

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

PRINTED: 05/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2012
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40380
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	Ridgeway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.	
F 226 SS=D	<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 observation, interview, record review and review of facility's policy, it was determined the facility failed to follow their Abuse Policy by not immediately reporting an allegation of resident to resident abuse to the appropriate agencies involving Resident #1 and Resident #2.</p> <p>The facility failed to follow it's policy related to reporting when, on 04/15/12, staff witnessed Resident #1 squeeze Resident #2's left hand causing a large black, purplish bruise on the resident's left hand. Review of the facility's Resident Incident/Accident Form, and Nurse's Notes, dated 04/15/12, revealed no documented evidence the appropriate state agencies were notified of the altercation.</p> <p>The findings include: Review of the facility's policy entitled "Abuse Reporting", dated 02/02/04, revealed upon receiving reports of mistreatment, abuse,</p>	F 226	<p>Ridgeway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgeway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen Obermaier</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/9/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 228	<p>Continued From page 1</p> <p>misappropriation of property, or neglect, the Administrator or Director of Nursing will immediately report the incident to the Division of Licensing and Regulation and other state agencies.</p> <p>Review of the closed medical record revealed Resident #1 was admitted to the facility, on 12/30/11, with diagnoses which included Pneumonia, Parkinson's Disease, and Bipolar Disorder. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 01/27/12, revealed the facility assessed Resident #1 to be cognitively impaired and as having verbal and other behaviors towards others which occurred daily. Review of the Comprehensive Plan of Care, with a revision date of 02/06/12, revealed a problem of Potential Mood Problem related to multiple psychiatric disorders with an increase in anxious behavior due to acute illness. Further review revealed on 02/25/12 there was an update related to Resident #1's potential for Injury related to behaviors with the goal of the resident to be free from injury to self and/or others and interventions to keep resident separated from the resident with whom he/she had the altercation.</p> <p>Review of Nurse's Notes, dated 04/15/12 at 8:40 AM, revealed Resident #1 was in the hallway in front of the nurse's station and reached over and got a hold of Resident #2's left hand with both his/her hands and squeezed the hand. Further review of Nurse's Notes revealed staff immediately took Resident #1 to his/her room and placed him/her on one to one observations by an assigned staff member. Resident #1 continued to have aggressive behaviors and at 2:00 PM, Resident #1 was sent to the hospital due to</p>	F 226	<p>Ridgeway Nursing and Rehabilitation does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Ridgeway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.</p> <p>Ridgeway Nursing and Rehabilitation strives to provide the highest quality care while assuring the rights and safety of all residents.</p> <p>F226 It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>1. Resident #1 is no longer a resident of this facility. Resident #2 remains in the facility with no ill effects not from this incident. This bruise to her hand has resolved.</p>		

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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F 226	<p>Continued From page 2 increased agitation.</p> <p>Review of the facility's Resident Incident/Accident Form for Resident #2, dated 04/15/12 at 6:40 AM, revealed a warm cloth was placed on Resident #2's left hand and the resident was able to move his/her hand. Review of Resident #2's Nurses's Notes, dated 04/15/12, revealed Resident #2 sustained a large black, purplish bruise on the top of his/her left hand which measured 12 centimeters by 13 centimeters and extended from the knuckle of the second and third fingers.</p> <p>Observation, on 04/25/12 at 10:40 AM, revealed Resident # 2 was sitting up in the hallway across from nurse's station. Further observation revealed a yellow/purple bruise on the top his/her left hand but no bruising noted to the resident's knuckles or fingers. Attempts were made to interview Resident #2 related to his/her bruise, but the resident was unable to recall any incident or how he/she obtained the bruise on his/her left hand.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 04/25/12, revealed she was at the nurse's station on the morning of 04/15/12 giving a shift change report and heard Resident #2 scream right behind her. She indicated as she turned around, she witnessed Resident #1 squeezing Resident #2's left hand with both his/her hands. She stated she immediately took Resident #1's hands off of Resident #1's left hand and as Licensed Practical Nurse (LPN) #2 assessed Resident #2's left hand, she took Resident #1 to his/her room and was assigned to one to one observations of the resident. Additional interview with CNA #2 revealed she thought the incident was abuse, especially since Resident #2 had</p>	F 226	<p>2. All residents are routinely monitored by the nursing staff for any signs and symptoms of abuse neglect or mistreatment. Resident behaviors are monitored and documented by the nursing staff.</p> <p>3. An inservice was conducted by the Administrator with nursing staff (licensed and CMTs) on 4/27/12 concerning the abuse policy, notification of the Administrator or Direction of Nursing, and implementation of interventions for residents experiencing behavioral episodes.</p> <p>4. As part of the facility's ongoing Quality Assurance program any incident will be reviewed by the Administrator or Director of Nursing to ensure the facility's policy and procedure has been followed. All incidents will be forwarded to the Quality Assurance committee to ensure all proper notifications have been made.</p> <p>5. 4/30/12</p>	4/30/12	

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #88 OWINGSVILLE, KY 40360		
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F 226	<p>Continued From page 3</p> <p>been asleep in his/her wheelchair just prior to the incident. She stated her process was to report to the nurse and since LPN #2 was there for the incident she was aware of the abuse allegation.</p> <p>Interview with LPN #2, on 04/25/12 at 4:00 PM, revealed she thought the resident to resident altercation was a reportable abuse allegation and therefore she reported the incident to the Administrator immediately after she had ensured the residents were separated and had assessed Resident #2's left hand.</p> <p>Interview with the Administrator, on 04/26/12 at 3:00 PM, revealed reporting a resident to resident altercation to the state agency would depend on who the residents were that were involved in the altercation. She indicated if there was an intent and if the resident was cognitively aware, then she would report the resident to resident altercation to the appropriate state agencies. Additional interview revealed she did not report the incident of Resident #1 squeezing Resident #2's hand because as soon as the incident happened the residents were immediately separated, Resident #2 was assessed for injuries, and Resident #1 was sent to the hospital related to his/her behaviors.</p>	F 226			