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PRINTED: 05/03/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185481	(X2) MULTIPLE CONSTRUCTION MAY 5 2010 A. BUILDING _____ B. WING _____ <small>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</small>	(X3) DATE SURVEY COMPLETED 04/07/2010
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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 AMENDED 2567 A standard health survey was conducted 04/06/10 through 04/07/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to assess the needs for one (1) resident (#4) of the fourteen (14) sampled residents for medically related social services. Resident #4's Power Of Attorney (POA) made hurtful statements about the resident to staff. Resident #4 had a physician's order for a psychiatric consult, was on suicide precautions and the facility failed to develop a plan to address specific needs of the resident. The resident did not have social service interventions on the plan of care once the resident was placed on suicide precautions. The findings include: Record review for Resident #4 revealed an admission date of 03/25/10 with diagnoses of	F 250	F-250 Resident # 4 care plan was immediately updated to include that he was placed on suicidal precautions. The nurse contacted Parkview Psychiatric who followed up with an onsite visit. Interview with the family and resident verified that Hospice was not appropriate for resident #4. Residents are assessed by using our Nursing Admission Assessment Tool (attachment A - mood and behavior section) to identify if they are at risk for suicidal tendency and voice threats of suicide. If identified, the residents care plan is updated and appropriate interventions are put in place. A Skilled Nursing Assessment (attachment B) is completed daily for skilled residents and weekly for non-skilled resident to identify if a resident at any time express verbal suicidal threats. If identified the care plan will be updated and	5-22-10

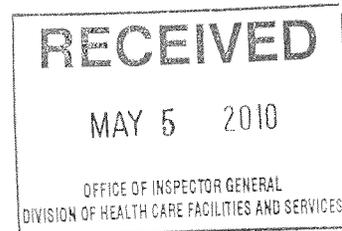
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Katherine Wood</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>5-4-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may 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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F 250	<p>Continued From page 1</p> <p>Chronic Renal Failure, Cancer of the Bladder, Urathra and Prostate, Hematuria, Anemia, Fatigue and Protein Malnutrition. The physician orders indicated the resident had an indwelling catheter due to the cancer diagnosis. The catheter was subsequently discontinued and the resident was utilizing adult briefs for incontinence. The nurse's notes dated 03/30/10 stated the resident's POA was in the hallway demanding the baby's diaper be changed. The resident told the staff that the statement by the POA was very upsetting. The resident further voiced concern regarding blood in the urine, wanted to know if other residents at the facility had the same problem and if they were ok now. The resident further voiced the desire to know what the odds were as far as his/her health was concerned. On 03/31/10 the POA again stated to the staff at the nurse's station, "is my baby ready to go." The nurse's notes dated 04/01/10 indicated the resident was in the bathroom with bloody urine and verbalized to the staff, "I could kill myself and I want to die." The resident was transferred to the hospital for evaluation. The resident subsequently returned to the facility the same day without any paperwork.</p> <p>Review of the record revealed the Adult Registered Nurse Practitioner (ARNP) wrote orders for suicide precautions and a psychiatric consult on 04/03/10. Record review on 04/06/10 did not reveal any psychiatric consult had been completed.</p> <p>Review of the Social Services notes dated 03/31/10 revealed the resident was questioned on whether he/she would like Social Services to talk with the POA regarding the statements made. The resident responded there is nothing you can</p>	F 250	<p>interventions will be put in place. Residents who are admitted with terminal diagnoses and qualify for Hospice are identified by the Nursing and/or our DRS will address with the family and/or resident during their 7-day care plan if they wish to have Hospice involved. If a resident becomes terminal during their stay with us a significant change will be triggered by the MDS and at time the campus staff will address the resident/family with Hospice services. Nurse management audited all other charts to assure not other residents are affected.</p> <p>The Director of Resident Services will complete additional training before May 22, 2010 to include care planning, counseling as needed, process for arranging services outside of campus and involving hospice agencies (attachment C). All licensed staff will be in serviced on our guideline for suicidal precautions.</p>	



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F 250	<p>Continued From page 2</p> <p>say, Per the Social Services notes no further interventions, education or assessment was completed for this resident until 04/05/10 when a Social Services note indicated the resident was sent to the hospital on 04/01/10 for statements of killing self and wanting to die. A late entry note dated 04/05/10 for 04/03/10 indicated there was no change in the resident since the last assessment. No mood or behaviors observed. The resident has been on suicide precautions since the incident on 04/01/10.</p> <p>Interview with the Social Services Designee (a staff member with a Psychology degree) on 04/06/10 at 4:15pm revealed when she spoke to the resident regarding the POA's statements, the resident did not want anything said to the POA. However, the facility did not put any interventions into place to promote the resident's well-being. There had been no conversation with the resident regarding the desire for Hospice Interventions, or advocacy for education regarding the disease process on the resident's behalf. In addition, Social Services was aware the resident was on every fifteen (15) minute checks due to the suicide precautions; however, Social Services was not sure if anything else had been done. The Social Services Designee had not ascertained if the resident had a plan to commit suicide or a means to carry out that plan. A contract with the resident to not harm them self was not approached by the Social Services. In addition, Social Services was not involved in the development of the plan of care for this resident as she only completed the assessments.</p> <p>Interview with the Executive Director on 04/06/10 at 4:25pm revealed the facility was keeping a close watch on the POA when visiting as the</p>	F 250	<p>The DRS and/or ED will audit resident charts by using the Resident Service/Social Service Audit form (attachment D). DRS/ED will audit 4 charts per week for 2 weeks, 2 charts per week for 2 weeks, than 4 charts per month. The results will be discussed and monitored during the monthly QA meeting.</p>	

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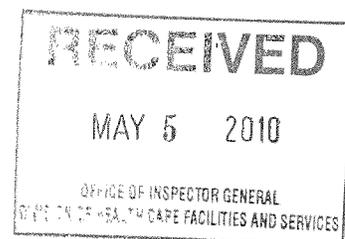
MAY 5 2010

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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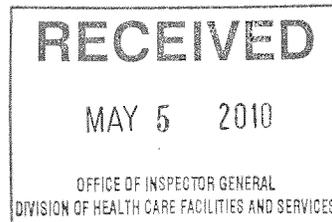
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F 250	Continued From page 3 resident was already on every 15 minute checks and the resident's room was across from the nurse's station. Even though there is not always someone at the nurse's station the potential was still there. The Executive Director further stated that the resident must request Hospice before the subject is discussed with the resident. In addition, these types of issues are typically discussed in the morning meeting with the Interdisciplinary team; however, this was missed and should have been followed up on by Social Services. Review of the facility policy titled Standard Suicide Response Guidelines dated 01/06 indicated the guidelines were designed and implemented in an attempt to identify and prevent psychosocial dysfunction. Report any of the following immediately; assess resident's environment for safety. Remove and store objects that could be used for self-harm (i.e.: shoe strings, cords, glass/metal objects, etc); and assess the resident for the physical ability to carry out the plan of demise. Review of the Executive Summary for Suicide Response Guidelines dated 01/06 indicated ongoing assessment and communication of the resident's mental condition is the responsibility of each team member within the campus.	F 250		
F 279 SS=D	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	F 279		



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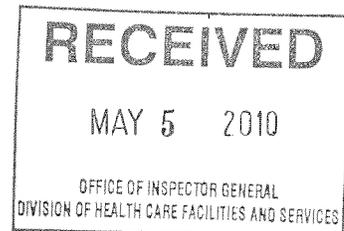
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F 279	Continued From page 4 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and 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). This REQUIREMENT is not met as evidenced by: Based on record review and Interview it was determined the facility failed to develop a plan of care for two (2) residents (#4 and #6) of the fourteen (14) residents sampled. Resident #4 did not have a plan of care to address suicidal precautions and Resident #6 did not have a plan of care to address the use of a Continuous Passive Motion (CPM) machine. The findings include: 1. Record review for Resident #4 revealed an admission date of 03/24/10 with diagnoses of Chronic Renal Failure and Cancer of the Bladder, Urethra and Prostate. The Nursing Admission Assessment and Data Collection form dated 03/25/10 revealed it was utilized as the plan of care also. The section titled Mood and Behavior revealed the resident was at a local hospital on 04/01/10 due to being upset and wanting to die. No further interventions were noted. Review of physician orders dated 04/03/10 revealed the	F 279	F-279 Resident #4 care plan was immediately updated to reflect that he was placed on suicidal precautions. Resident # 6 care plan was immediately updated to reflect the use of CPM machine. Nurse #1 was immediately trained on using a CPM machine. The MDS nurse audited the care plans of residents who have orders for CPM machines to verify that interventions were up to date. There are no residents identified to have suicidal precautions. Interdisciplinary Team we are in-serviced before May 22, 2010 on care planning. Licensed nursing staff will be in serviced before May 22, 2010 on following physician admitting orders and trained on using CPM machines. The licensed nurse job specific check off sheet (attachment F) has been updated to include training for CPM machines. All staff will be in serviced on our suicidal precautions guidelines before May 22, 2010.	5-22-10



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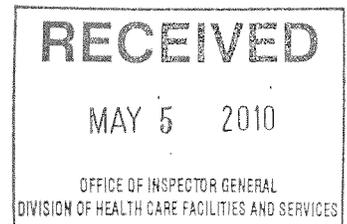
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F 279	<p>Continued From page 5</p> <p>staff were to place the resident on suicide precautions.</p> <p>Interview with the Minimum Data Set (MDS) RN#1 on 04/06/10 at 11:00am revealed the admission care plan did not have the interventions for suicide precautions and should have and the RN could not specify why it was not on the plan of care.</p> <p>Interview with Registered Nurse (RN) #3 on 04/06/10 at 4:55pm, who was the nurse on duty for the day, revealed she was aware of the suicide precaution interventions only because of previous experience at another employment.</p> <p>Interview with the Social Service Designee on 04/06/10 at 4:15pm revealed she only completed the assessments for the MDS process and does not develop plans of care. The Designee was aware the resident was placed on every 15 minute checks; however, she was not sure of any other interventions as she had not spoken to the resident to determine if there was a plan to commit suicide, a means to carry it out, or if a contract had been established with the resident to not harm them self.</p> <p>Interview with the Executive Director on 04/07/10 at 2:40pm revealed the care plan was missed by human error and not followed up on.</p> <p>2. Record review on 04/06/10 at 9:15am revealed Resident #6 was admitted on 04/03/10 status post Right Total Knee Arthroplasty, Osteoarthritis, Hypertension, Hypothyroidism, and Hyperlipidemia. Continued review of the physician's orders dated 04/03/10 revealed the resident would utilize a Continuous Passive</p>	F 279	<p>The DHS or designee will use the Chart Audit form (attachment E) to audit 4 resident charts per week for 4 weeks, 2 resident charts per week for 4 weeks, and 1 resident chart per week for 4 weeks. The audits will be discussed by the IDT in the monthly QA meeting.</p>	



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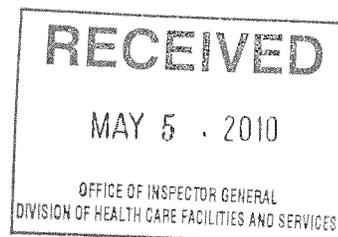
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F 279	Continued From page 6 Motion (CPM) machine one (1) to two (2) hours twice a day to his/her right knee. Record review of the Nursing Admission Assessment and Data Collection dated 04/03/10 at 2:45pm revealed the facility did not develop an initial plan of care to include the use of a CPM machine. Interview with Resident #6 on 04/06/10 at 4:30pm revealed the Resident was curious as to why he/she did not have a CPM machine, and continued to state that no one had ever mentioned using the machine on the post-operative knee. Telephonic interview with Licensed Practical Nurse (LPN) #1 on 04/07/10 at 2:10pm revealed she had not been trained on setting up a CPM machine therefore she did not place the CPM machine nor implement a plan of care.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation it was determined the facility failed to follow physician orders for two (2) of the fourteen (14) sampled residents (#4 and #6). Resident #4	F 309		



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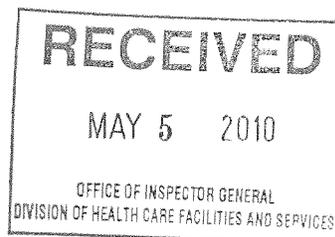
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F 309	<p>Continued From page 7</p> <p>had orders for a psychiatric evaluation and Resident #6 had physician orders for a Continuous Passive Motion (CPM) machine.</p> <p>The findings include:</p> <p>1. Record review for Resident #4 revealed diagnoses of Chronic Renal Failure, Cancer of the Bladder, Urethra and Prostate, Hematuria, Anemia, Fatigue, Insomnia and Protein Malnutrition. The physician orders dated 04/01/10 revealed the resident was sent to a local hospital for evaluation and treatment for suicidal statements. According to the nurse's notes dated 04/01/10 the resident stated "I could kill myself and I want to die." The resident was returned to the facility without any paperwork including orders or recommendations. The Adult Registered Nurse Practitioners (ARNP) note dated 04/03/10 stated suicide precautions and psychiatry consult for Anxiety and Depression. Continued review of the record did not reveal an evaluation by the consulting psychiatrist as of 04/06/10.</p> <p>Interview with the Minimum Data Set (MDS) RN#1 on 04/06/10 at 11:00am revealed the psychiatrist had not been to see the resident as of this day even though the order was given on 04/03/10. The ARNP ordered the psychiatry evaluation due to suicidal ideations. It was further noted there was no documentation that the psychiatrist was ever notified of the order for the consult and would be called today.</p> <p>Interview with RN #3 on 04/06/10 at 4:55pm revealed the psychiatrist was notified as of today; however, the psychiatrist could not see the resident until 04/11/10, ten (10) days after the incident that brought the resident to the hospital</p>	F 309	<p>F-309</p> <p>Resident #4's psychologist was notified by the nurse and he came to complete an onsite visit. Resident # 6 was immediately started on her CPM machine.</p> <p>Residents who have orders for CPM machines care plans were audited by MDS nurse to verify that interventions were up to date and placed on the resident care plan. There are no residents identified to have suicidal precautions.</p> <p>Licensed nursing staff will be in serviced before May 22, 2010 on following physician admitting orders and verify training on CPM machines and on suicidal precautions.</p> <p>The DHS or designee will use the Chart Audit Form (attachment E) to audit 4 resident charts per week for 4 weeks, 2 resident charts per week for 4 weeks, and 1 resident chart per week for 4 weeks. The audits will be discussed by the IDT in the monthly QA meeting.</p>	5-22-10



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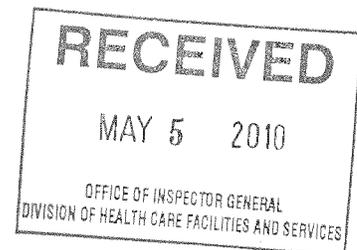
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F 309	<p>Continued From page 8 for evaluation.</p> <p>Interview with the ARNP on 04/07/10 at 10:25am revealed on 04/03/10 the resident, on examination, was very anxious and with chest pain. The intent of the suicide precaution order was for staff to watch the resident and ensure his/her safety because the staff indicated the resident made another statement of wanting to die on 04/03/10. The reason for the psychiatric consult was to have the resident's medication looked at due to the anxiety and not necessarily the statements made by the resident.</p> <p>Review of the record revealed a second call to the psychiatrist indicated he would visit the resident on 04/07/10 and the suicide precautions had been discontinued.</p> <p>2. Record review on 04/06/10 at 9:15am revealed Resident #6 was admitted on 04/03/10 status post Right Total Knee Arthroplasty, Osteoarthritis, Hypertension, Hypothyroidism, and Hyperlipidemia. Continued review of the physician's orders dated 04/03/10 revealed the resident would utilize a Continuous Passive Motion (CPM) machine one (1) to two (2) hours twice a day to her right knee.</p> <p>Observation of Resident #6 on 04/06/10 at 11:45am, 12:40pm, 2:00pm, and 4:30pm revealed no use of a CPM machine to the Resident's right knee, nor the presence of a CPM machine in her room.</p> <p>Interview with Resident #6 on 04/06/10 at 4:30pm revealed the resident was curious on why he/she did not have a CPM machine, and continued to state that no one had ever mentioned using the</p>	F 309		



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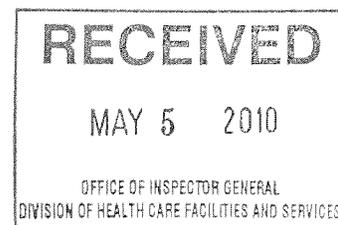
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F 309	<p>Continued From page 9 machine on his/her post-operative knee.</p> <p>Observation of Resident #6 on 04/07/10 at 8:30am, 10:00am, and 12:00noon revealed no use of a CPM machine, nor the presence of the machine in the resident's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 per telephone on 04/07/10 at 2:10pm revealed she had been the nurse who had taken off Resident #6 admission orders on 04/03/10. The nurse stated that she had been instructed by Registered Nurse (RN) #3 that Physical Therapy was responsible to place CPM machines on the residents. The LPN went on to state that she had never received any training on the CPM machine, and she was unaware of how to apply a CPM machine, or regulate the settings.</p> <p>Interview with RN #3 on 04/07/10 at 2:15pm revealed she did not instruct LPN #1 that Physical Therapy was responsible to apply and monitor the CPM machine. She went on to state that she was unaware that LPN #1 did not know how to apply or monitor the machine.</p> <p>Record Review on 04/07/10 at 2:30pm of the Five (5) Day Nurse Orientation Program revealed no training on the CPM machine had been included during the orientation process.</p> <p>Interview with the Physical Therapist on 04/07/10 at 11:00am revealed that it was the nurse's responsibility to apply and monitor the CPM machines. She continued to state that the Physical Therapist had presented a class on the CPM machine in the past, but that was well over a year ago.</p>	F 309		



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

PRINTED: 05/03/2010
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 04/07/2010
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 309	Continued From page 10 Interview with RN #2 on 04/07/10 at 10:45am revealed that most residents who have had knee surgery do have CPM machines placed, and that the nurses are responsible to place and monitor the machine. She went on to state that Physical Therapy had instructed her on the CPM application when she was initially employed. Interview with the Director of Nurses (DON) on 04/07/10 at 2:15pm revealed the nurses are not trained on the application/monitoring of the CPM machine during the orientation process, but the facility will now include this education during the orientation phase, as well as provide in-services to the employees.	F 309		



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

PRINTED: 05/24/2010
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 01 - GLEN RIDGE HEALTH CA B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
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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	INITIAL COMMENTS	K 000		
K 062 SS=E	<p>AMENDED</p> <p>A Life Safety Code survey was initiated and conducted on 04/15/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an E.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and a interview, conducted on 04/15/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility, conducted 04/15/10 at 3:30 PM, revealed six (6) sprinkler heads located on the front porch and six (6) sprinkler heads located at central court were stained with a brown/green substance that appeared to be consistent with corrosion.</p> <p>An interview with the Maintenance Director, on 04/15/10 at 3:35 PM, revealed he was unaware of the build-up of corrosion on the sprinkler heads.</p>	K 062	<p>K - 062</p> <p>The Director of Plant Operations contacted RC Fire Protection who came to assess and provide a quote to replace the sprinkler heads.</p> <p>All external sprinkler heads are affected and will be replaced.</p> <p>All exterior sprinkler heads are affected and will be replaced before May 22, 2010.</p> <p>Sprinkler heads will be inspected during quarterly fire sprinkler inspection.</p>	5-22-10

RECEIVED
MAY 25 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathleen Johnson</i>	TITLE Executive Director	(X6) DATE 5/4/10
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GLEN RIDGE HEALTH CA B. WING _____	(X3) DATE SURVEY COMPLETED 04/15/2010
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 062	Continued From page 1 Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		

