STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185306	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Terrace Nursing Home	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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52041 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. In interview with CNA 1 on 05/20/2025 at 10:29 AM, she stated there were usually signs on the residents' doors indicating if the resident was on EBP, contact precautions or not. She stated she did not know if there were any residents currently on the 600-hall who were on contact precautions or EBP. (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 - Few	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 were placed on EBP. LPN 1 reported for residents on contact precautions, they had pouches with supplies hanging outside the residents' doors. She further stated she did not know if there was anyone on contact precautions or EBP. 1. Review of the facesheet for R79 revealed the facility admitted the resident on 03/06/2025, with diagnoses that included chronic obstructive pulmonary disease, emphysema, acute respiratory failure with hypoxia, and urinary tract infection. Review of Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/01/2025, revealed the facility assessed R79 to have a Brief Interview for Mental Status (BIMS) score of 10 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 urinary 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 observation 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' names meant the resident was on EBP. She reported if the resident was on contact precautions there would be a 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 said R79 was on EBP possibly because he had a catheter. CNA 4 reported residents were usually on EBP because they had a catheter and/or wounds. She stated she had received training on how to wear PPE and 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 the 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 EBP or not. CNA 7 reported she had received training on proper PPE use and how to put on PPE; however, did not know how often she had received those trainings. She stated it was important to follow the facility's policy related 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 EBP policies could be swapping infections between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Infection Preventionist (IP) on 05/22/2025 at 9:00 AM, she stated she and the unit managers (UMs) did audits of staff for surveillance of appropriate handwashing and appropriate use of PPE once per week and more often than that if there were more residents on precautions. She reported for residents with chronic wounds that required a dressing, those residents should be on EBP. The IP said EBP was indicated by a yellow dot by the resident's name outside of their door. She additionally stated contact precautions were indicated by the supply bag hanging right outside of the resident's door and a sign placed on the door. In interview with the Director of Nursing (DON) on 05/23/2025 at 1:01 PM, she stated her expectation of her staff regarding the use of EBP was to use it appropriately and follow the facility's policy. She reported examples of high contact care were changing linens, bathing residents, changing their briefs, and performing their catheter care. The DON said using EBP properly was important to prevent the spread of disease. She stated everyone that worked in the facility received infection control training upon hire and yearly thereafter. The DON further stated the training included return demonstration of donning and doffing PPE and the difference between the different types of transmission-based precautions. In interview with the facility's Administrator on 05/23/2025 at 1:33 PM, she stated she expected staff to wear appropriate PPE according to the facility's EBP policy. She stated a negative outcome of her staff not using appropriate PPE per the EBP policy was the spread of infection from staff to residents and staff possibly taking infections home with them.