

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 06/05/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on interview, record review, and review of the Centers for Medicare and Medicaid (CMS) Long-Term Care Facility, Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) Assessment for 1 of 16 sampled residents (Resident (R)54).</p> <p>The findings include:</p> <p>Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual, Version 1.19.1, dated 10/2024, revealed under section O0110: Special Treatments, Procedures, and Programs, O0110C1, Oxygen therapy specified, Code continuous or intermittent oxygen administered via [by way of] mask, cannula, etc. [et cetera], delivered to a resident to relieve hypoxia in this item.</p> <p>Review of the Resident Face Sheet for R54 revealed the facility admitted the resident on 04/21/2025, with diagnoses to include pulmonary embolism, acute respiratory failure with hypoxia, pulmonary fibrosis, pulmonary hypertension, and atelectasis (complete or partial collapse of a lung or a lobe of a lung).</p> <p>Review of the admission MDS Assessment, with an Assessment Reference Date (ARD) of 04/25/2025, revealed the facility assessed R54 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Further MDS review revealed the use of supplemental oxygen was not reflected under Section O0110 Special Treatments, Procedures, and Programs of the MDS.</p> <p>Review of the Active Orders for R54 revealed an order, dated 04/23/2025, for nursing to manage oxygen administration in coordination with physician to prevent respiratory acidosis. Further review of the Active Orders revealed however, no physician's order specifying when the supplemental oxygen should be administered or a prescribed supplemental oxygen flow rate.</p> <p>Review of a nursing Progress Note, dated 04/22/2025 at 10:09 PM, revealed R54 had an oxygen saturation (O2 sat) level of 91 percent on room air. Further review revealed supplemental oxygen was administered to R54 at a rate of two liters per minute (2 LPM) by way of nasal cannula.</p> <p>Review of the physician Progress Note, for R54 dated 04/23/2025 at 8:04 PM, revealed, Assessment: S/p [status post] acute hypoxia respiratory failure, on oxygen. Further review of the physician Progress Note revealed the Plan was to Continue oxygen.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185461	If continuation sheet Page 1 of 7

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 06/04/2025 at 8:59 AM, R54 stated he/she used supplemental oxygen at night because his/her oxygen level dropped whenever he/she laid down. R54 further stated he/she had used the supplemental oxygen every night since his/her admission to the facility.</p> <p>During interview on 06/03/2025 at 2:32 PM, Licensed Practical Nurse (LPN) 1 stated R54 wore supplemental oxygen at nighttime.</p> <p>During interview on 06/04/2025 at 9:53 AM, LPN 2 stated R54 wore supplemental oxygen at nighttime.</p> <p>During a telephone (phone) interview on 06/04/2025 at 1:01 PM, LPN 4 stated she worked on the nightshift and had taken care of R54 several times. LPN 4 said she had observed the resident wearing supplemental oxygen. She further stated R54 had been wearing oxygen at night since his/her admission to the facility.</p> <p>During interview on 06/05/2025 at 9:22 AM, the MDS Coordinator stated when gathering data for an MDS Assessment, she looked at the resident's orders, progress notes, observations, events, therapy notes, and the initial admission assessment. She reported the oxygen administration for R54 should have been caught in the many audits that had been done; however, it had not been. The MDS Coordinator further stated that had been an error on the resident's MDS Assessment.</p> <p>During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated her expectation was that MDS assessments were completed accurately and timely.</p> <p>During interview on 06/05/2025 at 11:02 AM, the Executive Director (ED) stated his expectation was for staff to use the audits the facility had in place and to be thorough in completing the residents' MDS Assessments.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on interview, record review, and facility standard operating procedure review, the facility failed to obtain orders for supplemental oxygen use for 1 of 1 resident reviewed for respiratory care, out of the 16 total sampled residents (Resident (R)54).</p> <p>The findings include:</p> <p>Review of the facility's standard operating procedure (SOP) titled, Administration of Oxygen, last reviewed 12/13/2024, revealed, OVERVIEW Guidelines to properly Administering Oxygen and any Respiratory procedure. SOP DETAILS 1. Verify physician's order for the procedure.</p> <p>Review of R54's Resident Face Sheet revealed the facility admitted him/her on 04/21/2025, with diagnoses to include: pulmonary embolism, acute embolism and thrombosis of unspecified deep veins of left lower extremity, acute respiratory failure with hypoxia, atelectasis (complete or partial collapse of a lung or a lobe of a lung), pulmonary fibrosis, and pulmonary hypertension.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/25/2025, revealed the facility assessed R54 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact.</p> <p>Review of R54's Care Plan, revealed the facility identified included a problem, dated 04/30/2025, that indicated the resident had the potential for shortness of breath while lying flat. Further review revealed the interventions directed staff to administer supplemental oxygen per physician's order and as needed (dated 04/30/2025).</p> <p>Review of R54's Active Orders revealed an order dated 04/23/2025, for nursing to manage the resident's oxygen administration in coordination with the physician to prevent respiratory acidosis. Review of the Active Orders further revealed however, no physician's order specifying when R54's supplemental oxygen was to be administered or a with a prescribed supplemental oxygen flow rate.</p> <p>In interview on 06/04/2025 at 8:59 AM, R54 stated he/she used supplemental oxygen at night as his/her oxygen level dropped whenever he/she laid down. The resident further stated he/she had used supplemental oxygen every night since being admitted to the facility.</p> <p>Review of the nursing Progress Note, dated 04/22/2025 at 10:09 PM, revealed R54 had an oxygen saturation (O2 sat) level of 91 percent on room air. Review further revealed supplemental oxygen was administered to R54 at a rate of two liters per minute (2 LPM) by way of nasal cannula.</p> <p>Review of the physician Progress Note dated 04/23/2025 at 8:04 PM for R54, revealed under a section titled, Assessment it was noted the resident was status post (s/p) acute hypoxia respiratory failure, and was on oxygen. Review of the Progress Note further revealed under a section titled, Plan, it was noted to Continue oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing Progress Notes, dated 04/27/2025, 05/02/2025, 05/04/2025, 05/05/2025, 05/08/2025, 05/12/2025, 05/14/2025, 05/15/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/29/2025, and 05/31/2025, revealed it was documented R54 used supplemental oxygen. Further review of those nursing Progress Notes revealed staff should refer to physician's orders for the oxygen flow rate and delivery method for R54.</p> <p>In interview on 06/03/2025 at 2:32 PM, Licensed Practical Nurse (LPN) 1 stated R54 wore supplemental oxygen at night. LPN 1 further stated there should have been an order for R54's supplemental oxygen administration and a place to record the resident's oxygen saturation level.</p> <p>In interview on 06/04/2025 at 9:53 AM, LPN 2 stated R54 wore supplemental oxygen at night. She further stated there should have been an order for R54's supplemental oxygen.</p> <p>In a telephone (phone) interview on 06/04/2025 at 1:01 PM, LPN 4 stated she worked on the nightshift and had cared for R54 several times. LPN 4 further stated she had observed R54 wearing supplemental oxygen when she cared for the resident.</p> <p>In interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated a physician's order was needed for the administration of supplemental oxygen. The DHS said it was her expectation for nurses to obtain an order if a resident needed to use supplemental oxygen. She reported nurses could provide supplemental oxygen in an emergency situation and then immediately notify the physician for an order and parameters to follow. The DHS reviewed R54's physician orders and verified there was no order for supplemental oxygen for the resident. She further verified R54 wore supplemental oxygen nightly and had since being admitted to the facility.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, record review, facility policy review, and review of manufacturer's information, the facility failed to ensure the medication error rate was less than 5 percent (%). The facility had 4 medication errors out of 26 total opportunities, affecting 2 of 3 residents reviewed during the medication administration task (Resident (R)54 and R58), which resulted in a medication (med) error rate of 15.38 %.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Medication Administration - General Guidelines, revised 11/2018, revealed medications were to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Continued review of the policy revealed, the FIVE RIGHTS for medication administration revealed the rights included: right resident; right drug; right dose; right route; and right time and were to be applied for each medication being administered. Per policy review, The policy medications were to be administered in accordance with written orders of the prescriber. Further policy review revealed medications were to be administered within 60 minutes of the scheduled time, except before, with or after meal orders, which were administered based on mealtimes.</p> <p>1. Review of the Resident Face Sheet for R58 revealed the facility admitted the resident on 05/14/2025, with diagnoses that included gastrointestinal hemorrhage and constipation.</p> <p>Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/16/2025, revealed the facility assessed R58 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated the resident had moderate cognitive impairment.</p> <p>Review of the Active Orders for R58 revealed an order dated 05/19/2025, for polyethylene glycol 3350 powder (a laxative) 17 grams (gms) per dose with instructions to administer one lid full in water twice a day between 6:00 AM and 10:00 AM and between 6:00 PM and 10:00 PM.</p> <p>Observation of medication administration on 06/03/2025 at 8:28 AM, revealed Licensed Practical Nurse (LPN) 1 removed the bottle top from the polyethylene glycol 3350 powder, poured the powder into the bottle top. Continued observation revealed LPN 1 then without placing the top of the bottle on a flat surface and measuring the medication with the provided measurement lines on the inside of the bottle top itself, poured the powder into a drinking glass. Further observation revealed LPN 1 then poured approximately four ounces of red juice into the cup, stirred it, and gave it to R58 with his/her other medications.</p> <p>During interview on 06/03/2025 at 2:24 PM, LPN 1 stated she did not know the proper way to measure the correct dosage of polyethylene glycol 3350 powder.</p> <p>During interview on 06/04/2025 at 9:53 AM, LPN 2 stated powdered medications, such as polyethylene glycol, usually came with a scoop. The LPN reported if the powdered medication did not have a scoop, you should fill the cap of the medication bottle. LPN 2 further stated to make sure the medication was measured correctly, you should shake the lid or tap it on top of the cart to see if it was level.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 06/04/2025 at 10:12 AM, Registered Nurse (RN) 3 stated for powdered medications, such as polyethylene glycol, she used the clear medication cups for accuracy. RN 3 said if a staff member did not level the medication to ensure the correct amount was being administered, it would be a medication error.</p> <p>During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated for a powdered medication, such as polyethylene glycol 3350 powder, there was a line in the bottle top that staff were to utilize when administering the medication. The DHS further stated the medication should be filled to that line and confirmed by the nurse by checking it at eye level.</p> <p>2. Review of the Resident Face Sheet for R54 revealed the facility admitted the resident on 04/21/2025, with diagnoses that included diagnoses of hypokalemia (low potassium levels) and hypothyroidism (low thyroid levels).</p> <p>Review of the admission MDS Assessment, with an ARD of 04/25/2025, revealed the facility assessed R54 to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of the Active Orders for R54 revealed the orders contained the following:</p> <ul style="list-style-type: none"> - an order dated 04/21/2025 for calcium carbonate 500 milligrams (mg), one tablet once a day between 6:00 AM and 10:00 AM; - an order dated 04/21/2025 for ferrous gluconate 324 mg (38 mg of iron) with instructions to administer with breakfast, once a day between 6:00 AM and 10:00 AM; - an order dated 05/10/2025 for levothyroxine 125 micrograms (mcg) once a day between 6:00 AM and 10:00 AM; and - an order dated 04/21/2025 for potassium chloride extended release 20 milliequivalents (mEq) with instructions to administer with meals, twice a day between 6:00 AM and 10:00 AM and between 4:00 PM and 6:00 PM. <p>Review of the Manufacturer's Prescribing Information for levothyroxine sodium revealed the following instructions: Take UNITHROID [levothyroxine sodium] on an empty stomach at least 30 minutes to 1 hour before eating breakfast or 3 or more hours after dinner or your last meal of the day. Review further revealed to wait 4 hours before or after taking calcium or iron supplements (including prenatal vitamins).</p> <p>During observation of medication administration on 06/03/2025 at 8:42 AM, LPN 1 prepared R54's medications, including calcium carbonate 500 mg, ferrous gluconate 324 mg, levothyroxine 125 mcg, and potassium chloride 20 mEq, and placed them into one medication cup. Observation further revealed LPN 1 administered the medications to R54 with a 5-ounce glass of water.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 06/03/2025 at 2:24 PM, LPN 1 stated medications that were to be administered with food should be given within 15 minutes of consuming food. She confirmed R54's potassium was ordered to be given with food and verified the breakfast trays had not been delivered to the hallway at the time of the medication pass observation. The LPN reported she had not provided food for R54 during the morning medication pass. LPN 1 stated she also administered R54's levothyroxine along with the residents' other morning medications, including his/her calcium and iron.</p> <p>During interview on 06/04/2025 at 9:53 AM, LPN 2 stated a medication that was to be given with food should be given within 30 minutes of the resident consuming food, or a snack could be provided to the resident. She further stated typically, thyroid medications (such as the resident's levothyroxine) were given an hour before all other medications.</p> <p>During interview on 06/04/2025 at 10:12 AM, RN 3 stated if medication was to be given with food, the resident had to be eating when the medication was given. The RN said she usually waited until the resident had eaten before she gave the medication to the resident. RN 3 reported if it was not mealtime, a snack, such as pudding or crackers, could be given with the medication. The RN further stated levothyroxine was a medication that was to be administered separately from other medications and was usually given at 5:00 AM.</p> <p>During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated if medication was to be given with food. She said if a meal was not present at the time of the medication administration, the nurse should provide pudding or crackers during the medication pass to coat the resident's stomach. The DHS explained medications that were to be administered with food should be given to the resident with food. She reported levothyroxine was a medication that was to be given separately from other medications and on an empty stomach. The DHS confirmed R54 had not been asked if it was his/her preference to take all his/her medications together and there was no order for the levothyroxine to be given along with all the other medications. She stated her expectation was for the nurses to follow the physician's orders for medication administration. The DHS further stated all of the above discussed medication administration issues were medication errors.</p> <p>During interview on 06/04/2025 at 4:11 PM, Pharmacist 5 stated the recommendation for levothyroxine was to administer the medication an hour before all other medications and on an empty stomach for the best absorption. Pharmacist 5 said potassium should be given with food to prevent stomach upset and the physician's order should be followed.</p> <p>During interview on 06/05/2025 at 11:02 AM, the Executive Director stated his expectation was for the nurses to administer medications the proper way.</p>		