STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185461	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Ridge Health Campus	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, and facility document and policy review, the facility failed to protect a resident's right to be free from mental abuse perpetrated by a staff member for 1 of 2 sampled residents reviewed for abuse, out of the total sample of 16. The findings include: Review of the facility policy titled, Abuse and Neglect Procedural Guide, reviewed 08/29/2019, revealed the facility was to protect residents from abuse. Further review revealed Mental/Emotional Abuse was defined as the use of verbal or nonverbal conduct which caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Review of the Resident Face Sheet for Resident (R)214 revealed the facility admitted the resident on 03/11/2025, with diagnoses of emphysema, acute respiratory failure with hypoxia, acute kidney failure, and acute on chronic diastolic heart failure. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/17/2025, revealed the facility assessed R214 to have a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident had severe cognitive impairment. Review of the facility's Final Report/5 Day Follow-Up dated 04/18/2025, revealed in response to resident behaviors, Certified Resident Care Aide (CRCA) 6 directed an inappropriate hand gesture (middle finger gesture) toward R214. Per review, R214 reported the CRCA's action to the nurse on duty, who immediately obtained a statement from CRCA 6 and suspended the CRCA. Further review revealed after completion of its investigation, the facility determined, Findings of the investigation were verified as employee admitted to the hand gesture toward resident. Continued review of the facility's investigation information revealed a Statement of Witness Form, from CRCA 6 dated 04/18/2025, which noted the CRCA admitted she gave the middle finger at R214 before turning to walk down the hallway, with the resident following behind her in his/her wheelchair. During interview on 06/04/2025 at 12:07 PM, CRCA 6 stated that although she knew the hand gesture could be perceived as abuse, she had not considered it in that manner at the time. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 06/05/2025 at 4:30 PM, CRCA 7 stated she recalled being at the nurses' station with CRCA 6 when R214 activated his/her call light, and CRCA 6 went to answer it. She stated after a few minutes, CRCA 6 returned to the nurses' station, followed by R214. The CRCA reported R214 notified the Assistant Director of Health Services (ADHS) that CRCA 6 had demonstrated an inappropriate hand gesture at him/her. She explained that although she was not present when CRCA 6 made the gesture, she was present when CRCA 6 admitted to the ADHS that she made the gesture towards R214. During interview on 06/05/2025 at 10:43 AM, the ADHS stated she was on duty on the morning of 04/18/2025, when R214 approached the nurses' station and notified her that CRCA 6 made an inappropriate hand gesture towards him/her. The ADHS stated following R214's allegation, she questioned CRCA 6, who admitted making the hand gesture towards the resident. During interview on 06/05/2025 at 12:56 PM, the Director of Health Services (DHS) stated on 04/18/2025, around 3:00 AM, she received a telephone call from the ADHS who notified her that R214 alleged CRCA 6 made an inappropriate hand gesture towards him/her. She said the ADHS informed her CRCA 6 admitted to making the gesture towards the resident. The DHS further stated the hand gesture was inappropriate and was considered mental abuse. During interview on 06/05/2025 at 1:34 PM, the Executive Director (ED) stated CRCA 6's employment was terminated following R214's allegation, because the CRCA admitted the allegation had occurred.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to submit an initial report of an allegation of staff-to-resident abuse to the State Survey Agency (SSA) within two hours for 1 of 2 sampled residents reviewed for abuse (Resident (R)214). The findings include: Review of the facility policy titled, Abuse and Neglect Procedural Guide, reviewed 08/29/2019, revealed Mental/Emotional Abuse was defined as using verbal or nonverbal actions which caused or had the potential to cause a resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Review of the section of the policy titled, Identification, revealed the Executive Director (ED) was responsible for notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services (APS) and/or local law enforcement agencies, as indicated. Continued review of the policy revealed under the section titled, Reporting/response, revealed the facility was to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, but not later than two hours after the allegation was made if the event, that caused the allegation involved abuse or resulted in serious bodily injury. Further review revealed the alleged violation was to be reported to the Administrator of the facility and to other officials (including to the SSA and APS where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the Resident Face Sheet for R214 revealed the facility admitted the resident on 03/11/2025, with diagnoses of acute on chronic diastolic heart failure, acute respiratory failure with hypoxia, acute kidney failure, and type two diabetes mellitus. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/17/2025, revealed the facility assessed R214 as having a Brief Interview for Mental Status (BIMS) score of seven out of 15, indicating the resident had severe cognitive impairment. Review of the facility's Initial Report, dated 04/18/2025, revealed an initial report was submitted to the SSA related to an allegation of abuse involving Certified Resident Care Aide (CRCA) 6 having made an inappropriate hand gesture towards R214. Continued review of the Initial Report revealed the incident occurred on 04/18/2025 at 3:25 AM, and the ED was notified of the incident on 04/18/2025 at 3:42 AM. Further review revealed the facility had not submitted the report to the SSA until 7:48 AM on 04/18/2025, more than two hours after the allegation was reported. However, review of the facsimile (fax), Communication Result Report, included with the facility's documentation of the allegation, revealed a fax transmission of the Initial Report was attempted on 04/18/2025 at 9:02 AM. Per review of the fax, the transmission had been unsuccessful, due to an error code of E-3), which indicated there was no answer. Continued review revealed comparison of the number listed on the Communication Result Report to the fax numbers and contact numbers listed on the Initial Report revealed the facility attempted to submit a fax to a SSA telephone number, instead of a fax line number. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an electronic mail (email) correspondence from the ED to the SSA, dated 04/18/2025, revealed the initial report of the incident was submitted to the SSA on 04/18/2025 at 9:07 AM. In interview on 06/05/2025 at 4:30 PM, CRCA 7 stated she recalled being at the nurses' station with CRCA 6 when R214 activated their call light, and CRCA 6 left the nurses' station to answer the light. CRCA 7 stated few minutes later CRCA 6 returned to the nurses' station, with R214 following. The CRCA said R214 notified the Assistant Director of Health Services (ADHS) that CRCA 6 had demonstrated an inappropriate hand gesture towards him/her. In interview on 06/05/2025 at 10:43 AM, the ADHS stated the morning of 04/18/2025, R214 approached the nurses' station and notified her that CRCA 6 had made an inappropriate hand gesture towards him/her. The ADHS reported she immediately notified the Director of Health Services (DHS) via telephone call of the allegation and was instructed to suspend CRCA 6 pending an investigation of the allegation. In interview on 06/05/2025 at 12:56 PM, the DHS stated on 04/18/2025 around 3:00 AM, she received a telephone call from the ADHS who notified her R214 had alleged CRCA 6 made an inappropriate hand gesture towards him/her. The DHS said the ED was immediately notified. The DHS further stated she was aware the initial report of the incident must be submitted to the SSA within two hours. In interview on 06/05/2025 at 1:34 PM, the ED stated he was notified of R214's allegation made on 04/18/2025 between 3:45 AM and 4:00 AM. He said he was aware notification to the SSA must occur within two hours. After reviewing the initial report, the ED stated the report was submitted to the state on 04/18/2025; however, not within the required two hour timeframe. He further stated he was not aware the report had not been received by the SSA during the first transmission (fax) attempt or that the attempt had been made to fax the document to a telephone number instead of a fax number. The ED additionally stated he expected the initial report of an allegation to be sent to the SSA within the two-hour timeframe.