

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  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Glen Ridge Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  6415 Calm River Way Louisville, KY 40299	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>22445</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to assist one (1) of seven (7) residents sampled for review of activities of daily living (ADL) care, (Resident #3).</p> <p>Observation revealed Resident #3's feet were dry with a buildup of black, dry, and flaky skin between and under the toes. Additionally, the skin on the resident's heels was also observed as dry and flaky with a buildup of callused skin on the right heel.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Guidelines for Pressure Prevention, last reviewed on 12/31/2023, revealed to moisturize residents' skin with lotion or cream (if applicable) to keep skin soft and pliable. Continued review of the policy revealed to pay special attention to bony prominences and Keep skin clean, dry and free of body wastes, perspiration, and wound drainage.</p> <p>Review of Resident #3's Resident Face Sheet revealed the facility originally admitted the resident on 12/24/2022, and most recently readmitted him/her on 03/25/2022, with diagnoses that included chronic kidney disease with heart failure, chronic respiratory failure with hypoxia (inadequate oxygen supply at the tissue level), chronic obstructive pulmonary disease (COPD), and unspecified dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/21/2023, revealed the facility completed a Staff Assessment for Mental Status (SAMS) for Resident #3 which indicated the resident had short- and long-term memory impairment with moderately impaired cognitive skills for daily decision-making. Continued review of the MDS Assessment revealed Resident #3 had expressed no rejection of care, and was dependent on staff to put on and take off his/her footwear. Further review revealed Resident #3 was also dependent on staff for showering/bathing and required substantial to maximal assistance from staff for completion of personal hygiene.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's Care Plan revealed the facility identified a problem area that indicated the resident had impairment in his/her ADL functional status in regards to bed mobility, transfers, toileting, and eating. Per review, the problem start date was noted as 12/10/2021, and a date of last edit of 02/26/2024. Continued review revealed the interventions were for staff to encourage the resident to be as independent as safely possible. Further review revealed however, there was no evidence of an intervention that addressed Resident #3's bathing or hygiene. In addition, review further revealed an additional problem with a last edit date of 02/26/2024, which identified Resident #3 as at risk for skin breakdown related to reduced mobility, with an interventions directing staff to keep the resident as clean and dry as possible.</p> <p>During a concurrent observation and interview on 03/13/2024 at 11:00 AM, of Certified Resident Care Assistant (CRCA) #14 and CRCA #16 in the resident's room to provide care to Resident #3, who was lying on his/her bed. CRCA #14 and #16 both stated they were not assigned to care for Resident #3 that day; however, had been asked by the Director of Health Services (DHS) to provide any needed care for the resident at that time. Per observation, Resident #3's feet were observed to be dry with a buildup of black, flaky skin between and under the toes. Further observation revealed the skin on Resident #3's heels was observed as dry and flaky with a buildup of callused skin on the right heel.</p> <p>During a concurrent observation and interview on 03/13/2024 at 11:25 AM, Registered Nurse (RN) #10 entered Resident #3's room and stated the resident's feet were dry and flaky. RN #10 was observed to take a warm, wet washcloth and passed the washcloth between Resident #3's toes and underneath the resident's toes. Continued observation revealed the RN removed black-brown, dry skin that was approximately 0.5 inches in diameter from the resident's feet. In interview, after providing care of Resident #3's feet, RN #10 stated the resident's feet did not appear to have been washed</p> <p>During a follow-up interview on 03/13/2024 at 12:38 PM, RN #10 stated she did not think Resident #3's feet had been washed due to how dirty the resident's feet appeared.</p> <p>During a concurrent observation and interview on 03/14/2024 at 10:23 AM, CRCA #13 and CRCA #14 were observed providing Resident #3 with showering assistance. Per observation, when CRCA #14 washed Resident #3's feet, CRCA #14 removed a large amount of brown/black dried skin from between the resident's toes. CRCA #14 stated at that time, based on what she had seen the day prior and the amount of black, flaky skin she had just removed during the shower, she would say Resident #3's feet had not been washed in weeks.</p> <p>During an interview on 03/15/2024 at 9:24 AM, the DHS stated she expected Resident #3's feet to be clean.</p> <p>During an interview on 03/14/2024 at 11:53 AM, the Medical Director stated he had nothing to say about the condition of Resident #3's feet since the State Survey Agency (SSA) Surveyor and multiple staff members had seen the resident's feet with the buildup of dried skin. The Medical Director stated he did not expect Resident #3's feet to have been left in that type of condition.</p> <p>During an interview on 03/15/2024 at 1:45 PM, the Executive Director (ED) stated residents should be presentable at all times. The ED further stated he expected all residents' feet to be washed and kept clean.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>22445</p> <p>Based on observation, interview, and record review, the facility failed to identify and implement appropriate safety interventions for one (1) of six (6) sampled residents (Resident #213) reviewed for accidents/hazards out of the total sample of twenty (20) residents.</p> <p>The facility failed to identify loose screws in a round metal ring that covered the grab bar in Resident #213's shower which contributed to the resident's fall on 02/09/2024.</p> <p>The findings include:</p> <p>The State Survey Agency (SSA) was not provided a policy related to the prevention of accidents and incidents. However, during an interview with the Executive Director, on 03/15/2024 at 1:50 PM, he stated it was his expectation that maintenance issues would be reported and repaired for the safety of the residents.</p> <p>Review of Resident #213's Resident Face Sheet revealed the facility admitted him/her on 01/04/2024, with diagnoses that included dementia and osteoarthritis.</p> <p>Review of Resident #213's Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/05/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating he/she had severe cognitive impairment. Further review of the MDS Assessment revealed the facility additionally assessed Resident #213 as dependent on staff for bathing.</p> <p>Review of Resident #213's Care Plan, revealed the facility identified a problem with activities of daily living (ADLs) with a start date of 01/12/2024. Continued review revealed the facility assessed the resident to require staff assistance to complete self-care and mobility functional tasks completely and safely.</p> <p>Review of the facility's Event Report, for Resident #213 revealed on 02/09/2024, the resident sustained a fall in his/her bathroom. Per review of the Event Report, the fall was witnessed by Certified Occupational Therapy Assistant (COTA) #18, who assisted Resident #213 with a transfer from the shower bench to the wheelchair. Continued review revealed during Resident #213's transfer the resident slipped and was lowered to the floor by COTA #18. Review of the Event Report further revealed Resident #213 sustained a skin tear to his/her right and left elbow and a hematoma to the posterior upper arm.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/14/2024 at 2:27 PM, COTA #18 stated she entered Resident #213's room and the resident stated he/she needed to use the bathroom, so she assisted the resident to the bathroom where she lowered the resident's pants. She stated upon lowering the resident's pants she noticed he/she had been incontinent, so she called for assistance to provide incontinence care. COTA #18 stated Certified Resident Care Associate (CRCA) #12 came to assist and stated Resident #213 needed to take a shower. She stated she rolled the resident's wheelchair to the shower area of the bathroom and with her gait belt around the resident, she had Resident #213 stand while holding onto the grab bar. COTA #18 stated while she held onto the gait belt the resident started to pivot to sit in the shower chair and his/her feet slipped, so she and CRCA #12 assisted the resident to slide down the COTA's right leg and right arm. She stated Resident #213 initially placed his/her hand on the grab bar, but due to his/her dementia, she thought the resident's hand moved and ended up on the loose piece of the grab bar. COTA #18 stated she thought when the round piece of the grab bar moved it startled or frightened Resident #213, and he/she then lost momentum and focus which resulted in the fall. She stated the resident's elbow hit on the spinning part of the loose bar and Resident #213 sustained a skin tear that turned into a hematoma. COTA #18 further stated the slippage of the round thing on the grab bar had something to do with Resident #213's fall as the resident had his/her hand on that piece of the bar.</p> <p>During an interview on 03/14/2024 at 2:00 PM, CRCA #12 stated she responded to the call light turned on by the COTA that needed assistance with Resident #213. CRCA #12 stated COTA #18 had taken Resident #213 to the bathroom and was in the process of transferring him/her to the shower chair. She stated COTA #18 had the resident stand up from the wheelchair and hold onto the grab bar in the shower. CRCA #12 stated as Resident #213 pivoted, the resident's feet started to slip, and his/her hand was on the metal circle part of the grab bar which was loose. She stated as Resident #213 slid down and his/her arm hit the loose part of the metal circle which caused a skin tear. CRCA #12 stated she thought the fall resulted because of a combination of the resident's feet slipping and his/her hand on the loose part of the grab bar and he/she sliding down. She stated she had not noticed the round part of the grab bar being loose before, and after the incident the grab bar having a loose part was reported to Registered Nurse (RN) #19, that same day.</p> <p>During an interview on 03/14/2024 at 3:17 PM, RN #19 stated she was made aware of Resident #213's fall by one of the staff members involved; however, was unable to remember if it was CRCA #12 or COTA #18. RN #19 stated however, COTA #18 or CRCA #12 never mentioned the loose metal cover on the grab bar as being the cause of Resident #213's fall and skin tear. She stated when she went into Resident #213's room, the resident was in the bathroom sitting in the wheelchair, and she observed a small amount of blood on the resident's arm.</p> <p>Observation on 03/14/2024 at 2:12 PM, with CRCA #12 of Resident #213's shower area, revealed the round ring covering the screws on the grab bar, on the left wall of the shower, were movable and slid the entire length of the grab bar.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/14/2024 at 4:15 PM, the Director of Plant Operations (DPO) stated he checked for work orders; however, had no work orders to repair any issues for the room where Resident #213 resided while at the facility. He said he also had not been notified of any issues with the grab bar in the shower in Resident #213's room. Observation at the time of interview revealed the DPO looked at the grab bar in the room where Resident #213 resided and found the circular screw cover was loose from the wall and was able to slide up and down the grab bar. The DPO stated the circular screw cover, if properly applied would have been so snug it would not come off or slide up and down the grab bar. He stated since the edges of the screw cover were sharp, it was possible a resident could sustain a skin tear if the circle was away from the wall, and his/her skin encountered the sharp area.</p> <p>During an interview on 03/15/2024 at 9:53 AM, the Director of Health Services (DHS) stated Resident #213's fall had been reported to her by RN #19. The DHS stated RN #19 reported Resident #213 sustained a fall with a skin tear in the shower; however, had not given any details of how the fall occurred. She stated the nurses were expected to place immediate interventions in place that should relate directly to what caused the resident to fall in order to prevent another fall from occurring. The DHS further stated she had not been informed of the loose fitting on the grab bar that caused the resident's injury.</p> <p>During a concurrent observation and interview on 03/15/2024 at 10:08 AM, the DHS observed the grab bar in the shower where Resident #213 resided while at the facility, and stated no one had informed her the screw cover did not fit properly and slid across the entire grab bar. The DHS stated no one informed her that Resident #213's hand settled on the screw cover and when the cover moved, it startled the resident and that had affected his/her balance and resulted in the fall. She acknowledged the grab bar fitting had not been properly applied, and agreed the edge of the fitting was sharp. The DHS stated the cover should not slide.</p> <p>During an interview on 03/15/2024 at 1:50 PM, the Executive Director (ED) stated he expected maintenance issues to be fixed as soon as identified, and expected staff to report those issues especially if the issue could affect a resident's safety.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>31524</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to provide pharmaceutical services to meet the needs of one (1) of six (6) sampled residents reviewed for pharmacy services (Resident #209).</p> <p>The facility admitted Resident #209 on 09/25/2023; however, failed to ensure the resident's medications were ordered from the pharmacy until the following day, on 09/26/2023. Consequently, Resident #209 missed ten (10) doses of his/her routine medications on 09/26/2023, because the medications were not available.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Provider Pharmacy Requirements, revised in November 2018, revealed Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. Continued review of the policy revealed under the procedures area, section D the provider pharmacy agreed to perform the following pharmaceutical services provision of routine and timely pharmacy service as contracted, and emergency pharmacy services twenty-four (24) hours per day, seven (7) days per week. Per policy review, emergency or stat (needed urgently) medications were to be available for administration no more than four (4) hour(s) after the order was received by the pharmacy and a STAT request was made via a phone call from a facility representative. Further review revealed if an emergency or stat medication could not be provided to the facility within four (4) hours the facility was to be notified with an expected delivery window. Review further revealed all other new medication orders faxed prior to the daily cutoff were received and to be available for administration as soon as possible on the next routine delivery, unless indicated otherwise by facility personnel. In addition, medications were to be delivered by the primary pharmacy or back-up pharmacy, or were to be available from the emergency medication kit.</p> <p>Review of Resident #209's Resident Face Sheet revealed the facility admitted the resident on 09/25/2023 at 5:45 PM, with diagnoses that included pneumonia, acute and chronic respiratory failure with hypoxia, sarcoidosis of the lung (condition which cause small lumps of inflammatory cells in the lungs), acute pulmonary edema, diabetes, hypercholesterolemia, nonrheumatic aortic stenosis, and asthma.</p> <p>Review of Resident #209's Five-Day Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/28/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating he/she was intact cognitively. Per review of the MDS, Resident #209 also had active diagnoses that included heart failure, hypertension, and acute pulmonary edema.</p> <p>Review of Resident #209's Order History, revealed physician orders were started on 09/26/2023, the day after the resident's admission to the facility. Continued review of the Order History revealed Resident #209 had orders for the following medications:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- atorvastatin (treats high cholesterol) 40 milligram (mg) tablet by mouth (po) once per day;</li> <li>- furosemide (treats fluid retention) 40 mg tablet po twice a day;</li> <li>- hydrocodone-acetaminophen (narcotic pain medication) 7.5-325 mg tablet po twice per day;</li> <li>- ipratropium-albuterol solution for nebulization (treats chronic obstructive pulmonary disease) 0.5 mg-3 mg (2.5 mg base)/3 milliliters (mL), 1 inhalation twice per day;</li> <li>- levothyroxine (treats hypothyroidism) 75 microgram (mcg) tablet po daily;</li> <li>- losartan (treats high blood pressure) 25 mg tablet po daily;</li> <li>- metformin (treats high blood sugar levels) 500 mg tablet, 2 tablets po in the morning and 1 tablet po in evening; and</li> <li>- potassium chloride (potassium supplement)10 milliequivalent (mEq) extended release tablet po daily.</li> </ul> <p>Review of Resident #209's Medications Administration History, dated 09/01/2023 to 09/30/2023, revealed no documented evidence the resident had the following medications administered on 09/26/2023, due to lack of availability of the medications:</p> <ul style="list-style-type: none"> <li>- atorvastatin: one (1) dose;</li> <li>- furosemide: two (2) doses;</li> <li>- hydrocodone-acetaminophen: one (1) dose;</li> <li>- ipratropium-albuterol: one (1) dose;</li> <li>- levothyroxine: one (1) dose;</li> <li>- losartan: one (1) dose;</li> <li>- metformin tablet: two (2) doses; and</li> <li>- potassium chloride: one (1) dose.</li> </ul> <p>Review of Resident #209's Progress Notes, dated 09/26/2023 at 3:14 PM, revealed Registered Nurse (RN) #10 contacted the provider pharmacy to send the resident's antibiotic order, and the rest of his/her routine medications stat (immediately/urgently).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/13/2024 at 12:49 PM, RN #10 stated details about Resident #209 were unclear, but could recall the resident's name and the resident being transferred to the hospital. RN #10 stated when a resident was admitted, the physician orders from any hospital paperwork were entered into the facility's computer system and staff then called the pharmacy to obtain the medications. Per RN #10, if the pharmacy expedited the medications (stat), then the medications were to arrive within four (4) hours of the request. The RN stated staff could also pull some medications necessary from the facility's emergency drug kit (e-kit) if the medications were not available from the pharmacy.</p> <p>During an interview on 03/15/2024 at 9:39 AM, a Pharmacy Customer Care Representative stated the pharmacy received Resident #209's medication orders on 09/26/2023, between 1:00 and 1:40. The Pharmacy Customer Care Representative stated however, as the pharmacy no longer had a patient profile for Resident #209, there was no way to tell whether the order time was AM or PM. The Pharmacy Customer Care Representative further stated the pharmacy staff could also see the medications were ordered stat at some point on 09/26/2023.</p> <p>During an interview on 03/13/2023 at 10:08 AM, Licensed Practical Nurse (LPN) #2 stated when a resident was admitted and once the physician orders were verified, facility staff entered the medication orders into the computer system, then called the pharmacy. LPN #2 stated medications generally arrived from the pharmacy in a couple of hours. LPN #2 stated if the hospital sent a prescription for a medication, staff could administer the medications from the facility's e-kit. The LPN stated medications could be late due to pharmacy delivery, but she was not aware that a resident missing multiple doses of his/her medications. Further interview revealed LPN #2 stated staff could pull medications from the facility's medication storage/dispensing machine; however, not all medications a resident might need were in the machine.</p> <p>During an interview on 03/13/2024 at 12:20 PM, LPN #3 stated when a resident was admitted, staff entered their medication orders into a computer and called the pharmacy to have the medications sent stat. She stated if medications did not arrive in a timely manner, staff could retrieve the medications from the medication storage/dispensing machine.</p> <p>During an interview on 03/13/2024 at 1:07 PM, LPN #4 stated if staff sent a new resident's admission medication orders to the pharmacy before 3:00 PM, the pharmacy would send the medication to the facility that same night. Per LPN #4, if a resident was admitted after 3:00 PM, staff had to call the pharmacy to have the medications sent stat, which took four (4) to six (6) hours to receive. LPN #4 stated when residents' medications were not available she pulled the medications from the e-kit.</p> <p>During an interview on 03/13/2024 at 1:53 PM, LPN #5 stated when a resident was admitted to the facility, a nurse was to input the medication orders into the computer and call the pharmacy to have the medications sent stat because not all medications were in the facility's e-kit. She stated if a resident was admitted at or after 6:00 PM, the nurse was to call the pharmacy to expedite the resident's medications. LPN #5 stated the medications should arrive between 10:00 PM to 2:00 AM the same night. In continued interview the LPN stated the facility could not enter medication orders until the resident was physically present at the facility. She stated night shift staff should have called the pharmacy to ensure Resident #209's medications were at the facility before the morning shift. LPN #5 further stated it was not good for a resident to miss that many medication doses.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/13/2024 at 11:21 AM, the Medical Director stated there could be delays in the facility receiving medications because the correct list of medications might not be available until the resident was physically present in the facility. The Medical Director stated not receiving ordered medications could be detrimental to a resident. The Medical Director reviewed Resident #209's medications that were not administered on 09/26/2023, and stated that missing the medication doses had not caused further respiratory problems or caused the resident's condition to worsen.</p> <p>During an interview on 03/13/2024 at 2:21 PM, LPN #11 stated when a resident was admitted to the facility, she entered the medication orders in the computer, and said staff could have the pharmacy send the medications stat, which meant the medications should arrive within four (4) hours. She stated if a resident was admitted after 5:00 PM, and his/her medications were not ordered stat, the pharmacy would not deliver the medications until the next night. She stated there were medications available in limited supplies in the facility's e-kit. LPN #11 stated she did not remember Resident #209 or the situation with the resident's medications; however, LPN #11 further stated if medications were not available for administration, there should have been a note entered on the MAR, and the medications started the next day once they arrived. LPN #11 further stated apparently she did not notify the Director of Health Services (DHS) that some of Resident #209's medications were not available to give.</p> <p>During an interview on 03/14/2024 at 1:52 PM, the DHS stated she was not aware Resident #209's medications had not been available after admission until the next day. She stated she was also not aware the resident missed doses of his/her routine medications after admission. The DHS stated however, she expected residents to receive their ordered medications. She stated when a resident was admitted, nursing staff could request the medications be delivered stat, which could take up to four (4) hours or more to arrive at the facility. The DHS further stated some medications were available for administration in the facility's medication storage/dispensing machine.</p> <p>During an interview on 03/15/2024 at 8:57 AM, the Executive Director (ED) stated when the facility admitted a resident, he expected nursing staff to contact the pharmacy to acquire the medications timely and, if they were ordered stat, the medications should arrive within four (4) hours. The ED stated if a resident arrived in the evening for admission, the nurse ordering the medications needed to order the medications stat so the medications would be at the facility by midnight. The ED further stated he expected nursing staff to communicate with the DHS to determine why a resident's medications were not available for administration and to escalate the order if needed.</p>		