| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **185306** | A. BUILDING _____ B. WING _____ | **06/29/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **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 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) was able to exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility. On [DATE], staff failed to honor Resident #1's right to refuse care when staff held the resident's arms, legs, and ankles to provide incontinent care and change his/her brief. Resident #1 was resistive, combative, and crying, and had previously told the staff no when the staff attempted incontinent care at 2:00 AM and 4:30 AM; however, at 5:,[DATE]:00 AM, Registered Nurse (RN) #1 held Resident #1's right arm/hand down on the bed by using her hand and knee, causing a skin tear on his/her right forearm, and right hand near his/her thumb/forefinger. Certified Nurse Aide (CNA) #1 held the resident's left hand and Nurse Aide (NA) #1 held the resident's ankles. The findings include: Review of the facility's policy titled, Resident Rights, dated [DATE], revealed a resident has the right to refuse treatment. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable.<br>Observation and interview of Resident #1, on [DATE] at 2:30 PM, revealed there was a quarter-sized area, slightly torn open in a U or V shape, with no active bleeding and steri-strips in place to the resident's forearm and a small open area, darkened around it, with no active bleeding to the resident's right hand between his/her right thumb and forefinger. Resident #1 stated the injuries occurred on [DATE], when she (RN #1) pushed on it. The resident spoke in a low tone and became tearful frequently during our conversation. Review of a Nurse's Note documented by RN #1, dated [DATE] at 5:45 AM, revealed signee and three (3) aides attempting to change resident's wet brief - resident had refused multiple times when asked by aides to perform personal hygiene - resident trying to hit, scratch, kick staff - while changing brief, signee noticed small skin tear to hand and forearm where resident had apparently bumped (himself/herself) while trying to hit staff. Interview with CNA #1, on [DATE] at 2:55 PM, revealed, on [DATE], she and NA #2 (orientee) did rounds around 2:00 AM and Resident #1 was combative and did not want to be changed. CNA #1 stated when they went back to change the resident during rounds at 4:30 AM to 4:45 AM, the resident still refused to be changed, so they decided to finish their rounds and knew dayshift would be there shortly and they had a better rapport with the resident. CNA #1 revealed when they finished their rounds, RN #1 asked if they had changed the resident, and they told her no but RN #1 did not listen to her fully and said it was unacceptable and the resident had to be changed. CNA #1 stated RN #1 told them to grab a few people, and then RN #1, NA #1, NA #2, and herself went to the resident's room. She stated the staff put gloves on, and when they went to change the resident the resident said no and became combative. She stated RN #1 then grabbed the resident's right forearm and put her knee on the resident's hand. CNA #1 revealed RN #1 had the resident with one hand and the other hand trying to get the resident's brief off, and she was on the resident's left side, holding the resident's left hand, and was trying to help with the brief. She stated when we rolled the resident, NA #1 slid the brief underneath the resident, and fastened it. She revealed at that time, the resident saw his/her hand was bleeding and asked what happened. RN #1 told the resident that he/she hit it on the siderail and the resident said to get out and stop touching him/her. CNA #1 stated NA #1, NA #2 and herself stayed in the room while RN #1 went to get supplies for the skin tears on the resident's right arm/hand. She stated Resident #1 had a big area on his/her hand where RN #1's knee was placed, which was about half-dollar size with the skin pulled back; and, an area on his/her right forearm, where RN #1's fingernails dug into the resident's skin, and was bleeding. She revealed the resident was combative and resistive the whole time they were in there, which was not normal for the resident. She stated while the RN was gone out of the room, the resident was crying and saying she broke my heart, and when the RN came back, the resident stated look what you did to my hand, and RN #1 denied it stating the resident hit it on the siderail. CNA #1 added they left the room after RN #1 bandaged the resident's right hand and arm, and the resident was still crying. She stated CNA #2 (dayshift staff) met her in the hallway, and asked the resident what was wrong. The resident was crying and told CNA #2, look what the nurse did showing CNA #2 his/her right arm/hand. Interview with NA #1, on [DATE] at 11:05 AM, revealed on [DATE], she was walking down another hall when CNA #1 and NA #2 came up to RN #1 and told her that the resident would not let them change him/her. She stated RN #1 asked her to come along because we're going to need some help. That's unacceptable, (he/she) has to be changed. NA #1 revealed they went to the resident's room, turned the light on, and the resident started crying and talking about his/her deceased spouse. She revealed RN #1 told the resident that they were going to change his/her brief, and the resident said to leave him/her alone. She revealed CNA #1 held the resident's left arm, RN #1 held his/her right arm/hand with both hands and one (1) knee, and she held the resident's ankles, or right above that, which were crossed. NA #1 stated they changed the resident but the resident was combative. She stated the resident had blood on his/her right wrist or a little below it, and blood between his/her right fingers near the thumb. She revealed the resident tried to blame the nurse, and stated you did this, but the nurse denied it and told the resident, we had to change you, but we have to patch you up now. She stated RN #1 left the room to get bandages and the resident started crying about his/her deceased spouse and got hysterical. She stated the RN came back, patched him/her up and left the room. Interview with NA #2 (orientee), on [DATE] at 4:06 PM, revealed on [DATE], she and CNA #1 made rounds throughout the shift, and each time Resident #1 was resistive to being changed, so we decided to try again later. She stated they told RN #1 that they would change the resident later and RN #1 stated no we're not, that's not acceptable, (he/she's) got be changed. NA #2 stated there were four (4) staff in the resident's room, and RN #1 immediately grabbed the resident's right arm, holding her knee on his/her forearm, and her hands on his/her right wrist. She also revealed the nurse had long acrylic nails. NA #2 recalled the resident had a cut on the top part of his/her right forearm and the resident said look what you did, but RN #1 blamed it on the resident. She revealed the resident was combative and crying the whole time, thinking (his/her) spouse was cheating on (him/her). She stated the resident was still crying when all of them left the room. She revealed she left the shift afterward, and added that RN #1 had been in a bad mood, hateful and rude to staff all night, not sure about any other residents. Interview with CNA #2, on [DATE] at 12:25 PM, revealed she worked dayshift and received report from the third shift CNA (#1) regarding the [DATE] incident, which had just ended when she clocked in. She revealed they did a walk through during report and when CNA #1 told her about Resident #1, she checked on the resident, and he/she was upset/crying, saying that mean nurse hurt my hand. She added the resident's right hand had blood on it. Interview with RN #1 (alleged perpetrator), on [DATE] at 2:23 PM, revealed I prefer not to make a statement at this time. Interview with the Administrator, on [DATE] at 6:00 PM, revealed RN #1's, CNA #1's, NA #1's and NA #2's actions were not appropriate, and they did not follow the Resident Rights policy. She stated CNA #1 was re-inserviced on [DATE]; and, NA #1 and NA #2 were re-inserviced on [DATE], on Abuse and Dealing with a combative resident; to include stop, |

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

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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| F 0550<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>re-approach, try a different method, different person, offer a snack, blanket, and Never force a resident or hold them down. She stated RN #1 was terminated on [DATE]. The Administrator revealed no other action was taken. |
| F 0600<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, review of the facility's investigation, and review of the facility policy, it was determined the facility failed to protect one (1) of three (3) sampled residents from abuse (Resident #1). On [DATE], Resident #1 refused incontinent care at approximately 2:00 AM and 4:30 AM when Certified Nurse Aide (CNA) #1 and Nurse Aide (NA) #2 (orientee) made their rounds. When Registered Nurse (RN) #1 became aware of this, she told CNA #1, NA #1, and NA #2 that was unacceptable and the resident had to be changed. RN #1, CNA #1, NA #1, and NA #2 attempted to provide incontinent care to Resident #1 and the resident refused, was crying, and became combative. RN #1 grabbed Resident #1's right arm and held it to the bed with her hands and knee, while CNA #1 held the resident's left arm, and NA #1 held the resident's ankles with them crossed. RN #1 caused a skin tear on the resident's right forearm with her nails and on his/her right hand near his/her thumb/forefinger with her knee. Resident #1 stated she broke my heart and told RN #1 look what you did referring to his/her hand/arm, while still crying. CNA #1 reported the incident to the oncoming dayshift CNA; however, CNA #1, NA #1 and NA #2, failed to protect residents from any further abuse when they failed to report the incident to a supervisor prior to leaving the facility. The findings include: Review of the facility's policy related to Resident Abuse, Neglect, and Exploitation, last revised [DATE], revealed it is the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. All staff are trained to identify and report inappropriate behaviors such as derogatory language, rough handling, and ignoring residents while giving care. Any incidents of suspected abuse involving staff toward a resident shall immediately be reported to the employee's immediate supervisor and the Administrator and/or designee, at which time an investigation will begin. Allegations will be thoroughly investigated by the Abuse/Neglect Coordinator, Administrator and/or designee. The resident's safety and protection will first be assured. Employees witnessing an incident of resident abuse must report the incident immediately. The employee(s) witnessing the abuse may be considered as an accessory to the abuse if they do not report the incident. As such, they will be subject to disciplinary action in the form of warnings, or discharge from employment, and if appropriate, legal action. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Further review of the MDS revealed the resident required limited to extensive assistance with activities of daily living (ADLs), only supervision while eating. Interview with Resident #1, on [DATE] at 2:30 PM, revealed the areas on his/her right forearm and right hand happened, on [DATE], when she (RN #1) pushed on it. Resident #1 spoke in a low tone and became tearful frequently during the conversation. Observations with RN #2 at this time revealed there was a quarter-sized area, slightly torn open in a U or V shape, with no active bleeding and steri-strips in place, on the resident's right forearm. Further observation revealed a small open area, darkened around it, with no active bleeding, on the resident's right hand, between his/her right thumb and forefinger. Review of a Nurse's Note documented by RN #1, dated [DATE] at 5:45 AM, revealed signee and three (3) aides attempting to change resident's wet brief - resident had refused multiple times when asked by aides to perform personal hygiene - resident trying to hit, scratch, kick staff - while changing brief, signee noticed small skin tear to hand and forearm where resident had apparently bumped (himself/herself) while trying to hit staff. Interview with RN #1 (alleged perpetrator), on [DATE] at 2:23 PM, revealed I prefer not to make a statement at this time. Interview with CNA #1, on [DATE] at 2:55 PM, revealed on [DATE], she and NA #2 (orientee) did rounds around 2:00 AM and 4:,[DATE]:45 AM and Resident #1 was being combative and did not want to be changed. CNA #1 stated they decided dayshift would be there by the time they finished the 4:30 AM round so they would wait to change the resident because dayshift had a better rapport with the resident. She revealed when they finished their rounds, RN #1 asked if they had changed Resident #1 and they told her no but before they could explain they were waiting for dayshift, RN #1 stated it was unacceptable and the resident had to be changed. CNA #1 said RN #1 told them to grab a few people, and then RN #1, NA #1, NA #2 and herself went to the resident's room, put their gloves on, and when they went to change the resident, the resident said no. CNA #1 further revealed that was when RN #1 grabbed the resident's right forearm, put her knee on the resident's right hand, and used the other hand to get the resident's brief off. CNA #1 stated she was on the resident's left side holding his/her left hand, and was trying to help with the brief, and NA #1 was next to RN #1. She stated when they rolled the resident, NA #1 slid the clean brief underneath the resident, and fastened it. She stated at that time, the resident saw his/her hand was bleeding and asked what happened and RN #1 told him/her that he/she hit it on the siderail. The resident then said to get out and stop touching him/her. CNA #1 stated the resident had a half dollar size area with skin pulled back on his/her hand where RN #1's knee was placed, and, an area that was bleeding on his/her right forearm where RN #1's fingernails dug in to his/her skin (RN #1 had long fake (acrylic) fingernails). CNA #1 revealed the resident was combative and resistive the whole time, which was not normal for him/her. She stated while the RN was gone out of the room to get supplies for the skin tears, the resident starting crying and saying she broke my heart, and when the RN came back, the resident stated look what you did to my hand, and RN #1 denied it saying he/she hit it on the siderail. CNA #1 added they left the room after the resident hand and arm were bandaged and the resident was still crying. She stated the dayshift CNA (#2) met her in the hallway, and asked the resident what was wrong and the resident aid look what the nurse did showing her (his/her) right arm/hand. The resident was still crying. She stated when she gave report to CNA #2, CNA #2 told her she needed call the Director of Nursing (DON) or the Administrator to let them know about it. She said she left the facility at 6:00 AM; however, the Administrator, who was the Weekend Manager, called her when she got home, after CNA #2 had reported the incident to her. In addition, review of CNA #1's written statement revealed the resident was being combative, and the Charge Nurse grabbed his/her hand and put her knee with full force on the resident's hand, with her fingernails digging into his/her arm, which caused two (2) skin tears. Further review of the statement revealed CNA #1 reported the Charge Nurse had no reason to do what she did. The resident was panicking and becoming more combative when the Charge Nurse was on his/her arm/hand. Interview with NA #2, on [DATE] at 4:06 PM, revealed she and CNA #1 made rounds throughout the shift, and each time Resident #1 was resistive to being changed, so we decided to try again later. She stated they told RN #1 they were going to change the resident later and she stated no we're not, that's not acceptable, (he/she's) got be changed. NA #2 revealed there were four (4) staff in the resident's room, and RN #1 immediately grabbed his/her right arm, holding her knee on his/her right forearm, and had her hands on his/her right wrist. NA #2 recalled the resident had a cut on the top part of his/her right forearm and the resident said look what you did, but RN #1 blamed it on the resident. She revealed the resident was combative and crying the whole time,thinking (his/her) spouse was cheating on (him/her). and the resident was still crying when all of them left the room. She revealed RN #1 had been in a bad mood, hateful and rude to staff all night, not sure about any other residents. Further interview with NA #2, on [DATE] at 5:35 PM, revealed she did not report the incident because CNA #1 and NA #1 said they'd report it. She revealed the Administrator called her a few minutes after she got home, about 6:20 AM or 6:30 AM, on [DATE]; and the incident had occurred around 5:50 AM or 6:00 AM that morning. She stated she should have reported to another nurse before she left the building. In addition, review of NA #2's statement revealed the nurse held the resident down very roughly with her knee and dug her nails in (his/her) arm, which caused (him/her) to bleed. Nobody else acted that way, it was her anger. Interview with NA #1, on [DATE] at 11:05 AM, revealed on [DATE], she was walking down another hall when CNA #1 and NA #2 came up to RN #1 and told her that the resident would not let them change him/her. She stated RN #1 asked her to come along because we're going to need some help. That's unacceptable, (he/she) has to be changed. She stated they went to the resident's room, turned the light on, and the resident was still awake and he/she started crying and talking about his/her deceased spouse. She revealed, altogether, there were four (4) staff in the room. She stated RN #1 told the resident that they were going to change his/her brief, and the resident said to leave him/her alone. She revealed CNA #1 was holding the resident's left arm, RN #1 was holding his/her right arm/hand with both hands and one (1) knee, and she was holding the resident's ankles, or right above that, which were crossed. She stated they changed the resident but he/she was combative and they told him/her not to hit or kick us. She revealed the resident had blood on his/her right wrist or a little below |

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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>it, and blood between his/her right fingers near his/her thumb. She stated the resident tried to blame the nurse, and stated you did this, but the nurse denied it and told the resident, we had to change you, but we have to patch you up now. She stated RN #1 left the room to get bandages and the resident started crying about his/her deceased spouse and got hysterical. She stated the RN came back, patched him/her up and left the room. She revealed she thinks CNA #1 texted the DON after they left the room, and then she went back to work, gave report to dayshift, and clocked out. Further interview with NA #1, on [DATE] at 5:24 PM, revealed she did not have phone numbers to report what happened at that time. She stated she should have reported to the other nurse there. In addition, review of NA #1's written statement revealed I saw the Charge Nurse apply way too much force on the resident's right arm, and jerk (him/her). At one of those points, her nails must've dug into (his/her) skin, which caused two (2) skin tears. She did not need to put that much force on (him/her). (He/she) also started to get more combative after the fact. Interview with CNA #2, on [DATE] at 12:25 PM, revealed she worked dayshift and received report from the third shift CNA (#1) regarding the [DATE] incident, which had just ended when she clocked in. She revealed they did a walk through during report. She stated as soon as CNA #1 told her about Resident #1, she checked on the resident and the resident was upset/crying, saying that mean nurse hurt my hand and she observed blood on the resident's right hand. She revealed she reported to the Administrator, who was the Weekend Manager, and in the building that morning. She stated after she reported the incident, the Administrator took it over. In addition, review of CNA #2's written statement revealed in report, (CNA #1) told me that (RN #1) and the three (3) aides were told that they had to change (Resident #1). (Resident #1) was upset and (RN #1) held (his/her) hand down with her knee, causing a skin tear. Interview with RN #2, on [DATE] at 6:38 PM, revealed she came in at 6:00 AM on [DATE] (Saturday) and received report from RN #1. She stated RN #1 stated the resident was being combative and got a skin tear on his/her right arm. She revealed she had never had an issue with the resident; however, when she saw the resident after report, he/she was still upset and yelling/crying, and she observed steri-strips on the top of the resident's right arm. Interview with the SSD/Abuse Coordinator, on [DATE] at 1:40 PM and [DATE] at 9:35 AM, revealed she and the Administrator conducted a joint investigation. She stated the Administrator had come in as Weekend Manager on [DATE], early that morning. She stated the Administrator spoke to CNA #2, CNA #1, and NA #1 , and the Administrator then called her, and she came to the facility. She revealed the three (3) staff gave their written statements to the Administrator; however, RN #1 refused to give a statement, and was escorted out of the building. She stated the resident recalled the incident and what the nurse was wearing, but did not remember her name. Further interview with the SSD/Abuse Coordinator revealed the appropriate notifications (Physician, family, police) were made, and stated we felt it was abuse. Interview with the Director of Nursing (DON), on [DATE] at 10:25 AM, revealed looking at her phone, she did not have a text message from (CNA #1) or any other of the other staff involved, on [DATE]. The DON stated the staff should have immediately reported to the nurse on the other unit (LPN #1), before ever leaving the building. She revealed CNA #1 and NA #1 should have told LPN #1 when they first saw RN #1 was angry. She stated she did not get to speak to RN #1 after the incident on [DATE], but she was usually very attentive to the residents. Review of the facility's final investigation, dated [DATE], completed by the Social Services Director (SSD)/Abuse Coordinator, revealed Staff was attempting to change the resident when the resident became combative with staff. Resident has had confusion during the process of recovering from COVID-19. Staff attempted to redirect the resident with the resident continuing to be combative. Staff stopped trying to change the resident at this time to let (him/her) calm down. It is likely that the RN took her knee and pressed it onto the resident's right hand holding (him/her) down to prevent further combative behavior. In the process of this, it appears that the resident obtained skin tears and bruising to (his/her) right hand and arm. Skin assessments were completed and the skin tear was cleansed and dressed. Families and MD were notified as well as the local police department. The resident continues to have some confusion, but expresses no concerns from the incident. The RN is no longer an employee with the facility. Witness statements from CNA #1, CNA #2, NA #1, and NA #2 (orientee) were included in the investigation. Interview with the Administrator, on [DATE] at 10:20 AM, revealed she came in about 5:00 AM on [DATE] due to being the Weekend Manager. She stated CNA #2, who was a dayshift CNA, came to her after CNA #1 reported to CNA #2 about Resident #1. Further interview with the Administrator revealed CNA #2 reported to her that CNA #1 said the resident received a skin tear on his/her right hand, as well as bruising. She stated she called CNA #1, NA #1 and NA #2, who had already left the building from working nightshift. She revealed RN #1 was giving report to the dayshift RN (#2) and she spoke to RN #1 in the clean utility room, with RN #2 as a witness. She stated RN #1 was angry and upset, but she did not see any blood on her. She further revealed she gave RN #1 an opportunity to write a statement; however, she chose not to. She stayed with RN #1 until she finished charting, and walked her out. She revealed the investigation was completed on [DATE] and she called RN #1 and terminated her on [DATE]. Further interview with the Administrator, at 6:00 PM, revealed she did not know if CNA #1, NA #1 and NA #2 felt uncomfortable to say anything to RN #1, because she was their supervisor; but, their actions were not appropriate, and they did not follow the policy related to Abuse/Neglect related to reporting. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, facility final report of allegation, and facility policy review, it was determined the facility failed to ensure an allegation of abuse was reported immediately for one (1) of three (3) sampled residents (Resident #1). On 06/20/2020, Resident #1 refused incontinent care during rounds at approximately 2:00 AM and 4:30 AM. When Certified Nurse Aide (CNA) #1 and Nurse Aide (NA) #2 made Registered Nurse (RN) #1 aware of this, she told CNA #1, NA #1, and NA #2 (orientee) that was unacceptable and the resident had to be changed. RN #1 told NA #1 to accompany her, CNA #1, and NA #2 to the resident's room. When they attempted to provide incontinent care to Resident #1, the resident refused, was crying, and became combative. RN #1 then proceeded to grab Resident #1's right arm and hold it to the bed with her hands and knee, while CNA #1 held the resident's left arm, and NA #1 held the resident's ankles with them crossed. RN #1 caused a skin tear on the resident's right forearm with her nails and on his/her right hand near his/her thumb/forefinger with her knee. Resident #1 stated she broke my heart and told RN #1 look what you did referring to his/her hand/arm, while still crying. CNA #1 reported the incident to CNA #2 (dayshift CNA) during report; however, CNA #1, NA #1 and NA #2 failed to report the incident to a supervisor. CNA #2 reported the incident to the Administrator, who was the Weekend Manager, and had been in the building since 5:00 AM on 06/20/2020. The findings include: Review of the facility's policy related to Resident Abuse, Neglect, and Exploitation, last revised 07/08/17, revealed all staff are trained to identify and report inappropriate behaviors such as derogatory language, rough handling, and ignoring residents while giving care. Any incidents of suspected abuse involving staff toward a resident shall immediately be reported to the employee's immediate supervisor and the Administrator and/or designee, at which time an investigation will begin. Employees witnessing an incident of resident abuse must report the incident immediately. The employee(s) witnessing the abuse may be considered as an accessory to the abuse if they do not report the incident. As such, they will be subject to disciplinary action in the form of warnings, or discharge from employment, and if appropriate, legal action. Record review revealed the facility admitted Resident #1 on 01/29/2020 with [DIAGNOSES REDACTED]. Interviews on 06/24/2020 with CNA #1 at 2:55 PM and NA #2 (orientee) at 4:06 PM; and on 06/25/2020 with NA #1 at 11:05 AM, revealed Resident #1 refused incontinent care at approximately 2:00 AM and 4:30 AM when CNA #1 and NA #2 made their rounds. The CNA and Aides stated CNA #1 and NA #2 decided to wait for day shift due to them having a better rapport with the resident. The CNA and Aides revealed when Registered Nurse (RN) #1 was made aware the resident refused, RN #1 told NA #1 to come with her, CNA #1, and NA #2 (orientee), and stated that was unacceptable and the resident had to be changed. The CNA and Aides further stated when they and RN #1 attempted to provide incontinent care to Resident #1, the resident refused, was crying, and became combative; and, RN #1 proceeded to grab Resident #1's right arm and hold it to the bed with her hands and knee. They stated RN #1 caused a skin tear with her nails on the resident's right forearm and on his/her right hand near his/her thumb/forefinger with her knee. The CNA and Aides revealed Resident #1 stated she broke my heart and told RN #1 look what you did referring to his/her hand/arm, while still crying. Interview with CNA #2, on 06/26/2020 at 12:25 PM, revealed she received report from CNA (#1) regarding the 06/20/2020 incident. She stated they were doing a walk through during report, and CNA #1 told her about Resident #1. She stated she checked on the resident and the resident was was upset/crying, saying that mean nurse hurt my hand. She revealed the resident's right hand had blood on it. She stated she reported this immediately to the Administrator, who was the Weekend Manager, and in the building that morning. Review of the facility's final investigation, |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185306 | A. BUILDING _____ B. WING _____ | 06/29/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| 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 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>dated 06/22/2020, completed by the Social Services Director (SSD)/Abuse Coordinator, revealed the allegation was initially reported to the Administrator by CNA #2 (dayshift aide) on 06/20/2020, after receiving report from CNA #1 (nightshift aide) that morning. However, there was no documented evidence the facility identified and took action related to CNA #1, NA #1 and NA #2 failing to report the allegation to an immediate supervisor. Further interview with CNA #1 on 06/24/2020 at 2:55 PM revealed she made the day CNA (#2) aware of the incident when she met her in the hallway after leaving the room. She stated when she gave report to CNA #2, CNA #2 told her she needed call the Director of Nursing (DON) or the Administrator to let them know about it. She said she left the facility at 6:00 AM; however, the Administrator, who was the Weekend Manager, called her when she got home, after CNA #2 had reported the incident to the Administrator. Further interview with NA #2, on 06/28/2020 at 5:35 PM, revealed she did not report the incident because CNA #1 and NA #1 said they'd report it. She revealed the Administrator called her a few minutes after she got home, about 6:20 AM or 6:30 AM, on 06/20/2020; and the incident had occurred around 5:50 AM or 6:00 AM that morning. She stated she should have reported to another nurse before she left the building. Further interview with NA #1, on 06/28/2020 at 5:24 PM, revealed she did not have phone numbers to report what happened at the time and she thinks CNA #1 texted the DON, and the DON said to report to the other facility nurse. She stated she should have reported to the other nurse there. Interview with the DON, on 06/29/2020 at 10:25 AM, revealed she was not notified by the staff about RN #1 on 06/20/2020. She revealed the staff involved should have immediately reported to the nurse on the other unit, before ever leaving the building, and CNA #1 and NA #1 should have notified the other nurse when they first saw RN #1 was angry. Interview with the Administrator, on 06/25/2020 at 10:20 AM, revealed she came in about 5:00 AM on 06/20/2020 due to being the Weekend Manager. She stated CNA #2 reported to her that CNA #1 said the resident had received a skin tear on his/her right hand, as well as bruising, during the incident. She stated she called CNA #1, NA #1 and NA #2, who had already left the building from working nightshift. Further interview with the Administrator, at 6:00 PM, revealed she did not know if CNA #1, NA #1 and NA #2 felt uncomfortable to say anything to RN #1, but their actions were not appropriate, and they did not follow the policy related to Abuse/Neglect related to reporting. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement the care plan for one (1) of three (3) sampled residents (Resident #1). Resident #1 was care planned on 05/27/2020 to allow the resident to calm down then re-approach later, or try another staff member to provide care, if resident refuses to be change and becomes combative. On 06/20/2020, Resident #1 refused incontinent care and became combative during rounds at approximately 2:00 AM and 4:30 AM and Certified Nurse Aide (CNA) #1, and Nurse Aide (NA) #2 (orientee), followed the care plan and were going to let day shift try to provide incontinent care because the resident had better rapport with them, However, at 5:50 AM-6:00 AM, when Registered Nurse (RN) #1 was made aware the resident had refused incontinent care; she stated it was unacceptable and the resident had to be changed. RN #1 instructed CNA #1, NA #2, and NA #1 to accompany her to the resident's room. Resident #1 refused and was crying and combative and RN #1 proceeded to hold Resident #1 right arm down with her knee and hand which resulted in a skin tear on his/her right forearm and on his/her right hand near his/her thumb/forefinger. CNA #1 held the resident's left hand and NA #1 held the resident's ankles. The findings include: Review of the facility's Comprehensive Care Plan Policy, dated 01/2020, revealed residents receive care and treatment based on an assessment of their needs, the severity of their [DIAGNOSES REDACTED]. Record review revealed the facility admitted Resident #1 on 01/29/2020 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data<br>Set (MDS) assessment, dated 05/07/2020, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Review of Resident #1's Care Plan Focus, Resident exhibits socially inappropriate/disruptive behavior, refuses to be changed, hits/scratches/kicks staff at times, pseudolrellar effect (uncontrollable episodes of crying and/or laughing, or other emotional displays}, dated 05/27/2020, revealed an intervention if resident is combative, allow resident to calm down, then re-approach later, or try another staff member to provide care. However, interviews on 06/24/2020 with CNA #1 at 2:55 PM and NA #2 (orientee) at 4:06 PM; and on 06/25/2020 with NA #1 at 11:05 AM, revealed on 06/20/2020, when Registered Nurse (RN) #1 was made aware Resident #1 had refused incontinent care, she told CNA #1, NA #2 and NA #1, that was unacceptable and the resident had to be changed. RN #1 had CNA #1, NA #2, and NA #1 assist her to provide incontinent care but Resident #1 refused and was crying and became combative. RN #1 proceeded to grab Resident #1 right arm and hold it down on the bed with her hands and knee causing a skin tear on his/her right forearm and on his/her right hand near his/her thumb/forefinger. CNA #1 and NA #1 also helped change the resident. Observation and interview with Resident #1, on 06/25/2020 at 2:30 PM, revealed the areas on his/her right forearm and right hand happened, on 06/20/2020, when RN #1 pushed on it. The resident spoke in a low tone and became tearful frequently during the conversation. Observation revealed a quarter-sized area, slightly torn open in a U or V shape, with no active bleeding on resident's right forearm and a small open area, darkened around it, with no active bleeding on right hand between his/her right thumb and forefinger. Interview with RN #1 (alleged perpetrator), on 06/30/2020 at 2:23 PM, revealed I prefer not to make a statement at this time. Interview with the MDS Coordinator (RN #3), on 06/29/2020 at 3:20 PM, revealed residents have the right to refuse any care, but staff should try to find out why the resident refused care, or maybe try to find someone who has a good rapport with the resident. Interview with the Director of Nursing (DON), on 06/29/2020 at 10:25 AM, revealed she expected staff to follow residents' care plans when providing care. Interview with the Administrator, on 06/29/2020 at 4:05 PM, revealed staff should try to reapproach a resident if combative. |