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	06/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases for 7 of 40 sampled residents (Resident (R) 16, R32, R40, R50, R78, R82, and R88). The findings include: Review of the facility's policy titled, Infection Prevention Manual for Long Term Care, undated, revealed gowns should be worn when there is potential for soiling clothing with blood/body fluids; the type of personal protective equipment [PPE] should be appropriate for the procedure being performed and the type of exposure anticipated. Review of the facility's policy titled, Medication Administration, dated 07/01/2024, revealed the facility will ensure medications are administered in accordance with manufacturers' specifications and good nursing principles and practices. Further review revealed gloves should be applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications; and hands are washed with soap and water or sanitized after administration and with any resident contact. Review of the glucometer manufacturer's cleaning instructions titled, Assure Prism Multi Blood Glucose Monitoring, revealed to minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions. Further review revealed the meter should be cleaned and disinfected after use on each patient. Continued review revealed the cleaning procedure needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. Review of the facility's policy titled, Catheter Associated Urinary Tract Infection (CAUTI) Prevention, dated 12/29/2021, revealed the purpose is to ensure appropriate technique in the care and maintenance of foley catheters; secure catheter properly to prevent movement; and keep the collection bag and the tube off the floor. 1. Review of R16's admission Record revealed the facility admitted the resident on 01/03/2024 with diagnoses including type 2 diabetes and Parkinson's disease. Review of R16's Care Plan Report revealed an intervention was initiated on 03/02/2026 for enhanced barrier precautions (EBP) related to a wound. Observation on 06/02/2026 at 12:09 PM revealed Licensed Practical Nurse (LPN) 1 entered the room (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	during medication pass, staff dropped a glove on the floor, both gloves were removed and thrown away, hand hygiene was performed, and the staff or staff members donned new gloves prior to administration of any medication. In further interview with the Administrator on 06/04/2026 at 3:06 PM, he stated it was important staff followed the facility's infection prevention and control policies, so residents were properly cared for and kept safe. 3. Observation on 06/03/2026 at 8:21 AM revealed LPN3 obtained R50's blood pressure using a shared blood pressure cuff. After use, LPN3 removed the cuff and placed it on the medication cart without cleaning or disinfecting it. Further observation at 9:04 AM revealed LPN3 used the same shared blood pressure cuff to obtain R88's blood pressure. Following use, the cuff was again placed on the medication cart without being cleaned or disinfected. During the same observation, LPN3 used R88's personal glucometer to obtain a blood glucose reading and placed the glucometer on the medication cart before administering medications. After medication administration, LPN3 stated, I'm going to put this back in his [R88] room, without cleaning or disinfecting the glucometer. During an additional observation on 06/03/2026 at 9:05 AM, LPN4 used her personal electronic wrist blood pressure cuff on R40 and then went to use it on R82 without cleaning the equipment between residents. During an immediate interview, LPN4 stated she thought she only had to clean the one on wheels. She further stated there was a risk of spreading germs if equipment was not cleaned between residents. In an interview with LPN3 on 06/03/2026 at 9:13 AM, she stated that the glucometer should be cleaned after each use, and the blood pressure cuff should be disinfected after use with each resident using purple wipes. LPN3 stated that purple wipes were not on her cart, and she obtained blue-top Clorox disinfecting wipes to clean the equipment. LPN3 stated that it was important to clean and disinfect equipment after each use to prevent the spread of germs and bacteria. In an interview with the IP on 06/04/2026 at 9:27 AM, she stated we don't like them to use the wrist cuffs, but indicated that the expectation was for all blood pressure cuffs to be cleaned and disinfected between each resident use. She stated the wrist blood pressure cuffs were not provided by the facility and were purchased by the nursing staff, on their own. She further stated the facility provides nurse on a stick blood pressure equipment for staff to use. The IP stated the residents' personal glucometers were to be cleaned and sanitized after each use and to be treated as a shared device. She further stated that cleaning and disinfecting equipment after each use was important to prevent the spread of infection. In an interview with the DON on 06/04/2026 at 8:35 AM, she stated the facility categorized infection control risks as low, medium, and high. She stated that shared blood pressure cuffs were considered low risk equipment and were expected to be cleaned between residents with the facility's blue top Clorox disinfectant wipes. The DON stated it was important to clean shared blood pressure cuffs between each resident to prevent the spread of infection and limit potential exposure to infections. She further stated that although the residents have their own individual glucometers, staff were still expected to clean and disinfect the device after each use, the same as they would for shared equipment. The DON stated that proper cleaning and disinfection was important to prevent the potential transmission of infections. In an interview with the Administrator on 06/04/2026 at 1:13PM, he stated the shared wrist cuffs had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	all been removed from the units. He further stated the staff were expected to clean equipment, including blood pressure cuffs and glucometers, in between each resident and in between use as it was important to prevent infections. 4. Observation on 06/03/2026 at 9:49 AM revealed R32 was lying in bed with the catheter bag located on the left side of the bed frame. The bed was in a lowered position, and the catheter bag was touching the floor. During an interview with LPN6 on 06/04/2026 at 10:46 AM, she stated the catheter bag should not hang on the floor because the floor was dirty. During an interview with the IP on 06/04/2026 at 3:24 PM, she stated the catheter bag should not be on the floor due to infection control concerns. During an interview with the DON on 06/04/2026 at 4:07 PM, she stated the catheter bag should be hung from the bed frame and not in the bend of the frame. During an interview with the Administrator on 06/04/2026 at 4:39 PM, he stated the catheter bag should not touch the floor due to infection control.