PRINTED: 02/07/2012
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: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 01/26/2012
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated on 01/25/12 and concluded on 01/26/12 to investigate KY17713. The Division of Health Care substantiated the allegation as verified by the evidence. Federal and state deficiencies were cited.	F 000	The submission of this plan of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Glen Ridge. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities(for title 18/19 programs). To this end, this plan of correction shall serve as our credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
F 280 SS=D	483.20(d)(3); 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interviews and closed record review, and review of the facility's policies, it was determined the facility failed to revise the care plan for one (1) of four (4) sampled residents.	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X [signature] TITLE X E.D. (X6) DATE X 2/14/12

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 280	Continued From page 1 The facility failed to revise the care plan for Resident #1 with interventions to address the Stage II coccyx pressure ulcer. The findings include: Review of the facility's policy The Wound Risk assessment Guidelines, revised 04/2008, revealed shall be completed upon admission to outline the reisk factors that will require care plan interventions to mitigate the risk to the extent possible. Recognized risk factors shall have care plan interventions/approaches indentified and put in place to mitigate the risks to the extent possible. Review of the General Wound and Skin Care Guidelines, revised 02/08, revealed, item #5 of the Skin Care Guidelines item stated... evaluate for elbow and heel protectors. Review of the Weekly Skin Assessment Guidelines, revised 04/08, revealed #3. The date the assessment is to be completed shall be assigned by the DHS or designee and indicated by the corresponding date blocked off on the treatment administration record (TAR). Review of the closed clinical record of Resident #1 revealed the facility admitted the resident on 12/20/11 with diagnoses of Right Hip Fracture, Diabetes, Anemia, Hematuria, Hypertension, Renal Insufficiency, Low Thyroid, Dementia, Muscle Weakness, Difficulty Walking and Arthrosclerosis. The Assessment Review and Considerations form, dated 12/20/11, identified Resident #1 as a pressure ulcer risk due to impaired mobility and incontinence. A care plan	F 280	1. Resident #1 was discharged from facility on (date). 2. Care Plans for current residents as of 2/15/12 will be revised by the Interdisciplinary Team by February 29th, 2012 to insure accuracy and completeness. Revisions to care plans were made as necessary to reflect current status of resident. 3. Licensed staff and IDT team were in serviced by the Director of Health Services on 2/1/12, 2/2/12, 2/3/12, 2/5/12 related to care plan revisions and it's importance when resident condition changes. 4. Ongoing monitoring for compliance will be achieved by random audits of five charts per week by DHS or ADHS for 90 days. DHS or ADHS will also attend Care Plan meetings once a month to monitor compliance. Condition changes are reviewed in Morning CQI meetings and care plans will be revised at that time to reflect resident condition. Ongoing monitoring will also occur by Home Office MDS Support and through Home Office Peer Review. Findings from audits will be reported to Quality Assurance monthly and monitored by that committee for compliance. Non-compliance will require development of action plan to correct.	2/29/12

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	185461	A. BUILDING B. WING	C 01/26/2012

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F 280	Continued From page 2 was initiated to address the Risk for Pressure. A body graft identified an incision on the left hip and a bruise in the right flank area. A blood blister was identified on the left heel. The Admission Assessment/Care Plan dated 12/20/11 identified the resident required to be turned every two hours and the heels were to be elevated off the bed. On 12/30/11 the facility identified the resident with a left heel bruise. An intervention was added to the care plan for skin prep to the left heel and cover with kerlix. The skin Impairment Circumstance Investigation dated 12/31/11 identified a stage II coccyx ulcer due to skin moisture from incontinence. No revisions or interventions were made to the care plan addressing the Stage II coccyx ulcer. Interview with the Minimum Data Set Coordinator, on 01/25/12 at 12:30 PM, revealed the facility utilized the Nursing Admission Assessment and Data Collection form completed by nursing on admission as the care plan until the comprehensive care plan is developed by the 21st day. The nursing staff are responsible for revising the care needs of the resident on this form until the 21st day. Review of the Skilled Nursing Assessment and Data Collection forms dated 12/20/11 through 01/04/12 revealed no revisions were made to address pressure ulcers for Residet #1. Interview, on 12/25/12 at 11:10AM, with the Director of Nursing (DON) revealed the General Wound and Skin Care guidelines were not followed by nursing staff for interventions to be placed on the Nursing Admission Assessment and Data Collection form.	F 280		

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F 280	Continued From page 3 Interviews with the Executive Director and Division Clinical Support Nurse on 01/26/12 at 10:45AM and 10:50AM revealed both stated interventions for pressure ulcers should have been placed on the care plan for Resident #1 and it was not.	F 280		

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