

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/12/2012
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended Statement of Deficiencies - 06/05/12 A standard health survey was conducted 04/10/12 through 04/12/12. A Life Safety Code Survey was conducted on 04/10/12. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before remedies would be imposed. KY #18144, KY #18151, and KY # 18175 was investigated in conjunction with the standard survey. The Division of Health Care Substantiated KY #18144 in the category of infection control; however, no regulatory violations were identified related to the allegation. KY #18175 was reinvestigated and found to be Substantiated with continued non-compliance found in F280. KY #18151 and was found to be Unsubstantiated. This was a NHI survey with entrance to the facility at 5:30 AM on 04/10/12.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156		

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 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted 04/10/12 through 04/12/12. A Life Safety Code Survey was conducted on 04/10/12. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before remedies would be imposed.</p> <p>KY #18144, KY #18151, and KY # 18175 was investigated in conjunction with the standard survey. The Division of Health Care Substantiated KY #18144 in the category of infection control; however, no regulatory violations were identified related to the allegation. KY #18175 was reinvestigated and found to be Substantiated with continued non-compliance found in F279. KY #18151 and was found to be Unsubstantiated.</p> <p>This was a NHI survey with entrance to the facility at 5:30 AM on 04/10/12.</p>	F 000	<p>The submission of this Plan Of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Glen Ridge. This facility recognized it's obligation to provide legally and medically necessary care and services to it's residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive care facility. (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p>	
F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is</p>	F 156		

RECEIVED
 MAY 21 2012
 5-21-12
 OFFICE OF THE GENERAL SUPERVISOR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x Rachel C. Bufford</i>	TITLE <i>x ED</i>	(X6) DATE
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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.

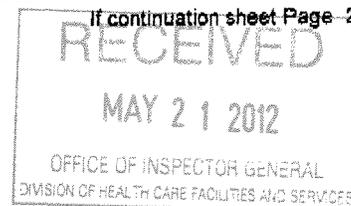
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F 156	<p>Continued From page 1</p> <p>entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone</p>	F 156	<p>1. Resident's A, B, and C have been discharged from the facility.</p> <p>2. All resident's receiving medicare services are now issued a notice of medicare provider non coverage letter with information on appeal rights prior to termination of medicare services by the Director of Resident Services.</p> <p>3. During weekly medicare meetings, the DRS will be notified of all identified medicare pending discharges by the ED/DHS/ADHS. The Executive Director or Director of Health Services will re-educated Director of Resident Services and Business Office Manager on Beneficiary Notice Requirements on 5/23/12.</p> <p>4. Prior to termination of Medicare services ED or DHS will audit 5 resident clinical records weekly to ensure the appropriate beneficiary notice requirement was provided. These audits will continue for 12 weeks. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for three consecutive months.</p> <p>5. Completion date:5/27/2012</p>	
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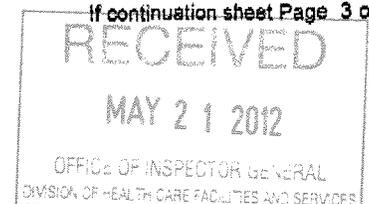
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F 156	<p>Continued From page 2</p> <p>numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156		
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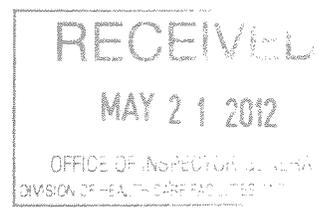
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F 156	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Medicare residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) Unsampled closed record review (Unsampled Residents A,B, and C) with expanded review of fifty-one records. The facility failed to issue a letter of non-coverage, with information on beneficiary appeal rights for those residents that were discharged from the facility after Medicare Part A services were terminated.</p> <p>The findings include:</p> <p>Review of the facility's admission/financial agreement provided information on how the resident could apply for benefits under Medicare and Medicaid. A copy of the facility's Demand Bill policy and procedure was included in the admission packet and provided to the resident or responsible party during the admission process.</p> <p>During Liability Notices & Beneficiary Appeal Rights review conducted, on 04/012/12 at 4:00 PM, it was found the facility had failed to issue the non-coverage letters to any Medicare Part-A residents notifying the residents of when a skilled service would end and the resident's right to request an appeal.</p> <p>1. A closed record review of Unsampled Resident-B revealed the resident received Medicare Part-A skilled services from 03/04/12-03/30/12 then the resident was discharged to</p>	F 156		
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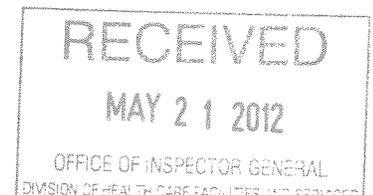
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F 156	<p>Continued From page 4</p> <p>home. Medicare Part A skilled services was discontinued on 03/30/12 with remaining ninety-four (94) skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>2. A closed record review of Unsampled Resident-C clinical record revealed the resident received Medicare Part-A skilled services from 02/06/12- 03/21/12. Medicare Part A skilled services was discontinued on 03/21/12 with forty-four (44) skilled days left. The facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>3. A closed record review of Unsampled Resident-D revealed the resident received Medicare Part-A skilled services from 03/06/12- 03/26/12. Medicare Part A skilled services was discontinued on 03/26/12 with remaining eighty (80) skilled days left. The facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>Continued review of the discharged list of resident who had a Medicare Part-A skilled stay from January 25, 2012-April 10, 2012, revealed fifty-four residents (including Unsampled Residents B, C, and D) did not receive the appropriate Liability and appeal notices.</p> <p>Interview with the Executive Director, on 04/12/12 at 2:10 PM, revealed she had just become aware that the facility was not issuing the appropriate liability and appeal notices. She stated it was the responsibility of the Director of Resident Services/Social Services to issue the Notice of</p>	F 156			

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MAY 21 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 156	Continued From page 5 Medicare Non-Coverage letter prior to the discontinuation of the skilled service. She further stated upon knowledge that the letters were not being issued, she instructed the Social Service Director to start issuing the letters and the identified problem was taken to the Quality Assurance (QA) meeting. The Executive Director could not provide documented evidence that this had been done. Interview with the Director of Resident Services/Social Service Director, on 04/12/12 at 2:20 PM, revealed she did not know she was responsible for the Liability Notices & Beneficiary Appeal letters after a resident's Medicare Part A skilled services were terminated. She stated she thought the business office had issued those letters and she had not provided the notice of non-coverage to residents who were discharged from the facility even though the residents had not exhausted all their skilled days. She thought the letters were only issued when an insurance company had denied any further coverage. She indicated she was informed by the Executive Director by e-mail, on 03/19/12, that the Non-Coverage letters must be issued and sent a copy of the letter to her. She stated she then began to issue the letters. Review revealed three (3) Notice of Medicare Non-Coverage letters were issued on 04/11/12 for end of skilled services on 04/16/12, 04/17/12, and 04/21/12. The letters were signed by the residents.	F 156		
F 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these	F 168		



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F 168

Continued From page 6 agencies.

This REQUIREMENT is not met as evidenced by:
 Based on observation and interview it was determined the facility failed to include all survey results in the survey book for residents, staff, and visitors to review.

The findings include:

Observation made of the survey binder in the front lobby, on 04/12/12 at 10:40 AM, revealed the only documents present were the last survey dated 02/2011 and the Life Safety code results dated 02/2011. No other documents were observed in the survey binder.

Interview with the Director of Nursing (DON), on 04/12/12 at 4:15 PM, revealed she was aware the survey results were to be available to residents. The DON stated she was not aware that all the results were not placed in the binder. She further stated it was the residents right to be able to view the survey results.

Interview with the Administrator, on 04/12/12 at 11:15 AM, revealed she was not aware of deficiencies resulting from a complaint investigation was to be posted in the survey binder along with the standard surveys results. She further stated it was the residents right to view the survey results.

483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS

A facility must assess a resident using the

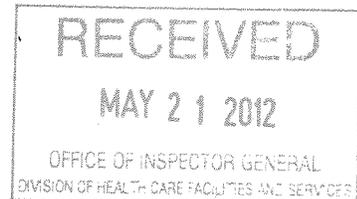
F 168

- All copies of survey results to include annual Life safety and complaint surveys have been placed in the survey binder in the front lobby by the ED.
- All residents have the potential to be affected by the deficient practice.
- ED/DHS will be re-serviced by Toni DuVall clinical support on regulatory compliance regarding all survey results being available for residents, staff, and visitors to review on 5/22/12.
- DHS/ADHS to audit survey binder weekly to assure compliance for 12 weeks. Binder will be audited during biannual peer review for one year. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.
- Completion date is May 27th, 2012

- Resident #2 quarterly assessment was completed by MDS coordinator on 4/12/12.
- All residents Obra

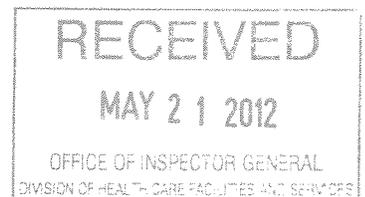
F 276

F 276
SS=D



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F 276	<p>Continued From page 7</p> <p>quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy Clinical Documentation Systems, and the Resident Assessment Instrument (RAI) 3.0 Manual, it was determined the facility failed to ensure a quarterly review assessment was completed within the required timeframe for one (1) of the sixteen (16) sampled residents. The facility did not complete Resident #2's quarterly assessment, that was due on 03/12/12, until 04/12/12, which was 31 days late.</p> <p>The findings include:</p> <p>Review of the facility's policy Clinical Documentation Systems, not dated, revealed quarterly assessments were not discussed regarding timeframe for completion and assessment.</p> <p>Review of the RAI 3.0 Manual, dated September 2010, revealed the quarterly (non comprehensive) must be completed at least every ninety-two (92) calendar days with fourteen (14) days to complete.</p> <p>Record review for Resident #2 revealed the last quarterly review occurred on 12/06/11. The next quarterly review was to be completed by 03/12/12. The quarterly assessment was not completed until 04/12/12, which was thirty-one</p>	F 276	<p>assessment schedules were initially audited by MDS/DHS coordinator on 4/11/12 to assure assessments completed within their required time frame.</p> <p>Any non compliance was corrected in the following way.</p> <p>a. Late assessments were completed on 4/11/12, 4/12/12, 4/13/12, 4/20/12.</p> <p>b. Second audit completed by ED/DHS on May 15, 2012</p> <p>c. OBRA assessments will be current as of May 27th, 2012.</p> <p>3. Systemic changes will be implemented as follows. MDS coordinator will use a separate monthly calendar to track Obra assessments to ensure assessments are completed per regulatory time frame. MDS coordinators will be re-in serviced by Clinical Assessment Coordinator on RAI requirements with an emphasis on time frame of Obra assessment on May 18th, 2012.</p> <p>4. Audits will be completed to cross match mds date reports with MDS calendar to assure timely Obra assessments. Audits will be completed by DHS/ADHS as follows.</p> <p>3 obra assessments audited monthly x 3 months, then 2 assessments x 2 months, then 1 assessment x 1 month. These audits will be submitted to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months.</p> <p>5. Completion Date: May 27, 2012</p>	



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F 276

Continued From page 8
 (31) days late.

Interview with the MDS Coordinator, on 04/10/12 at 2:30 PM, revealed Resident #2 was assigned to the other MDS coordinator who was out for the week. The MDS Coordinator revealed she was unable to find any information regarding the completion of the quarterly assessment. The MDS Coordinator revealed review of the MDS schedule had Resident #2 scheduled to have the assessment completed but did not know why it was not done.

F 276

F 279
 SS=D

Continued interview with the MDS Coordinator, on 04/12/12 at 2:45 PM, revealed residents need to be evaluated every quarter to see if there are changes and because it was required. The assessments provide us with a picture of the resident. The MDS Coordinator revealed a potential to not catch a change from the residents baseline.

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

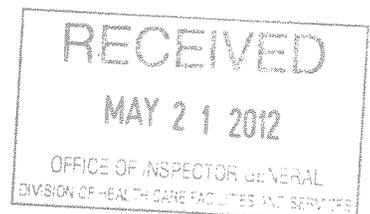
The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and

F 279

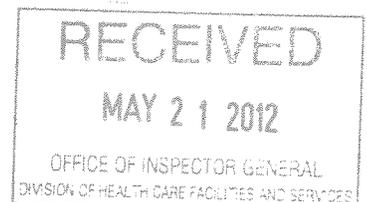
1. Resident# 3 careplan was updated by MDS coordinator to include care and maintenance of foley catheter on May 14, 2012.

2. All residents with foley catheter care plans will be audited by DHS/ADHS to insure compliance on 5/15/12. Any non compliance will be corrected.



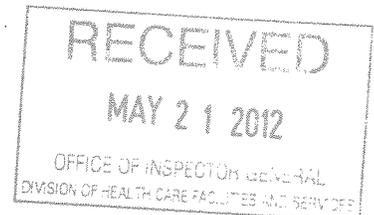
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
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F 279	<p>Continued From page 9</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review it was determined the facility failed to develop a comprehensive care plan in regard to an indwelling catheter for one (1) of sixteen (16) sampled residents, Resident #3.</p> <p>This is repeat deficient practice for three years.</p> <p>The findings include:</p> <p>Policy review of the Executive Summary Clinical Documentation System, no date given, revealed an initial assessment will be initiated with a temporary care plan developed within twenty-four (24) hours and completed within seventy-two (72) hours of the admission. Ongoing assessments will be completed daily for skilled residents and monthly for non-skilled residents. In addition to these requirements an assessment will be completed with episodic events such as an incident or a change in medical condition. The initial interdisciplinary team conference will be scheduled within the first fourteen (14) days of admission with problem areas identified and care plans developed. Subsequent team conferences shall be scheduled based on payer requirements, condition changes, and resident needs with the</p>	F 279	<p>3. MDS coordinators and ADHS will receive comprehensive training of the RAI process with an emphasis on scheduling and careplans. This training will be conducted by the regional Clinical Assessment Coordinator on May 18, 2012 .</p> <p>MDS coordinators will review physicians orders daily during CQI with care plans updated during this interdisciplinary team meeting.</p> <p>4. All comprehensive care plans will be audited by the DHS/ ED weekly x 2 months, then 10 care plans x 2 month, then 5 care plans x 2 month. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months.</p> <p>5. Completion date: May 27, 2012</p> <p>Addendum: Comprehensive careplans to be audited by ED, DHS, ADHS, and unit manager</p>	



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F 279	<p>Continued From page 10</p> <p>care plans updated or initiated as indicated through the re-evaluation of the resident's physical, emotional and psychosocial functioning.</p> <p>Record review of Resident #3's History and Physical, dated 03/19/12, revealed Resident #3 had a history of right lower extremity amputee up to the hip and bladder problems with spasms. Under the section titled Genital/ Urinary (G/U) female, it stated Foley catheter. Record review of Resident #3's Physician Orders, dated 03/16/12, indicated under the incontinence section, a Foley catheter (F/C) was utilized.</p> <p>Observation of Resident #3's Foley cath care, on 04/11/12 at 10:40 AM, revealed there was a Foley catheter present.</p> <p>Record Review of Resident #3's care plan, revealed there was no care plan addressing Resident #3's Foley catheter. Record review of the Admission Assessment on the Minimum Data Set (MDS), dated 03/23/12, revealed the Section H, appliances revealed a letter "A" was checked indicating Indwelling Catheter.</p> <p>Interview with the Assistant MDS Coordinator, on 04/12/12 at 2:20 PM, revealed the MDS Coordinator was responsible for completing Resident #3's care plan, but was currently on vacation. The Assistant MDS Coordinator stated that when she updates care plans, she normally looks at orders and checks to see what was triggered on the MDS. The Assistant MDS Coordinator further stated a care plan would always be provided for triggered items on the MDS.</p>	F 279	



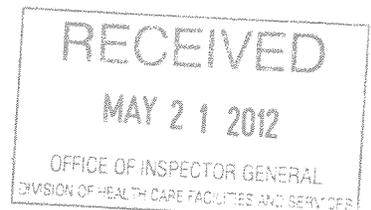
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F 279	Continued From page 11 Interview with the Director of Nursing (DON), on 04/12/12 at 4:15 PM, revealed the admitting nurse would initiate the care plan and the MDS Coordinator would be responsible to complete the care plan and catch any other care plans that were missing from the triggered items of the fourteen day assessment.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Clinical Documentation Systems and the Resident Assessment Instrument (RAI) version 3.0	F 280	1, Resident #2 and #5 comprehensive care plan and CNA assignment sheets were updated 4/12/12 by MDS coordinator /unit manager to reflect current status. Resident #2's care plan conference was held 4/25/12 with both the resident and family in attendance. 2. All comprehensive care plans and CNA assignment sheets will be reviewed and revised to assure accuracy of current status by the DHS/ADHS/unit manager on May 24th, and May 25, 2012.	

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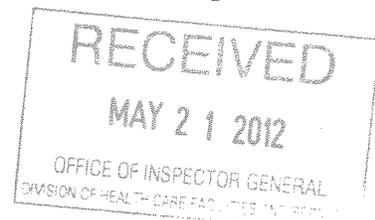
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F 280	<p>Continued From page 12</p> <p>Manual, it was determined the facility failed to ensure the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment for two (2) of the sixteen (16) sampled residents (Resident #2, and 5). In addition, the facility failed to invite Resident #2 or their representative to care plan meetings and care plan conferences were not being held with interdisciplinary input for the health care unit.</p> <p>The findings include:</p> <p>Review of the facility's policy Clinical Documentation Systems, not dated, revealed the initial interdisciplinary team conference will be scheduled within the first 14 days of admission with problem areas identified and care plans developed. Subsequent team conferences shall be scheduled based on payer requirements, condition changes, and resident needs with the care plans updated or initiated as indicated through the re-evaluation of the resident's physical, emotional, and psychosocial functioning.</p> <p>Review of the RAI 3.0 Manual, September 2010, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently: review and revise the current care plan; and communicate with the resident or his/her family or representative regarding the resident care plans, and their wishes.</p> <p>1. Review of the comprehensive plan of care for</p>	F 280	<p>3. MDS coordinators/DHS/ unit manager/ ADHS will be reeducated by the regional Assessment coordinator on correct procedure for reviewing and revising care plans on May 18th, 2012. The interdisciplinary team which includes DHS, ADHS, MDS, social services, dietary, activities and therapy will be re-educated by the regional assessment coordinator on the policy and procedure for care plan meeting with an emphasis on the importance of the interdisciplinary team attending as well as the resident and their representative being invited Director of resident services will be reeducated on the process of inviting residents and their representative to care plan meeting to include health center residents.</p>



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F 280	<p>Continued From page 13</p> <p>Resident #2, on 04/10/12, revealed a goal date for all problem areas of 03/06/12. There was no evidence in the resident's clinical record the care plan was reviewed and revised on or after 03/06/12. Review of the care plan conferences signature page revealed the last conference occurred on 12/06/11 with only nursing in attendance.</p> <p>Interview with Resident #2's Power of Attorney (POA), on 04/12/12 at 2:05 PM, revealed the family had never been invited to a care plan meeting.</p> <p>Interview with the MDS Coordinator, on 04/10/12 at 2:30 PM, revealed she was unable to find a note from the interdisciplinary team, or any evidence, that a care plan meeting was ever conducted or that the care plan was reviewed and revised on or after 03/06/12.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/12/12 at 10:15 AM, revealed the purpose of the care plan was to make sure a resident was being taken care of properly and to ensure their needs and goals were being met. The LPN revealed once a goal was met the resident should be reevaluated and the problem should be either removed, revamped, or revised. The LPN revealed a potential for not knowing where a resident was at physically or mentally, or if they have improved or declined. The LPN revealed the care plan was an evaluation tool.</p> <p>Interview with the MDS Coordinator, on 04/12/12 at 10:25 AM, revealed the other MDS coordinator was assigned to complete the MDS assessment and review the residents care plan. The MDS</p>	F 280	<p>The Director of Resident Services will document in the resident clinical record that family have been invited to careplan.</p> <p>4. All comprehensive care plans will be audited to assure updated timely with changes and for accuracy by the DHS/ADHS/unit manager weekly x 2 months, then 10 care plans x 2 month, then 5 care plans x 2 month. Careplans will also be audited during careplan meetings, morning, CQI, and peer review to assure accuracy. The Executive Director will audit RAI calendar monthly to assure residents and their representative have been sent letters inviting them to the Resident care plan conference. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months.</p> <p>5. Completion date: May 27, 2012</p>



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F 280	<p>Continued From page 14</p> <p>Coordinator reveled their current system used a calendar with the date of the admission and lists of the MDS assessments and their due dates. The MDS Coordinator revealed they had recognized the current system was not working and had got another large calender to hang on the wall as a visual reminder, but only got the calendar updated for the first three days of March, then got busy and never completed the calender. The MDS Coordinator revealed letters were sent out to family members stating care plan meetings were due, when the facility received a response, a meeting was scheduled. However, the MDS Coordinator revealed if the family did not respond the meeting was not held. The MDS Coordinator revealed there was no interdisciplinary team meetings. The MDS Coordinator revealed they do an informal phone call to another department if they feel something in the care plan should be revised, but nothing was done as a group to cover all disciplines of care for the residents on the Health Care side of the building. The MDS Coordinator revealed the purpose of the care plan was to accurately reflect the kind of care the facility was going to provide to the resident and without that there was a potential to lose that individuality and care that was specific to the resident.</p> <p>Interview with Guest Relations representative, on 04/12/12 at 10:40 AM, revealed she did not send letters regarding care plan meetings to the residents on the Health Care side. The Guest Relations representative revealed one of the MDS coordinators had talked about guest relations possibly sending letters for all residents, but that had not actually happened.</p>	F 280	

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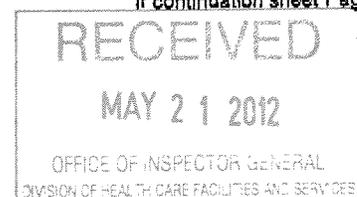
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F 280	<p>Continued From page 15</p> <p>Interview with Social Services, on 04/12/12 at 4:50 PM, revealed guest relations should have been sending care plan letters to all residents once she received the names from the MDS Coordinator. Social Services revealed she was unable to find where the family of Resident #2 was ever invited to a care plan meeting.</p> <p>Interview with the Director of Health Services (DHS), on 04/12/12 at 4:10 PM, revealed care plan conferences had only been the MDS department representing nursing, and the other members came if the family wanted to attend. The DHS revealed the facility should still be having an interdisciplinary review of the care plans regardless of the family's attendance. The DHS revealed she had not been monitoring to ensure care plan conferences were taking place and revealed it was not good for the resident or the care they provide. The DHS revealed the Assistant Director of Health Services (ADHS) was assigned to monitor the care plan for Resident #2, and it should have been caught that the care plan had not been revised. The DHS revealed she was ultimately responsible .</p> <p>Interview with the Assistant Director of Health Services (ADHS), on 04/12/12 at 4:35 PM, revealed she did not know what the dates on the care plan signified and had never looked at them or paid attention to the dates listed on a care plan.</p> <p>2. Review of the clinical record revealed the facility re-admitted Resident #5 on 03/19/12 with diagnoses of Spinal Stenosis, Chronic</p>	F 280		

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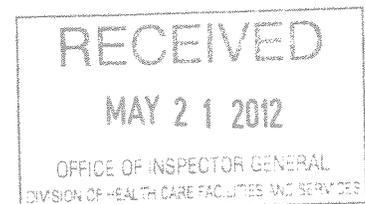
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F 280	<p>Continued From page 16</p> <p>Obstructive Pulmonary Disorder (COPD), and Leukocytosis. The admission orders included oxygen at 3L per minute continuously. Additionally, Resident #5 received a Medical Doctor (MD) order to keep the head of the resident's bed (HOB) elevated at a thirty (30) degree angle at all times on 03/26/12.</p> <p>Review of the comprehensive care plan, dated 03/14/12, revealed interventions for Breathing Difficulty; however: 1) use of oxygen was not identified as an intervention and 2) elevate HOB at least forty-five (45) degrees was listed as a current intervention. Interventions for Potential Alteration in Skin Integrity revealed the Hob elevated less than thirty (30) degrees.</p> <p>Review of the Certified Nurse Assistant (CNA) Assignment Sheet revealed, Resident #5 was identified as using oxygen at 2L per minute.</p> <p>Observation, on 04/10/12 at 9:10 AM, 12:50 PM, and 1:30 PM, revealed Resident #5 wearing oxygen set at 2L per minute.</p> <p>Interview, on 04/12/12 at 9:00 AM, with CNA #1 revealed the CNA worksheet was updated by the Staffing Development/Scheduling Coordinator. The CNA stated she received a new assignment sheet daily and if there were any needed changes she was to inform the Scheduling Coordinator.</p> <p>Interview, on 04/12/12 at 9:05 AM, with Registered Nurse (RN) #2 revealed the Scheduling Coordinator asked for information from the nurses or aides to update the CNA Assignment Sheet and it should have Resident #5 receiving 3L per minute instead of 2L per</p>	F 280	



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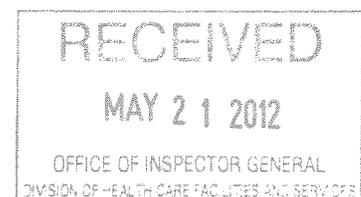
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F 280	<p>Continued From page 17</p> <p>minute. She stated the comprehensive care plan was updated by the MDS Coordinator from MD orders and the twenty-four (24) hour report sheet. The RN stated if the resident did not receive oxygen at 3L per minute, the resident could become hypoxic or have poor wound healing. She stated the HOB as one intervention of thirty (30) degrees and another intervention of forty-five (45) degrees was contradictory. The nurse also stated if the HOB was elevated at forty-five (45) degrees the resident's skin integrity could become impaired.</p> <p>Interview, on 04/12/12 at 2:50 PM, with the MDS Coordinator revealed the MDS Coordinator was responsible to update the comprehensive care plan. She stated she reviewed MD orders for changes to the resident's care. The MDS Coordinator stated if Resident #5's care plan did not identify oxygen as an intervention, it was possible for the oxygen to be removed from the resident, resulting in the resident not receiving enough oxygen to alleviate breathing difficulties. She also stated the HOB intervention identified at forty-five (45) degrees could place more pressure on the resident's wound. The MDS Coordinator stated she had not received training by the facility on how to complete or revise a comprehensive care plan.</p> <p>On 04/12/12 at 10:25 AM, interview with the Staffing Development/Scheduling Coordinator revealed she was responsible for staff training at the facility. She stated she had not trained the MDS Coordinators on the comprehensive care plan.</p> <p>Interview, on 04/12/12 at 4:15 PM, with the</p>	F 280		



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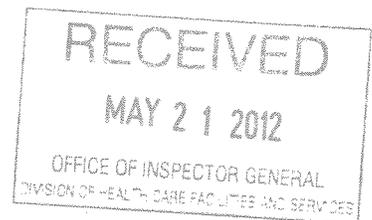
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F 309	<p>Continued From page 19</p> <p>orders specify rate of flow, route, and rationale.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 03/19/12 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Spinal Stenosis, and Leukocytosis. Admission orders included continuous oxygen at 3L per minute. The April 2012 orders did not include the use of oxygen.</p> <p>Observation, on 04/10/12 at 9:10 AM, 12:50 PM, and 1:30 PM revealed Resident #5 wearing oxygen by nasal cannula with a setting of 2L per minute.</p> <p>Interview, on 04/12/12 at 9:05 AM, with Registered Nurse (RN) #2 revealed Resident #5 was to have oxygen at 3L per minute. The RN stated management reviews and compares, at the end of the month, the current month's orders with next month's orders. She stated Resident #5 should have had an order for oxygen on April 2012's list of orders. The nurse stated if the resident received 2L per minute instead of 3L per minute as ordered, the resident could be hypoxic and have poor wound healing.</p> <p>On 04/12/12 at 10:25 AM, interview with the Staff Development/Staffing Coordinator stated the floor nurses, and at times herself, would review and compare orders near the end of the month, and again on the last day of the month, for the following month. She stated if an order was not transcribed on the next month's orders, the nurse conducting the review should look for a discontinuation order or write in the continued order. She stated if Resident #5 did not receive oxygen as ordered the resident may not receive</p>	F 309	<p>3. Nurse managers have been assigned a specific unit to review monthly change over for accuracy. All nurses have been reinserviced by the DHS/Clinical support on correct procedure for monthly change over starting May 18, 2012. Any staff not present for this inservice (ie on vacation, ect) will be inserviced by May 26th. Any staff not able to be inserviced by May 26th (i.e. FMLA, Leave of absence) will not be allowed to work until they have been inserviced.</p> <p>4. Audits will be conducted on monthly change over as follows. 30 rewrites(5 per unit) audited monthly x 1 month, then 20(4 per unit) rewrites x 1 month, then 10(2 per unit) rewrites x 1 month by DHS, ADHS, unit manager. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months.</p> <p>5. Completion date: May 27,2012</p>	



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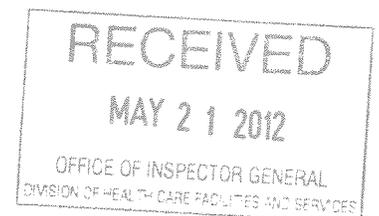
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/12/2012
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 309	Continued From page 20 enough oxygen to keep her systems functioning the way they should. Interview, on 04/12/12 at 4:15 PM, with the Director of Nursing (DON) revealed the Staff Development/Staffing Coordinator, or trained floor nurses, verify orders for the current month with the following month. She stated if Resident #5 received oxygen at 2L per minute instead of 3L per minute as ordered, then the MD order was not followed. The DON stated if the March 2012 oxygen order did not continue onto the April 2012 orders, it was possible Resident #5 would not have received needed oxygen as ordered and could experience respiratory distress.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	1. The jar of unidentified cream was disposed of as well as all other open containers without open dates. 2. All carts will be audited by PCA pharmacy on May 18, 2012, any medications or treatments noted without residents name or open date will be disposed of. 3. Nursing staff will be re-inserviced by PCA on May 18th regarding policy and procedure for medication administration with an emphasis on placing an open date when opening a multi dose container.	



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F 431	<p>Continued From page 21 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the pharmacy's policy it was determined the facility failed to label and date multi-use medications when opened for two (2) of four (4) medication carts on both units (health and transitional units). In addition, the facility failed to ensure drugs and biologicals were labeled in accordance with acceptable practice with name of drug, appropriate accessory/cautionary instructions, and expiration date.</p> <p>The findings include:</p> <p>1. Review of PCA Pharmacy Policy (IC 10), with effective date of 02/01/10, revealed medications are labeled in accordance with state and federal laws. Labels are permanently affixed to the outside of the prescription container. Each label must include: resident's name; specific directions for use; including route of administration; medication name; and strength of the medication; prescriber's name; date dispensed; quantity of</p>	F 431	<p>4. All medication carts will be audited weekly by DHS/ADHS x 3 months and quarterly during Peer/CAT review. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months.</p> <p>5. compliance date: May 27, 2012</p>



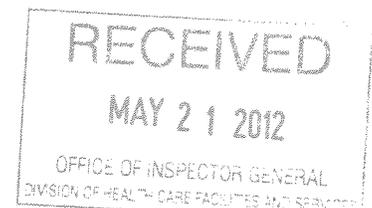
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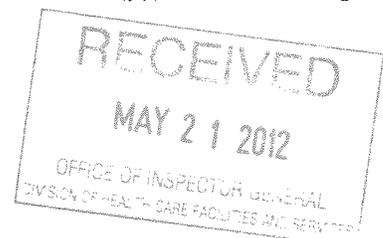
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F 431	<p>Continued From page 22</p> <p>mediation; expiration date; and accessory labels indicating storage requirements and special procedures.</p> <p>Observation of the treatment cart for Health Unit on 04/11/12 at 3:30 PM, revealed a plastic jar of unidentified cream with no resident's name, medication label or any specific directions of use on the jar. There was an expiration date of 06/09/12 written on the jar.</p> <p>Interview with RN #3, on 04/11/12 at 3:30 PM, revealed topical creams should have labels that identified the resident the medication was intended for with instructions on how to use.</p> <p>2. Review of PCA Pharmacy Policy 11 B-1, Administration Procedures for all Medications, section H, with a effective date of 02/01/2010, revealed when opening a multi-dose container, place the date on the container.</p> <p>Observation, on 04/11/12 at 2:00 PM, of the Transition Unit medication cart, revealed one opened vial of Novolin R insulin with no date when opened.</p> <p>Interview with RN #4, on 04/11/12 at 2:15 PM, revealed any multi-dose medication container should be dated when opened. She stated insulin should not be used after twenty-eight (28) days and if the date opened is not known, staff would not know when to discard. It was the facility policy to date when opened and there had been an inservice training regarding this a few weeks ago.</p> <p>Observation of the Health Care Unit medication cart, on 04/11/12 at 3:15 PM, revealed six (6)</p>	F 431		
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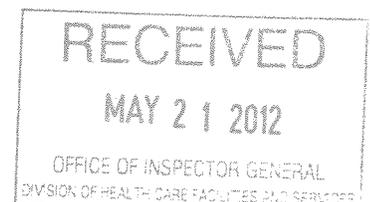
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F 431	Continued From page 23 multi-dose bottles with no date when opened. The medications included Guaifenesin syrup, Tussin DM cough syrup, Nystatin oral swish, Phenytoin suspension, Multi-vitamin liquid, and Mintox liquid. Interview, on 04/11/12 at 3:30 PM, with RN #3 revealed multi-dose containers should be dated when opened. She removed the medications; however, she could not say why the medications had not been dated upon opening. Interview with the facility's contracted Pharmacist, on 04/12/12 at 3:30 PM, revealed the acceptable procedure for multi-dose bottles of medications would be to date upon opening. Insulin should be dated upon opening. Interview with the Director of Nursing, on 04/12/12 at 4:55 PM, revealed it was her expectation that multi-dose containers of medications and insulin should be dated upon first use. It was the responsibility of the person administering medications to check each medication for expiration dates.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		



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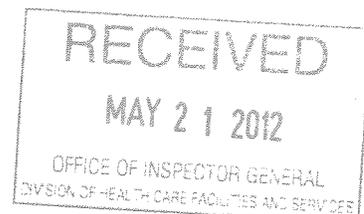
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F 441	Continued From page 24 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Infection Control Policies and Procedures, it was determined the facility failed to implement the infection control practices to prevent the spread of infection for four (4) of sixteen (16) sampled residents. (Residents # 3, 5, 10, and unsampled A). Facility staff broke sterile technique during a dressing change for	F 441	1. The make shift linen cart was disposed of during survey. Resident number A was provided with a clean bed pan and his sink was immediately disinfected. 2. All residents have the potential to be effected by the deficient practice. 3. cna #3, nurse #4, nurse #2, nurse #1 and all other nurses, cmt's and cna's will receive reeducation on infection control policy and procedures with an emphasis on hand washing and proper changing of gloves by May 26th, 2012 by DHS, ADHS, unit manager. Nurses Education will include sterile technique and clean technique. All nursing staff will complete a skills check off on hand washing and proper glove use with return demonstration by May 26th, 2012 by DHS/ADHS/unit manager	



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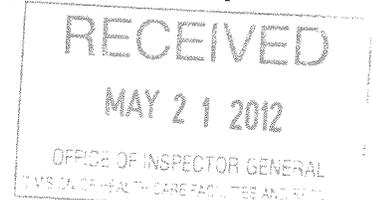
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F 441	<p>Continued From page 25</p> <p>Residents #5, and no hand washing between glove changes during a clean dressing change was observed for Residents #10.</p> <p>The facility staff failed to complete hand washing or change gloves between catheter care and a skin assessment for Resident #3.</p> <p>In addition, a fracture bedpan with dried feces on the outside, was noted for Unsampled Resident A. Upon tour of the facility on 04/10/12 at 5:30 AM, staff were observed on the 100 Hall rolling a makeshift linen cart from room to room, with two large dirty linen bags (with dried feces on the outside) tied to the cart.</p> <p>This is repeat deficient practice for two years.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Interview with the Director of Nursing (DON) on 04/12/12 at 11:45 AM, revealed there was not a policy for linen carts in the hallway, because it was not the Corporate policy to have linen carts in the halls. <p>Observation on tour of the facility, at 5:30 AM on 04/10/12, revealed CNA #3 pushing a makeshift linen cart (uncovered) down the hallway, containing clean towels, wash clothes, and sheets. The cart also had a box of clean gloves lying on top of the cart. There were two large dirty linen bags observed tied to the handle of the same clean linen cart. Observation also revealed dried feces on the outside of the soiled bags which had an odor.</p>	F 441	<p>4. The ED/DHS will observe 2 staff members washing of their hands and glove usage 3 x week x 6 months. The DHS/ADHS will observe 2 nurses completing dressing changes 3 x week x 6 months. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 6 consecutive months.</p> <p>5. Completion date: May 27, 2012 Addendum to #4: Auditors to include DHS, ADHS, unit manager, not ED.</p>



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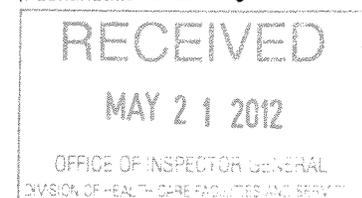
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F 441	<p>Continued From page 26</p> <p>Interview with CNA #3, on 04/10/12, at 6:00 AM, revealed it was not facility practice to tie the dirty linen bags on the clean cart. The CNA stated they really were not supposed to use those carts but to use the linen closets instead.</p> <p>Interview with the Director of Nursing on, 04/12/12, at 11:45 AM, revealed staff should not be using the carts, especially with the dirty bags attached. The DON stated they do not use the carts in the facility, and staff should be using the linen closets which are centrally located.</p> <p>2. Policy review of the Guidelines for Handwashing, revised 10/2004, revealed handwashing was the single most important factor in the prevention of transmitting infections. All health care workers shall wash their hands frequently and appropriately. Health Care Workers shall wash hands at times such as after removing gloves, worn per standard precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc.</p> <p>Observation of the foley cath care and the skin assessment for Resident #3, on 04/11/12 at 10:40 AM, revealed Licensed Practical Nurse (LPN) #4 providing catheter care, peri-care and a back assessment with the same donned gloves. LPN #4 was observed to take her soiled hands and rub through Resident #3's hair to observe for any skin concerns. LPN #4 was observed to not change her gloves until the back assessment was completed.</p> <p>Interview with LPN #4, on 04/11/12 at 11:00 AM, revealed she should of changed her gloves and</p>	F 441		



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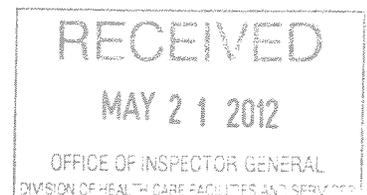
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F 441	<p>Continued From page 27</p> <p>washed her hands after providing catheter care to Resident #3. LPN #4 stated she was thinking it, but she should of acted on it. LPN #4 further stated she was to wash her hands to prevent the spread of infection.</p> <p>Interview with the Director of Nursing (DON), on 04/12/12 at 3:00 PM, revealed nurses were inserviced to change their gloves and wash their hands when their gloves became soiled. The DON further stated the staff are to wash their hands for infection control purposes.</p> <p>3. Review of the Guidelines for use of Bedpans and Urinals, no date provided, revealed upon the completion of the procedure: A. staff were to take the bedpan or urinal into the bathroom. Check the feces or urine for unusual appearance and report output as necessary; B. measure and record output as necessary; C. empty the bedpan or urinal into the commode. Flush the commode; D. clean the bedpan or urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. Store the bedpan or urinal per facility policy.</p> <p>Observation made on the initial tour of the facility, on 04/10/12 at 5:45 AM, in room 110 revealed a large amount of feces observed in a fracture pan stored in the middle of Unsampled Resident A's sink.</p> <p>Interview with the Certified Nursing Assistant (CNA) #3, on 04/10/12 at 6:00 AM, revealed feces should not be stored in the sink. The sink was where residents washed their hands and brushed their teeth. CNA #3 stated an infection control issue could occur.</p>	F 441	



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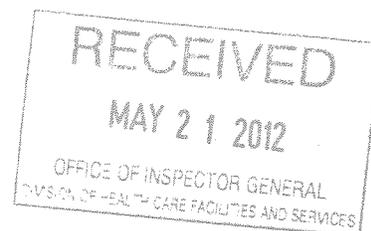
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F 441	Continued From page 28 Interview with the LPN #3, on 04/10/12 at 6:08 AM, revealed feces should not be stored in the sink because of the risk for contamination. Interview with the DON, on 04/12/12 at 3:00 PM, revealed the bedpan should be cleaned immediately after defecation. The resident should be transferred off of the bedpan and what ever remains dumped in the toilet. The DON stated it was not appropriate to store a used bedpan in the sink. The sink was used to wash hands and brush teeth. The DON further stated this was poor hygiene and infection control. 3. The facility did not provide a policy on sterile dressing changes. Review of the clinical record revealed the facility re-admitted Resident #5 on 03/19/12 with diagnoses of Olecranon Bursitis, Leukocytosis, and Spinal Stenosis. The resident's Doctor (MD) order, dated 04/02/12, revealed the resident's elbow wound dressing was to follow sterile technique. Observation, on 04/10/12 at 9:25 PM, revealed during a sterile dressing change for Resident #5, Registered Nurse (RN) #1 did not maintain sterile technique. The RN put on sterile gloves, opened the dressing packages and threw trash away, then proceeded to put on the clean dressing. Interview, on 04/10/12 at 10:25 AM, with RN #1 revealed she did not maintain sterile technique after putting on sterile gloves. She stated she should have opened the packages or thrown trash away prior to putting the sterile gloves on.	F 441			



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F 441	<p>Continued From page 29</p> <p>The RN stated she had not been trained by the facility on sterile dressing changes.</p> <p>Interview, on 04/12/12 at 9:05 AM, with RN #2 revealed a dressing change that did not follow sterile technique could introduce infection. She stated the facility had not provided training in sterile dressing changes.</p> <p>On 04/12/12 at 1:35 AM, interview with the Staff Development/ Staffing Coordinator revealed there had not been any training on sterile dressing changes at the facility. She stated the purpose of sterile technique was for extra prevention and if the dressing changed was not sterile the resident would be at risk of infection.</p> <p>Interview, on 04/12/12 at 4:15 PM, with the Director of Nursing (DON) revealed the facility did not have a policy for sterile dressing change and had not provided training in sterile dressing changes. She stated if sterile technique was not followed, the resident would be at risk of infection.</p> <p>4. Review of the facility's policy General Guidelines for Dressing Changes, dated December, 2009, revealed: 1) hands should be washed after removing a soiled dressing; and 2) after applying a clean dressing.</p> <p>Review of the facility training record revealed the Guidelines for Hand washing training in March 2011 and the Infection Control training in April 2011 both included hand washing after taking off gloves. LPN #1 participated in both training.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident on</p>	F 441	



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
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F 441	<p>Continued From page 30 04/04/12 with diagnoses of Prolapsed Uterus, Left Humeral Fracture, and Leukocytosis.</p> <p>Observation, on 04/11/12 at 3:25 PM, revealed Licensed Practical Nurse (LPN) #1 did not wash her hands when changing gloves during a dressing change and skin assessment for Resident #10. The LPN changed her gloves after removing a soiled dressing and after the clean dressing was applied.</p> <p>Interview, on 04/12/12 at 8:50 AM, with LPN #1 revealed she did not wash her hands when changing gloves for a clean dressing change. She stated it was possible to contaminate her hands even when wearing gloves and not washing her hands between glove changes could transfer infection. The LPN stated she had participated in hand washing training at the facility.</p> <p>Interview, on 04/12/12 at 1:35 PM, with the Staffing Development/Staffing Coordinator revealed hands should be washed anytime gloves are changed and hand washing training was provided to staff in April 2011 and March 2011. She stated not washing hands could spread infection.</p> <p>On 04/12/12 at 4:15 PM, interview with the Director of Nursing (DON) revealed hands should be washed between glove changes due to the risk of infection.</p>	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520

Continued From page 31
 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

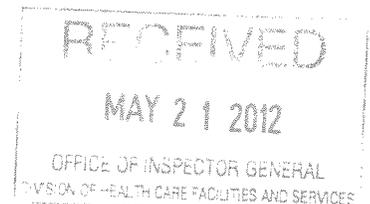
A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
 Based on observation, interview, and record review it was determined the facility failed to have an effective Quality Assurance (QA) committee to ensure ongoing compliance of corrected deficiencies. The facility was cited for problems in the areas of F-279 (development of care plans) for three (3) consecutive standard surveys and F441 (infection control) for the past two (2) years. Review of the plan of correction submitted for the 2011 survey revealed the facility was to monitor noncompliance through the QA committee. However, interview with the Administrator

F 520

1. QA meetings will be scheduled monthly for the months of May, June, July and August. These meeting will include the ED, DHS, Medical Director, and 3 other team members. Home office Compliance Support will also attend the QA meetings for the next three months to ensure QA process is effective.
 2. All residents have the potential to be affected by the deficient practice.
 3. The ED, Medical Director and DHS will be inserviced by the clinical support (Toni Duvall) on May 22nd on the regulatory requirements of a QA committee with an emphasis of a thorough QA meeting. The focus of the next 4 months of QA meeting will be on infection control, and care plan compliance as well as any other opportunities noted by the committee. The current MDS nurses will be re-educated by the MDS support



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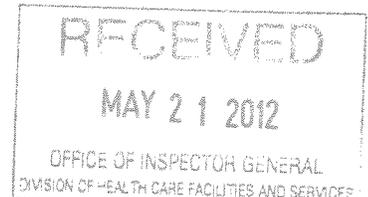
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F 520	<p>Continued From page 32</p> <p>revealed even though she had looked at the previous plan of correction (POC), she was not aware of any continued concerns. The facility conducted monthly audit of care plans; however, review of the audits revealed only residents' names and room numbers. The facility had not develop any new plans of action regarding the audits.</p> <p>The findings include:</p> <p>Review of the facility's policy Guidelines for the Quality Assessment and Assurance Process, not dated, revealed a purpose to provide continuous evaluation of campus systems to distinguish between isolated, pattern or systemic concerns, ensure systems are functioning appropriately, to prevent problems from arising to the extent possible, recognize incremental change that may be early signs of potential/future problems, and correct identified issues.</p> <p>1. Review of the QA signature sheets revealed no documented evidence a physician representative was in attendance at the QA meeting since January 2011.</p> <p>Interview with the Executive Director (ED), on 4/12/12 at 4:45 PM, revealed she started in October, 2011 and a physician had not attended a QA meeting until March 2012. The ED revealed there are two Medical Directors that cover the facility and usually attends the QA meeting. She stated the importance of the Medical Director attending the QA meeting was to provide an interdisciplinary approach that ultimately affected the residents. The ED revealed the facility</p>	F 520	<p>nurse, Charlette Moreno on May 18, 2012 regarding compliance with timely completion and submission/ transmission of MDS's. The campus ED and DHS will review the MDS schedule daily in the morning meeting and review the available data reports of submissions/ transmissions of MDS to ensure compliance Weekly. Based on review of the schedule and transmission report available, appropriate interventions will be implemented to ensure timeliness MDS submission-transmission. Any deficient practice will result in re-training, re-education and/or counseling of the MDS nurses. The home office MDS support nurse, Charlette Moreno will review the campus submission/transmission data report weekly to ensure timely completion and transmission. The support nurse will report any deficient practice to the clinical support nurse Toni Duvall for immediate intervention. The findings will also be reported in the campus morning meeting and monthly QA for appropriate intervention as indicated.</p>	
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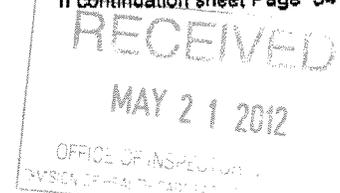
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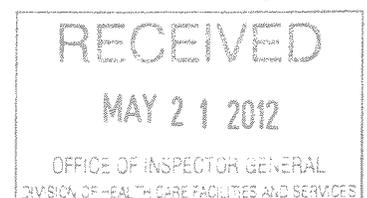
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F 520	<p>Continued From page 33</p> <p>decided to have monthly QA meeting; however, there was no evidence a physician representative was present. She stated she was ultimately responsible to ensure the entire team was present during QA meetings. However, she indicated she was aware that neither the Medical Director or any physician representative were not present at the QA meetings since January 2011.</p> <p>Interview with the Medical Director, on 04/12/12 at 6:44 PM, revealed the last QA meeting he attended was in March, 2012. The Medical Director revealed he could not remember the last QA meeting prior to March. The Medical Director revealed he thought he was supposed to attend a meeting quarterly, but he was not for sure. The Medical Director revealed the facility normally told him when to attend a meeting.</p> <p>2. Observation during the course of the standard survey, 04/10/-12, 2012, revealed deficient practice was found for issues regarding care planning and infection control. The facility failed to maintain compliance in areas that would prevent cross-contamination during wound care dressings, glove change, hand washing, and linens. Refer to F441.</p> <p>In addition, the survey found care plans were not developed or revised as indicated and care plan conferences were not being held. Refer to F279 and F280.</p> <p>Interview with the Director of Clinical Support, on 04/12/12 at 5:30 PM, revealed audits conducted by the facility were destroyed by the previous Director of Health Services (DHS). However, the facility could not provide evidence the QA had</p>	F 520	<p>Current licensed staff will be re-educated by DHS, ADHS, and staffing/in-service coordinator regarding infection control practices regarding treatment administration by 5/26/12. All new licensed staff will also receive infection control training with special focus on administration of treatments.</p> <p>The campus will conduct audit/observation treatments as stated in F441 provided by the campus licensed staff to ensure understanding and compliance with standards of infection control practices. All licensed staff will be observed/audited by May 26, 2012. The findings from these audits/observations will be reported in morning meeting as well as monthly QA committee. Based on the findings, appropriate interventions will be implemented. any deficient practice noted will result in re-training, re-education and/or counseling. The new licensed staff will also be audited/observed and findings reported to morning meeting and monthly QA. The ED, DHS, medical director and QA committee members will be reeducated on the facilities QA policy on the policy and procedure to ensure understanding and acceptance of the standard by May 22, 2012. The MD will attend at least quarterly.</p>	
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F 520	Continued From page 34 identified this problem and acted upon it. Review of the audits provided by the facility revealed the audit only consisted of a resident name and room number with no other information provided.	F 520	The campus will conduct monthly QA committee meetings per the facility policy and procedure. The scheduled audits will be completed by designated committee members and the audits will be reviewed by the clinical support nurse Toni DuVail, and the home office compliance nurse, Mike Daily, to ensure accuracy and thoroughness. The QA committee will review the completed audits and based on findings, appropriate interventions will be implemented and documented. any deficient practice will result in re-education, re-training, and/or counseling. The current POC will be reviewed in the monthly QA committee meeting to ensure the action items outlined in the POC are being conducted and the results reviewed to ensure ongoing progress. The MD will be in the May 22, 2012 QA committee meeting to ensure his understanding of the POC and any action items he is to implement. The POC action items will be reviewed weekly by the ED/DHS to ensure the items are being completed, follow up provided and documented based on findings from the review. This weekly review will continue for three months and then Quarterly thereafter for one year. The QA committee will include the home office compliance nurse monthly, beginning in May for the next 6 months to ensure the campus leadership understand, accepts, and complies with facility QA policy and procedures. 5. Completion Date: May 27th, 2012	



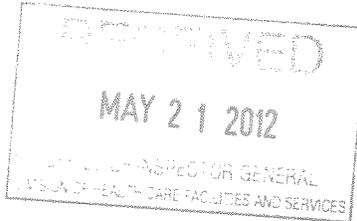
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2008</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURES: One (1) story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II generator, fuel source is natural gas with propane backup.</p> <p>A standard Life Safety Code survey was conducted on 04/10/12. Glen Ridge Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire).</p>	K 000		
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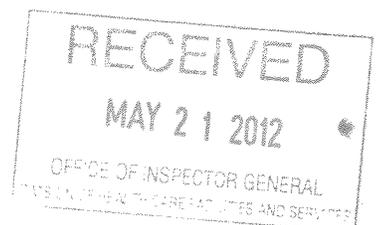


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X LeBufford</i>	TITLE <i>A ETD</i>	(X6) DATE <i>5/21/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from 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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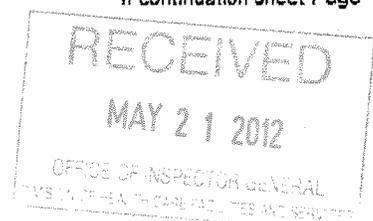
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K 000	Continued From page 1	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at an E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was fifty-nine (59) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/10/12 at 10:22 AM, with the Director of Plant Operations revealed the wall behind the dryers in the Laundry Room, had an approximately twelve (12) inch by twelve (12) inch opening cut into the wall, exposing the existing piping.</p> <p>Interview, on 04/10/12 at 10:22 AM, with the Director of Plant Operations revealed the opening was cut into the wall to repair the existing piping</p>	K 029	<ol style="list-style-type: none"> 1. The opening in the wall behind the dryer in the laundry was 4/18/12 properly resealed to resist the passage of smoke. 2. Director of Plant Operations completed an observation of all hazardous areas to assure intact fire rating walls on April 13th, 2012. Any observed openings found will be properly resealed. 3. The Plant Operation support will reinserviced Director of Plant Operations on regulatory requirements with an emphasis on assuring all fire barriers are intact on May 21st, 2012. 4. The Ed will make monthly observation of fire barrier walls to assure barriers are intact as per regulatory requirements. These audits will continue monthly x 3 months. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months. 5. Compliance date: May 27, 2012 	



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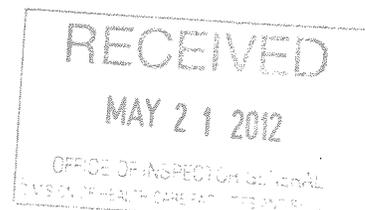
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K 029	Continued From page 2 and had not been resealed properly to resist the passage of smoke in the event of a fire. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029			



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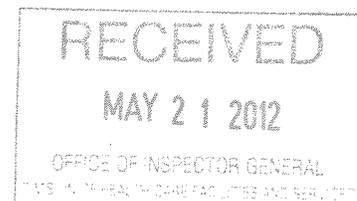
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K 029	Continued From page 3	K 029		
K 143 SS=D	Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the room being used to transfer liquid oxygen had the proper signage displayed, in accordance with NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was fifty-nine (59) on the day of the survey.	K 143	1. Signage was immediately displayed outside the oxygen room located on the 100 hall by the Director of Plant Operations. 2. all other areas housing oxygen were observed by the Director of Plant Operations to assure signage was present On April 13th, 2012. 3. The Executive Director will reinserviced the Director of Plant Operations on regulatory requirements on proper precautionary signage is displayed on all rooms housing oxygen on May 23, 2012. 4. The ED/DHS will audit oxygen rooms weekly x 3 months to assure proper signage is present. These audits will be presented to the QA committee for review. These audits will continue until 100% compliance is reached for 3 consecutive months. 5. Compliance date: May 27, 2012	



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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 143	<p>Continued From page 4</p> <p>The findings include:</p> <p>Observation, on 04/10/11 at 8:54 AM, with the Director of Plant Operations revealed the room located in the 100 Hall, of which oxygen was being transferred, did not have the proper precautionary signage displayed on or near the door.</p> <p>Interview, on 04/10/11 at 8:54 AM, with the Director of Plant Operations revealed he was not aware that the proper precautionary sign was not on display as required for the oxygen room.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>18.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>8-6.2.5.2. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) The area is mechanically ventilated, is sprinkled, and has ceramic or concrete flooring; and (c) The area is posted with signs indicating that</p>	K 143			



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

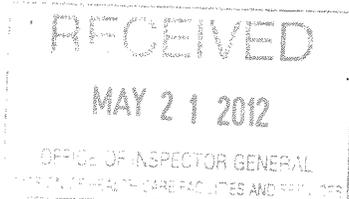
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K 143	Continued From page 5 transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 147 SS=E	NFFA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy (70) beds and the census was fifty (59) on the day of the survey. The findings include: Observations, on 04/10/12 between 9:15 AM and 11:30 AM, with the Director of Plant Operations revealed: 1) In Resident Room 114, a refrigerator and a microwave were plugged into a power strip.	K 147	1. The Director of Plant Operations removed power strips from room 144 and from the Director of Environmental Services office. The hydro collators located in the Physical Therapy rooms were plugged into a ground fault circuit interrupter outlet. 2. Entire facility observation completed on April 13th, 2012 by Plant Operations with no other power strips noted and all other equipment requiring GFCI outlets were appropriate. 3. ED/Plant Operations Support will reeducated Director of plant Operations on regulatory requirements to assure electrical wiring is maintained in accordance with NFPA standards on May 21, 2012. 4. Ed will make weekly facility observations x 3 months to assure that all wiring is maintained in accordance with the NFPA standards. 5. Compliance date: May 27, 2012	



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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
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K 147	<p>Continued From page 6</p> <p>2) In the Director of Environmental Services Office, a refrigerator was plugged into a power strip.</p> <p>3) In the Physical Therapy Room located in the 500 Hall, a Hydrocollator was plugged into a standard electrical outlet, instead of a Ground Fault Circuit Interrupter (GFCI) outlet required in wet areas.</p> <p>4) In the Physical Therapy Room located in the Administrative Hall, a Hydrocollator was plugged into a standard electrical outlet, instead of a GFCI outlet required in wet areas.</p> <p>Interviews, on 04/10/12 between 9:15 AM and 11:30 AM, with the Director of Plant Operations revealed he was not aware of power strips being misused in Resident Room 114 and the Director of Environmental Services Office. Further interview revealed he was not aware of the requirement for the Hydrocollators (containing water) to be protected by plugging into a Ground Fault Circuit Interrupter (GFCI) outlets.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	

