

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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A standard recertification survey was initiated on 11/05/13 and concluded on 11/07/13. A Life Safety Code inspection was conducted on 11/06/13. The facility was cited at the highest Scope and Severity of an "D". An Abbreviated survey was initiated on 11/05/13 and concluded on 11/07/13 to investigate KY20947 and KY20880. The Division of Health Care unsubstantiated the allegations.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency Center 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 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to act upon the legal representative's recommendations and to communicate the decisions made based on those recommendations for one (1) of twenty (20) sampled residents. The legal representative had informed the facility staff of concerns with the resident's care and the facility staff failed to act upon the voiced concerns and recommendations. The findings include: Review of the facility's Grievance/Concern policy,	F 244	F244 1. On 11/6/13 Resident #5's legal representative met with the Director of Nursing and Assistant Director Nursing to discuss concerns regarding resident's care. At that time legal representative voiced two concerns. These concerns were noted on facility Grievance Form on 11/6/13 by the Director of Nursing. The concern related to incontinence care was resolved on 11/8/2013 by the Director of Nursing and Resident #5 was already and continues receiving speech therapy services related to the dietary concern that was voiced. On 11/12/13, a care plan meeting was held with the legal representative of Resident #5. At that time her concerns were discussed and she indicated she was satisfied with the interventions put into place.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wiane Harvett, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/29/13</i>
--	-------------------------------	------------------------------

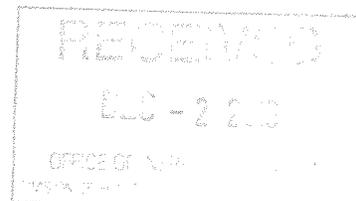
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

DK

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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 244	<p>Continued From page 1</p> <p>revision date 06/10/13, revealed all residents and/or their representatives may voice recommendations and concerns. The facility would investigate, document and follow up on all concerns and grievances registered by the resident or resident representative. The purpose was to ensure prompt receipt and resolution of the resident/representative concern/grievance.</p> <p>Phone interview with Resident #5's legal representative, on 11/05/13 at 5:30 PM, revealed they visited the facility often. The representative stated he/she had voiced concerns to the 200 Register Nurse (RN) Unit Manager #1 (UM) and the Director of Nursing (DON) regarding the resident's incontinent care and dietary concerns. The representative stated the only communication the UM or the DON provided they would check on the situation.</p> <p>Phone interview with the UM #1, on 11/07/13 at 3:23 PM, revealed she was aware of the legal representative's concern with the resident's skin irritation. She continued to state the family member recommended an increase in the resident check and change times. The UM stated the family's concerns were relayed to the DON.</p> <p>Interview with the DON, on 11/07/13 at 4:15 PM, revealed the facility investigates any concern from a resident or family. She revealed the concerns were to be documented as a grievance and the resident/family was to be notified of the resolution. However, she was unable to recall any of Resident #5's family concerns.</p> <p>Interview with the Administrator, on 11/07/13 at 5:00 PM, revealed the facility's expectation was for concerns to be addressed immediately. She</p>	F 244	<p>On 11/6/13, the Director of Nursing and Administrator were re-educated to the Grievance Policy by the Manager of Clinical Operations. Unit Manager #1 was re-educated to the Grievance Policy by the Administrator on 11/11/13.</p> <p>2. On 11/22/2013 a letter was mailed by the Social Service Director to current legal representatives, family members and residents' informing all on the grievance process within the center. As of 11/11/13, grievances received have been documented by the staff member receiving the grievance or by the person voicing the grievance and reviewed by the Interdisciplinary Team to determine proper interventions and resolution and then the resident/family notified of the resolution by the appropriate staff member as determined by the nature of the grievance.</p> <p>3. Nursing, Dietary, Therapy, Housekeeping, Social Services, Maintenance and Administrative staff have been re-educated on the grievance policy and procedure as of 11/26/2013 by the Assistant Director of Nursing. Newly hired employees will receive education on the Grievance Policy during orientation from the Social Services Director ongoing.</p>		



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

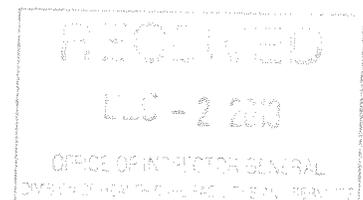
PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

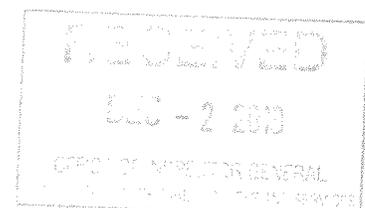
<p>F 244</p> <p>F 280 SS=D</p>	<p>Continued From page 2 also revealed some family concerns were voiced daily that are not documented.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to support and encourage participation in the care plan process for one (1) of twenty (20) residents. Resident #5. The facility had care plan meetings on 02/27/13 and 10/20/13 and failed to invite the legal representative of Resident #5 who was diagnosed with Downs Syndrome.</p>	<p>F 244</p> <p>F 280</p>	<p>4. The Administrator and/or Social Services Director will perform audits of the grievance process to determine that resident/family concerns are documented with appropriate intervention and follow up by interviewing 3 residents/family members daily (Monday thru Friday) for two weeks, three times a week for two weeks, weekly for two months, and then monthly for 3 months. Any concerns identified will be addressed at that time. The Social Services Director will submit a summary of the findings to the Performance Improvement Committee monthly x6 months for review and further recommendation.</p> <p>5. Date of compliance 11/27/2013</p> <p>F280</p> <p>1 Care plan meeting held on 11/12/2013 for Resident #5 with legal representative, Administrator, Director of Nursing, Social Services Director, and Speech Therapy. All open concerns were addressed. Legal representative voiced satisfaction with proposed resolutions.</p> <p>2. Social Services Director audited scheduled care plan meetings to determine if current residents/families had been invited to attend care plan conferences from 1/1/13 through 11/21/13, and found no other concerns were identified.</p>	
------------------------------------	--	---------------------------	--	--



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

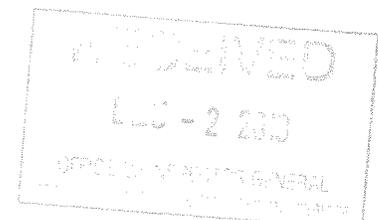
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 3</p> <p>The findings include:</p> <p>Review of the facility's Care Plan policy, dated 06/01/01, revealed the care plan meeting was to promote participation of the resident and/or Health Care Decision Maker (HCDM). The standard of practice in the absence of the HCDM would included the care plan date, update information and documentation in the progress note.</p> <p>Review of Resident #5's clinical record revealed the facility admitted the resident on 02/18/13, with diagnoses of Down Syndrome and Mild Intellectual Disabilities. Review of the facility's admission consent revealed the resident had a legal representative. Further review of progress notes revealed no evidence Resident #5 was care planned quarterly.</p> <p>Phone interview with Resident #5's legal representative, on 11/05/13 at 5:30 PM, revealed they were a daily visitor to the facility. The representative stated he/she was not notified of the resident care conference, or invited to participate in the nursing care, medical treatment or activity decisions.</p> <p>Interview with the Social Services Director, on 11/07/13 at 4:30 PM, revealed the facility would provided all residents or legal representative a written invitation which included the date and time for the care plan conference. She stated Resident #5's legal representative had the right to be informed and participate in the care plan conference; however, she thought the resident was invited, but was unable to provide any evidence.</p>	F 280	<p>3. The Social Services Director was re-educated by Administrator on resident and/or legal representatives' right to participate in planning care and treatment or changes in care and treatment on 11/8/2013. Nursing, Dietary, Therapy, Housekeeping, Social Services, Maintenance and Administrative staff were re-educated on resident and/or legal representatives' right to participate in planning care and treatment or changes in care and treatment as of 11/26/2013 by the Assistant Director of Nursing.</p> <p>4. The Social Services Director will review 5 resident care plan meetings weekly for 4 weeks then monthly times 5 months to determine that notification is given to residents/family regarding an invitation to attend plan of care meetings. Any concerns identified will be addressed at that time. The Social Services Director will submit a summary of findings to the Performance Improvement Committee monthly times 6 months for review and further recommendations.</p> <p>5. Date of compliance 11/27/2013</p>		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 282 SS=D	<p>Continued From page 4</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy reviews, it was determined the facility failed to provide care in accordance with the plan of care for one (1) of twenty (20) sampled residents, Resident #3. The facility staff failed to provide Resident #3's oxygen therapy as care planned. The findings include: Review of the facility's care plan policy (undated), revealed the purpose of the care plan was to provide necessary care and services to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan would be comprehensive and individualized with measurable objectives to meet the resident's needs and goals, and the care plan would be communicated to appropriate staff members.</p> <p>Review of the clinical record, revealed the facility initially admitted the resident on 03/14/08, discharged and readmitted on 10/02/12 with diagnoses of Dementia, Parkinson's Disease, Cerebral Atherosclerosis, Psychotic Disorder, Vision Impairment with a prosthetic left eye, Glaucoma, Hyperlipidemia, and Dysphagia. Review, of the comfort care component within the comprehensive care plan for Resident #3,</p>	F 282 F 282	<p>F282</p> <p>1. Resident # 3 oxygen flow rate was corrected on 11/7/2013 by the licensed nurse and the MD was notified with no new orders. Resident #3 was assessed by a licensed nurse on 11/7/2013 and it was determined that resident oxygen saturation remained at 97% and no negative effect was noted.</p> <p>2. Residents with oxygen noted on care plans were reviewed to determine that oxygen flow rates were set according the residents plan of care on 11/7/2013 by the Director of Nursing, Assistant Director of Nursing and Unit Manager. No other concerns were identified. The Director of Nursing, Assistant Director of Nursing and Unit Manager completed an audit of resident care plans and the resident to determine that care plan interventions are provided in accordance with the plan of care on what 11/8/2013. No other concerns were identified.</p> <p>3. Nursing staff have been re-educated by the Assistant Director of Nursing as of 11/26/2013 on the importance of following the care plans including but not limited to providing the ordered flow rate with oxygen therapy. New employees will receive this education during orientation from the Assistant Director of Nursing on going. Nursing managers/supervisors were re-educated by the Assistant Director of Nursing on</p>	



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

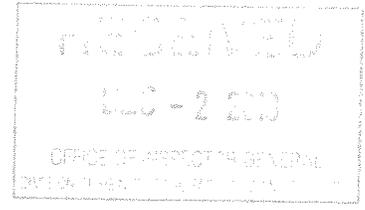
PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

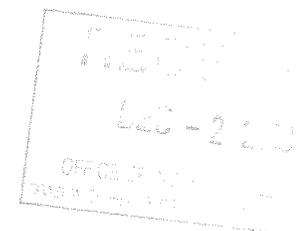
F 282	<p>Continued From page 5</p> <p>revealed oxygen therapy was to be delivered per the physician's order. Review of the physician's orders, revealed Resident #3 was to receive oxygen at 2-4 Liters per nasal cannula, continuously, and was to be titrated to keep the blood oxygen saturation greater than 90%, every shift, every day.</p> <p>Interview, on 11/05/13 at 8:25 AM, during initial tour of the North Hall unit revealed Licensed Practical Nurse (LPN) #5 stated Resident #3 was to receive continuous oxygen per nasal cannula at two (2) liters per minute.</p> <p>Observation, on 11/05/13 at 11:05 AM, revealed Resident #3's oxygen flow rate was set at 1.5 Liters/minute. Further observations on 11/05/13 at 1:00 PM, and again at 3:50 PM revealed Resident #3's oxygen, per nasal cannula, continued to flow at 1.5 Liters/minute.</p> <p>Observations, on 11/06/13 at 8:00 AM, 8:40 AM, 10:00 AM, and 11:25 AM, revealed Resident #3's oxygen was delivered per nasal cannula at a flow rate of 1.5 Liters/minute.</p> <p>Observations, on 11/07/13 at 8:20 AM, and 9:05 AM, revealed Resident #3 was abed and oxygen therapy was being delivered, per nasal cannula, at 1.5 Liters/minute.</p> <p>Interview, on 11/07/13 at 9:07 AM with LPN #1, revealed Resident #3's oxygen was to flow at 2 Liters/minute, but upon inspection of the concentrator at Resident #3's bedside, LPN #1 stated the flow rate was set at 1.5 L/minute. LPN #1 further stated the oxygen flow rate was supposed to be checked for accuracy every shift by the nurse assigned to Resident #3, but this</p>	F 282	<p>11/7/2013 on monitoring for compliance with provision of services according to physician orders and the plan of care including oxygen flow rates.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or the Nursing Supervisors will complete an audit of 3 residents daily for two weeks (Monday thru Friday), three times a week for two weeks, weekly for two months, and then monthly for 3 months to determine compliance with the care plan and physician orders including oxygen flow rate. Any concerns identified will be addressed at that time. A summary of the audit findings will be submitted to the facility Performance Improvement Committee by the Director of Nursing monthly for six months for further review and recommendation.</p> <p>5. Date of Compliance is 11/27/2013</p>	
-------	---	-------	---	--



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

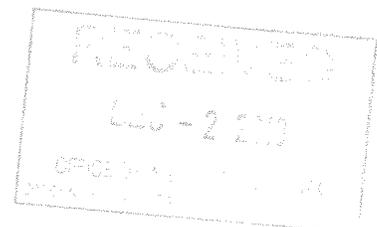
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 6 was the first opportunity on her shift to check the oxygen flow rate at the concentrator. Interview, on 11/07/13 at 1:20 PM, with the North Hall Unit Manager (UM) revealed the nurse assigned to Resident #3 was responsible for ensuring that the oxygen was flowing per the physician's order. The UM stated she also made daily rounds and checked Resident #3's oxygen flow rate and thought it was set at 2 Liters per minute, but she stated she had looked at the flow rate window from a standing position, and did not look directly at the flow rate window of the concentrator. The UM manager stated the inaccurate oxygen flow rate and lack of monitoring by the nurses could result in oxygen delivery that would not meet the resident's need for optimal blood oxygen concentrations. Interview, on 11/07/13 at 2:10 PM, with the Director of Nursing (DON), revealed the nurse(s) assigned to Resident #3 should have monitored the oxygen flow rate for accuracy with physician's order, and Resident #3's care plan was not followed since continuous oxygen therapy per the physician's order was a component of Resident #3's plan for comfort care.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 1. Resident # 3 oxygen flow rate was corrected on 11/7/2013 by the licensed nurse and the MD was notified with no new orders. Resident #3 was assessed by a licensed nurse on 11/7/2013 and it was determined that resident oxygen saturation remained at 97% and no negative effect was noted.		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

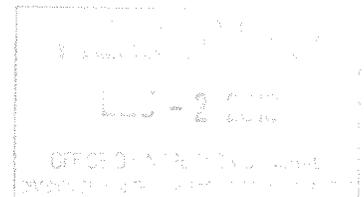
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy reviews, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of twenty (20) sampled residents, Resident #3. Multiple observations throughout the standard survey revealed oxygen therapy for Resident #3 was not delivered at the flow rate ordered by the physician. The findings include: Review of the Policy/Procedure for Delivery of Oxygen Therapy by Oxygen Concentrator (Revised 10/01/12) revealed oxygen flow rates were to be verified by the physician's order and the liter flow rate was to be documented once oxygen therapy was initiated. The policy/procedure did not reveal who was responsible for monitoring the flow rate for accuracy during the course of the therapy. Interview, on 11/07/13 at 4:15PM with the DON, revealed the facility could not provide a policy for following physicians' orders. Observation, on 11/07/13 at 9:05 AM revealed LPN #1 measured Resident #3's blood oxygen saturation rate and obtained a result of 98%. Review of the clinical record revealed the facility initially admitted Resident #3 to the facility on 03/14/08, discharged, and readmitted on 10/02/12 with diagnoses of Dementia,	F 309	2. Residents with oxygen noted on care plans were reviewed to determine that oxygen flow rates were set according to the residents plan of care on 11/7/2013 by the Director of Nursing, Assistant Director of Nursing and Unit Manager. No other concerns were identified. The Director of Nursing, Assistant Director of Nursing and Unit Manager completed an audit of resident care plans and the resident to determine that care plan interventions are provided in accordance with the plan of care and that necessary care and services are provided on what date. No other concerns were identified. 3. Nursing staff have been re-educated by the Assistant Director of Nursing as of 11/26/2013 on the importance of following the care plans including but not limited to providing the ordered flow rate with oxygen therapy and the requirement that necessary care and services are provided to maintain the highest practicable physical, mental, and psychosocial well-being for the residents. New employees will receive this education during orientation from the Assistant Director of Nursing on going. Nursing managers/supervisors were re-educated by the Assistant Director of Nursing on 11/7/2013 on monitoring for compliance with provision of services according to physician orders and the plan of care to ensure that necessary care and services are provided to maintain the		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 8</p> <p>Parkinson's Disease, Cerebral Atherosclerosis, Psychotic Disorder, Vision Impairment with a prosthetic left eye, Glaucoma, Hyperlipidemia, and Dysphagia. Further review of the clinical record revealed the physician ordered continuous oxygen therapy for Resident #3 to be delivered per nasal cannula at 2-4 liters per minute to keep blood oxygen saturation levels greater than 90% every shift, every day.</p> <p>Interview, on 11/05/13 at 8:25 AM, during initial tour of the North Hall unit with Licensed Practical Nurse (LPN) #5 revealed Resident #3 was to receive continuous oxygen therapy per nasal cannula at 2 liters per minute.</p> <p>Observation, on 11/05/13 at 11:05 AM, revealed Resident #3's oxygen flow rate was set at 1.5 Liters/minute. Further observations on 11/05/13 at 1:00 PM, and again at 3:50 PM revealed Resident #3's oxygen, per nasal cannula, continued to flow at 1.5 Liters/minute.</p> <p>Observations, on 11/06/13 at 8:00 AM, 8:40 AM, 10:00 AM, and 11:25 AM, revealed Resident #3 was abed, and oxygen therapy was delivered per nasal cannula at a flow rate of 1.5 Liters/minute.</p> <p>Observations, on 11/07/13 at 8:20 AM and 9:05 AM, revealed Resident #3 was abed and oxygen was being delivered, per nasal cannula, at 1.5 Liters/minute.</p> <p>Interview, on 11/07/13 at 9:07 AM, with LPN #1 revealed Resident #3's physician had ordered an oxygen flow rate of 2 Liters/minute, but upon inspection of the concentrator at Resident #3's bedside, LPN #1 stated the flow rate was set at 1.5 L/minute. LPN #1 further stated the oxygen</p>	F 309	<p>highest practicable physical, mental, and psychosocial well-being for residents including accuracy of oxygen flow rates.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or the Nursing Supervisors will complete an audit of 3 residents daily for two weeks (Monday thru Friday), three times a week for two weeks, weekly for two months, and then monthly for 3 months to determine compliance with the care plan and physician orders including oxygen flow rate to ensure that necessary care and services are provided to maintain the highest practicable physical, mental, and psychosocial well-being for residents. Any concerns identified will be addressed at that time. A summary of the audit findings will be submitted to the facility Performance Improvement Committee by the Director of Nursing monthly for six months for further review and recommendation.</p> <p>5. Date of Compliance is 11/27/2013</p>		



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

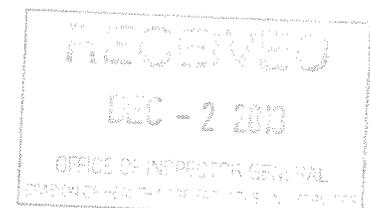
PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

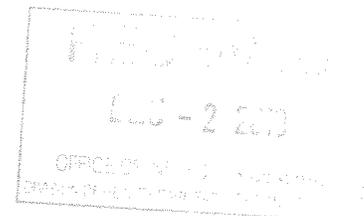
F 309	<p>Continued From page 9</p> <p>flow rate was supposed to be checked for accuracy every shift by the nurse assigned to Resident #3, but this was her first opportunity this shift to check the resident's oxygen flow rate.</p> <p>Interview, on 11/07/13 at 1:20 PM, with the North Hall Unit Manager (UM), revealed the nurse assigned to Resident #3 was responsible for ensuring that the oxygen was flowing at the rate ordered by the physician. The UM stated she also made daily rounds and checked Resident #3's oxygen flow rate and she thought it was set at 2 Liters per minute, but she further stated she had looked at the flow rate window from a standing position, and did not look directly at the flow rate window of the concentrator. The UM stated an inaccurate oxygen flow rate and task of monitoring by the nurses could result in oxygen delivery that would not meet the resident's needs for optimal blood oxygen concentrations. The UM stated nurses were in-serviced monthly on various nursing practices and standards of care, but she could not remember exactly when the nurses had last received an in-service on oxygen therapy and the associated resident care.</p> <p>Interview, on 11/07/13 at 2:10 PM, with the Director of Nursing (DON) revealed the nurse(s) assigned to Resident #3 should have monitored the oxygen flow rate for accuracy to the physician's order. He/she should have contacted the UM regarding any questions or concerns with Resident #3's oxygen therapy. Further, the DON stated licensed nurses were provided in-service for the required competencies related to the delivery and management of oxygen therapy.</p>	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

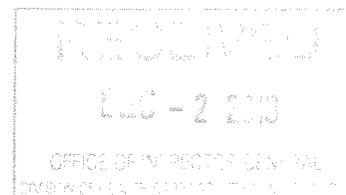
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 10 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 1. Resident #1 was assessed by a licensed nurse on 11/7/2013 to determine any signs of infection or adverse effects with no concerns identified. LPN #3 was re-educated by the Director of Nursing and Assistant Director of Nursing to the Infection Control Policy including trach care, hand washing procedures and the use of gloves on 11/7/2013. LPN #3 was observed by Assistant Director of Nursing on 11/8/2013 for infection control practices during trach care to determine compliance. No further concerns were identified. 2. An assessment of current residents was completed by Director of Nursing and Assistant Director of Nursing on 11/8/2013 to determine any adverse effects from infection control practices including trach care, hand washing and the use of gloves. No concerns were identified.		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

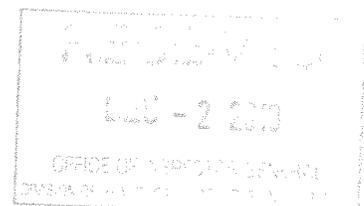
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the staff followed the Infection Control Program for one (1) of twenty (20) sampled residents. Resident #1. The staff failed to ensure they washed their hands utilizing sterile technique during tracheostomy (trach) care for Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Tracheostomy Care, revised 10/01/12, revealed the soiled dressing and inner cannula should be removed, hands should then be cleansed, followed by set up of the sterile trach kit.</p> <p>Review of the facility's policy regarding Hand Hygiene, revised 10/01/13, revealed hands should be washed with soap and water after removing gloves. Additionally, hands should be decontaminated with soap and water before putting on gloves.</p> <p>Review of the facility's Licensed Nurse Orientation Checklist, dated 09/2013, revealed respiratory treatments and procedures, infection control, competency evaluation, and wound care were included; however, trach care was not specifically identified on the orientation checklist in any category.</p> <p>Review of the Infection Control Process Surveillance Monitoring Tool, not dated, revealed hand hygiene, use of sterile gloves and materials, and avoidance of contamination of sterile procedures were all included for monitoring.</p>	F 441	<p>3. Licensed nursing staff have been re-educated by the Assistant Director of Nursing as of 11/27/13 on the Infection Control Practices including trach care, hand washing, and appropriate use of gloves. Newly hired licensed nurses will be educated by the Assistant Director of Nursing on Infection Control practices including trach care, hand washing, and glove use during orientation ongoing.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or the Nursing Supervisors will conduct infection control audits daily for two weeks (Monday thru Friday), weekly for two months, and then monthly for 3 months to determine compliance with infection control policies and procedures including trach care, hand washing practices, and glove use. Any concerns identified will be addressed at that time. A summary of the audit findings will be submitted to the facility Performance Improvement Committee for six months for further review and recommendation.</p> <p>5. Date of Compliance is 11/27/2013</p>	



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

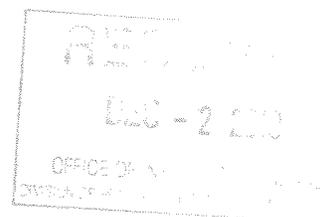
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 The facility did not provide evidence of a training program in trach care for nurses. Additionally, the facility did not provide evidence of having used the Infection Control Process Surveillance Monitoring Tool, nor evidence of any monitoring of trach care. Review of the clinical record for Resident #1 revealed the facility re-admitted the resident 12/16/12 with a diagnosis of Neoplasm of the Respiratory System. The resident's November 2013 orders included trach care every shift every day. Observation, on 11/01/13 at 7:47 AM, revealed Licensed Practical Nurse (LPN) #3 washed her hands, put on gloves, and set up the sterile trach kit. The LPN then picked up and carried the trash can closer to her, changed gloves, and removed the inner cannula and soiled dressing. The nurse cleaned the trach site, removed the soiled gloves, and then put on sterile gloves to finish the procedure. Interview with LPN #3, on 11/01/13 at 1:20 PM, revealed trach care was a sterile technique and hands should be washed prior to putting on sterile gloves. The LPN stated she did not want to leave the sterile field that was in place. The nurse indicated she did not remember if the facility had provided training on trach care, or provided guidance on what to do if hands needed to be cleaned after the sterile field had been set up for use. The LPN stated the Assistant Director of Nursing (ADON), who was also the Staff Educator, conducted competencies for nursing skills; however, there was not a competency for trach care. The LPN stated a trach was	F 441		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

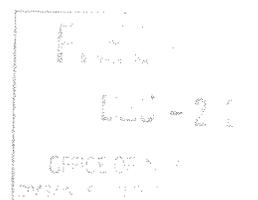
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 13</p> <p>susceptible to infection and without washing hands before conducting a sterile procedure the resident could get an infection.</p> <p>On 11/01/13 at 3:39 PM, interview with the ADON revealed she was also the Staff Educator and the Infection Control Nurse. The ADON stated trach care would be a sterile technique. She stated hands should be cleansed with hand sanitizer or soap and water after changing a dressing, and before donning sterile gloves. She stated new nurses were mentored on the floor with a seasoned nurse, similar to a preceptor, and trach care should be part of that training. The ADON indicated she had not conducted any trach care education since she began working at the facility in June 2013. She also stated she was responsible to monitor and conduct observations of trach care if it was being conducted while she was on the unit. The ADON indicated she did not document monitoring of trach care, nor was there a schedule to monitor trach care. She revealed if hands were not washed prior to a sterile procedure, the resident could get an infection. She also stated a trach was an open site and was at risk of infection.</p> <p>Interview, on 11/01/13 at 4:03 PM, with the Director of Nursing (DON) revealed trach care was a sterile technique and hands should be washed prior to putting on sterile gloves. She also indicated hands should be washed each time before putting on gloves and any time gloves were removed. The DON stated nurses received training on trach care during orientation and as needed. She stated the ADON as the Nurse Educator and Infection Control Nurse was responsible for training and monitoring trach care, including the infection control surveillance audits.</p>	F 441		



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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 The DON stated she was unaware when the last time trach care had been monitored and was unsure if there was a schedule for monitoring trach care. She indicated the infection control surveillance did not specify trach care and was a broad infection control monitoring tool. The DON revealed she did not have any evidence of training or monitoring related to trach care.	F 441		



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III, unprotected construction.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet and dry sprinkler system.</p> <p>GENERATOR: Type II 55KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/06/13. Regency Care and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and ten (110) certified beds and the census was ninety-six (96) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction for Regency Center 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."</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diane Harrett</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/29/13</i>
---	-------------------------------	------------------------------

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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.

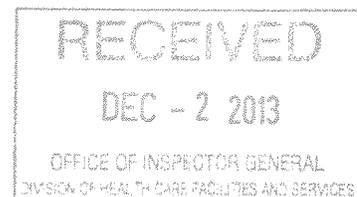
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Fire)	K 000		
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/07/13 at 2:47 PM, with the Maintenance Director and the Maintenance Assistant revealed the fire resistant, rated smoke</p>	K 025	<p>K 025</p> <ol style="list-style-type: none"> 1. The West Hall smoke barrier next to resident room 201 was filled with a Red 3M regulated fire caulk on 11/7/13 by the Maintenance Director. 2. On 11/7/13 all remaining smoke barriers were checked by the Maintenance Director and Maintenance Assistance for any other penetrations. No other areas were identified. 3. The Maintenance Director and Maintenance Assistant were re-educated on the requirements to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA 101 Life Safety Code by the Administrator on 11/20/13. 	



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

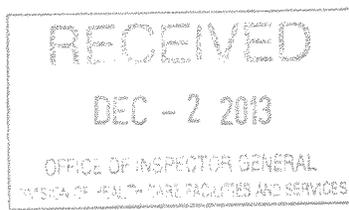
PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 025	<p>Continued From page 2</p> <p>barrier located in the West Hal next to Resident Room 201, had been penetrated above the ceiling by newly installed electrical conduit. The space around the penetrations had not been filled with a material rated equal to the smoke barrier and could not resist the passage of smoke in the event of an emergency.</p> <p>Interview, on 11/07/13 at 2:47 PM, with the Maintenance Director and the Maintenance Assistant revealed they were unaware of the penetration in the smoke barrier and acknowledge it would not resist the passage of smoke in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 	K 025	<p>4. The Maintenance Director or Maintenance Assistant will monitor smoke barriers and record findings using Maintenance audit tool on daily rounds x5 days and then weekly x7 weeks, and then monthly x4 months to determine that all smoke barriers are intact. Any concerns identified will be addressed at that time. The Administrator will report a summary of findings to the monthly Performance Improvement Committee for six months for further review and recommendation.</p> <p>5. Date of compliance 11/27/13</p>	
-------	--	-------	---	--



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 025 Continued From page 3
2. Be made by an approved device designed for the specific purpose.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, the Administrative Staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-six (96) on the day of the survey.

The findings include:

Observation, on 11/06/13 at 1:08 PM, with the Maintenance Director and Maintenance Assistant revealed the door to the Supply Room located in the Reception Area did not have a self-closing device installed on the door. Office supplies and

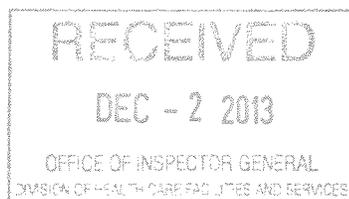
K 025

K 029

K029
1. The Maintenance Director installed a self-closing devise to the Supply Room located in the Reception Area on 11/12/13.

2. On 11/7/2013 Maintenance Director inspected all remaining fire walls and doors in the center to determine compliance with NFPA 101 Life Safety Code Standard including the presence of self-closing devices on other doors as required. No other areas were identified.

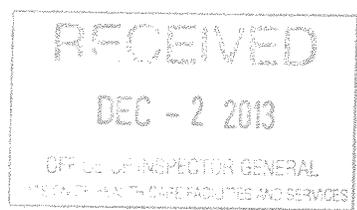
3. The Maintenance Director and Maintenance Assistant were re-educated on 11/20/13 on the requirements for Protection of Hazards in accordance with NFPA standards by the Administrator.



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 paper were stored on wooden shelves. Interview, on 11/06/13 at 1:08 PM, with the Maintenance Director and the Maintenance Assistant revealed they were not aware the door to the Supply Room was not equipped with a self-closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or	K 029	4. The Maintenance Director or Maintenance Assistant will monitor fire walls and doors to record findings using maintenance audit tool on weekly rounds X4 weeks and then monthly X5 months to determine compliance with Protection of Hazards including self-closing devices on doors as indicated in the NFPA standards. A summary of findings will be reported to the Performance Improvement Committee by the Maintenance Director, monthly times 6 months for review and further recommendation. 5. Date of compliance 11/27/13.	



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 029 Continued From page 5
combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 029

K 038 K 038

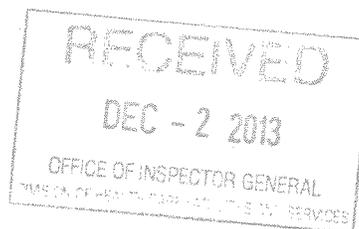
1. On 11/11/13 the exit access doors located in the large Storage Room at the end of North Hall and the adjacent Physical Therapy department door were signed with proper instructions for a delayed egress door by the Maintenance Director.

2. On 11/7/13 Maintenance Director and Maintenance Assistant inspected all remaining egress doors to determine doors with delayed egress had the proper signage displayed in compliance with NFPA 101 Life Safety Code Standard. No other areas were identified.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately thirty-five (35) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-six (96) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had the proper signage displayed.

The findings include:

Observations, on 11/06/13 between 10:17 AM and 10:38 AM, with the Maintenance Director and



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

K 038 Continued From page 6

Maintenance Assistant revealed the exit access doors located in the large Storage Room located at the end of the North Hall and the adjacent Physical Therapy Department were equipped with delayed egress locks, but did not display the proper signage on the doors.

Interviews, on 11/06/13 between 10:17 AM and 10:38 AM, with the Maintenance Director and Maintenance Assistant revealed they were not aware the two (2) delayed egress doors did not display the proper signage required for doors equipped with delayed egress.

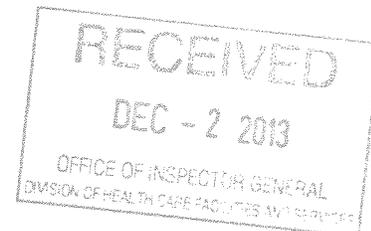
Reference:
NFPA 101 (2000 edition)

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat

K 038

3. The Maintenance Director and Maintenance Assistant were re-educated on 11/11/13 by the Administrator on the requirements that an irreversible process shall release the lock within 15 second upon application of a force to the release device the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 in in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. As of 11/26/13 all staff including Nursing, Dietary, Activities, Social Services, Therapy, Maintenance, Housekeeping and Administration were educated by the Maintenance Director and Assistant Director Nursing on delayed egress doors.



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

K 038 Continued From page 7
detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

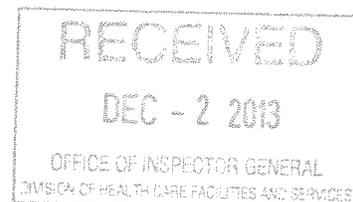
(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:
PUSH UNTIL ALARM SOUNDS
DOOR CAN BE OPENED IN 15 SECONDS

K 038 4. The Maintenance Director or Maintenance Assistant will monitor egress doors and record findings using maintenance audit tool on weekly rounds X4 weeks and then monthly X5 months to determine compliance with exit access is arranged so that exits are readily accessible at all times in accordance with NFPA standards. A summary of findings will be reported to the Performance Improvement Committee by the Maintenance Director, monthly times 6 months for review and further recommendation.

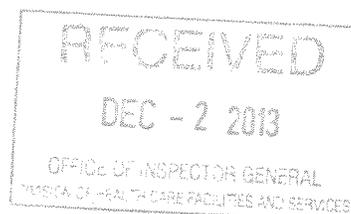
5. Date of compliance 11/27/13



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

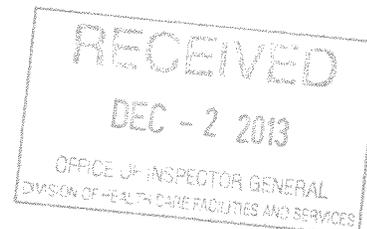
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 8 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety (90) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge. The findings include: Observation, on 11/06/13 between 10:17 AM and 10:38 AM, with the Maintenance Director and	K 045	K. 045 1. On 11/20/2013 contractor, Advanced Mechanical installed two bulb light fixtures located above the exit from the large storage room at the end North Hall and above the adjacent Physical Therapy Department exit door. 2. On 11/7/13 Maintenance Director and Maintenance Assistant inspected all remaining egress doors to determine if the lighting provided other areas were identified. 3. 11/20/13 Maintenance Director and Maintenance Assistant were educated on the Illumination of Means of Egress in accordance with NFPA 101 by the Administrator.	



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

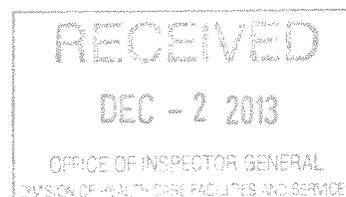
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 045	<p>Continued From page 9</p> <p>Maintenance Assistant revealed the exits from the large storage room at the end of the North Hall and the adjacent Physical Therapy Department, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exits were equipped with light fixtures containing one bulb.</p> <p>Interview, on 11/06/13 between 10:17 AM and 10:38 AM, with the Maintenance Director and the Maintenance Assistant revealed they were not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of</p>	K 045	<p>4. The Maintenance Director or Maintenance Assistant will audit egress doors in regards to proper illumination and record findings using maintenance audit tool on weekly rounds X4 weeks and then monthly X5 months to determine compliance with NFPA standards. A summary of findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times 6 months for review and further recommendation.</p> <p>5. Date of compliance 11/27/13</p>



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 10 occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	K147 1. Refrigerator found plugged into a power strip located in resident room 106 was removed and was plugged directly into the electrical wall outlet on 11/11/2013 by the Maintenance Director. 11/11/2013 resident residing in room 106 was educated on the usage of power strips with the use of a refrigerator by the Administrator and Maintenance Director. 2. On 11/7/2013 Maintenance Director and Maintenance Assistant inspected all remaining rooms to determine if remaining refrigerators were plugged into the recommended outlet in compliance with NFPA 101 Life Safety Code. No other areas were identified.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147		



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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2013
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 147	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/06/13 at 9:40 AM, with the Maintenance Director and the Maintenance Assistant revealed a refrigerator was plugged into a power strip located in Resident Room 106.</p> <p>Interview, on 11/06/13 at 9:40 AM, with the Maintenance Director and Maintenance Assistant revealed they were aware of the requirements for the usage of power strips; however, they were not aware of the resident's refrigerator being plugged into a power strip located in Room 106.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>3. On 11/20/2013 a letter was sent to current residents and responsible parties with information regarding the appropriate use of power strips in a LTC setting by the Administrator. As of 11/26/13 all staff including Nursing, Dietary, Activities, Therapy, Maintenance, Housekeeping, Social Services and Administration were educated on the appropriate use of power strips in a LTC setting by the Assistant Director of Nurses.</p> <p>4. The Maintenance Director or Maintenance Assistant will audit resident rooms for power strip usage and record findings using maintenance audit tool on weekly rounds X4 weeks and then monthly X5 months to determine compliance with NFPA standards with reference to minimum number of receptacles so as to avoid the need for extension cords or multiple outlet adapters. A summary of findings will be submitted to the Performance Improvement Committee by the Maintenance Director monthly x6 months for further review and recommendation.</p> <p>5. Date of compliance 11/27/2013.</p>

