

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

PRINTED: 09/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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F 000	INITIAL COMMENTS  An abbreviated survey was conducted from 08/24/11 through 08/26/11 for complaints KY #16947 and KY#16906. KY#16947 was substantiated with regulatory violations and complaint KY#16906 was found to be unsubstantiated with no regulatory violations. Deficiencies were cited with the highest scope and severity of a "D".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Regis Woods Care &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined the facility failed to follow the plan of care for one (1) of three (3) residents. Resident #1 attempted to exit a door of the facility and sustained a fall.  The findings include:  Record review revealed the facility completed a Wander Assessment on 07/27/11 for Resident #1. The facility identified Resident #1 as a high risk for elopement.  Further review of the record for Resident #1 revealed the facility admitted Resident #1 on 07/19/11 with diagnoses that included a History of falls and Pain. The facility assessed Resident #1 as being confused and delusional. The Care Plan	F 282	F282  1. Resident #1's care plan was reviewed and updated to reflect the current needs of the resident on 8/19/11 by the Unit Manager.  2. Current resident's care plans were reviewed by 8/21/11 by the Director of Nursing, Assistant Director of Nursing and Unit Manager to ensure that interventions are being followed as indicated.  3. Registered nurses, licensed practical nurses and certified nursing assistants will be re-educated by the Director of Nursing or Assistant Director of Nursing as of 9/23/11 related to importance of following the resident care plan to ensure interventions are implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*x Joseph Davett* *x Administrator* *x 9/10/2011*

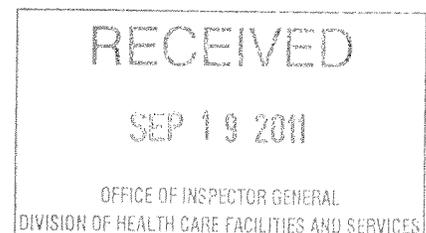
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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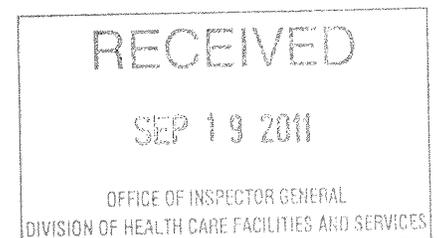
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F 282	Continued From page 1 (CP) developed 07/28/11 directed staff to keep Resident #1 in a highly visible area. Documentation in the nursing notes on 08/10/11 at 3:49 PM revealed, Resident #1 had been re-directed several times in the shift for wandering in other resident rooms.  Record review revealed, on the evening of 08/19/11, at approximately 8:30 PM, Certified Nursing Assistant (CNA) #2 toileted Resident #1 and then assisted the resident in their wheelchair to the sitting area in front of the nursing station on NF1. No staff was at the nurses station to observe Resident #1. When CNA #2 went to care for another resident, Resident #1 wheeled to the closed fire doors of the unoccupied Personal Care Unit (PC), opened the fire doors, and propelled his/her wheelchair approximately two-thirds (2/3) of the way down the hallway before standing and ambulating to the exit door. The resident then leaned against the door and it opened. As the door opened Resident #1 fell to the floor.  Interview, on 08/24/11 at 3:35 PM, with CNA #2 revealed she placed Resident #1 in front of the NF1 nursing station and left Resident #1 alone with no other staff member present to watch him/her. CNA #2 was aware Resident #1 wandered and was not to be left without visual monitoring.	F 282	4. The Ambassador Team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Solana Program Director, Health Information Manager, Dietary Manager, Dietician, Housekeeping/Laundry Manager, Maintenance Director, Activities Director, Admissions, Business Office) will complete an audit on 3 residents twice a week for three months to ensure care plan interventions are being implemented as indicated by the residents plan of care. A summary of the audit findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Director of Nursing monthly times three months for further review and recommendation.  5. Date of compliance 9/24/2011.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323  1. Resident #1 was transferred to the hospital for evaluation and treatment on 8/19/11 and returned within 24 hours with no injuries. A family meeting was	



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F 323	Continued From page 2 prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined the facility failed to provide adequate supervision to prevent falls for one (1) of three (3) sampled residents. Resident #1 sustained a fall when an exit door opened that the resident leaned against while in an unsupervised and unoccupied area of the facility.  The findings include:  Observation, on 08/24/11 at 01:45 PM, in the facility's Personal Care Unit (PC) revealed, the unit had been closed since 12/31/10 for renovation. The nearest nursing station was 1000 feet or more from the PC hallway. The lobby exit doors had a wanderguard alarm that alarmed to the PC nursing station.  Observation, on 08/24/11 at 2:10 PM, in the NF2 hallway revealed Resident #1 was wheeling toward NF1 in a wheelchair. Resident # 1 was redirected back to the NF2 unit by staff.  Observation, on 08/24/11 at 2:20 PM, in front of the NF2 nursing station, revealed Resident #1 was sitting in a wheelchair in the open area. A wanderguard was noted in place on his/her right ankle. 1:1 observation by staff was taking place.  Observation, on 08/25/11 at 10:05 AM, revealed	F 323	held by the Interdisciplinary Team (Administrator, Director of Nursing, and Assistant Director of Nursing, Social Services and Unit Manager) on 8/20/11 and family agreed to visit resident in the evenings and take him leave of absence more frequently to assist in reducing his anxiety.  2. Current residents at risk for falls and elopement were reviewed by the Director of Nursing Services, Assistant Director of Nursing Services and Unit Managers by 8/21/11. Interventions were implemented to reflect current needs of the residents on or before 8/21/11.  3. Registered Nurses, licensed practical nurses and certified nursing assistants will be re-educated as of 9/23/11 by the Director of Nursing or Assistant Director of Nursing related to implementation of care plan interventions and providing supervision as indicated to assist in preventing falls.  A door lock with key pad was installed on 8/26/11 on the doors leading to the unoccupied personal care unit. These doors were supervised by staff 24/7 until the door lock with key pad was installed on 8/26/11.  Staff will be educated as of 9/23/11 by the Administrator, Maintenance Director or Assistant Maintenance Director related to new locking mechanism with key pad on the		



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F 323	Continued From page 3 the PC hallway fire doors opened easily.  Interview, on 08/24/11 at 2:10 PM with the Director of Maintenance, revealed there was no wanderguard alarms at the entrance of the PC hallway. The unit closed 12/31/10 and the fire doors were closed but not locked.  Interview, on 08/24/11 at 2:40 PM with Licensed Practical Nurse (LPN) #1, revealed on 08/19/11 at approximately 8:50 PM Resident #1 had been found on the floor at the PC exit with the door partially open.  Interview by telephone, on 08/24/11 at 3:35 PM, with Certified Nursing Assistant #1 revealed she had toileted Resident #1 and had placed his/her wheelchair in the sitting area in front of the NF2 nursing station around 8:30 PM. At around 8:45 PM she went to look for the resident because he/she was no longer in front of the nursing station. She stated she located Resident #1 on the PC unit and further stated Resident #1 had fallen at the exit door entrance and was unable to get up without assistance.  Interview, on 08/25/11 at 3:15PM, with the Director of Nursing revealed the facility had three (3) nurses on the 3-11 shift and four (4) CNA's on the 3-11 shift. She stated staffing is based on census and the acuity of the residents.	F 323	unoccupied personal care unit doors.  4. The Ambassador Team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinator, Social Services Director, Solana Program Director, Health Information Manager, Dietary Manager, Dietician, Housekeeping/Laundry Manager, Maintenance Director, Activities Director, Admissions, Business Office) will complete an audit on 3 residents twice a week for three months to ensure that residents care plan interventions are being implemented as indicated by the residents plan of care and providing supervision as indicated to assist in preventing falls. A summary of the audit findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Director of Nursing monthly times three months for further review and recommendation.  5. Date of compliance 9/24/2011.	

