

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

PRINTED: 12/16/2013
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 12/05/2013
--	--	--	--

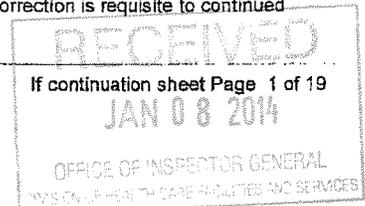
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A standard health survey was conducted 12/03/13 - 12/05/13 and a Life Safety Code survey was conducted on 12/03/13 with deficiencies cited at the highest scope and severity at an "F".	F 000		
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 interview, record review, and review of facility policy, it was determined the facility failed to ensure care and services were provided in regards to following physician orders for one (1) of thirteen (13) sampled residents (Resident #10). On 10/16/13 the facility received an order to discontinue Zocor and start Lipitor related to pharmacy recommendation; however, the facility continued to administer Zocor for 50 days past the discontinue date. The findings include: Review of the facility's policy, regarding Guidelines for Medication Orders, undated, revealed it did not address orders written on the Pharmacy New Admission Medication Regimen	F 309	The submission of this plan of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Glen Ridge. This facility 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 (POC) shall serve as the credible allegation of compliance with all state and federal requirements governing the management of the facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Henry Adkins W</i>	TITLE <i>X Exec. Dir.</i>	(X6) DATE <i>X 1-7-14</i>
--	------------------------------	------------------------------

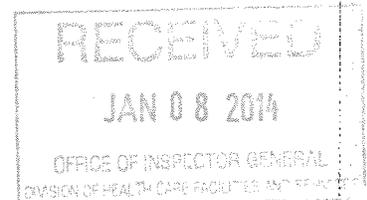
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

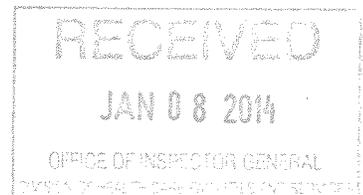
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 1</p> <p>Review or the monthly Pharmacy Medication Regimen Review recommendations.</p> <p>Review of the policy regarding Consultant Pharmacist Reports, effective 09/01/13, revealed the Consultant Pharmacist performs a comprehensive medication regimen review (MRR) per regulatory guidelines or agreement. The MRR includes evaluating the residents' response to medication therapy to determine that the resident maintains the highest practical level of functioning and prevents or minimizes adverse consequences related to medications. Findings and recommendations are reported to the Director of Health Services (DHS) or attending physician. Resident-specific irregularities or clinical significant risk associated with medications are documented in the resident's active record and reported to the DHS and/or prescriber. Notification made is dependent on severity of irregularity. Recommendations are acted upon and documented by the facility staff or prescriber.</p> <p>Review of the medical record for Resident #10 revealed the facility re-admitted the resident on 10/09/13 with Diagnoses of Dementia, Depression, Hypertension, Peripheral Vascular Disease and Hyperlipidemia. The facility completed a Basic Interview for Mental Status (BIMS) on 10/16/13 when the resident scored a nine (9) out of fifteen (15). The residents' admission medications included Zocor 40 mg every bedtime and Amlodipine 10 mg every day. Review of the New Admission MRR, dated 10/09/13, revealed the Pharmacist documented severe drug interactions between Zocor and Amlodipine. Recommend changing Zocor to Lipitor 20 mg or Pravachol 40 mg at bedtime to</p>	F 309	<p>1. Medication for Resident #10 was discontinued (D/C'd) on 12-4-13. Zocor was D/C'd and Lipitor was started.</p> <p>Resident was assessed by the DHS on 12-4-13 for any negative effects of the possible medication interaction and none were found.</p> <p>2. All charts were audited on 12-4-13 by the DHS and ADHS to ensure that no other MD orders or pharmacy recommendations were missed. No other MD orders or pharmacy recommendations were found not completed.</p>	12-20-13



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

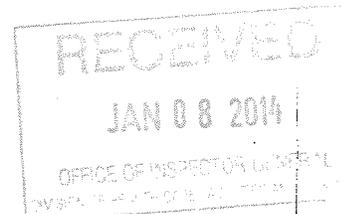
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 2</p> <p>decrease the risk of Myopathy. The Nurse Practitioner (NP) wrote the order to discontinue Zocor and start Lipitor 20 mg at bedtime on 10/16/13 on the New Admission Medication Regimen Review form at the bottom of the form designated for the Physician signature. There was no indication the medication order was taken off by the facility. The Consultant Pharmacist #1 completed a monthly MRR on 11/04/13 and 12/04/13 on the back of same form the order was written.</p> <p>Continued review of the medical record for Resident #10 revealed Consultant Pharmacist #1 completed a review on 11/04/13 with no recommendations or changes. Consultant Pharmacist #1 completed a monthly review on 12/04/13 and noted medications changed including an addition of Lyrica, decrease in Amlodipine and an increase in Lisinopril. Review of the Physician orders revealed the medication changes had been ordered on 11/27/13. The only recommendation was a diagnosis for the use of Lyrica.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/05/13 at 8:50 AM, revealed it looked like the order was received on 10/16/13 to discontinue Zocor and start Lipitor 20 milligrams as recommended by the consultant pharmacist for Resident #10, but it was never taken off. She stated the resident remained on Amlodipine and Zocor currently.</p> <p>Interview with Resident #10, on 12/05/13 at 9:50 AM, revealed the resident expressed pain in the feet at night, but there had been no change in pain symptoms recently.</p>	F 309	<p>3. Nursing staff was in-serviced on 12-13-13 medication orders and transcribing orders. Nursing staff was Also in-serviced on Pharmacy recommendations and ensuring those are completed.</p> <p>Nursing management team, Director of Health Services (DHS), Assistant Director of Health Services (ADHS), MDS nurses, In-service Coordinator and Medical Records Coordinator (MRC) will review all new and re-admission charts to to ensure that all MD orders are transcribed correctly. DHS and ADHS will also review all pharmacy recommendations and if a MD order is obtained that it was transcribed correctly and followed.</p> <p>The Constant Pharmacist was educated on 12-5-13 on the process for medication reviews by the DHS and Executive Director (ED). He was also educated on reviewing the orders to ensure that his recommendations were followed from the previous month.</p> <p>On every visit to the facility the Pharmacist will inform the DHS of any concerns</p>	



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

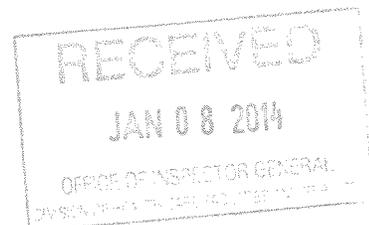
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 3</p> <p>Interview with Consultant Pharmacist #2, on 12/05/13 at 8:58 AM, revealed the interaction of Zocor and Amlodipine was the absorption of Zocor was inhibited and could cause a buildup of Zocor in the blood stream leading to muscle pain and could cause Rhabdomyolysis. She stated the recommendation was for residents on both Zocor and Amlodipine that Zocor should not be over a 20 milligrams daily dose.</p> <p>Interview with Clinical Consultant #1, on 12/05/13 at 9:05 AM, revealed the process for residents admitted to the facility was new orders were faxed to the Pharmacy. The Pharmacist at the Pharmacy completed their MRR and returned the form to the facility in the medication totes delivered to the facility. She stated the Nurse who received the MRR from the Pharmacy should have reviewed this form when it was received and followed up on the recommendation. She stated most likely the nurse put the MRR in the Physician binder to be reviewed and signed off. She stated when the Nurse Practitioner wrote the order on 10/16/13 the nurse should have reviewed the MRR and taken the order off.</p> <p>The nurse scheduled to work on 10/16/13 day shift was unavailable for interview.</p> <p>Interview with the Director of Health Services (DHS), on 12/05/13 at 10:00 AM, in regards to the missed order on Resident #10, revealed she would have expected the nurse to call the Physician if they had received a Pharmacy recommendation on admission orders and it should not have waited seven (7) days to be addressed. She stated, apparently the nurse who received the MRR from the Pharmacy in the medication tote on 10/09/13 or 10/10/13, did not</p>	F 309	<p>He may find with his recommendations not being followed the previous month.</p> <p>4. Ongoing monitoring will be achieved by continued daily chart reviews of all orders during daily Clinical Care Meeting, as previously described, monthly Pharmacist reviews, and follow-up of any deficient practices found in QAA monthly. Non compliance will result in development of action plan as directed by Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>	



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

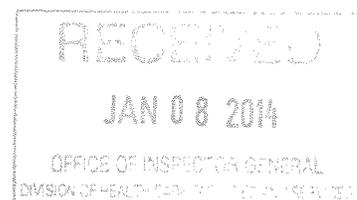
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 4</p> <p>call the Physician about the recommendation for Resident #10 and placed it in the Physician binder. She stated the facility did chart audits within twenty-four hours of admission but the recommendation may not have been on the chart by the time the facility did the chart review the next day for Resident #10. She stated one failure of the system was the Pharmacist did not pick the error up on their monthly reviews. She went on to say the DHS was not forwarded any new admission pharmacy recommendations but only the monthly review recommendations. She stated she was not aware of any training or inservices on transcribing orders, Pharmacy recommendations, or procedures for admission orders since she had been at the facility.</p> <p>Interview with LPN #4, on 12/05/13 at 10:21 AM, revealed she had worked at the facility for two (2) years. When she receives the admission MRR she would call the Physician depending on the recommendation. She stated she would have called the Physician on the recommendation written for Resident #10 because it stated severe interaction. She stated either way the MRR would have been placed in the Physician binder for the Physician to sign off on the review. She went on to say it was not unusual for the Physician or NP to write the order on the admission MRR form. LPN #4 stated the MRR form sometimes was sent in an envelope in the pharmacy tote an addressed to the DNS and the nurse may not have seen the recommendation. She stated after the initial MRR review was completed and the Physician signed off, the form would have been placed under the medication tab in the chart and only the Pharmacy consultant would review it again and should have followed up on it. The break in the system was</p>	F 309		



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

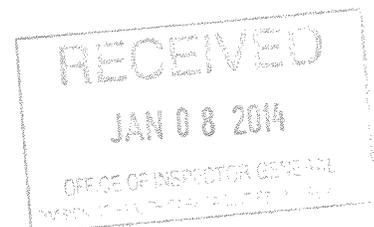
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 5 communication.</p> <p>Follow up interview with LPN #3, on 12/05/13 at 10:33 AM, revealed she would have called the Physician if she would have received the recommendation written for Resident #10. She stated the admission MRR was sent to the facility with the Pharmacy delivery in an envelope. She stated if there was a recommendation she would call the Physician because she didn't want to miss anything. She stated all admission MRR are filed in the Physician binder to get signed off even if there was not any recommendations. She stated the nurse was responsible to review the admission MRR when the Physician made rounds and take any written orders off. She stated the initial admission MRR was then placed under the medication tab in the chart. LPN #3 stated when the Consultant Pharmacist completed their monthly review they let the nurse know of any new recommendations and the nurse would call the Physician. She stated when the Physician or NP made rounds they would flag the new orders and if it was a pharmacy recommendation the Physician/NP would place the order in the chart so the nurse would see the new order.</p> <p>Interview with the Executive Director, on 12/05/13 at 2:34 PM, revealed the ED stated an in-service was conducted about two (2) weeks ago by the DON related to Physician orders and transcribing orders.</p> <p>Review of the agenda for the November Staff Meeting included a bullet listing of things covered. The third bullet stated when obtaining a doctors order be sure to write out the telephone order completely including date and time. All daily orders and admission orders are to be</p>	F 309			



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

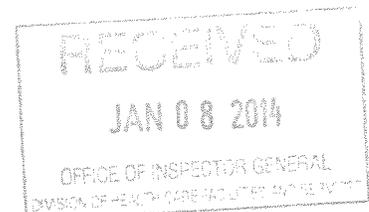
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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	<p>Continued From page 6 transcribed to the Medication and Treatment Administration record.</p> <p>Interview with Consultant Pharmacist #1, on 12/05/13 at 1:16 PM, revealed he was the Pharmacist responsible for monthly MRR for the facility. He stated admission MRR's were completed at the Pharmacy when admission orders were received. The Admission MRR was returned to the facility and the facility responded to the recommendation. He stated it then became his responsibility to complete the monthly MRR. He acknowledged he made a mistake in not catching the missed order written for Resident #10 when he completed the monthly MRR review on 11/04/13 and 12/04/13. He stated he normally looked at Physician orders and telephone orders received since the previous review, but may not always look at the medication record to ensure the orders were transcribed. He stated he failed to look at the medication record for Resident #10 to ensure the order was taken off. He stated he would have made the same recommendation as Consultant Pharmacist #2, but would not have used the wording "severe" interaction.</p> <p>Follow up interview with the DHS, on 12/05/13 at 2:18 PM, revealed her expectation of the Consultant Pharmacist regarding monthly MRRs was to look at medications for Diagnosis, interactions, and new orders. She stated she would have expected the Pharmacist to ensure the order written for Resident #10 on 10/16/13 was written on a telephone order form and verify the order was transcribed and implemented. She stated the duplicate Physician order form was the system the facility used to verified orders had been transcribed and followed. In addition, she stated, normally the NP would write the</p>	F 309		



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

PRINTED: 12/16/2013
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 12/05/2013	
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	<p>Continued From page 7 recommendation on a Physician order form.</p> <p>Interview with Nurse Practitioner (NP) #1, on 12/05/13 at 3:30 PM, revealed she made rounds weekly at the facility. She stated she visited residents on the Rehabilitation Unit weekly, but not necessarily on the Long Term Care (LTC) side related to billing as some of those residents are private pay. She stated she generally rounded on the LTC side two (2) times a month. She stated she would ask nursing if there were any concerns with residents on the LTC side and reviewed the Physician book. She stated she did not recall writing the order for Resident #10 on 10/16/13 or who the nurse was that worked on 10/16/13. The NP stated she previously had to write all orders on a Physician order form, but was told she did not have to do that anymore. She stated when she looked at the Physician book and wrote an order she would hand the order to the nurse. In regards to Pharmacy reviews and recommendations, she stated it was not uncommon to have multiple or stacks of forms in the Physician book at a time. She stated she would review them, write orders as needed, and hand the stack back to the nurse all together. She went on to say some residents had already been discharged from the facility by the time she reviewed them and signed them off. She stated she did not know of an interaction between Zocor and Amlodipine.</p> <p>Continued interview with the Executive Director (ED) and Director of Health Services (DHS), on 12/05/13 at 2:34 PM, revealed the ED was aware of previous deficiencies related to medication errors including an Immediate Jeopardy in 2011. She stated her expectation of the Consultant</p>	F 309		



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

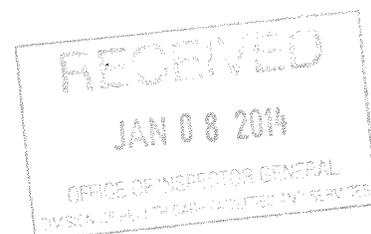
PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

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 12/05/2013
--	---	--	---

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
--------------------	--	---------------	---	----------------------

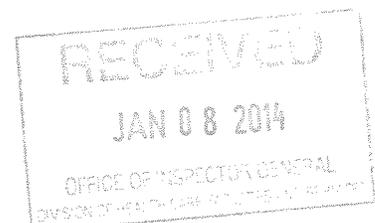
F 309	Continued From page 8 Pharmacist was to review monthly medication orders, but not necessarily all the orders of a resident since admission. She stated she was responsible to ensure monthly pharmacy recommendations are followed through by the DHS and Assistant DHS. She stated the DHS and ADHS over cited the Physician orders. She stated the DHS gets a copy of Pharmacy recommendation including admission MRR and monthly MRR. When informed the DHS stated she did not get admission MRR recommendations she stated she was not aware of this. She went on to say if the nurse had followed up on the recommendation and taken the order off we would not have this problem. The DHS acknowledged the Consultant Pharmacist should be a backup to catch medication errors related to transcription and Pharmacy recommendations. She went on to say Pharmacy recommendation on an admission MRR, as was the case with Resident #10, was an exception and that the facility rarely gets a recommendation on the admission MRR.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

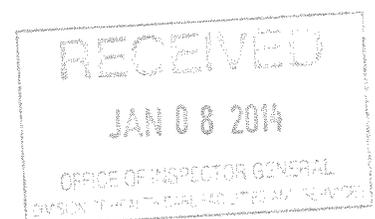
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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)
F 425	<p>Continued From page 9 the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Pharmacy Consultant provided services according to facility policy and regulatory requirement for one (1) of thirteen (13) sampled residents (Resident #10). The facility's Pharmacy Consultant failed to identify a transcription error on an order received for Resident #10, based on the admission Pharmacy Medication Regimen Review recommendation related to a severe interaction of Zocor and Amlodipine for two (2) consecutive months following the written order. In addition, interview with Consultant Pharmacist #1 revealed he stated he would have made the same recommendation.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Medication Orders, undated, revealed it did not address orders written on the Pharmacy's New Admission Medication Regimen Review or the monthly Pharmacy medication regimen review recommendations.</p> <p>Review of the policy regarding Consultant Pharmacist Reports, effective 09/01/13, revealed</p>	F 425	<p>1. Medication for Resident #10 was discontinued (D/C'd) on 12-4-13. 12-20-13 Zocor was D/C'd and Lipitor was started.</p> <p>Resident was assessed by the DHS on 12-4-13 for any negative effects of the possible medication interaction and none were found.</p> <p>2. All charts were audited on 12-4-13 by the DHS and ADHS to ensure that no other MD orders or pharmacy recommendations were missed. No other MD orders or pharmacy recommendations were found not completed.</p>



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

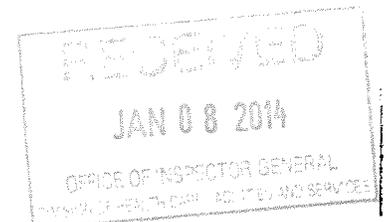
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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 425	<p>Continued From page 10</p> <p>the consultant pharmacist performs a comprehensive medication regimen review (MRR) per regulatory guidelines or agreement. The MRR includes evaluating the residents' response to medication therapy to determine that the resident maintains the highest practical level of functioning and prevents or minimizes adverse consequences related to medications. Findings and recommendations are reported to the Director of Health Services (DHS) or attending physician. Resident-specific irregularities or clinical significant risk associated with medications are documented in the resident active record and reported to the DHS and/or prescriber. Notification made is dependent on the severity of irregularity. Recommendations are acted upon and documented by the facility staff or prescriber.</p> <p>Review of the medical record for Resident #10 revealed the facility readmitted the resident on 10/09/13 with Diagnoses including Dementia, Depression, Hypertension, Peripheral Vascular Disease and Hyperlipidemia. The facility completed a Basic Interview for Mental Status (BIMS), on 10/16/13 when the resident scored a nine (9) out of fifteen (15). The residents' admission medications included Zocor 40 mg every bedtime and Amlodipine 10 mg every day.</p> <p>Review of the New Admission MRR, dated 10/09/13, revealed the Pharmacist documented a severe drug interaction between Zocor and Amlodipine. He than recommend changing Zocor to Lipitor 20 mg or Pravachol 40 mg at bedtime to decrease the risk of Myopathy. The Nurse Practitioner (NP) wrote the order to discontinue Zocor and start Lipitor 20 mg at bedtime on 10/16/13 on the New Admission Medication</p>	F 425	<p>3. Nursing staff was in-serviced on 12-13-13 medication orders and transcribing orders. Nursing staff was Also in-serviced on Pharmacy recommendations and ensuring those are completed.</p> <p>Nursing management team, Director of Health Services (DHS) , Assistant Director of Health Services (ADHS), MDS nurses, In-service Coordinator and Medical Records Coordinator (MRC) will review all new and re-admission charts to to ensure that all MD orders are transcribed correctly. DHS and ADHS will also review all pharmacy recommendations and if a MD order is obtained that it was transcribed correctly and followed.</p> <p>The Constant Pharmacist was educated on 12-5-13 on the process for medication reviews by the DHS and Executive Director (ED). He was also educated on reviewing the orders to ensure that his recommendations were followed from the previous month.</p> <p>On every visit to the facility the Pharmacist will inform the DHS of any concerns</p>	



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

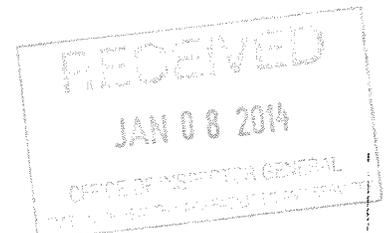
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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)
F 425	<p>Continued From page 11</p> <p>Regimen Review form at the bottom of the form designated for the Physician's signature. There was no indication the medication order was taken off by the facility. The Consultant Pharmacist #1 completed a monthly MRR on 11/04/13 and 12/04/13 on the back of same form the order was written.</p> <p>Continued review of the medical record for Resident #10 revealed Consultant Pharmacist #1 completed a review on 11/04/13 with no recommendations or changes. Consultant Pharmacist #1 completed a monthly review on 12/04/13 and noted medications changed included an addition of Lyrica, decrease in Amlodipine and an increase in Lisinopril. Review of the Physician's orders revealed the medication changes had been ordered on 11/27/13. The only recommendation was a diagnosis for the use of Lyrica.</p> <p>Interview with Clinical Consultant #1, on 12/05/13 at 9:05 AM, revealed the process for residents admitted to the facility was new orders were faxed to the Pharmacy. The Pharmacist at the Pharmacy completed their MRR and returned the form to the facility in the medication totes delivered to the facility. She stated the Nurse who received the MRR from the Pharmacy should have reviewed this form when it was received and followed up on the recommendation. She stated most likely the nurse put the MRR in the Physician's binder to be reviewed and signed off. She stated when the Nurse Practitioner wrote the order on 10/16/13 the nurse should have reviewed the MRR and taken the order off.</p> <p>Interview with the Director of Health Services (DHS), on 12/05/13 at 10:00 AM, revealed one</p>	F 425	<p>He may find with his recommendations not being followed the previous month.</p> <p>4. Ongoing monitoring will be achieved by continued daily chart reviews of all orders during daily Clinical Care Meeting, as previously described, monthly Pharmacist reviews, and follow-up of any deficient practices found in QAA monthly. Non compliance will result in development of action plan as directed by Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

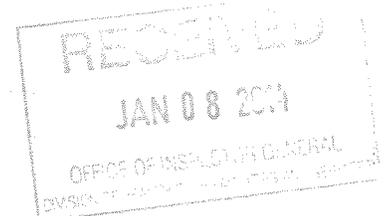
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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 425	<p>Continued From page 12</p> <p>failure of the system was the Pharmacist did not pick the error up on their monthly reviews. She went on to say the DHS was not forwarded any new admission pharmacy recommendations but only the monthly review recommendations. She stated she was not aware of any training or in-services on transcribing orders, Pharmacy recommendations, or procedures for admission orders since she had been at the facility.</p> <p>Follow up interview with LPN #3, on 12/05/13 at 10:33 AM, revealed when the Consultant Pharmacist completed their monthly review they let the nurse know of any new recommendations and the nurse would call the Physician. She stated when the Physician or NP made rounds they flag the new orders and if it was a pharmacy recommendation the Physician/NP would place the order in the chart so the nurse would see the new order.</p> <p>Interview with the Nurse Practitioner (NP), on 12/05/13 at 3:30 PM, revealed in regards to Pharmacy reviews and recommendation, she stated it was not uncommon to have multiple or stacks of forms at a time in the Physician book. She stated she would review them, and write orders as needed.</p> <p>Follow up interview with the DHS, on 12/05/13 at 2:18 PM, revealed her expectation of the Consultant Pharmacist on monthly MRR was to look at medications for Diagnosis, interactions, and new orders. She stated she would have expected the Pharmacist to ensure the order written for Resident #10 on 10/16/13 was written on a telephone order form and verify the order was transcribed and implemented. She stated the duplicate Physician order form was the</p>	F 425			



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

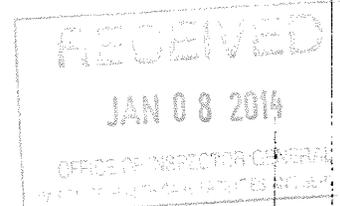
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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 425	<p>Continued From page 13</p> <p>system the facility used to verify orders had been transcribed and followed.</p> <p>Interview with the Executive Director and the Director of Health Services (DHS), on 12/05/13 at 2:34 PM, revealed the ED was aware of previous deficiencies related to medication errors including an Immediate Jeopardy in 2011. She stated her expectation of the Consultant Pharmacist was to review monthly medication orders, but not necessarily all the orders of a resident since admission. She stated she was responsible to ensure monthly pharmacy recommendations were followed through by the DHS and Assistant DHS. She stated the DHS and ADHS had over sight of the Physician orders. She stated the DHS received a copy of the Pharmacy recommendations including admission MRRs and monthly MRRs. When informed, the DHS stated she did not get admission MRR recommendations, and she was not aware of this. She acknowledged the Consultant Pharmacist should be a backup to catch medication errors related to transcription and Pharmacy recommendations. She stated the Pharmacy recommendation on an admission MRR, as was the case with Resident #10, was an exception and that the facility rarely gets a recommendation on the admission MRR.</p> <p>Interview with Consultant Pharmacist #1, on 12/05/13 at 1:16 PM, revealed he was the Pharmacist responsible for monthly MRR for the facility. He stated admission MRR 's were completed at the Pharmacy when admission orders were received. The Admission MRR was returned to the facility and the facility responded to the recommendation. He stated it then became his responsibility to complete monthly</p>	F 425			



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

PRINTED: 12/16/2013
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 12/05/2013	
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 425	Continued From page 14 MRRs. He acknowledged he made a mistake in not catching the missed order written for Resident #10 when he completed the monthly MRR review on 11/04/13 and 12/04/13. He stated he normally looked at Physician orders and telephone orders received since the previous review, but may not have looked at the medication record to ensure the orders were transcribed. He stated he failed to look at the medication record for Resident #10 to ensure the order was taken off. He stated he would have made the same recommendation as Consultant Pharmacist #2, but not used the wording severe interaction.	F 425		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		



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

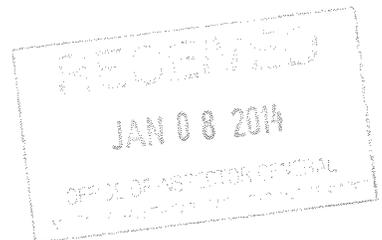
PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

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 12/05/2013
--	--	--	--

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
--------------------	--	---------------	---	----------------------

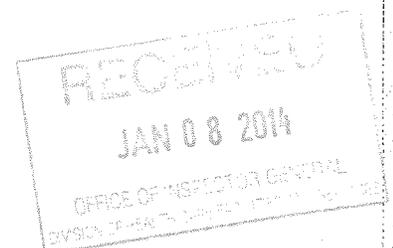
F 520	<p>Continued From page 15 and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Casper reports, and past cited deficiencies, it was determined the facility failed to have an effective Quality Assurance (QA) committee to identify and correct quality deficiencies to ensure ongoing compliance with federal and state regulations. The facility was cited for failure to obtain and follow Physician orders, transcribe and administer correct medication dose, and failed to ensure pharmacy services were provided consistently for accurate receiving and administering of medications to meet the needs of each resident for four (4) consecutive standard surveys. In addition, the facility had an Immediate Jeopardy in July 2011 related to the same deficient practice that resulted in a resident being hospitalized for not getting the anticoagulant medication ordered by the physician. Review of the plan of correction submitted for the January 2013 survey revealed the facility was to monitor noncompliance through the QA committee. The facility failed to have an effective QA committee to identify problems utilizing audits that would encompass the entire physician order process.</p> <p>The facility failed to ensure one (1) of thirteen (13) sampled residents received the correct medication as ordered by the physician. Resident #10. Refer to F-309 and F-425.</p> <p>The findings include: Review of the facility's Casper reports, dated</p>	F 520	<p>1. Medication for resident #10 was discontinued(D/C'd) on12-4-13. Zocar was discontinued and Lipitor was started. All subsequent recommendations for this resident were reviewed and all recommendations in compliance for the resident. Resident was assessed by DHS on 12-4-13for any negative effects of the possible medication interaction and none were found. This assessment was documented in resident record and proper notification made to MD and family no new orders given.</p> <p>2. All charts were audited on 12-4-13 by the DHS and ADHS to ensure that no other MD orders or pharmacy recommendations were missed. No other MD orders or pharmacy recommendations were found not completed. QA meeting held on 1-7-14 with Medical Director in attendance to discuss, review and determine root cause of noncompliance. There has been inconsistency with follow up and attention to detail in some areas. The Nurse managers have been educated by Clinical Director on 1-7-14 and roles redefined related to follow up in these meetings to improve compliance. Leadership staff has been stabilized, so continuity should be maintained related to Quality Assurance activities.</p>	1-17-14
-------	---	-------	---	---------



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

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

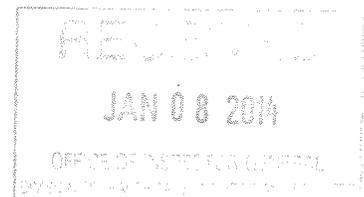
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 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 520	<p>Continued From page 16</p> <p>12/02/13, revealed the facility was cited for F-309 (care and services) for the last four (4) standard surveys, January 2013, 2012, 2011, and 2010. Review of the past statement of deficiencies revealed the deficient practice involved failure to follow physician orders, transcribe physician orders correctly, and medication errors. Review of the Plan of Correction for the January 2013 survey revealed the facility would conduct chart audits and those audits would be reviewed in the QA meetings to ensure compliance was achieved and maintained.</p> <p>Review of the QA signature sheet revealed the facility conducts QA meetings at least quarterly with the required members. The last QA meeting was held on 11/26/13 with a physician representative in attendance.</p> <p>Review of the medical record for Resident #10 revealed the facility readmitted the resident on 10/09/13 with diagnoses that included Dementia, Depression, Hypertension, Peripheral Vascular Disease and Hyperlipidemia. The admission medication orders from the hospital included Zocor 40 mg one (1) at bedtime and Amlodipine 10 mg, one (1) every day. Review of the new admission Medication Regime Review, dated 10/09/13, revealed the Pharmacist documented a severe drug interaction between Zocor and Amlodipine. The Pharmacist recommended changing the Zocor to Lipitor 20 mg or Pravachol 40 mg at bedtime to decrease the risk of Myopathy. The recommendation was placed in the physician's binder to be reviewed on the next visit to the nursing facility. The recommendation was reviewed by the Nurse Practitioner (NP) on 10/16/13 who agreed with the pharmacy recommendation and wrote an order to</p>	F 520	<p>3. Nursing staff was in-serviced on 12-13-13 medication orders and transcribing orders. Nursing staff was also in-serviced on pharmacy recommendations and ensuring those are completed. QA meeting held on 1-7-14 to educate Leadership on QA process and impact of continued noncompliance. Medical Director in attendance at this meeting. DHS and ED educated in the QA process and its impact on maintaining compliance to regulatory requirements and resident care. Nursing management team, DHS, ADHS, MDS nurses, In-service coordinator and Medical Records Coordinator will review all new and re-admission charts to ensure that all MD orders are transcribed correctly. DHS and ADHS will also review all pharmacy recommendations and if a MD order is obtained that it was transcribed correctly and followed. He may find with his recommendations not being followed the previous month.</p>		



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

PRINTED: 12/16/2013
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 12/05/2013
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 520	Continued From page 17 discontinue Zocor and start Lipitor 20 mg at bedtime. The NP wrote the order on the New Admission Medication Regimen Review form and signed at the bottom of the form, designated for the Physician's signature. There was no evidence the new medication order for Lipitor was taken off by the facility. Consultant Pharmacist #1 completed a monthly medication regime review on 11/04/13 and 12/04/13 using the back of the same form the order was written; however, he did not identify the resident was still receiving Zocor and Amlodipine. Refer to F-425. Interview with the Executive Director (ED), on 12/05/13 at 2:34 PM, revealed the Quality Assurance (QA) Committee met monthly and a physician representative was present, but not the pharmacy consultant. The ED revealed she had recently taken that position at the nursing facility, but had good knowledge of what deficiencies were cited in past surveys. She stated she was aware of previous cited deficiencies related to medication errors and a failure to transcribe and follow physician orders including an Immediate Jeopardy in July 2011. The ED stated she had over sight of the contract pharmacy; however, could not say how the QA Committee how they monitored pharmacy services. The QA Committee had addressed education of staff; however, there had been no follow-up to determine if the education was effective. She stated during the morning meetings (Monday-Friday), she would review any physician order received with the Director of Health Services (DHS) and her assistant. They would conduct a chart audit to ensure the physician's orders were transcribed onto the Medication Administration Record (MAR) correctly; however, the medication error involving Resident #10	F 520	4. Ongoing monitoring will be achieved by continued daily chart reviews of all orders during daily clinical meeting as previously described, monthly Pharmacist reviews and follow up of any deficient practices found in QAA monthly. Noncompliance will result in development of action plan as directed by Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained. It is the responsibility of the ED to insure that QA processes are maintained and followed to meet resident care and regulatory requirements. This process is reviewed twice a year during home office peer review process. Any noncompliance identified at this time will be addressed by Home Office staff.		



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

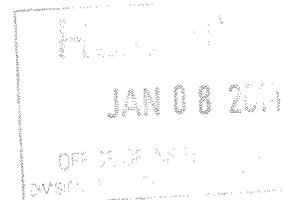
PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

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 12/05/2013
--	---	--	---

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 520	<p>Continued From page 18</p> <p>occurred during the admission process in October 2013, and was not captured by the audit. She indicated the Consultant Pharmacist would conduct monthly drug regime reviews for each resident that included reviewing all medication orders. She considered the pharmacist's review to be a second check to ensure the residents were receiving the correct medications as ordered by the physician and to report any irregularities. She stated the DHS would receive a copy of the Pharmacist's recommendations and she would refer those recommendations to the resident's physician. The ED further stated staff nurses were supposed to write a telephone order when receiving a physician order and transcribe the medication onto the MAR to be administered. She indicated if the nurse had taken the physician order for Lipitor (10/16/13) off for Resident #10, they would not have this problem. Refer to F-309. She stated the Pharmacy Consultant should be a backup to catch medication errors related to transcription and Pharmacy recommendations; however, the Pharmacist failed to identify Resident #10 continued to receive the wrong medication against the pharmacist's recommendation for almost two (2) months, until surveyor intervention. The Pharmacist had conducted two (2) drug regime reviews since the physician order to change the medication and failed to identify the resident was receiving the wrong medication. Refer to F-425.</p>	F 520		
-------	---	-------	--	--



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

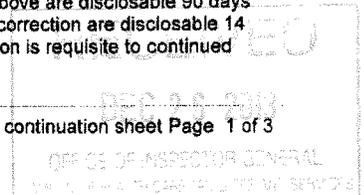
PRINTED: 12/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185481	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GLEN RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2013
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 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</p> <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 heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Natural Gas with propane back-up.</p> <p>A standard Life Safety Code survey was conducted on 12/03/13. Glen Ridge Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>1. No residents were affected by this deficiency. 12-20-13</p> <p>2. All residents had the potential to be affected by the missing no exit sign. None were affected.</p> <p>3. Deficiency was corrected immediately. Three "NO EXIT" signs were put on the three doors immediately after the deficiency was found.</p> <p>4. All doors with out an exit , will be maintained with a "NO EXIT" sign. DPO will ensure this on monthly rounds. He will report compliance with this monthly in QAA.</p>	

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

x Henry Adams III *x Exec. Dir* *x 12-26-13*

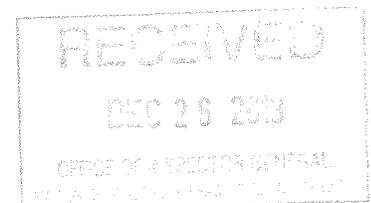
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.



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

PRINTED: 12/04/2013
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 01 - GLEN RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2013
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 000	Continued From page 1 A deficiency was cited and identified at the F level.	K 000		
K 022 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards. This deficiency affected three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility has seventy (70) certified beds and the census was fifty-one (51) on the day of the survey. The findings include: Observations, on 12/03/13 at 11:08 AM, with the Director of Plant Operations revealed three (3) doors opening into an enclosed courtyard, located at the recently constructed enclosed corridor, the Main Dining Room and the corridor near the Conference Room, could be confused as exits, as the doors were not identified with signage displaying, "No Exit". Interviews, on 12/03/13 at 11:08 AM, with the	K 022		



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

PRINTED: 12/04/2013
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 01 - GLEN RIDGE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2013
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 022	<p>Continued From page 2</p> <p>Director of Plant Operations, revealed he was unaware of the doors not being identified with proper signage according to NFPA standards. The Courtyard used to be open to a Public Right-of-Way, but was now enclosed by the construction of an enclosed Corridor connecting the 400 Wing Nursing Station to the Main Entrance Lobby.</p> <p>Interview, on 12/03/13 at 11:51 AM, with the Executive Director revealed the proper signage had been purchased by the facility, but were not displayed at the time of the observations.</p> <p>Reference:</p> <p>NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs.</p>	K 022		

