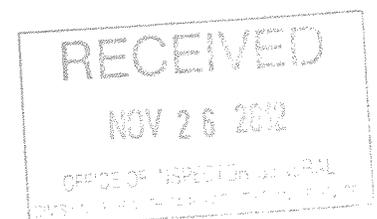




DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2012  
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 10/31/2012	
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 1</p> <p>a routinely scheduled medication is withheld or refused, the nurse is to initial and circle the initials on the resident's MAR in the space provided for that dosage administration. An explanatory note is then to be placed in the nursing notes or on the back of the MAR.</p> <p>Interview with Resident #1, on 10/31/12 at 11:17 AM, revealed the eye drops were not given as ordered. Resident #1 stated there were several doses that had been missed, particularly the ones due at 6:00 PM. He/She stated the drops were important due to recent eye surgery.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 04/10/08 with diagnoses of Osteoarthritis, Hypertension, Anemia and Glaucoma. The facility completed a Resident Assessment on 08/22/12 and determined Resident #1 was cognitively intact. Resident #1 had surgery on 10/08/12 to relieve pressure which affected the nerves in the eyes (Glaucoma). Post operatively the physician wrote orders for a steroid eye drop (Pred Forte 1%) every three hours while awake and an eye drop for temporary relief of corneal edema (Muro 128) three times a day.</p> <p>Review of the Medication Administration Record (MAR) for Resident #1 revealed the following doses of Pred Forte 1% were not initialed as given: 10/13/12 - 12 AM, 3 AM, 6 AM; 10/19/12 - 12 PM; 10/22/12 - 6 AM, 6 PM; 10/23/12 - 6 PM; 10/26/12 - 3 PM, 6 PM; and 10/29/12 - 12 AM. The following doses of Muro 128 were not initialed as given: 10/08/12 - 4 PM; 10/21/12 - 4 PM; 10/27/12 - 12 AM; and 10/28/12 - 12 AM.</p>	F 309	<p>Administration Records 3x/week x 4 weeks, weekly x 8 weeks and then monthly x3 months to determine that medications are administered as ordered and/or documentation to explain why the medication was withheld is completed. Any concerns identified will be addressed when identified. A summary of audit findings will be submitted to the Administrator and Director of Nursing when completed for review and further recommendation. The Director of Nursing will submit a summary of these audits to the Performance Improvement Committee monthly x6 months review and further recommendation to sustain compliance.</p> <p>5. Compliance date 11-20-12</p>	



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F 309	<p>Continued From page 2</p> <p>Interview with LPN #1, on 10/31/12 at 6:00 AM, revealed if a dose of medication was not given the MAR was initialed and a circle put around the initials indicating the medication was not given.</p> <p>Interview with LPN #3, on 10/31/12 at 3:25 PM, revealed if a dose of medication was missed or refused she would initial the dose on the MAR and then circle her initials and chart in the nurses notes the reason for the missed dose and would contact the MD and family member to inform them of the missed dose. She stated that anytime there was a missed dose of medication there was the potential for negative consequences.</p> <p>Interview with LPN #2, on 10/31/12 at 3:40 PM, revealed missed doses of medication could have negative consequences for the resident. She stated that if a box on the MAR was left empty it appeared the medication was not given.</p> <p>Interview with DON, on 10/31/12 at 3:50 PM, revealed after a medication was administered to a resident the nurse would review the MAR and initial the medications administered. If the medication was refused, the nurse would initial and circle the initials. The nurse would then document the reason the medication was not given and document who was notified of the missed dose. She stated if there are blank spaces on the MAR it appeared the medication was not given. The DON stated any missed dose of medication could have a negative impact on the resident. She stated the system had been broken and the facility needed to work on better documentation.</p>	F 309		

