

RECEIVED

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

FEB 21 2013

PRINTED: 02/05/2013
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 01/25/2013
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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 000	INITIAL COMMENTS A recertification survey was initiated on 01/23/13 and concluded on 01/25/13 with a Life Safety Code survey initiated on 01/23/13 and concluded on 01/24/13 with the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	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	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	services provided to the residents of Glen Ridge. The facility recognizes its 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 for participation in title 18/19 programs. To this end, this plan of correction shall serve as the credible allegation of compliance	
	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure staff were knowledgeable of care needs, followed the facility's policy and provided care according to the comprehensive careplan and the needs of the residents for one (1) of the sixteen (16) sampled residents (Resident #5).</p> <p>The findings include: Review of the facility's policy Interdisciplinary Team Care Plan Guideline, revised on 01/2008, revealed a purpose to ensure appropriateness of services and communication that will meet the resident's needs in accordance with state and federal guidelines. The Policy revealed nurse</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE <i>2-21-13</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 their 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.

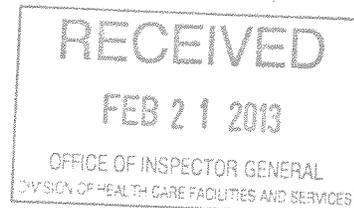
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 1</p> <p>managers shall communicate pertinent care plan approaches to the nurse aides via the Nurse Aide Assignment Sheet.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 06/05/11 with the following diagnoses: Alzheimer's; Anemia; and Chronic Obstructive Pulmonary Disease. The facility assessed the resident, on 10/24/2012, as requiring extensive assistance for personal hygiene which included brushing teeth. Review of the comprehensive plan of care revealed the facility identified an ADL self-care deficit and planned an intervention to assist with personal hygiene as needed including oral/dental care.</p> <p>Observation of Resident #5, on 01/23/13 at 12:05 PM, revealed the resident sitting in the hallway in a wheelchair. A thick build up of residue was noted around the resident's teeth during the conversation. Observation of the resident, on 01/24/13 at 9:00 AM, revealed a continued thick build up of residue around the resident's teeth.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 01/25/13 at 9:49 AM, revealed the night shift was responsible to provide all morning care, including oral hygiene for Resident #5. After requesting the CNA to observe the resident's mouth and status of oral hygiene, the CNA revealed the resident's mouth was not clean and appeared to have a build up of substance on the teeth. The CNA revealed there was a potential for infection, bad breath, bacteria, erosion of the gums, and poor appetite. The CNA revealed she had not noticed the teeth that morning while assisting the resident up for the day. The CNA</p>	F 282	<p>with all state and federal requirements governing the management of the facility. It is thus submitted as a matter of statute only.</p> <p>1. Resident #5 was assessed for oral care needs and care provided as necessary. CNA assignment sheet updated on 1-25-13 to reflect current care needs.</p> <p>2. Care Plans reviewed for residents with ADL deficits on 1-29-13 by DHS, ADHS, staff development to determine other affected residents. Nurse managers (DHS, ADHS, MDS, Medical Records, and staffing coordinator) made rounds to visually inspect oral cavity of residents with similar ADL needs. Any non-compliance corrected and careplans updated.</p> <p>3. Education will be provided to nursing staff to include cna's by DHS and/or inservice coordinator on 2-19-13, 2-20-13, 2-26-13, and 2-27-13 related to following plan of care with emphasis on communicating care to CNA's to provide daily care needs. Education will be provided to nurses and CNA's to include return demonstration of Grooming-nail care, hair care, oral care/dentures appropriate and oral care to prove competency. Licensed nurses will sign off on competency.</p> <p>4. Ongoing monitoring will be achieved through daily rounding by DHS, ADHS, unit supervisor. Department leaders are assigned designated rooms to observe residents daily to ensure oral care, hair care nail care, and grooming is being provided. Concerns are discussed in morning meeting and addressed timely. CNA's not following plan of care as designated on assignment sheets will be educated coached, and counseled as necessary.</p>	3-4-13

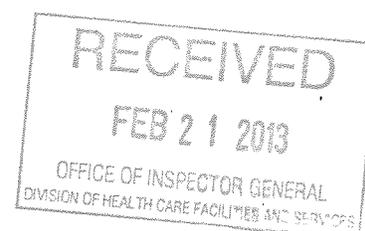


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F 282	<p>Continued From page 2</p> <p>revealed she was familiar with the resident and the hygiene needs that were required.</p> <p>Interview with CNA #2, on 01/25/13 at 1:50 PM, revealed the unit had a Get Up list that identified Resident #5 to receive assistance with dressing only by night shift, and having day shift provide all AM care, which included oral care.</p> <p>Review of the night shift Get Up list indicated Resident #5 was to be dressed only by the night shift. However, review of the nursing assistant assignment sheet revealed Resident #5 was identified as a Rise and Shine.</p> <p>Follow up interview with CNA #1, on 01/25/13 at 2:03 PM, revealed the Nursing Assistant Assignment Sheet was printed from the computer by each nursing assistant at the beginning of their shift. The CNA revealed the sheet identified the resident as a Rise and Shine, which meant the resident got up early, therefore night shift provided all AM hygiene. The CNA revealed she had never seen the Get Up list before and was not aware she was responsible for providing all AM care, including oral hygiene. The CNA revealed she had brushed the residents teeth, after it was identified by the state surveyor, and reported most of the residue was able to be removed.</p> <p>Interview with the Resident #5's family member, on 01/25/13 at 11:25 AM, revealed the facility did not provide oral care and noticed the poor condition of the resident's teeth. The resident's family member revealed oral hygiene had gotten worse.</p>	F 282	<p>The Rounding Tool that will be used to validate rounds is the DHS rounding tool which assesses Resident Grooming-nail care, hair care, oral care/dentures appropriate and clean clothing, foot wear, resident rooms and call lights. These completed rounding sheets will be reviewed by QA committee during monthly meetings to ensure compliance is achieved and maintained. These audits will continue until 100% compliance is met x 6 consecutive months with action plans developed for areas requiring correction.</p>	



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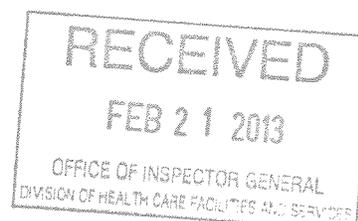
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F 282	<p>Continued From page 3</p> <p>Interview with Licensed Practical Nurse (LPN) #1, 01/25/13 at 2:15 PM, revealed she had noticed the lack of oral care to the resident and was not aware of the confusion about who was to provide AM care. The LPN confirmed the two (2) lists did not match and that the Nursing Assistant Assignment Sheet was not updated to reflect who was responsible to perform oral care to Resident #5.</p> <p>Interview with the Assistant Director of Nursing Services (ADNS), on 01/25/13 at 2:28 PM, revealed AM care was expected and had not been monitored. The ADNS revealed she was not aware of the conflicting information between the Nursing Assistant Assignment Sheet and the Get Up list. The ADNS revealed the facility did not provide education on the new list and was not monitoring understanding of the form, or the completion of AM care.</p> <p>Interview with Medical Records, on 01/25/13 at 2:39 PM, revealed she was responsible for updating the Nursing Assistant Assignment Sheet. However, Medical Records revealed she had not been notified there was a change regarding ADL care to dependent residents.</p> <p>Interview with the Director of Nursing Services (DNS), on 01/25/13 at 3:21 PM, revealed the Care Plan identified specific care required for each resident and acted as a guide on what care to perform. The DNS revealed she was not aware a new list was implemented by the ADNS. The DNS revealed oral care was an expectation and was not being monitored to ensure it was being done as indicated on comprehensive plan of care.</p>	F 282		

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309	<p>1. Resident #1 was weighed after identification of order and weight was 211.4 on 1-23-13 MD notified and no new orders obtained. RD reviewed resident on 1-24-13 and made no recommendations. Resident #14 received an order to discharge to home on 10-23-12. 2. All residents with orders for weekly weights were reviewed by DHS, ADHS, and unit manager on 1-28-13 to ensure no other residents were affected by this practice. RD reviewed residents on weekly weights on 1-25-13</p>	3-4-13
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to obtain and follow physician's orders for two (2) of sixteen (16) sampled residents. The staff failed to follow an order for Resident #1 to monitor and record weights for four (4) weeks and failed to obtain an order to discharge Resident #14 to home.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Medication Orders, not dated, revealed a current list of orders would be maintained in the clinical record for each resident and orders would be written and maintained in chronological order. Also, telephone and verbal orders would be recorded on the physician order sheet when received by the nurse taking the order.</p> <p>1. Review of the clinical for Resident #1 revealed the facility admitted the resident on 09/03/10 with diagnoses of Respiratory Failure, Diversion Colostomy, a history of Coumadin Toxicity; a</p>		<p>to determine if weight tracking in place and to make recommendations related to current nutritional status. Any recommendations were followed up with md notification. Clinical records for residents discharged to home during last 30 days were reviewed by medical records coordinator on 1-28-13 to insure discharge orders were obtained. 3. Nurses will be in-serviced by DHS, ADHS, or staffing coordinator on 2-19-13, 2-20-13, 2-26-13, and 2-27-13 related to importance of following MD orders related to weight tracking and discharge orders. Medical Records person will also be educated by DHS on 2-20-13 related to auditing of discharge records to ensure that discharge orders are obtained. Staff competency will be determined by staff demonstrating how to write a d/c order and stating what documents need to be completed at discharge. Medical Records will be responsible for follow up to ensure d/c orders are obtained.</p>	



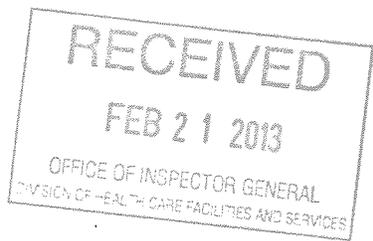
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F 309	<p>Continued From page 5</p> <p>history of Sepsis, and Encephalopathy. Review of the medication regimen for Resident #1 revealed he/she was ordered Furosemide 40 mg daily and HCTZ 12.5 mg daily. Review of the Nutrition Assessment and Data Collection tool completed by the facility's Registered Dietician (RD) on 11/15/12, revealed Resident #1's status of a BMI of 33.7 with excess kilocalorie intake, and weight changes that fluctuated up and down over the two (2) months prior to the report. Weekly weights for four (4) weeks were recommended by the RD, with regular diet, thin liquids, milk with meals, and snacks.</p> <p>Review of the physician's orders revealed on 11/16/12 Resident #1's physician ordered weekly weights for four (4) weeks. According to the Medication Administration Record (MAR), the first weight measurement was scheduled for 11/18/12, and the second weight was scheduled for 11/25/12, but no weights were recorded in these designated sections of the MAR.</p> <p>Review of the Resident's Weight Log revealed monthly weights for Resident #1, one of which fell within the time frame ordered by the physician, and it was recorded on 12/03/12, as 183 pounds with the wheelchair. Further review of the weight log revealed Resident #1's weight was recorded on 01/03/13 as 185 pounds, on 01/23/13 as 178 pounds, and on 01/25/13, as 181 pounds, all with the wheelchair.</p> <p>Interview, on 01/25/13 at 1:55 PM with RN #1 revealed Resident #1's physician ordered weekly weights for four (4) weeks, but apparently the weights were not measured on the days designated in the MAR. According to RN #1, it</p>	F 309	<p>Charge nurses will review weights as they are obtained daily/weekly/monthly. Previous weights will be reviewed to ensure that variances are identified and followed up on. Any resident with variances based on their orders will be reweighed for accuracy. MD responsible party, and RD will be notified of variance greater than 5% or if MD order states differently.</p> <p>Nurses in turn will monitor to ensure CNA's are obtaining weights/reweights as ordered and report to DHS/ADHS. Medical Records coordinator to check all discharge charts to ensure discharge orders are on chart.</p> <p>1. 100% of discharge charts will be audited in morning clinical meeting to assure discharge orders obtained. 100% of daily, weekly, and monthly weights will be audited to assure compliance and physician notification of variances greater than 5%. These audits will be reviewed by QA committee during monthly meetings to ensure compliance is achieved and maintained. These audits are on going.</p>	

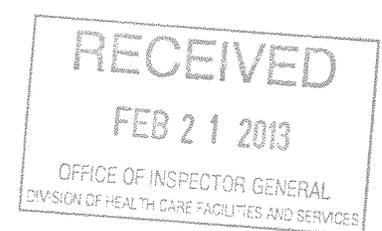


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F 309	<p>Continued From page 6</p> <p>was important to follow the physician's order to determine if Resident #1's weight had stabilized or continued to fluctuate. RN# 1 stated in addition to Resident #1's nutritional status, his/her cardiac status and taking prescribed daily doses of Furosemide 40mg and HCTZ 12.5mg could impact his/her weight fluctuations.</p> <p>Interview, on 01/25/13 at 2:25 PM, with the Director Nursing Services (DNS), revealed the physician's order for weekly weights for four (4) weeks, for Resident #1, was not followed. The DON stated that by not weighing Resident #1 as ordered, a significant change in weight might have been missed, and such data was important for the diagnosis and ongoing management of Resident #1's condition.</p> <p>2. Review of the clinical record for Resident #14 revealed the facility admitted the resident on 09/25/12 with a diagnosis of Acute Cephalic Vein Thrombosis. A nurse's note, dated 10/23/12 at 10:00 AM, revealed the facility discharged the resident home on 10/23/12 with discharge instructions, including a list of medications and contact information for home health services. The medical record did not contain a physician order for the resident to discharge from the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/25/13 at 3:10 PM, revealed the nurse stated she was the nurse who received the physician order for discharge and forgot to write the telephone order from the physician. The LPN stated the telephone order should have been</p>	F 309		



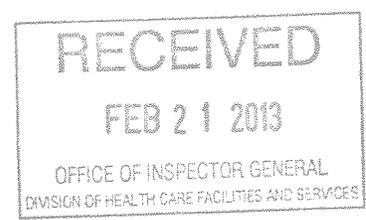
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F 309	<p>Continued From page 7</p> <p>written and later signed by the physician. The nurse stated she had been trained to receive physician orders and the transcription of the orders. The LPN stated if there was not a physician order in the chart for the resident to be discharged, then it could mean the resident was not discharged from the facility.</p> <p>Interview, on 01/25/13 at 3:35 PM, with the Director of Nursing Services (DNS) revealed a physician order was necessary for a resident to be discharged from the facility. The DNS stated without a discharge order by the physician the facility would not know where a resident was to be discharged to, the medications for the resident to receive, or what additional services would be needed for the resident.</p>	F 309		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide oral care to one (1) of the sixteen (16) sampled residents (Resident #5). The facility assessed Resident #5 as being unable to carry out the activities of daily living (ADL) to maintain oral hygiene.</p> <p>The findings include:</p>	F 312		



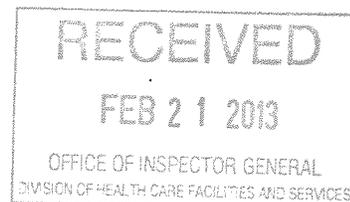
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F 312	<p>Continued From page 8</p> <p>Review of the facility's policy Oral Care Guidelines, dated 06/2010, revealed the purpose was to provide each resident with good oral hygiene. Oral care was to be performed with AM and PM care, and as needed per request of the resident.</p> <p>Observation of Resident #5, on 01/23/13 at 12:05 PM, revealed the resident sitting in the hallway in a wheelchair. A thick build up of residue was noted around the resident's teeth during the conversation. Observation of the resident, on 01/24/13 at 9:00 AM, revealed a continued thick build up of residue around the resident's teeth.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 06/05/11, with the following diagnoses: Alzheimer's; Anemia; and Chronic Obstructive Pulmonary Disease. The facility assessed the resident, on 10/24/12, as requiring extensive assistance for personal hygiene, which includes brushing teeth. Review of the comprehensive plan of care revealed the facility identified an ADL self-care deficit and planned an intervention to assist with personal hygiene as needed including oral/dental care.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 01/25/13 at 9:49 AM, revealed the night shift was responsible to dress Resident #5 and provide all morning care, including oral hygiene. The CNA revealed she normally brushed the resident's teeth after lunch, but the resident was combative, so that was dependent upon the resident's mood. After requesting the CNA to</p>	F 312	<p>1. Resident #5 was assessed for oral care needs and care provided as necessary. CNA assignment sheet updated on 1-25-13 to reflect current care needs.</p> <p>2. Care Plans reviewed for residents with ADL deficits on 1-29-13 by DHS, ADHS, staff development to determine other affected residents. Nurse managers (DHS, ADHS, MDS, Medical Records, and staffing coordinator) made rounds to visually inspect oral cavity of residents with similar ADL needs. Any non-compliance corrected and careplans updated.</p>	3-4-13



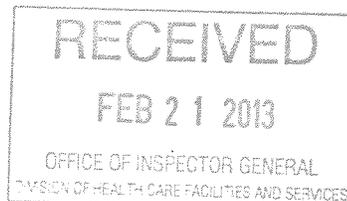
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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F 312	Continued From page 9 observe the resident's mouth and status of oral hygiene, the CNA revealed the resident's mouth was not clean and appeared to have a build up of substance on the teeth. The CNA revealed there was a potential for infection, bad breath, bacteria, erosion of the gums, and poor appetite. The CNA revealed she had not noticed the teeth that morning while assisting the resident up for the day. The CNA revealed she was familiar with the resident and the hygiene needs that were required.	F 312	3. Education will be provided to nursing staff to include cna's by DHS and/or inservice coordinator on 2-19-13 and 2-20-13 as well as 2/26/13 and 2/27/13 related to following plan of care with emphasis on communicating care to CNA's to provide daily care needs. Education will be provided to nurses and CNA's. Oral Care Procedure will be demonstrated and CNA's will have to return demonstration of of Grooming-nail care, hair care, oral care dentures appropriate prove competency. Licensed nurses will sign off on competency. 4. Ongoing monitoring will be achieved through daily rounding by DHS, ADHS, and/or unit supervisor. Department leaders are assigned designated rooms to observe residents daily to ensure insure oral care, hair care nail care, and grooming is being provided. Concerns are discussed in morning meeting and addressed timely. CNA's not following plan of care as designated on assignment sheets will be educated coached, and counseled as necessary. These completed rounding sheets will be reviewed by QA committee during monthly meetings to ensure compliance is achieved and maintained. These audits will continue until 100% compliance is met x 6 consecutive months with action plans developed for areas requiring correction.	
	Interview with CNA #2, on 01/25/13 at 1:50 PM, revealed Resident #5 was combative, but she had developed a good rapport with the resident and was able to provide some ADL care without resistance. The CNA revealed she was not usually assigned to the resident, but often helped out. The CNA revealed she was not asked to assist with the resident's oral care. The CNA revealed the unit had a Get Up list that identified Resident #5 as receiving assistance with dressing only by the night shift and that day shift was responsible to provide all AM care, including oral care. Review of the night shift Get Up list identified Resident #5 as being dressed only by the night shift. Review of the nursing assistant assignment sheet revealed Resident #5 was identified as a Rise and Shine. Follow up interview with CNA #1, on 01/25/13 at 2:03 PM, revealed the Nursing Assistant Assignment Sheet was printed from the computer by each nursing assistant at the beginning of their perspective shift. The CNA revealed the sheet identified Resident #5 as a Rise and Shine, which			



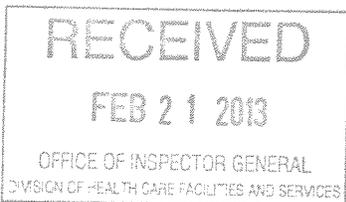
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F 312	<p>Continued From page 10</p> <p>meant the resident got up early so the night shift would provided all AM hygiene. The CNA revealed she had never seen the Get Up list before and was not aware she was responsible for providing all AM care, including oral hygiene. The CNA revealed she had brushed the residents teeth, after it was pointed out by the state surveyor, and revealed most of the residue was able to be removed.</p> <p>Interview with the Resident #5's family member, on 01/25/13 at 11:25 AM, revealed the facility did not provide oral care and he/she had noticed the poor condition of the residents teeth. The resident's family member revealed oral hygiene had gotten worse.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/25/13 at 2:15 PM, revealed she had noticed the condition of the resident's teeth on 01/24/13, but was unsuccessful at attempting to providing oral care. However, the LPN revealed she did not tell the CNA's about the issue with oral care or request assistance. The LPN revealed the Get Up sheet was new and recently implemented. The LPN revealed she thought the night shift was responsible for providing oral care to those identified on the Get Up list. The LPN revealed the Nursing Assistant Assignment Sheet was not accurate and needed to be updated to reflect responsibility of ADL's.</p> <p>Interview with Medical Records, on 01/25/13 at 2:39 PM, revealed she was responsible for updating the Nursing Assistant Assignment Sheet, but had not been notified there was a Get Up list or changes in the care to be provided. Medical Records revealed after reviewing both</p>	F 312	<p>The Rounding Tool that will be used to validate rounds is the DHS rounding tool which assesses Resident Grooming- nail care, hair care, oral care/ dentures appropriate and clean clothing, foot wear, resident rooms and call lights. These completed rounding sheets will be reviewed by QA during monthly meetings to ensure compliance is achieved and maintained. These audits will continue until 100% compliance is met x6consecutive months with action plans developed for areas requiring correction.</p>	
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F 312	Continued From page 11 forms she was not able to determine what shift would be responsible for ADL care. Interview with the Assistant Director of Nursing Services (ADNS), on 01/25/13 at 2:25 PM, revealed she had developed the Get Up sheet assigning which shift would be responsible for providing ADL care to dependent residents. The ADNS revealed no education was provided to the staff at the time the list was implemented. The ADNS revealed she did not review the Nursing	F 312		
F 371 SS=F	Assistant Assignment sheet when developing the Get Up list and was not aware they did not match. The ADNS revealed she did not monitor the effectiveness or outcome of the Get Up ADL care list. Interview with the DNS, on 01/25/13 at 3:21 PM, revealed oral care was expected and she had not been monitoring to ensure resident's were receiving oral care. The DNS revealed training was provided the staff on how to provide ADL's to residents with behaviors. The DNS revealed the CNA's were expected to report to the nurse if they were unable to provided hygiene. The DNS revealed she had not been monitoring to ensure this was being done. The DNS revealed she was neither aware of the Get Up list developed by the ADNS nor the discrepancies on the nursing assistant care sheets. The DNS revealed a potential for mouth sores, and problems with the gums, teeth, and appetite. 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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F 371	<p>Continued From page 12 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to prepare and serve food in a sanitary manner. During meal preparation and service, two (2) of three (3) male staff in the kitchen were not wearing beard covers, one (1) of five (5) kitchen staff did not have hair fully restrained, and one (1) of five (5) kitchen staff members used hand sanitizer in the kitchen preparation area.</p> <p>The findings include:</p> <p>1. Review of the facility's policy regarding Dietary Hair Restraint Policy and Procedure, not dated, revealed dietary staff were required to wear beard and hair restraints to keep hair from contacting exposed food and equipment.</p> <p>Observation in the kitchen, on 01/23/13 at 8:35 AM and 01/24/13 from 11:35 AM thru 1:15 PM, revealed the Cook had a full facial type beard, was preparing and serving food, and did not have a cover for his beard.</p> <p>Observation, on 01/24/13 at 11:35 AM thru 1:15 PM, in the kitchen revealed the Assistant Director of Food Services had a goatee type beard and did not have a beard cover on during food</p>	F 371	<p>1. All residents had the potential to be affected by these practices. On 1-24-13 no resident showed any signs of food related illness, therefore no residents identified as being affected by cited deficiency.</p> <p>2. On 1-24-13 no resident showed any signs of food related illness, therefore no residents identified as being affected by cited deficiency. On 1-24-13 staff were immediately informed to cover all exposed hair by dietary manager when made aware. DFS observed all dietary staff to determine if appropriate beard covers and hair nets were in place as well as use of sanitizer and hand washing. No other non compliance identified by staff. On 1-24-13 residents and food observed during lunch and dinner by DFS with no adverse effects noted.</p> <p>3. Dietary staff was in serviced on 2/6/13 by DFS related to storage, preparation and service of food under sanitary conditions. Emphasis was on use of hair restraints, handwashing, and the use of gloves. Dietary staff return demonstrated proper hand washing as well as using a hair restraint/beard restraint on 2/25/13 2/26/13, and 2/27/13 and competency signed off by DFS/ADFS. DHS will inservice DFS and ADFS on proper handwashing on 2-22-13. Uniform requirements will also be posted in the department.</p> <p>4. Handwashing competency audits will be completed once a month for 6 months and will be maintained and reviewed in QA meeting following plan of correction acceptance. Infection control and sanitation will also be addressed monthly in QA meetings as well as during visits by dietary support, dietician, and reviewed during peer process.</p>	3-4-13
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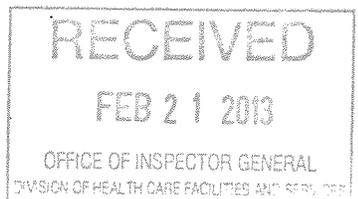
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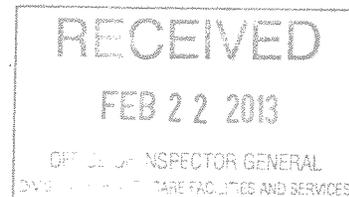
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F 371	<p>Continued From page 13 preparation.</p> <p>Observation, on 01/24/13 at 12:30 PM, revealed the Dietary Manager was assisting with food service in the main dining room and had her hair partially unrestrained by a hair net.</p> <p>Interview, on 01/25/13 at 10:35 AM, with the Cook revealed beard covers were not worn at the facility by staff with beards. The Cook stated he had not received training using hair restraints and without a beard cover, hair could fall into the residents' food and contaminate it.</p> <p>On 01/25/13 at 10:40 AM, interview with the Assistant Director of Food Services revealed there was no policy regarding beard restraints. He stated it was possible for facial hair to fall into food if hair was not restrained and could contaminate the resident's food.</p> <p>Interview with the Dietary Manager (DM), on 01/25/13 at 10:50 AM, revealed the purpose of a hair restraint was to keep hair out of the food. The DM stated there were male kitchen staff with beards and beard restraints should have been worn. She stated she was unaware her hair restraint did not fully cover her hair. The DM stated food could become contaminated if hair fell into the food. The DM stated she had been with the facility four (4) days and was still learning the facility's processes.</p> <p>2. Review of the facility's policy regarding Proper Glove Use Fact Sheet, not dated, provided by the facility with the Food Sanitation and Safety Policy and Procedure, Section 2, page 23, also not dated, revealed when staff used gloves they</p>	F 371	<p>Ongoing compliance will be achieved with dietary staff inservices twice a year. Daily observation of staff practices will occur by DFS and ADFS.</p> <p>Non compliance will be addressed through coaching, education, and progressive discipline as necessary.</p> <p>RD will also monitor during scheduled sanitation checks. Dietary support will monitor during campus visits. All audits will be reviewed by QA committee to determine need for</p>	



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F 371	Continued From page 14 should wash their hands before putting gloves on and when changing the gloves. Observation in the kitchen, on 01/24/13 at 11:55 AM, revealed the Cook used hand sanitizer in the kitchen prior to donning gloves to begin the food service tray line. Interview with the the Cook, on 01/25/13 at 10:35 AM, revealed he had been trained to use hand sanitizer instead of hand washing between glove changes. He stated it was possible for the sanitizer to get into the residents' food and contaminate it. Interview, on 01/25/13 at 10:50 AM, with the Dietary Manager (DM) revealed she was not aware of the use of hand sanitizer in the kitchen and the hand sanitizer was not as effective as washing hands. The DM stated hand sanitizer could get into the food and contaminate it, affect the taste of the food, or cause problems for resident with an allergy to the alcohol. She stated she had not begun to monitor food service as she had only been at the facility four (4) days.	F 371	education and monitoring. Any noncompliance will be addressed and action plan developed until substantial compliance is achieved for 6 consecutive months.
F 431 SS=D	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	F 431	



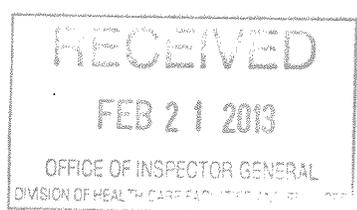
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F 371	<p>Continued From page 14</p> <p>should wash their hands before putting gloves on and when changing the gloves.</p> <p>Observation in the kitchen, on 01/24/13 at 11:55 AM, revealed the Cook used hand sanitizer in the kitchen prior to donning gloves to begin the food service tray line.</p> <p>Interview with the the Cook, on 01/25/13 at 10:35 AM, revealed he had been trained to use hand sanitizer instead of hand washing between glove changes. He stated it was possible for the sanitizer to get into the residents' food and contaminate it.</p>	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be</p>	F 431		

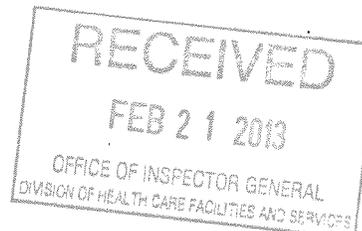


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F 431	<p>Continued From page 15</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys</p>	F 431	<p>1. No residents were affected by the cited deficiency.</p> <p>2. All medication and treatment crash carts were checked during the time of the survey by the DHS, to insure no other expired or discontinued supplies were present. Expired supplies were disposed of at that time.</p> <p>3. Nurses will be inserviced on storage of drugs and biologicals by DHS and/or inservice coordinator on 2/19/13, 2/20/13, 2/26/13 and 2/27/13 with an emphasis on removal of expired or discontinued supplies from medication and treatment carts. There will be a line added to crash cart check list to assess for expired items. Carts will be checked daily by charge nurses to insure no expired supplies are present. Any found will be disposed of immediately. Staff nurses will demonstrate ability to check for expired solutions and sign acknowledgement of such.</p> <p>4. Ongoing monitoring will occur through weekly cart checks by DHS unit supervisor or ADHS. Medication carts and supply rooms will be audited. DHS, ADHS, or unit supervisor will conduct random audits of 50% of carts and supply rooms on a weekly basis for 90 days and then monthly thereafter. Results of audits will be reviewed during monthly QA meetings and non compliance will be addressed with action plans developed that will be followed until substantial compliance is achieved x 6 consecutive months. Consult pharmacist will check medication and treatment carts for expired supplies monthly as part of routine consultation visits. Results of audits will be monitored through monthly QA process</p>	3-4-13
	<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, record review, and review of the facility's policy, it was determined the facility failed to have a system that ensured expired treatment supplies were removed from treatment carts and crash carts for two (2) of four (4) carts reviewed.</p> <p>The findings include:</p> <p>1. Review of the facility's policy, Disposal of Expired Supplies (not dated), revealed supplies remaining in the facility after expiration date</p>			



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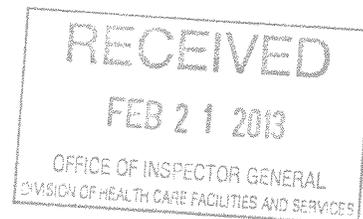
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F 431	<p>Continued From page 16</p> <p>would be removed from stock and disposed of, and routine review of the supply room should be conducted to identify items that had expired. Further, this was the responsibility of the Director of Health Services, Assistant Director of Health Services, and Licensed Nurses.</p> <p>Observation, on 01/25/13 at 9:00 AM, of the treatment cart for the 100, 200, and 300 hallways, revealed a bottle of Dakin's Solution with an expiration date of 12/2012.</p>	F 431		
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	<p>Interview, on 01/25/12 at 11:00 AM, with Registered Nurse (RN) #1 revealed it was the responsibility of the nurses that administer the residents' treatments to remove discontinued or expired supplies from use, but at this time there was no routine process for inspecting and removing expired and/or discontinued products from the treatment carts.</p> <p>Interview, on 01/25/13 at 2:20 PM, with the Director of Nursing Services (DNS), revealed licensed nurses were responsible for removing discontinued and/or expired supplies from the treatment carts. The problem with not routinely inspecting and removing outdated supplies would be the potential for using ineffective products, or using products unnecessarily during care of the residents.</p> <p>2. Review of the facility's policy for crash carts, titled Guidelines for Crash Cart Contents, not dated, revealed the crash carts should be examined for expired products.</p>			
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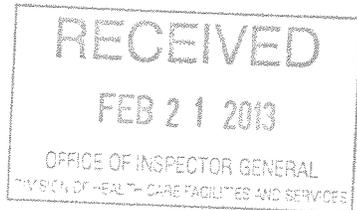
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F 431	<p>Continued From page 17</p> <p>Review of the Crash Cart Checklist, dated 01/01/13 through 01/31/13, revealed 02 with attached nasal canula, suction machine assembled, Yaunker catheter, sterile water x 2, nasal canula x 3, Ambu bag, mouth shield, dual chamber airway x 2, suction kit x 2, oxygen mask x 2, face mask with shield x 3, emergency kit x 2, face mask x 3, eye shield x 2, CPR (Cardiopulmonary Resuscitation) board, one box of medium gloves, box of disposable gowns, one pack of biohazard bags, sharps container. Each of these items were checked on the Crash Cart Checklist; however, nothing was indicated to check for expired items.</p> <p>Observation of the Crash Cart, on 01/24/13 at 3:55 PM, revealed 2 sets of suction catheters which were expired on 08/2011.</p> <p>Interview with Registered Nurse (RN) #3, on 01/24/13 at 3:59 PM, revealed night shift staff was suppose to check that all items were present in the crash cart. RN #3 verified there was nothing on the Crash Cart Check list which stated to remove expired biologicals. RN #3 also stated the suction catheter may not work probably if they were outdated. RN #3 stated the suction catheter may not suction properly when in a crisis situation.</p> <p>Interview with RN #2, on 01/25/13 at 3:30 PM, revealed night shift was supposed to audit the crash cart nightly. RN #2 stated the Crash Cart Checklist just identified that the items were present and not that they were expired.</p> <p>Interview, on 01/25/13 at 2:20 PM, with the</p>	F 431		



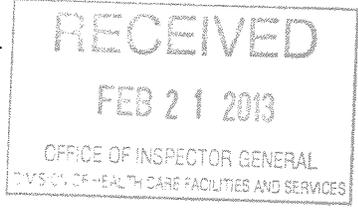
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 01/25/2013
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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 431 F 502 SS=D	Continued From page 18 Director of Nursing Services (DNS), revealed licensed nurses were responsible for removing discontinued and/or expired supplies from the treatment carts. The problem with not routinely inspecting and removing outdated supplies would be the potential for using ineffective products, or using products unnecessarily during care of the residents. 483.75(j)(1) ADMINISTRATION	F 431 F 502		
	<p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to have a system in place to ensure the quality of laboratory equipment, failed to monitor for expiration dates, failed to dispose of eight (8) expired laboratory Vacutainer's in one (1) medication room and failed to ensure staff was knowledgeable of the expiration dates.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Disposal of Expired Supplies, not dated, revealed supplies remained in the facility after expiration date were to be removed from stock and disposed of at that time. Routine review of the supply room should be conducted to identify items that have been expired.</p> <p>Observation of the Medication Room, on 01/24/13</p>			



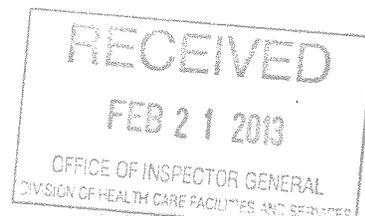
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F 502	<p>Continued From page 19</p> <p>at 3:55 PM, revealed six (6) blue top laboratory Vacutainer's, expired on 07/2012, one (1) gray top Vacutainer expired on 08/2012, one (1) dark blue Vacutainer expired on 07/2012.</p> <p>Interview with Registered Nurse (RN) #3, on 01/24/13 at 3:59 PM, revealed it was the night shift's nightly duty to check for expired medications and supplies. RN #3 stated when she did blood draws she did not know to check for an expiration date on the Vacutainer. She was not aware there was even an expiration date on the Vacutainer. She further stated the lab specimen may not be at it's best potential if stored in a Vacutainer that was expired and the results could potentially be in-accurate.</p> <p>Interview with the Director of Nursing Services (DNS), on 01/25/13 at 4:00 PM, revealed expired laboratory collection tubes could potentially cause an inaccurate result. The DNS revealed the Assistant Director of Nursing Services (ADNS) and Medical Records were responsible to check the medication rooms. The DNS revealed Medical records was responsible for ordering supplies and did not notice the tubes were expired. The DNS revealed she was not monitoring to ensure ADNS and Medical Records were monitoring the laboratory supplies for expired tubes.</p>	F 502	<ol style="list-style-type: none"> 1. No residents were affected by the cited deficiency. 2. All laboratory supplies were checked by the DHS/ADHS during the time of the survey to insure no other expired or discontinued supplies were present. Any found were disposed of at that time. 3. Nurses will be in serviced on expiration of lab supplies by DHS and or inservice coordinator on 2/19/13, 2/20/13, 2/26/13 and 2/27/13 with an emphasis on removal of expired or discontinued laboratory supplies. Lab Carts and medication rooms will be checked daily by charge nurses to insure no expired supplies are present. Any found will be disposed of immediately. Staff nurses will complete a post test following being inserviced on demonstrate ability checking for expired laboratory supplies and sign acknowledgement of such. 4. Ongoing monitoring will occur through weekly supply room checks by DHS, ADHS, or unit supervisor. Supply rooms will be audited. DHS, ADHS or unit supervisor will conduct random audits of 50% supply rooms on a weekly basis for 90 days and then monthly thereafter. Results of audits will be reviewed during monthly QA meetings and non compliance will be addressed and action plans developed that will be followed until substantial compliance is achieved x 6 consecutive months. 	3-4-13



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01 - GLEN RIDGE HEALTH CAMPUS</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2013
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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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2006</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p>	K 000		
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	<p>TYPE OF STRUCTURE: One (1) story, Type III(000)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas with propane back-up.</p> <p>A standard Life Safety Code survey was initiated on 01/23/13 and concluded on 01/24/13. Glen Ridge Health Campus was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of sixty four (64) on the day of the survey.</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>			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE <i>2-21-13</i>
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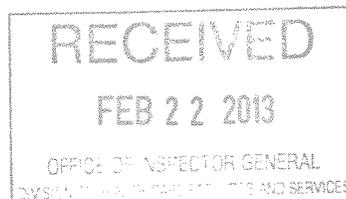
A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RW

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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 8415 CALM RIVER WAY LOUISVILLE, KY 40299	
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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 F 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 certified for seventy (70) beds with a census of sixty four (64) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 at 1:34 PM, with the Director of Plant Operations revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The room was identified as the Clean Linen Room to the Laundry.</p>	K 029	<ol style="list-style-type: none"> 1. A self closing device was put on the door between clean linen room and laundry on 1/25/2013. 2. Residents residing in affected areas were assessed to determine that no adverse conditions present. 3. Plant operations director will be educated by home office support DPO related to requirements for self closing or containing hazardous combustibles no later than 3-1-13. 4. Ongoing monitoring will be achieved during routine preventative maintenance rounds and documented on DPO logs and reviewed in QA for the next 6 months. Other monitoring will occur during peer review process every 6 months. 	3-4-13



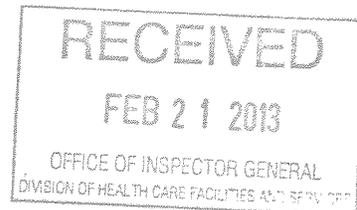
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K 029	<p>Continued From page 2</p> <p>Interview, on 01/24/13 at 1:34 PM, with the Director of Plant Operations revealed he was not aware the door to this room was required to be self-closing.</p> <p>Interview, on 01/24/13 at 11:45 AM, with the Executive Director revealed she was not aware the door to this room was required to be self-closing.</p>	K 029		
	<p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.</p> <p>Table 18.3.2.1 Hazardous Area Protection</p> <p>Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft² (9.3 m²) 1 hour</p>			



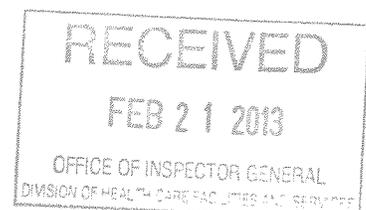
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K 029	Continued From page 3 Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour	K 029		
K 050 SS=F	Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4 Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material 1 hour Trash collection rooms 1 hour NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it	K 050		

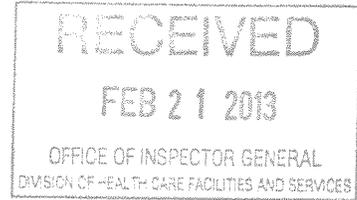


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K 050	Continued From page 4 was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of sixty four (64) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times quarterly.	K 050	1. No residents were affected by this deficiency. 2. Director of plant operations will conduct fire drills on each shift at various/ unexpected times. Starting in the month of March, fire drills will be conducted per the following scheduled: March- 11pm, April- 7am, May- 3pm, June- 1am, July- 9am, August- 5pm, September- 3am, October- 11am, November- 7pm, December- 5am. 3. Deficiency had been identified on January 15th through audit of the home office and DPO was in-serviced on this date. ED re-inserviced DPO on 2-12-13 regarding regulatory compliance of K50. 4. Ed will audit fire drill times monthly. Audits will continue for 6 months. Results of audits will be monitored through monthly QA. Fire drill schedules will also be reviewed every 6 months during peer review process.	3-4-13
	<p>The findings include:</p> <p>Fire Drill review, on 01/23/13 at 1:20 PM, with the Director of Plant Operations revealed the facility failed to conduct fire drills at unexpected times on all shifts.</p> <p>Interview, on 01/23/13 at 1:20 PM, with the Director of Plant Operations revealed he was not aware the fire drills were not being conducted as required.</p> <p>Interview, on 01/24/13 at 11:45 AM, with the Executive Director revealed she was not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns,</p>			



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K 050 Continued From page 5
maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.
Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

K 050

~~**K-144** **SS=F** **NFPA 101 LIFE SAFETY CODE STANDARD**~~

~~**K 144**~~

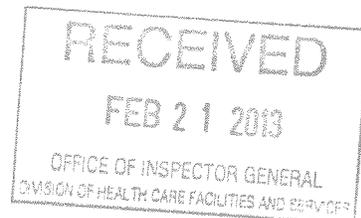
Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.

~~1. No residents were affected by this deficiency
2. DPO immediately corrected deficiency upon notification. All residents have the potential to be affected by the deficiency. The 9 potential resident rooms were checked and non affected.
3. Plant Ops will be in-service by home office DPO support on deficiency by March 1st, 2013.
4. ED to complete monthly audits for 3 months to ensure facility is in compliance. Results of audits will be documented and monitored through monthly QA process and through Peer Review process every six months. If non compliance continues, action plans will be required that will track progress and be reviewed.~~

~~3-4-13~~

This STANDARD is not met as evidenced by:
Based on observation, interviews and generator testing record review, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of sixty four (64) on the day of the survey.

The findings include:



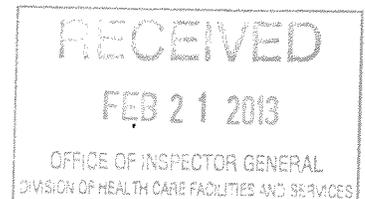
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K 144	<p>Continued From page 6</p> <p>Observation, on 01/24/13 at 10:37 AM, with the Director of Plant Operations revealed the battery charger for the facilities emergency generator was connected directly to the generators battery.</p> <p>Interview, on 01/24/13 at 10:37 AM, with the Director of Plant Operations revealed he was not aware of the requirement.</p> <p>Interview, on 01/24/13 at 11:45 AM, with the Executive Director revealed she was not aware of the requirement.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all</p>	K 144		



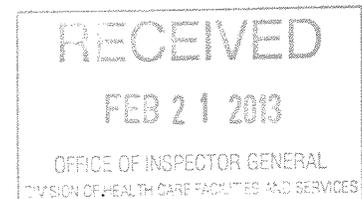
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 7</p> <p>appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p>	K 144		



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165461	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GLEN RIDGE HEALTH CAI B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2013
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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 144 Continued From page 8
2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.
3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.

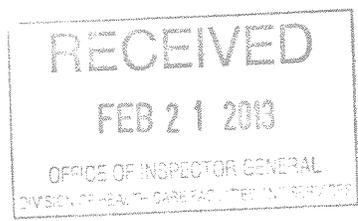
K 144

K 147 SS=D
NFPA 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 three (3) of nine (9) smoke compartments, residents, staff, and visitors. The facility is certified for seventy (70) beds with a census of sixty four (64) on the day of the survey. The facility failed to ensure the proper use of power strips, and extension cords.

The findings include:
1. Observations, on 01/23/13 at 1:30 PM, with

K 147

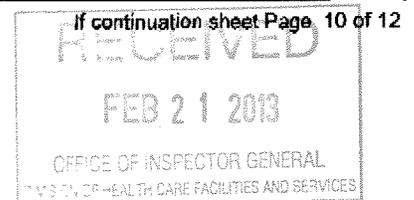


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K 147	<p>Continued From page 9</p> <p>the Director of Plant Operations revealed laundry soap dispensing pumps used to pump liquid detergent into the facilities washing machines was plugged into a power strip located in the Laundry Room.</p> <p>Interview, on 01/23/13 at 1:30 PM, with the Director of Plant Operations revealed he was not aware the power strip was being used in the Laundry Room.</p>	K 147	<p>1. No residents were affected by this deficiency. The refrigerator that was plugged into a power strip in the Director of Environmental office was immediately unplugged and a plug was added on 2/18/13. The refrigerator that was plugged into a power strip in the MDS office was immediately removed and a plug was installed on 2/18/13. The lift batter chargers that were plugged into a power strip was immediately removed and a plug added on 2/19/13. The refrigerator in the CSS office was immediately removed and a plug added on 2/20/13.</p>	3-4-13
	<p>Interview, on 01/24/13 at 11:45 AM, with the Executive Director revealed she was aware of the proper use of power strips.</p> <p>2. Observations, on 01/24/13 between 10:00 AM and 11:30 AM, with the Director of Plant Operations revealed:</p> <ol style="list-style-type: none"> 1) A refrigerator was plugged into a power strip located in the Director of Environmental Services Office. 2) An extension cord was plugged into a lamp located in room #302. 3) An extension cord was in use located in room #308. 4) A refrigerator was plugged into a power strip that was plugged into another power strip located in the MDS Office. 5) Lift battery chargers were plugged into a power strip located in the 500 Unit Nurses Station Med Room. 6) A refrigerator was plugged into a power strip located in the Community Service Representative Office. 		<p>2. All residents had the potential to be affected. DPO rounded to ensure no other infractions identified. None observed. All power strips/extension cords were immediately removed from resident rooms 302 and 308, as well as office areas identified. Refrigerator plugged into acceptable power outlet. Lift Battery charges corrected. CSR refrigerator plugged into acceptable outlet.</p> <p>3. Additional plugs have been added in affected areas including Director of environmental service office, CSS office, MDS office, 500 unit nurses station.</p> <p>4. DPO will do random audits weekly to ensure no other extension cords or power strips have been added to rooms within the facility. These audits will continue for 6 months. Results of audits will be monitored through monthly QA process and through peer review process every 6 months.</p>	



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K 147 Continued From page 10
Interview, on 01/124/13 between 10:00 AM and 11:30 AM, with the Director of Plant Operations revealed he was aware of the requirements for power strips and extension cords; however, he was not aware they had been brought into the facility and misused.

Interview, on 01/24/13 at 11:45 AM, with the Executive Director revealed she was aware of the proper use of power strips and extension cords.

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Reference: NFPA 101 (2000 Edition)

9.1.2 Electric.
Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

Reference: NFPA 70 400-8
(Extensions Cords) Uses Not Permitted.
Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:
(1) As a substitute for the fixed wiring of a structure
(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
(3) Where run through doorways, windows, or similar openings
(4) Where attached to building surfaces

Reference: NFPA 99 (1999 edition)



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K 147	Continued From page 11 3-3.2.1.2 D 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.	K 147		
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