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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>185461</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (X3) DATE SURVEY COMPLETED<br><br><b>06/18/2026</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Glen Ridge Health Campus</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6415 Calm River Way , Louisville, Kentucky, 40299</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                     |  |
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| F0000                                                               | INITIAL COMMENTS<br><br>A recertification and abbreviated survey concluded on 06/18/2026. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 06/16/2026-06/18/2026 Survey Census: 63 Sample Size: 28 No deficiencies were related to 2790879, 2797546, 3045023.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | F0000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 07/15/2026                                          |  |
| F0887<br>SS = F                                                     | <p>COVID-19 Immunization</p> <p>CFR(s): 483.80(d)(3)(i)-(vii)</p> <p>§483.80 Infection control</p> <p>§483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:</p> <p>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;</p> <p>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;</p> <p>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;</p> <p>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.</p> <p>(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and</p> |                                                                            | F0887               | <p>What corrective action(s) will be accomplished for those residents/participants found to have been affected by the deficient practice? All staff and residents have the potential to be affected by the alleged deficient practice. All staff continued course of employment without incidence.</p> <p>How will you identify other staff members/residents having the potential to be affected by the same deficient practice? All staff employed by facility and residents living in facility had the potential to be affected. Staff are to be educated and offered the Covid-19 vaccine and have the opportunity to accept or decline the Covid-19 vaccine. Beginning on 6/22/2026 and completed 7/13/2026, Employee Engagement Manager met with all current employees and completed education and offered the employees the opportunity to accept or decline covid vaccine and have them sign declination waiver. Any newly hired staff will have education and be offered Covid-19 vaccine, with opportunity to accept or decline and sign declination waiver during new hire orientation by Employee Engagement Manager. The campus does not use agency staff.</p> <p>What measure will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur? On 7/15/2026, Executive Director, Director of Health Services, Infection Prevention Nurse and Employee Experience Manager were educated by Clinical Support on importance of educating and offering employees Covid-19 vaccine with opportunity to accept or decline vaccine with real time discussion and post test questions to ensure competency with 100% accuracy on posttest. All staff was educated on importance of offering Covid-19 vaccine with</p> |  | 07/22/2026                                          |  |

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 reverse for further 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  | TITLE | (X6) DATE |
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| F0887<br>SS = F                                                     | <p>Continued from page 1</p> <p>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and</p> <p>(B) Each dose of COVID-19 vaccine administered to the resident, or</p> <p>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.</p> <p>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:</p> <p>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;</p> <p>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and</p> <p>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review and facility policy review, the facility failed to maintain staff documentation of screening, education, offering, and current COVID-19 vaccination status for all staff members.</p> <p>The findings include:</p> <p>Review of the facility's policy, "COVID-19 Health Care Staff Vaccination" revised 11/10/2025, revealed under Tracking and Monitoring 1. The facility must develop and maintain a tracking system for facility staff regarding COVID-19 vaccination. 2. Tracking system to include: a. Facility staff member (to include all categories listed above under "Facility Staff" b. Specific vaccine received including manufacturer and date of each dose or date of next scheduled dose. C. Booster information including date of booster and manufacturer. d. If granted an exemption, include the type of exemption. e. List any temporary delays in vaccination and include when the staff member can safely resume the vaccination. f. And declinations.</p> | F0887                                                                      | <p>Continued from page 1</p> <p>opportunity to accept or decline vaccine with real time discussion.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained? Beginning on 7/8/2026, the Infection Prevention Nurse will collaborate Employee Engagement Manager to review all newly hired staff Covid-19 vaccine paperwork is complete, ensuring all staff are educated and being offered Covid-19 vaccine. Staff will be given opportunity to accept or decline vaccine. This audit will be completed weekly z 1 month, every other week x 2 months and then monthly x 3 months. As a quality measure, the Director of Health Services will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met.</p> <p>Date of Compliance 7/20/2026</p> | 07/22/2026                                          |

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| F0887<br>SS = F                                                     | <p>Continued from page 2</p> <p>The facility was unable to provide documentation regarding any staff member who had either accepted or declined the Covid vaccine.</p> <p>In an interview with IP on 06/18/2026 at 9:50AM, she stated staff have not requested the Covid vaccine and she does not track Covid vaccinations for staff members.</p> <p>In a follow up interview with IP on 06/18/2026 at 11:45 AM, she stated she has never offered, tracked or documented staff receiving or declining Covid vaccinations since becoming IP in 2024.</p> <p>In an interview with Director of Nursing on 06/18/2026 at 5:07 PM, she stated it is the Infection Preventionist's responsibility to manage and track Covid-19 immunizations of staff members. She stated the reason for that is to ensure everyone is up to date to prevent the spread of Covid. She stated Covid is a risk if it is not tracked.</p> <p>In an interview with the Administrator on 06/26/2026 at 5:26 PM, he stated it is the Infection Preventionist's responsibility to manage and track Covid-19 immunizations of staff members. He stated the reason for that is to ensure staff are up to date and Covid is kept to a minimum in the facility. He continued stating there was a risk of a wide spread Covid infection in the facility by not tracking.</p> | F0887                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                       |  | 07/22/2026                                          |  |
| F0607<br>SS = E                                                     | <p>Develop/Implement Abuse/Neglect Policies</p> <p>CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | F0607                                                                      | <p>What corrective action(s) will be accomplished for those residents/employees found to have been affected by deficient practice? All residents have the potential to be affected by deficient practice. All identified staff background checks were run with no findings and maintain compliance. All newly hired staff continued employment without incidence. All residents in facility remain free from abuse and neglect.</p> <p>How did you identify other residents/staff having the potential to be affected by the same deficient practice? All staff and residents have the potential to be affected. Residents and staff are to remain free from abuse and neglect while at facility. On 7/10/2026, the Employee Engagement Manager reviewed all staff paperwork to ensure background checks are initiated, completed and results verified before candidate begins employment.</p> <p>What measure will be put in place or what systematic changes will you make to ensure that the</p> |                                                                                                       |  | 07/22/2026                                          |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F0607<br>SS = E                                                     | <p>Continued from page 3</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review and facility policy review, the facility failed to implement written policies and procedures that prohibited and prevented abuse, neglect, exploitation of residents, and misappropriation of residents' property. The facility failed to run background, Office of Inspector General (OIG) Abuse Registry, and Kentucky Adult Caregiver Misconduct (KACMR) checks prior to start dates for 6 of 10 employees.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse, Neglect and Exploitation Procedural Guidelines," revised 12/16/2024, revealed the facility would, "screen all potential employees for a history of abuse, neglect or mistreatment of patients during the hiring process. It will consist of but not limited to the following: 1. State licensing authorities 2. State Nurse Aide Registry Verification 3. Reference checks from previous/current employers 4. Criminal background checks of all non-professional staff.</p> <p>Review of the facility's policy, "Background Check Screening Policy," revised 10/28/2025, revealed in bold ink letters, "The background check must be completed, and results verified before a candidate begins employment."</p> <p>Review of Activity Associate personnel file revealed a hire date of 01/28/2026. However, further review revealed the facility received a background check, the OIG Abuse Registry on 02/13/2026 and KACMR on 02/05/2026.</p> |                                                                            |  | F0607                                                                                                 | <p>Continued from page 3</p> <p>deficient practice does not recur? On 7/15/2026, Clinical Support educated the Executive Director, Director of Health Services and Employee Engagement Manager on Abuse and Neglect emphasizing importance of new hire background initiated, completed and results verified before candidate begins employment. Director of Health Services provided all staff education on Trilogy's Abuse, Neglect and Exploitation procedural guidelines and was started on 6/30/2026 and completed on 7/15/2026. This occurred with real time discussion and post op test questions to ensure 100% competency. Any newly hired staff will have education provided by Executive Director during new hire orientation. The campus does not use agency staff.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained? Beginning 7/15/2026, Executive Director will review newly hired employee files to ensure background checks are initiated, completed and results verified before candidate begins employment weekly x 1 month, every other week x 2 months and monthly x 3 months. A quality measure, the Director of Health Services will review any findings and corrective actions at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met.</p> <p>Compliance Date: 7/20/2026</p> |                                                     | 07/22/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>Glen Ridge Health Campus</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6415 Calm River Way , Louisville, Kentucky, 40299</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| F0607<br>SS = E                                                     | <p>Continued from page 4</p> <p>Review of Cook. 1's personnel file revealed a hire date of 02/04/2026. However, further review revealed the facility received the background check, and OIG Abuse Registry on 02/25/2026 and KACMR on 02/05/2026.</p> <p>Review of Environment Services Assistant 1's personnel file revealed a hire date of 03/04/2026. However, further review revealed the facility received background check, OIG Abuse Registry and KACMR on 03/10/2026.</p> <p>Review of Registered Nurse (RN) 4's personnel file revealed her hire date was 04/15/2026. However, further review revealed the facility received background check, OIG Abuse Registry and KACMR on 04/17/2026.</p> <p>Review of Certified Nursing Assistant (CNA) 4's personnel file revealed her hire date was 06/04/2025. However, further review revealed the facility received background check and OIG Abuse Registry on 06/25/2025. The KACMR was performed by facility on 06/06/2025.</p> <p>Review of CNA5's personnel file revealed their hire date was 12/19/2023. However, further review revealed the facility received background check, OIG Abuse Registry and KACMR on 12/27/2023.</p> <p>In an interview on 06/18/2026 at 5:07 PM, the Director of Nursing (DON) stated it was the responsibility of the facility's human resource staff member to perform abuse registry and background checks. She continued that currently, potential employee background and abuse checks were performed offsite at corporate by an "employee experience manager" because this location currently did not have a human resource staff member in that role; and they have been without since the beginning of June 2026. The DON stated the reason for performing checks was to ensure people we hire are not on those registries. Further, the DON stated a risk of not performing background and abuse checks prior to staff start date was the facility would not know if employees were on the registry or not and that could result in people working with residents who were on the registry.</p> |                                                                            |  | F0607                                                                                                 |                                                                                                                          |                                                     | 07/22/2026                 |

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

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>185461</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                              |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>06/18/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Glen Ridge Health Campus</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6415 Calm River Way , Louisville, Kentucky, 40299</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| F0607<br>SS = E                                                     | Continued from page 5<br>In an interview with the Administrator on 06/18/2026 at 5:26 PM, he stated it was the responsibility of the "employee experience manager" to perform abuse registry and background checks. He stated the facility does not currently have an employee in that role since June 14, 2026. He stated the reason for performing background and abuse checks was to ensure no one hired was on the registry and they were capable of working with residents. He continued that a risk could be residents are put at risk if someone could potentially be on the registry. |                                                                            |  | F0607                                                                                                 |                                                                                                                          |                                                     | 07/22/2026                 |