## Department of Health & Human Services Centers for Medicare & Medicaid Services

Printed: 07/31/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185306	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025			
Ridgewood Terrace Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Cornwall Drive  Madisonville, KY 42431				
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	Provide and implement an infection prevention and control program.					
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52041					
Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 18 sampled residents, (Resident (R)79).  The findings include:  Review of a facility policy titled Enhanced Barrier Precautions (EBP), undated, revealed EBP were used in conjunction with standard precautions. Per review, EBP expanded the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of multi-drug resistant organisms (MDRO) to staffs' hands and clothing. Further review of the policy revealed EBP precautions were indicated for residents with wounds and/or indwelling medical devices such as urinary catheters, even if the resident was not known to be infected or colonized with a MDRO.  Observation of the facility's 600-hall on 05/20/2025 at 10:00 AM, revealed two enhanced barrier carts located in hallway against the walls in between every other door on one side of the hallway, resident rooms [ROOM NUMBERS] and rooms [ROOM NUMBERS]. Continued observation revealed enhanced barrier and contact precaution signs lying on top of the carts.					
	In interview with Hydration Aide 1 on 05/20/2025 at 10:02 AM, she stated the (EBP) carts in the hallway stored the PPE supplies for the aides and nurses. She reported the yellow stickers on the name plates outside of the residents' rooms meant the resident was either on contact precautions or EBP. The Hydration Aide further stated she was not sure how to differentiate whether a resident was on contact precautions or EBP.					
	doors indicating if the resident was	2025 at 10:29 AM, she stated there wer s on EBP, contact precautions or not. S e 600-hall who were on contact precau	he stated she did not know if there			
	(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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 185306

If continuation sheet Page 1 of 3

## Department of Health & Human Services Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  INTERPRETATION NUMBER: 185306  NAME OF PROVIDER OR SUPPLIER Ridgewood Terrace Nursing Home  STREET ADDRESS, CITY, STATE, ZIP CODE 150 Comwall Drive Madisonville, KY 42431  For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.  [Each deficiency must be preceded by full regulatory or LSC identifying information)  In interview with Licensed Practical Nurse (LPN) 1 on 05/20/2025 at 10:52 AM, she stated residents had yellow dots by their names outside of their doors if they were on EBP. She said only certain wounds wer planed on EBP. LPN 1 reported for residents on contact precautions, they had pouches with supplies  Residents Affected - Few  In interview of the facesheet for R79 revealed the facility admitted the resident on 03/06/2025, with diagnot unique yract infection.  Review of Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD 04/01/2025, revealed the facility assessed R79 to have a Brief Interview for Mental Status (BIMS) score out of 15, indicating the resident had moderate cognitive impairment.  Review of R79's physician orders revealed the resident was to be on EBP related to an indwelling urinar catheter.  Observation of the 600-hall on 05/22/2025 at 11:00 AM, revealed a yellow dot beside R79's name outsid the room door, with PPE in an EBP cart located between rooms [ROOM NUMBERS]. Continued observer revealed Certified Nurse Aide (CNA) 7 and CNA 4 providing direct care for R79 in the residents room (603-A), at bedside without wearing the necessary personal protective equipment (PPE) required for the resident was one and a sign that as its see the nurse hanging outside the residents woon cather precautions.  In interview with CNA 4 on 05/21/2025 at 8:30 AM, she stated the yellow stickers beside residents room each other PPE when required and she should have done so this time, but, she stated the row other personal protective equipment (PPE) require				No. 0938-0391	
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Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few  Residents Affected - Few  1. Review of the facesheet for R79 revealed the facility admitted the resident on 03/06/2025, with diagnothat included chronic obstructive pulmonary disease, emphysema, acute respiratory failure with hypoxia, urinary tract infection.  Review of Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD 04/01/2025, revealed the facility assessed R79 to have a Brief Interview for Mental Status (BIMS) score out of 15, indicating the resident had moderate cognitive impairment.  Review of R79's physician orders revealed the resident was to be on EBP related to an indwelling urinar catheter.  Observation of the 600-hall on 05/22/2025 at 11:00 AM, revealed a yellow dot beside R79's name outside the room door, with PPE in an EBP cart located between rooms [ROOM NUMBERS]. Continued observative revealed Certified Nurse Aide (CNA) 7 and CNA 4 providing direct care for R79 in the resident's room (603-A), at bedside without wearing the necessary personal protective equipment (PPE) required for the resident's enhanced barrier precautions.  In interview with CNA 4 on 05/21/2025 at 8:30 AM, she stated the yellow stickers beside residents' name meant the resident was on EBP. She reported if the resident was on contact precautions there would be bag with supplies and a sign that said see the nurse hanging outside of the resident's door.  In additional interview with CNA 4 on 05/22/2025 at 11:05 AM, she stated she typically wore a gown and other PPE when required and she should have done so this time, but, she stated I honestly forgot. She seems the processing the stated I honestly forgot. She seems the processing the stated I honestly forgot. She seems the processing the stated I honestly forgot. She seems the processing the processing the stated I honestly forgot. She seems the processing the	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
because they had a catheter and/or wounds. She stated she had received training on how to wear PPE on infection control through monthly meetings and if there was anything that needed to be addressed. The CNA further stated a negative outcome of not following proper EBP was the spread of a harmful infection.  In interview with CNA 7 on 05/22/2025 at 11:10 AM, she stated she knew the yellow dot on the outside of residents' doors by their name indicated the resident was on EBP. She said she normally worked on the 400-hall and stated she was not very familiar with R79 and did not pay attention to whether he was on E or not. CNA 7 reported she had received training on proper PPE use and how to put on PPE; however, on the known how often she had received those trainings. She stated it was important to follow the facility's prelated to EBP and contact precautions to protect the resident from their germs and the germs of other residents. The CNA further stated negative outcomes of not following the facility's infection control and E policies could be swapping infections between residents.  (continued on next page)	Level of Harm - Minimal harm or potential for actual harm	In interview with Licensed Practical yellow dots by their names outside placed on EBP. LPN 1 reported for hanging outside the residents' door precautions or EBP.  1. Review of the facesheet for R79 that included chronic obstructive puurinary tract infection.  Review of Admission Minimum Data 04/01/2025, revealed the facility assout of 15, indicating the resident has Review of R79's physician orders recatheter.  Observation of the 600-hall on 05/2 the room door, with PPE in an EBP revealed Certified Nurse Aide (CNA (603-A), at bedside without wearing resident's enhanced barrier precaut In interview with CNA 4 on 05/21/20 meant the resident was on EBP. Shag with supplies and a sign that sate In additional interview with CNA 4 on other PPE when required and she served was on EBP possibly because because they had a catheter and/or on infection control through monthly CNA further stated a negative outcome In interview with CNA 7 on 05/22/20 residents' doors by their name indication of the CNA 7 reported she had received related to EBP and contact precautive residents. The CNA further stated in policies could be swapping infection	Nurse (LPN) 1 on 05/20/2025 at 10:52 of their doors if they were on EBP. She residents on contact precautions, they is. She further stated she did not know revealed the facility admitted the residulmonary disease, emphysema, acute of a Set (MDS) Assessment with an Assessessed R79 to have a Brief Interview for disease different was to be on EBP at 22/2025 at 11:00 AM, revealed a yellow of cart located between rooms [ROOM NA) 7 and CNA 4 providing direct care for the necessary personal protective equations.  225 at 8:30 AM, she stated the yellow is the reported if the resident was on contact and see the nurse hanging outside of the providing sand if there was anything the or wounds. She stated she had received a meetings and if there was anything the one of not following proper EBP was the providing on proper PPE use and those trainings. She stated it was interesting the resident from their gregative outcomes of not following the integrative	2 AM, she stated residents had a said only certain wounds were had pouches with supplies if there was anyone on contact sent on 03/06/2025, with diagnoses respiratory failure with hypoxia, and ressment Reference Date (ARD) of or Mental Status (BIMS) score of 10 or Mental Status (BIMS) score of 10 or Mental Status (BIMS) represent the resident's room uipment (PPE) required for the stickers beside resident's room uipment (PPE) required for the stickers beside residents' names are resident's door.  She typically wore a gown and a stated I honestly forgot. She said sidents were usually on EBP of training on how to wear PPE and that needed to be addressed. The ne spread of a harmful infection.  The yellow dot on the outside of the id she normally worked on the ention to whether he was on EBP how to put on PPE; however, did aportant to follow the facility's policy yerms and the germs of other	

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			10. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Ridgewood Terrace Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Cornwall Drive  Madisonville, KY 42431	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 - Few	In interview with the Infection Prever managers (UMs) did audits of staff once per week and more often that residents with chronic wounds that was indicated by a yellow dot by the precautions were indicated by the son the door.  In interview with the Director of Nut staff regarding the use of EBP was examples of high contact care were their catheter care. The DON said stated everyone that worked in the The DON further stated the training difference between the different type. In interview with the facility's Admir appropriate PPE according to the facility.	entionist (IP) on 05/22/2025 at 9:00 AM for surveillance of appropriate handwan that if there were more residents on prequired a dressing, those residents se resident's name outside of their door supply bag hanging right outside of the rsing (DON) on 05/23/2025 at 1:01 PM to use it appropriately and follow the fe changing linens, bathing residents, cousing EBP properly was important to prediction control training included return demonstration of donoes of transmission-based precautions instrator on 05/23/2025 at 1:33 PM, she acility's EBP policy. She stated a negary was the spread of infection from staff	If, she stated she and the unit ashing and appropriate use of PPE precautions. She reported for hould be on EBP. The IP said EBP is She additionally stated contact resident's door and a sign placed in the stated her expectation of her acility's policy. She reported hanging their briefs, and performing revent the spread of disease. She ing upon hire and yearly thereafter. In hing and doffing PPE and the stated she expected staff to wear tive outcome of her staff not using