therefore, they should have ensured the investigation was completed.</p> <p>A review of the Timecard Report for CMT #2 and CMT #3, dated 04/28/12, revealed both employees clocked out for lunch at 10:31 AM. A review of the facility's Incident/Investigation Report, dated 04/28/12, revealed a written statement by NASR #5; however, there were no other statements included in the investigation. A review of the Timecard Report for NASR #5, on 04/28/12, revealed she did not clock out until 11:48 AM, at least one hour and fifteen minutes after the allegation was reported to LPN #8. An</p>	F 490	three months or until compliance is sustained.	6/20/12

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 490	<p>Continued From page 52</p> <p>interview with NASR #5, on 05/16/12 at 3:45 PM, revealed she gave Resident #5 a shower and provided incontinent care for another resident on 04/28/12, prior to her suspension.</p> <p>An interview with the Director of Nursing (DON), on 05/17/12 at 2:35 PM, revealed LPN #8 contacted her at home, on 04/28/12, to report the allegation. She revealed LPN #8 was instructed to gather statements from anyone around the area, from any resident that could have heard the comment, and from residents cared for by NASR #5. She was not aware NASR #5 continued to provide care for the resident after the allegation was reported to LPN #8. She expected LPN #8 to suspend NASR #5 immediately. She did not speak to the resident about the allegation.</p> <p>An interview with the Social Services Director, on 05/17/12 at 9:10 AM and 3:00 PM, revealed she was the facility's abuse coordinator. She was not knowledgeable of the facility's policy/procedure related to abuse/neglect. She revealed if allegations of abuse/neglect were unsubstantiated, they were not reported to the State Agency. She was not aware of the allegation made by Resident #5; however, she attended the Quality Assurance (QA) committee meeting (where the investigation was discussed), on 04/30/12.</p> <p>An interview with the Administrator, on 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the allegation was reported. She stated that the resident was not upset about the comment; however, she admitted she did not question the resident about what happened. The Administrator revealed the investigation did not</p>	F 490			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 490	Continued From page 53 have enough information to determine the findings of the allegation. She revealed Social Services was responsible for ensuring a thorough investigation, with assistance from the DON and Administrator. She further verified it was discussed in the QA committee meeting, on 04/30/12, with no concerns. She revealed the allegation was not reported to the State Agency, as it did not qualify as verbal abuse. An interview with the Corporate Compliance Nurse, on 05/17/12 at 5:00 PM, revealed he did review the investigation in the QA committee meeting, on 04/30/12. The allegation was unsubstantiated due to the statement by NASR #5; however, he admitted it was not a thorough investigation to determine the findings of the allegation. He could not recall if he recommended a more thorough investigation after review, on 04/30/12. He revealed the facility did not report to the State Agency because the allegation was unsubstantiated. He stated that any allegation of abuse would be reported; however, he did not feel this was verbal abuse. However, interview with CMT #3 revealed this was an allegation of abuse.	F 480	<u>F 520 (G) QAA COMMITTEE MEMBERS/ MEET</u> <i>Residents Found to Have Been Affected</i> Employee #5, State Registered Nursing Assistant (NASR) who was directly involved in the allegation of Resident #5 was investigated and is no longer an employee of the facility. Employee #2 had reported the allegation appropriately. Employee #8 who is a Licensed Practical Nurse was educated on the facility Abuse Prohibition and Control policies and post tested on June 1, 2012. Additionally a formal counseling was completed with employee #8 on June 5, 2012. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 520. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. <i>Systemic Changes</i> An experienced skilled nursing facility consultant was contracted on May 29, 2012 to assist the facility in the areas of Abuse Prohibition and Control and		
F 520 SS=G	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	F 520			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLANO 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	
F 520	<p>Continued From page 54</p> <p>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.</p> <p>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 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 interview, record review, review of the facility's policy/procedure and Plan of Correction, it was determined the facility's Quality Assessment and Assurance Program failed to follow their Plan of Correction related to the implementation of an appropriate plan of action related to an investigation involving care and services of one resident (#5), in the selected sample of 19 residents. While feeding Resident #5 in the dining room, on 04/27/12, Nurse Aide State Registered (NASR) #5 allegedly made a comment that the resident was drinking his/her water similar to her "dog." The comment was reported by Resident #5 to Certified Medication Tech (CMT) #2 on Saturday, 04/28/12. CMT #2 reported the allegation to Licensed Practical Nurse (LPN) #8, who was the Administrative Licensed Nurse on duty. LPN #8 failed to remove</p>	F 520	<p>Quality Assessment and Assurance programs.</p> <p>A newly created position was developed by the Administrator on May 29, 2012 that included a Job Description for a facility Quality Assurance (QA) Nurse. The QA Nurse will complete detailed reviews and adherence of policies in the facility of areas identified through the Continuous Quality Improvement Committee, the Administrator and other staff members.</p> <p>A review of the Quality Assurance and Assessment (QAA) Committee and the QAA policies have been reviewed and revised on May 31, 2012 to better identify and address quality issues on a more immediate basis. The QAA Committee structure has been changed to include the Medical Director, Quality Assurance Nurse, Administrator, Director of Nursing, Social Services Director, Corporate Compliance Officer, and Infection Disease Control Preventionist.</p> <p>The Interdisciplinary Team (IDT) was educated on June 5, 2012 on the newly developed Continuous Quality Improvement (CQI) Investigation system. The newly developed CQI Investigation system was implemented on June 7,</p>		

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORO 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	
F 520	<p>Continued From page 55</p> <p>NASR #5 immediately from resident care. NASR #5 was allowed to work at least one hour and fifteen minutes after the allegation was reported. LPN #8 failed to conduct a thorough investigation to determine the findings of the allegation. The facility's Incident Investigation Report contained one statement only, from the alleged perpetrator. The Administrator was made aware of the allegation, on 04/28/12; however, could not provide evidence that she notified the Registered Nurse (RN) Corporate Compliance Nurse immediately. The investigation was discussed in the Quality Assurance and Assessment (QAA) Committee meeting, on 04/30/12; however, there were no issues identified related to the investigation. The investigation was determined as unsubstantiated, on 04/30/12, and the allegation was not reported to the State Agency. NASR #5 was terminated on 05/07/12 due to misconduct.</p> <p>Refer to (F225, F226, F241, and F490)</p> <p>Findings include:</p> <p>A review of the facility's investigation policy/procedure, revised 02/26/10, revealed all incidents that occurred in the facility required thorough investigation and accurate documentation so the facility could evaluate the reason the incident occurred, take corrective measures to curtail the number of incidents, assure resident safety and report any incidents of abuse according to state and federal guidelines. The investigation required the review of the following: Data Collection-interview the alleged resident or victim; interview witnesses to include the assigned caregiver, caregivers in the</p>	F 520	<p>2012 and all staff educated on this same date. The CQI investigation system is designed for the participation of all employees.</p> <p>The facility conducted training on June 5, 2012 to the IDT team and all other staff on June 8, 2012 to educate all staff on the QAA policies, committee structure, and how to involve themselves in the QAA process. A Post Test for QAA was administered to staff on June 8, 2012. The facility conducted training on June 1-6, 2012 to educate all staff on the newly revised Abuse and Dignity policies. A Post Test for Abuse and Dignity was conducted on these same dates.</p> <p>Monitoring</p> <p>The QAA Committee approved the revised policies for Abuse Prohibition and Control and Quality Assessment and Assurance on May 31, 2012. The QAA Committee will meet weekly beginning May 31, 2012 for a minimum of four weeks and until regulatory compliance is achieved. The Quality Assurance Nurse will submit findings of all clinical reviews to the QAA Committee meeting for recommendations and follow-up. All allegations of Abuse will be submitted to the QAA Committee by the Social Services</p>		

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

PRINTED: 06/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 520	<p>Continued From page 56</p> <p>Immediate area, remote or potential witnesses; and interview the alleged suspect. Data Analysis-summarize the analysis of facts gathered that either established reasonable cause for the incident or establish the need for further investigation before a reasonable cause for the incident could be established.</p> <p>A review of the facility's Continuous Quality Improvement Program policy/procedure, revised 03/30/10, revealed monitoring and evaluation of resident care and services with a focus on continuous improvement were the fundamental activities of any quality improvement process.</p> <p>A review of the facility's Abuse, Neglect, and Exploitation policy/procedure, revised 02/07/12, revealed in case of alleged abuse involving an employee against a resident, that employee should be suspended immediately pending further investigation by the Administrator and/or designee. The Administrator and/or designee would conduct an investigation of the allegation and report the results of the investigation within five working days to the Division of Long-Term Care.</p> <p>A review of the facility's inservice sign-in sheet for "Investigation of Incident", dated 02/17/12, revealed LPN #8, the Administrator, and RN Corporate Compliance Nurse attended the inservice.</p> <p>A review of the facility's Plan of Correction, compliance date 03/11/12, revealed Licensed Administrative Staff would be appointed on a rotating basis to provide four hours of on-site supervision on weekends. The Licensed</p>	F 520	Director and reviewed by the QAA Committee for recommendations and follow-up.	6/20/12	

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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
F 520	<p>Continued From page 57</p> <p>Administrative Staff would report any neglect investigation reports or issues involving care and services to the Administrator and DON. The Plan of Correction further revealed "In the event that an occurrence would be noted on the rotating weekend rounds, the Administrator would be notified immediately who would immediately notify the RN Corporate Compliance Nurse. An evidence based investigation would be conducted and all appropriate agencies, family, Medical Doctor (MD) notified." "Findings from the weekend rotations of Licensed Administrative Staff were reported to the Interdisciplinary Team (IDT)/QA Committee on Monday so that any investigations could be discussed and appropriate action could be taken.</p> <p>An interview with various members of the QAA Committee, on 05/17/12 at 8:00 PM, revealed no issues had been identified by the committee since 03/12/12.</p> <p>An interview with LPN #8, on 05/14/12 at 2:00 PM and 3:10 PM, on 05/16/12 at 2:35 PM, and on 05/17/12 at 2:00 PM, revealed she was the Administrative Licensed Nurse in the facility, on 04/28/12. The allegation of verbal abuse was reported to her; however, she did remove NASR #5 from resident care immediately, per the facility's policy. LPN #8 revealed she did not conduct a thorough investigation of the allegation. She did not get statements from all staff/witnesses that were involved, per the facility's policy.</p> <p>An interview with the Administrator, on 05/14/12 at 4:00 PM, and on 05/17/12 at 4:05 PM, revealed she was at the facility, on 04/28/12, after the</p>	F 520		

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

PRINTED: 08/18/2012
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HDME			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 CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 520	<p>Continued From page 58</p> <p>allegation was reported. She could not provide evidence that she notified the RN Corporata Compliance Nurse of the allegation, on 04/28/12. The Administrator admitted she did not question the resident directly about what happenad. The Administrator revealed the investigation did not have enough information to determine the findings of the allegation; however, It was discussed in the QAA committee meeting, on 04/28/12, with no concerns. The allegation was not reported to the State Agency, as it did not qualify as verbal abuse. NASR #5 was terminated due to the "questionable" incident.</p> <p>An interview with the Corporate Compliance Nurse, on 05/17/12 at 5:00 PM, revealed he did review the investigation in the QAA committee meeting, on 04/30/12. He revealed the facility did not notify him prior to 04/30/12. The allegation was unsubstantiated due to the statement by NASR #5; however, he admitted it was not a thorough investigation to determine the findings of the allegation. He could not recall if he recommended a more thorough investigation after review, on 04/30/12. He revealed the facility did not report because the allegation was unsubstantiated. He stated that any allegation of abuse would be reported to the State Agency; however, he did not feel this was verbal abuse.</p> <p>While the facility's investigation did not substantiate the allegation of verbal abuse, the QAA Committee did not identify, that their staff failed to follow their policy and procedure related immediate suspension efter receiving an allegation of abuse, failed to immediately notify the Administrator which prevented the Administrator from immediately notifying the</p>	F 520			

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

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	
F 520	Continued From page 59 Corporate Consultant. Furthermore the IDT/QAA Committee review of the allegation failed to identify that the investigation was not thorough, due to this failure they did not ensure appropriate action was taken as detailed in the facility's plan of correction. Furthermore, the Corporate Consultant could not provide evidence that he had identified these failures and could not provide evidence that he had ensured necessary action was taken to prevent the recurrence in falling to follow regulation and policy.	F 520			

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



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 05/15/2012
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 000	<p>INITIAL COMMENTS</p> <p>AMENDED 06/08/12 K56 closet sprinkler protection</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 05/15/12. Ridgewood Terrace Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred ten (110) beds with a census of ninety two (92) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000	<p>Preparation and execution of this plan of</p> <p>Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>K 017 D Facility failed to ensure that rooms open to the corridor would not interfere with egress requirements</u></p> <p><i>Residents Found to Have Been Affected</i> The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE 06/11/2012

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: 06/08/2012
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 05/15/2012
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 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	<i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by K 017. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.	
K 017 SS=D	Deficiencies were cited with the highest deficiency identified at "F" level. NFFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred	K 017	<i>Systemic Changes</i> On June 4, 2012, the State Fire Marshall provided an on-site facility visit and deemed that the therapy room by the east wing nurses' station could be removed from serving as a designated emergency exit. On June 6, 2012, B.W. Akin Electrical removed the previous exit sign designating the therapy room as part of the exit corridor and installed a new exit sign over the east nurses' station to direct traffic to the 200 Hall as the new exit corridor denoting the shortest distance (less than 250 feet) out of the building. The maintenance department placed signage designating that the therapy room exit was "not an exit" on June 7, 2012. On June 7, 2012, the maintenance department modified the displayed floor plan to denote the new exit. <i>Monitoring</i> The maintenance department will in-service employees on the	

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 017	Continued From page 2 ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed a therapy room that was part of the exit corridor by the east wing nurses' station. The contents of these rooms are not permitted to be in an area open to the corridor. Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed this area was originally designed as a sunroom and had been converted to a therapy area. NFPA 101 (2000) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by	K 017	modifications of the exit corridors on June 7, June 8 and June 11, 2012 and new employees during new hire orientation. Completion Date: June 11, 2012 <u>K 018 F Facility failed to ensure there were no impediments to closing of corridor doors</u> <u>Residents Found to Have Been Affected</u> Residents in rooms 503, 505, 506, 403, 309, 303, 302, 301, 203, 205, 206, 111, 112, 108, 105, and 103 were affected by K 018. Wheelchairs and a standard chair were removed from the doors of resident rooms by the maintenance department on May 18, 2012. <u>Identification of Other Residents with the Potential to be Affected</u> All residents have the potential to be affected by K 018. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. <u>Systemic Changes</u> On June 1, 2012, department heads and supervisors were assigned room monitoring assignments to include monitoring of wheelchairs, standard	6/11/12

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

PRINTED: 06/08/2012
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 06/15/2012
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 017	Continued From page 3 quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017	chairs, or equipment that may be located in the corridor doors to the resident rooms. On weekends, monitoring will be completed by Charge Nurses during Charge Nurse rounds. Any equipment blocking the doors will be removed. On June 6, 2012, all rooms were checked for wheelchairs, standard chairs, or equipment blocking the doors of residents rooms with none found. <i>Monitoring</i> The monitoring logs will be reported by the department heads and supervisors Monday through Friday in the morning Interdisciplinary Team meeting. The Charge Nurse rounds identifying doors blocked by wheelchairs, standard chairs, or equipment will be collected and reported on Monday at the morning Interdisciplinary Team meeting. Random audits will be conducted of all rooms by the maintenance department one time weekly for four weeks or until resolved. Completion Date: June 6, 2012	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		6/6/12

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

PRINTED: 06/08/2012
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 05/16/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 018	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observations, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the corridor doors to the resident rooms numbered 503, 505, 506, 403, 309, 303, 302, 301, 203, 205, 206, 111, 112, 108, 105, and 103 were blocked by wheelchairs, and a standard chair. Interviews, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director confirmed the observation of the doors not closing due to the items blocking the doors. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than	K 018	<u>K 027 E Cross-corridor doors would not close completely when tested</u> <i>Residents Found to Have Been Affected</i> Residents located on each of the resident halls were affected by K 027. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff have the potential to be affected by K 027. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. <i>Systemic Changes</i> On May 18, 2012, the maintenance department installed rubber seals to cross-corridor doors located between the 600 and 500 halls and the doors between 500 and 400 halls to block the passage of smoke and seal in the gaps between the doors. <i>Monitoring</i> The maintenance department will place the checking of the rubber seals on cross-corridor doors on the Preventive Maintenance Calendar and monitor a minimum of twice annually to ensure that the doors resist the passage of smoke. Completion Date: May 18, 2012	5/18/12

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

PRINTED: 06/08/2012
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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 018	<p>Continued From page 5</p> <p>20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that</p>	K 018	<p><u>K 029 Facility failed to meet Protection of Hazards</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 029.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff have the potential to be affected by K 029. Systemic and Monitoring actions listed below will include all residents, visitors and staff who have the potential to be affected.</p> <p><i>Systemic Changes</i> On June 4, 2012, the maintenance department repaired and filled the block wall behind the door of the laundry area.</p> <p>On June 4, 2012, the maintenance department in-serviced the laundry staff to keep the laundry door closed. In additions, signs stating, "Keep Laundry Doors Closed at all Times" were posted on the doors.</p> <p>On June 4, 2012, the maintenance department installed door closures on the doors of the medical records office and the therapy office due to</p>	

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	PROMOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 6 necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	the storage of combustibles inside the offices.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 10.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the cross-corridor doors located between the 600 and 500 halls and the doors between 500 and	K 027	Monitoring The Maintenance Director and Laundry Supervisor will ensure that the laundry, medical records office, and therapy office doors stay closed at all times by conducting random audits of the doors two times a week for four weeks beginning June 7, 2012. Completion Date: June 7, 2012 K 050 F Fire Drills Residents Found to Have Been Affected All residents were found to be affected by K 050. Identification of Other Residents with the Potential to be Affected All residents, staff, and visitors were found to be potentially affected by K 050. Systemic and Monitoring actions listed below will include all residents, visitors and staff who have the potential to be affected. Systemic Changes	6/7/12

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

PRINTED: 06/08/2012
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 05/15/2012
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 027	Continued From page 7 400 halls would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	On May 18, 2012, the Maintenance Director reprinted the Fire Drill Sign Off Sheets to delineate the nursing department work schedule of two - 12 hour shifts instead of three-8 hour shifts as is currently printed on the Fire Drill Sign Off Sheets. Beginning on June 6, 2012, a fire drill was held at approximately 10 am so as to establish a baseline to hold further drills at unexpected times under varying conditions at least quarterly on each shift. Another fire drill was held at 9:30 pm on June 6, 2012 which was at least a two hour difference of time from the previously held fire drill. Fire drills will continue to be held by the maintenance department at random times on both shifts with two hour offsets from the month before beginning June 6, 2012 through June 13, 2012. <i>Monitoring</i> The Maintenance Director will provide a written report to the Quality Assurance Committee one time monthly for three months to ensure compliance with K 050. The Maintenance Director will report results of the timing of fire drills at the next Quality Assurance Committee meeting scheduled on June 14, 2012.	
K 029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186308	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 029	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the door to laundry area had chipped out the block wall behind the door which was holding the door open to the corridor. Further observation showed the medical records office and the therapy office need a closer added to the door due to the storage of combustibles inside the offices.</p> <p>Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware the busted block was holding the door open. Further interview revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards.</p>	K 029	<p>Completion Date: June 14, 2012</p> <p><u>K 051 F Annunciator Panel</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 051.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff had the potential to be affected by K 051. Systemic and Monitoring actions listed below will include all residents, visitors and staff who have the potential to be affected.</p> <p><i>Systemic Changes</i> On June 6, 2012, B W Akin Electrical relocated the Fire Alarm Control Panel Annunciator from the corridor across from the dining room and next to the kitchen area to the west side nurses' station.</p> <p>Beginning on June 6, 2012 till June 12, 2012, nurses will be in-serviced by the maintenance department on monitoring the Fire Alarm Control Panel Annunciator. Newly hired nurses will be in-serviced by the maintenance department during new hire orientation.</p> <p><i>Monitoring</i></p>	6/14/12

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

PRINTED: 08/08/2012
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 05/15/2012
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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 9 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	Completion Date: June 12, 2012 <u>K 056 F No Sprinklers on Overhangs</u> <i>Residents Found to Have Been Affected</i> All residents were found to be affected by K 056. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors, and staff have the potential to be affected by K 056. Systemic and Monitoring actions listed below will include all residents, visitors, and staff who have the potential to be affected. <i>Systemic Changes</i> On June 5, 2012 and completed on June 6, 2012, Tri State added sprinkler heads to overhangs located at the end of the 500 hall, 200 hall and the kitchen exit area. On June 5, 2012 and completed on June 6, 2012, Tri State Fire Protection changed the sprinkler heads on the east and west wing sunrooms and the front lobby area so that they would be the same instead of mixed response.	6/12/12
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050	<i>Monitoring</i>	

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

PRINTED: 06/08/2012
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 05/15/2012
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 050	<p>Continued From page 10</p> <p>that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 05/15/12 at 11:30 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Second shift fire drills were being conducted predictably between 6:00 PM and 7:00 PM.</p> <p>Interview, on 05/15/12 at 11:30 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required. He stated that he tried to conduct the drills after dinner and before bed time in order to not disturb the residents.</p>	K 050	<p>Monitoring of the sprinkler heads will be completed annually per agreement with Tri State Fire Protection.</p> <p><i>Completion Date</i> June 6, 2012</p> <p><u>K 062 E 18" storage of the sprinkler head</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 062.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff have the potential to be affected by K 062. Systemic and Monitoring actions listed below will include all residents, visitors, and staff who have the potential to be affected.</p> <p><i>Systemic Changes</i> On May 17, 2012, the maintenance department cut down the three activities closets and the top shelves removed to allow no storage within 18" of the sprinkler head.</p> <p>On May 17, 2012, the maintenance department cut down the closets in the respiratory storage area to allow no storage within 18" of the sprinkler head.</p>	6/6/12

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

PRINTED: 06/08/2012
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 06/16/2012
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 050	Continued From page 11 This is a repeat deficiency. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	On May 19, 2012 and May 20, 2012, shelves in the laundry area were boxed in at the top of the shelves by the maintenance department to comply with NFPA 13 (1999 Edition).	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by:	K 051	<i>Monitoring</i> Storage areas will be monitored at least quarterly by the maintenance department to ensure that no storage is within 18" of the sprinkler heads. The Maintenance Director will provide quarterly reports to the Quality Assurance Committee to ensure continued compliance with K 062. <i>Completion Date</i> May 20, 2012 <u>K 066 D Ashtrays not of the approved type</u> <i>Residents Found to Have Been Affected</i> All residents were affected by K 066. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff have the potential to be affected by K 066. Systemic and Monitoring actions	5/20/12

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

PRINTED: 06/08/2012
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 06/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 051	<p>Continued From page 12</p> <p>Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 at 4:15 PM, with the Maintenance Director revealed the Fire Alarm Control Panel (FACP) Annunciator was located in the corridor across from the dining room and next to the kitchen area. The nurses at the nursing station could not visually see any annunciation panels.</p> <p>Interview, on 05/16/12 at 4:16 PM, with the Maintenance Director revealed he was unaware the annunciation panel was required to be in an area that is monitored 24/7.</p> <p>Reference: NFPA 72 (1999 Edition). 1-5.7.1.1</p> <p>The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation.</p>	K 051	<p>listed below will include all residents, visitors and staff who have the potential to be affected.</p> <p>Systemic Changes On May 22, 2012, the Maintenance Director replaced the ashtrays located at the staff smoking area with self-closing ashtrays made of approved, non-combustible material.</p> <p>Monitoring The Maintenance Director will ensure that ashtrays made of approved, non-combustible material and self-closing are located at the staff smoking area by monitoring the continued use of the approved, self-closing, non-combustible ashtrays in the staff smoking areas one time monthly for three months or until resolved.</p> <p>The Maintenance Director will report findings of the monitoring to the Quality Assurance Committee monthly for three months.</p> <p>Completion Date May 22, 2012</p> <p><u>K 072 D Facility stores items in exit corridor</u></p> <p><i>Residents Found to Have Been Affected</i></p>	5/22/12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2012
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 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and temper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the overhangs were 48 inches or greater and did not have sprinkler coverage located at the end of the 500 hall, 200 hall and the kitchen exit area.</p> <p>Interview, on 05/15/12 between 1:00 PM and 5:00</p>	K 056	<p>All residents were found to be affected by K 072.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, employees and visitors have the potential to be affected by K 072. Systemic and Monitoring actions listed below will include all residents, employees and visitors who have the potential to be affected. On May 16, 2012, the maintenance department relocated the tray cart and shred bin to another area that did not obstruct or impede the exit corridor by the kitchen. The shred bin was moved to a more central location in the medical records room on June 5, 2012 by the maintenance department.</p> <p><i>Systemic Changes</i> The 32 gallon trash can that serves as a shred bin was removed from the exit corridor by the kitchen to another area on May 16, 2012 by the maintenance department. On June 5, 2012, the shred bin was moved to a permanent, more central location in the medical records room by the maintenance department.</p> <p>All staff received in-servicing on the location of the shred bin in the medical records room on June 5, 2012 by the Maintenance Director.</p>	

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 056	<p>Continued From page 14</p> <p>PM, with the Maintenance Director revealed he was unaware the porches were 4' including the overhang at the top of the roof..</p> <p>Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the east end west wing sunrooms and the front lobby area had sprinklers of a mixed response. Further observation showed room# 301 had sprinklers of a mixed response.</p> <p>Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was unaware the area had sprinkler heads of a mixed response.</p> <p>Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions</p>	K 056	<p>On May 16, 2012, the Maintenance Director moved the lunch tray cart stored in the exit corridor by the kitchen to the dining room where it will be stored between times of usage.</p> <p><i>Monitoring</i> The maintenance department will provide random audits one time weekly for four weeks to ensure that the shred bin and tray cart are located in the appropriate area.</p> <p>The Maintenance Director will report results of the random audits of the proper placement of the shred bin and tray cart to the QA Committee weekly for four weeks beginning June 7, 2012.</p> <p><i>Completion Date:</i> June 7, 2012</p> <p><u>K 073 F Stuffed animals not sprayed with flame retardant</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 073.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and employees have the potential to be affected by K 073. Systemic and Monitoring</p>	6/7/12	

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

PRINTED: 06/08/2012
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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 056	Continued From page 15 are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056	actions listed below will include all residents, visitors and employees who have the potential to be affected. Stuffed animals and fake floral arrangements in rooms 601, 602, 607, 611, 504, 508, 402, 403, 405, 410, 309, 206, and 103 were treated with a fire retardant spray by the maintenance department, tagged and dated beginning on May 17, 2012 and completed on June 8, 2012. <i>Systemic Changes</i> The facility revised the Policy and Procedure on Flammable Items and Materials on June 6, 2012. The Policy and Procedure on Flammable Items and Materials will be mailed to family members and delivered to residents on June 8, 2012 to serve as notification that personal items that include, but not limited to, decorated pillows, wreaths, artificial flowers, and stuffed animals/toys are encouraged to be limited to five or less. The mailing will also instruct family members and residents to inform the social services or maintenance department of any new items brought to a resident so that the item can be treated with flame retardant spray.		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred	K 062			

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/15/2012
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 062	<p>Continued From page 16</p> <p>ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed the three activities closets in the facility had storage within 18" of the sprinkler head along with the respiratory storage area. Further observation showed that the laundry area had shelving that was 12" from the sprinkler heads.</p> <p>Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was aware of the distance requirement from sprinkler heads but was not aware the closet shelves were built to close to the sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated</p> <p>In Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p>	K 062	<p>A monthly audit will be conducted by a Social Services and/or Maintenance Representative to check each room to ensure non-flame retardant items have been treated starting June 7, 2012. Items that have been treated will be identified by a tag that is dated on the date of treatment and logged in the Maintenance Log Book.</p> <p>The Maintenance Director will report results of the monthly audits to the QA Committee once a month for three months or until the issue is resolved beginning on June 7, 2012.</p> <p><i>Completion Date:</i> June 8, 2012</p> <p><u>K 104 F Facility failed to ensure fire/smoke dampers were maintained</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 104.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and employees have the potential to be affected by K 104. The Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p>	6/8/12

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

PRINTED: 06/08/2012
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 05/15/2012
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 062	Continued From page 17 (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062	Systemic Changes On June 6, 2012, B. W. Akin Company sent an order form to the Maintenance Director showing that the lead damper seals for the fire dampers were ordered. B. W. Akin will test the fire damper upon receipt of the lead damper seals. The testing will be documented and maintained in the Maintenance Log Book. Monitoring The Maintenance Director issued a written request for annual testing of the fire dampers to B. W. Akin on June 7, 2012. Documentation of the fire damper testing will be maintained in the Maintenance Log Book. Completion Date June 7, 2012	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066	K 144 F Annunciator Panel; Flashlight Residents Found to Have Been Affected All residents were affected by K 144.	6/7/12

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

PRINTED: 06/08/2012
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 06/16/2012
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 066	<p>Continued From page 18</p> <p>area is posted with signs that read NO SMOKING or with the International symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 at 4:20 PM, with the Maintenance Director revealed the ashtrays located at the staff smoking area were not of the unapproved type. They did not have a metal</p>	K 066	<p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents, employees and visitors have the potential to be affected by K 144. Systemic and Monitoring actions listed below will include all residents, employees and visitors who have the potential to be affected.</p> <p><i>Systemic Changes</i></p> <p>On June 6, 2012, B.W. Akin Electrical moved the emergency generator annunciation panel to the west nurses' station where the panel can be monitored 24/7.</p> <p>On June 7, 2012 and June 8, 2012, the maintenance department in-serviced all nursing staff on the method of monitoring the panel in the event that there would be an occurrence of alarm conditions of the emergency power source.</p> <p>On May 30, 2012, B.W. Akin Company installed a battery powered emergency light over the generator.</p> <p><i>Monitoring</i></p> <p>The maintenance department will monitor the functioning of the annunciation panel monthly per the Preventive Maintenance Calendar.</p> <p>The Maintenance Director will submit the Preventive Maintenance Calendar and action log to the QA</p>	

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

PRINTED: 08/08/2012
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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 066	<p>Continued From page 19 container with a self-closing lid.</p> <p>Interview, on 05/15/12 at 4:20 PM, with the Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into</p>	K 066	<p>Committee on a quarterly basis beginning June 14, 2012.</p> <p><i>Completion Date:</i> June 14, 2012</p> <p><u>K 147 E Power strips</u></p> <p><i>Residents Found to Have Been Affected</i> All residents were affected by K 147.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, employees and visitors have the potential to be affected by K 147. Systemic and Monitoring actions listed below will include all residents, employees and visitors who have the potential to be affected. On May 30, 2012, the following actions were taken by the maintenance department:</p> <ol style="list-style-type: none"> 1.) The maintenance department removed the power strip in the activities office and moved the refrigerator closer to the electrical receptacle and plugged the refrigerator into the receptacle. 2.) The maintenance department removed the power strip in the west wing medication room and a new 	6/14/12	

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/16/2012
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 066	Continued From page 20 which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	receptacle was added for the refrigerator.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 05/15/12 at 1:55 PM, with the Maintenance Director revealed a 32 gallon trash can, that was being used a shred bin, and a lunch tray cart stored in the exit corridor by the Kitchen. Interview, on 05/15/12 at 1:55 PM, with the Maintenance Director revealed the facility routinely stored the items in this corridor. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1	K 072	3.) The maintenance department removed the power strip in Room 508 and plugged the mini nebulizer into the wall receptacle. 4.) The maintenance department removed the power strip from the housekeeping office, along with a power strip plugged into another power strip and a receptacle was added for the refrigerator. 5.) The maintenance department removed the extension cord and power strip from the east wing medication room and a new receptacle was added for the refrigerator. <i>Systemic Changes</i> On May 30, 2012, receptacles were added in the east and west medication room and in the housekeeping office to ensure that sufficient receptacles are located to avoid the need for extension cords or multiple outlet adapters. <i>Monitoring</i> The maintenance department will conduct quarterly audits of the building to ensure that sufficient	

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

PRINTED: 06/08/2012
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 06/15/2012
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 072	Continued From page 21 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	receptacles are located to avoid the need for extension cords or multiple outlet adapters.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed several stuffed animals and fake floral arrangements throughout the facility with no flame retardant applied. Room numbers 601, 602, 607, 611, 504, 508, 402, 403, 405, 410, 309, 206, and 103 are some examples of this deficiency Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed they were aware decorations were required to be treated with a fire retardant spray and that any item brought into the facility was supposed to be	K 073	This audit will be included on the Preventive Maintenance Log and reported to the QA Committee on a quarterly basis beginning June 14, 2012. <i>Completion Date:</i> June 14, 2012	6/14/12

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 073	Continued From page 22 checked in on arrival. Further he was unaware the facility was to have a written policy for documentation that wreaths and other decorations are being treated. This is a repeat deficiency . Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 05/15/12 at 11:40 AM, with the Maintenance Director revealed no documentation for fire damper testing.	K 104		

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 104	Continued From page 23 Interview, on 05/15/12 at 11:40 AM, with the Maintenance Director revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The	K 144			

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

PRINTED: 08/08/2012
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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISDNVILLE, 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 144	<p>Continued From page 24</p> <p>facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 at 4:15 PM, with the Maintenance Director revealed the facility was equipped with an emergency generator. The generator is not equipped with an annunciation panel that is in a 24 hour monitored area to make staff aware of alarm conditions with the generators. The annunciator panel is in the corridor next to the dining room and kitchen.</p> <p>Interview, on 05/15/12 at 4:15 PM, with the Maintenance Director revealed he was not aware the generator needed an annunciation panel, at a workstation monitored 24/7, to inform staff of alarm conditions of the emergency power source.</p> <p>Observation, on 05/15/12 at 4:15 PM, with the Maintenance Director revealed there was no battery powered lighting for the generator. This lighting is in case of a generator failure there will be light to work on the generator.</p> <p>Interview, on 05/15/12 at 4:15 PM, with the Maintenance Director revealed he was not aware the generator needed to have battery powered emergency lighting.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by</p>	K 144		

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

PRINTED: 06/08/2012
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 05/15/2012
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	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	<p>Continued From page 25</p> <p>operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)</p> <p>The annunciator shall indicate alarm conditions of the emergency or auxilliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxillary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temparature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these condilions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency</p>	K 144			

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

PRINTED: 06/08/2012
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 05/15/2012
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 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 144	Continued From page 26 lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds and the census was ninety two (92) on the day of the survey. The findings include: Observations, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed: 1) A refrigerator was plugged into a power strip located in the activities office. 2) A refrigerator was plugged into a power strip located in the west wing med room. 3) A mini nebulizer was plugged into a power strip located in room# 508. 4) A refrigerator was plugged into a power strip located in the house keeping office, along with a	K 147		

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 D. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2012
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 147	<p>Continued From page 27</p> <p>power strip plugged into another power strip.</p> <p>5) A refrigerator was plugged into an extension cord, which was plugged into a power strip located in the east wing med room.</p> <p>Interview, on 05/15/12 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware the extension cord and the power strips were being misused.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		