STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185254	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Nursing & Rehabilitation Facility	406 Wyoming Road Owingsville, KY 40360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, and review of the facility's policy, the facility failed to protect 1 of 11 sampled residents from physical abuse involving a resident to resident altercation, Resident (R) 21. On 01/13/2024 at 1:20 PM, State Registered Nurse Aide (SRNA) 7 witnessed R72 smack R21 in the face for taking R72's teddy bear away from her. Per review of the progress notes, R21 stated she thought her nose had been broken after the incident. The findings include: Review of the facility's policy titled, Abuse, Neglect, Protection, Prevention, and Reporting Policy, dated 08/04/2024, revealed the facility will conduct screenings and trainings to prevent and identify instances of abuse. Further review of the policy revealed that all reports of abuse will be investigated, ensuring the protection of victims and the reporting of all instances of abuse. Review of the facility's policy titled, Resident Rights Policy, dated of 08/13/2024, revealed all residents have the right to be treated with respect, dignity, and in a manner and environment that promotes maintenance or enhancement of their quality of life. Review of the Long-Term Care Facility-Initial Self-Reported Incident Form, dated 01/13/2024 at 3:03 PM, revealed the incident occurred on 01/13/2024 on A hall next to the nurses' station at 1:20 PM. Further review revealed R21, R72, and R240 were sitting near the nurses' station and SRNA7 witnessed R72 slap R21 in the face when R72 thought R21 had taken her stuffed teddy bear. While Licensed Practical Nurse (LPN) 4 was on the phone reporting the incident to the Administrator, she heard R240 yell out oh that hurt, and then R240 reported to LPN4 that R72 hit her on the right shoulder, which was not witnessed. Review of a witness statement from SRNA7, dated 01/13/2024, revealed SRNA7 stated that R72 was showing R21 her teddy bear when R21 took the bear to look at it and R72 got mad. R72 then leaned over and swatted R21 in the face on her nose twice. Review of R21's Face Sheet revealed the facility admitted the resident on 08/25/2022 with diagnoses to include acute kidney failure, anxiety, hypertension, and malignant of neoplasm of the upper lobe of the right lung. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/03/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident was severely cognitively impaired. Review of R21's Progress Notes, dated 01/13/2024 at 2:58 PM, revealed she had an acute change in condition that detailed the incident, and the nurse practioner (NP) made no recommendations for follow up care. Review of R21's Progress Notes, dated 01/13/2024 at 3:18 PM, revealed in an acute monitoring note that she was hit by R72 when she took R72's teddy bear and R21 stated she felt like her nose was broken. An attempt was made by the State Survey Agency (SSA) Surveyor to interview R21, on 05/05/2025 at 2:33 PM, but she was unable to answer questions due to a low BIMS score. Review of R72's Face Sheet revealed the facility admitted the resident on 11/22/2023 with diagnoses to include cerebral ischemia, hypertension, heart failure, and cognitive social/emotional deficit related to cerebrovascular disease. Review of R72's quarterly MDS, with an ARD of 01/05/2025, revealed the resident had a BIMS score of 4 out of 15, which indicated the resident was severely cognitively impaired. Review of R72's quarterly Minimum Data Set (MDS), dated 01/05/2024, revealed R72 was assessed as having physical and verbal behaviors directed toward others, 4 to 6 days but not daily. She was also assessed as having behavior symptoms not directed toward others, 1 to 3 days. Review of R72's Comprehensive Care Plan (CCP) from before the incident, dated 11/24/2023, and after the incident, dated 01/17/2024, revealed she was care planned for the focus of behaviors: yelling and cursing at staff and residents; agitation and aggression; combative with staff; exit seeking; refusing to put on clothes; looking in other residents' rooms; attempting to take other residents' items; raising fist at staff; hitting residents; using foul language; taking brief and pants off; and refusing skin checks. The goal was that R72 would have a reduction in these behavioral episodes. Further review of R72's CCP revealed the following interventions were in place: allow space; reapproach later if resident was resistive to care; ask for help if R72 was demonstrating abusive/resistive symptoms; convey acceptance during periods of inappropriate behaviors; encourage diversional activities that include providing art materials; communication of staff with R72 as tolerated; keeping environment as calm as possible; redirecting R72 as needed by all staff; removing R72 from public areas when behaviors posed a risk for harm; and when resident became agitated/had aggressive behaviors provide a quiet, calm setting. Review of R72's Progress Notes, dated 01/13/2024 at 2:58 PM, revealed in an acute monitoring note that she slapped her roommate in the face because she took her teddy bear and then moved to another resident and hit her while the nurse was making a phone call to report the abuse. R204 stated to LPN4 that R72 smacked her. Review of R72's Progress Notes, dated 01/13/2024 at 4:36 PM, revealed in a change in condition note that the NP made a recommendation for close monitoring. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R72's Progress Notes, dated 01/13/2024 through 01/21/2024, revealed she had acute monitoring notes for being on 1:1 supervision. An attempt was made by the SSA Surveyor to interview R72, on 05/05/2025 at 1:43 PM, but she was unable to answer questions due to a low BIMS score. Attempts were made by the SSA Surveyor on 05/06/2025 at 6:23 PM and 05/07/2025 at 12:13 PM to call SRNA7 for an interview, and she did not answer. A request was made for SRNA7 to return a call but she did not. In an interview on 05/06/2025 at 6:26 PM with Family Member (F) 12, the daugher of R72, she stated that she was never told that her mother had hit other residents in 2024. F12 stated she did not know if the facility had the psychiatry provider treat R72 or if they had changed her medications to help with her aggressive behaviors after the incidents. In an interview on 05/06/2025 at 6:32 PM with F13, the daughter of R21, she stated she remembered the facility telling her about another resident hitting her mother. She stated she did not remember the specific details of the incident but that her mother was not injured and had no changes in her mood. She further stated she thought it was an argument that precipitated the incident, and it was over something silly. In an interview with SRNA1 on 05/07/2025 at 9:01AM, she stated she remembered the incident when R72 smacked R21. SRNA1 stated staff no longer allow R72 to sit close enough to other residents to hit them. In an interview with LPN4 on 05/07/2025 at 12:26 PM, she stated she did not remember the exact instance of R72 hitting R21 because R72 had in the past frequently hit other residents. In an interview with LPN2 on 05/07/2025 at 8:50 AM, she stated R72 had a rough voice and said what she thought, and can be rude. She stated R72 was combative with staff but she never knew her to be that way with other residents. In an interview with the Psychiatric Nurse Practitioner (PNP) on 05/07/2025 at 1:27 PM, he stated R72 had a medication adjustment adjustment after the incident. Her Celexa (ordered for depression) was increased from 10 milligrams (mg) to 20 mg and he made other recommendations to the Medical Director for things to order if they did not see a decrease in R72's aggressive behaviors. In a concurrent interview with the Assistant Director of Nursing (ADON) 1, ADON2, and the Director of Nursing (DON) on 05/08/2025 at 7:59 AM, all stated that abuse should be reported immediately. In an interview with the Administrator on 05/08/2025 at 8:18 AM, she stated it was her expectation that staff report any incident that they feel could be abuse immediately to her, as she was the abuse coordinator, and the facility had been doing a lot of education about abuse. She stated signs were posted at the nurses' station with her phone number listed on them so that staff could contact her.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from misappropriation of resident property for 1 of 4 sampled residents, Resident (R) 51. The findings include: Review of the facility's policy titled, Medication Administration, dated 08/04/2024, revealed the person who prepares the dose for administration is the person who administers the dose and the individual who administers the medication dose records the administration on the resident's Medication Administration Record (MAR) which would show that the medication has been given. Review of the facility's policy titled, Preparation and General Guidelines; IIA7: Controlled Substances, dated 11/2021, revealed accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: date and time of administration; amount administered; remaining quantity; initials of the nurse administering the dose; and completed after the medication is administered. Review of R51's admission Record revealed the facility admitted the resident on 11/22/2022 with diagnoses to include chronic obstructive pulmonary disease (COPD) and pain due to internal orthopedic devices, implants, and grafts. Review of R51's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/29/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Review of R51's Physician Orders revealed an order was in place for a scheduled oxycodone (related to pain) 5 milligram (mg) tablet four times a day. Review of R51's Controlled Drug Record for 09/25/2025 revealed an oxycodone 5 mg tablet was signed out by Licensed Practical Nurse (LPN) 14 the following four times during her shift: 8:00 AM, 12:00 PM, and twice at 5:00 PM. Review of R51's electronic MAR revealed an oxycodone 5 mg tablet was only administered twice on 09/25/2025 by LPN14 at 12:00 PM and 6:00 PM. Review of a Medication Error Report, dated 09/26/2024, revealed one extra dose of oxycodone 5 mg was administered to R51 on 09/25/2024 at 8:00 AM by LPN14. A request was made on 05/09/2025 at 7:30 AM and again at 10:15 AM for shift change controlled substance count sheets for all medication carts for 09/26/2024, 09/28/2024, and 10/22/2024, but none of the requested documentation was received. LPN14 no longer worked at the facility at the time of survey and the State Survey Agency (SSA) Surveyor was unable to contact her for an interview. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN4 on 05/07/2025 8:44 AM, she stated controlled substances were locked in a box on the medication cart and when she pulled a medication from the box, she signed it out immediately on the controlled substance log. She further stated a complete controlled substance count was performed at shift change with the oncoming nurse. LPN4 stated if any discrepancies were found after the count, they were reported immediately to the Director of Nursing (DON). In an interview with LPN8 on 05/07/2025 at 9:18 AM, she stated when she started her shift on 09/25/2024, she completed a controlled substance count of the medication cart with LPN14, who had worked the previous shift with no issues found. LPN8 stated when she started her medication pass on B hall, several residents complained of pain and asked for pain medication, but when she checked the log, medications were signed out and could not be dispensed again. LPN8 stated she attempted numerous times to contact the previous administrator; when she finally reached him and the DON, she was asked to send copies of the controlled substance logs, which she did. LPN8 stated ultimately the facility completed a medication error report for R51 that stated an extra dose of medication was administered by LPN14 to R51. LPN8 stated the facility policy for controlled medication administration was order checked, medication pulled from the cart, signed off on the logbook, administered to resident, and then signed off on the MAR. In an interview with the DON on 05/07/2025 at 2:21 PM, she stated she received a phone call from LPN8 on 09/25/2024 that some residents complained pain medication was not given by the previous nurse. The DON stated she went to the facility and immediately initiated an investigation that included a complete full house narcotic count audit and a review of resident MARs. The DON stated nothing was found with the audit, but she continued her investigation, and it was ultimately determined LPN14 administered an extra dose of oxycodone 5 mg to R51, so a medication error report was completed. She further stated the resident was assessed and there were no signs of an adverse reaction. In an additional interview with the DON on 05/08/2025 at 7:39 AM, she stated it was her expectation nurses signed controlled substances out of the logbook immediately when pulled from the cart and signed out on the MAR immediately after the medication was administered. The DON stated all scheduled pain medications appeared with a red bar on the MAR as a reminder for staff to follow up, but the medications administered on an as needed basis were white, so sometimes the nurses signed them out of the logbook but forgot the MAR. She further stated she had provided reeducation to all nursing staff on this matter. In an interview with the Administrator on 05/08/2025 at 2:52 PM, she stated it was her expectation the controlled substance log and the MAR for each resident matched every time a controlled medication was pulled from the cart because all medications had to be accounted for. When asked if R51 was charged for the two unaccounted for oxycodone 5 mg tablets, she stated that was a good question, but never supplied a definitive answer. Additionally, the Administrator stated a situation such as this would be presented and discussed at a Quality Assurance Process Improvement (QAPI) meeting.