

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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 000	INITIAL COMMENTS	F 000	

F 243  
SS=E

A standard and abbreviated health survey investigating KY #00014598 and KY #00014615 were conducted 05/25/10 through 05/27/10. The facility was found to not meet minimum requirements with deficiencies cited at the highest scope and severity of an "E". The facility has the opportunity to correct the deficiencies before remedies would be recommended for imposition. Complaint KY #00014598 was found to be unsubstantiated and KY #00014615 was found to be substantiated with deficiencies cited.

483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP

A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review it was determined the facility failed to allow Resident Council meetings to be held in private.

The findings include:

During a group interview with Resident Council members during the standard survey, Resident #27 stated that the Resident Council had met

F 243

1. A resident council meeting was held on June 17, 2010, to inform the resident's that they have the right to organize and participate in a resident group. At this meeting the resident's were informed that if the counsel wanted a staff member to attend, that staff member had to be invited to attend the meetings.

2. Resident's residing in the center have the potential to be affected.

3. The Administrator will receive a list from the resident council president listing the staff members they would like to be present at their meeting. Residents will be provided a private location to meet in the activities room

4. The Activities Director will discuss any issues brought forward at the resident council meetings during the monthly Performance Improvement Committee meeting for review X 3 months to ensure sustained compliance.

5. Date of Compliance 6/26/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

*[Signature]*

X Administrator X 6-18-2010

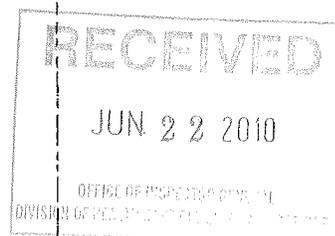
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

SN

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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 243	Continued From page 1  privately at one time but the council was then told that a staff member would need to be present at the meetings.  Review of the Resident Council meeting minutes dated 02/09/10 revealed four (4) staff members were present during the meeting. Resident Council meeting minutes dated 03/09/10 and 04/07/10 revealed evidence of five (5) staff members present.  Interview with the Activity Director, on 05/26/10 at 11:50am, revealed the Resident Council did not meet privately and this occurred prior to his employment (July 2009). He stated the change may have occurred due to some of the council members having strong personalities, such as Resident #27, and the group meeting could get out of control.  Interview with the Assistant Activity Director, on 05/26/10 at 12:30pm, revealed the prior Activities Director made the decision to have staff present during Resident Council meetings. She stated the meetings would get out of control due to some residents having strong personalities, so staff needed to be present to keep residents on task.  Interview with the Resident Council President, Resident #28, on 05/27/10 at 10:00am revealed the resident was unaware the council could meet privately.  Interview with Resident Council Vice President, Resident #27, on 05/27/10 at 10:35am, revealed it had been less than a year since the council was told that staff would need to be present in resident council meetings.	F 243			



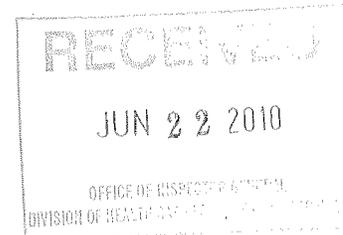
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

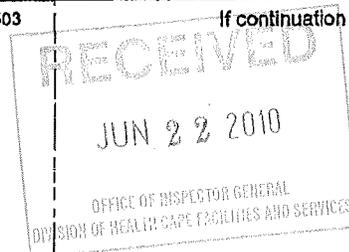
F 243	Continued From page 2	F 243		
F 282 SS=D	<p>Interview with the Administrator on 05/27/10 at 4:00pm revealed she had notified the Resident Council of their right to meet privately. However, council members, during group, revealed they were not aware of the facility policy, Resident Council, dated 12/09 which stated staff or visitors may attend meetings of the resident council at the group's invitation.</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 and record review it was determined the facility failed to implement the Care Plan for one (1) of twenty-eight (28) sampled residents. Resident #6 had interventions on the care plan to include the use of splints and Range of Motion during care that were no longer being provided to the resident and staff were not aware Resident #6 had those interventions in place.</p> <p>The findings include: A review of the medical record for Resident #6 revealed an admission date of 07/23/09 with diagnoses including; Traumatic Brain Injury, convulsions, and pressure wounds. The annual Minimum Data Set (MDS) assessment dated 08/05/09 and Quarterly MDS dated 05/07/10 revealed Resident #6 had a cognition level as 3,</p>	F 282	<p><b>F 282</b></p> <p>1. The Care Plan of resident #6 was updated on 5/29/10 to reflect that the splints were discontinued on 9/9/09. The CNA care plan for resident #6 was updated to include ROM during care on 5/29/10.</p> <p>2. A record review of residents care plans and CNA care cards will be completed on or before 6/25/10 to ensure splints and ROM programs are updated to reflect the current plan of care.</p> <p>3. Nursing Staff were re-educated before 6/25/10 by the SDC regarding updating and implementing interventions on the care plan and CNA care cards to ensure resident's needs are being met.</p>	



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

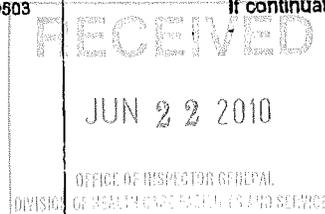
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(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 3	F 282			
	<p>severally impaired. The medical record revealed the resident was in a "semi-vegetative state". The MDS assessment revealed Resident #6 had a functional limitation of Range of Motion on both sides to all extremities with full loss.</p> <p>Observation of Resident #6 on 05/25/10 at 11:45am revealed the resident was on a Dermafloat air mattress. The resident's eyes were open but the resident did not respond to verbal stimuli. There were fall mats on both sides of the bed. The resident had contractures to the arms, hands, wrists, legs, and feet. There were no splints in place.</p> <p>Observation of Resident #6 on 05/26/10 at 2:00pm revealed the resident in the bed. Staff were assisting the resident. The resident had a helmet in place that was worn when the resident was up in a chair. The resident had stiffness to all extremities. There was no observation of range of motion by the facility staff.</p> <p>A review of the care plan for Resident #6 revealed an intervention to apply splints as ordered, initiated on 07/23/09. Another intervention initiated on 07/23/09 stated; remove the splint for care and check skin, and further intervention identified on the Care Plan dated 07/23/09 was to do active/passive range of motion during care. The nurse aide care plan initiated on 03/20/10 did not include splint application, but did have hand roll checked. The nurse aide care plan did not contain information that included active/passive range of motion during care.</p> <p>An Interview with Licensed Practical Nurse #4 on 05/27/10 at 7:30am revealed that Resident #6 did</p>		<p>4. The Unit Managers will validate that the care plan and CNA care cards have been updated to include needed interventions. The UM will review findings with clinical team at morning meeting. The ADNS/DNS will review fifteen (15) charts per week for three (3) weeks, and then monthly for three (3) months to validate accuracy of CNA care cards and nursing Care Plans. Findings will be reported to the Performance Improvement Committee monthly X 3 months to ensure sustained compliance.</p> <p>5. Date of Compliance 6/26/2010</p>		



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

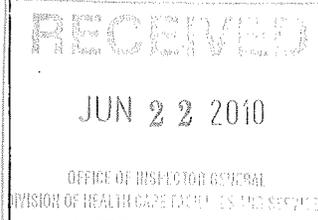
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/27/2010
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 4  not wear any splints or rolls to the hands.  An interview with Certified Nursing Assistant (CNA) #1 on 05/27/10 at 8:15am revealed she believed that Resident #6 wore splints to the legs for two (2) hours a day. She also stated that as far as she knew the resident did not get range of motion. The CNA stated the Therapy Department in-services the staff on Range of Motion for the residents.  An interview with the Assistant Director of Nursing (ADON), who was previously the Unit Manager for the 100 hall, on 05/27/10 at 3:30pm, revealed she did attend the Care Plan meetings. She stated they went over the residents' problems and goals but did not go over each intervention. She stated that the nurse who took the order off should have reviewed the care plan for updates. The ADON also stated that they started using a new system this year in which the MDS staff are putting care plan revisions in the new computer system. She continued to say they are bringing the 24 hour reports to the care plan meetings and any new orders written on the resident is reviewed there. The ADON stated that the splints for Resident #6 were discontinued because they were causing skin problems. The ADON was unaware the intervention for range of motion for Resident #6 during care was not on the CNA care plan. The ADON stated the Therapy Department did in-services with the CNA's to ensure they were educated on Restorative Range of Motion. The ADON stated it is important that the interdisciplinary care plans and CNA care plans be updated to ensure the residents are receiving the care they need.  A review of the Therapy notes revealed there had	F 282			



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

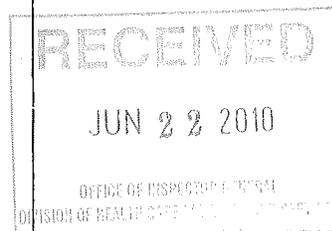
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/27/2010
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5	F 282		
F 318 SS=D	<p>been training sessions regarding positioning, adaptive equipment, and range of motion for Resident #6 in August, September, and October of 2009.</p> <p>Interview with CNA #2 on 05/27/10 at 3:15pm revealed she was aware Resident #6 was to get range of motion during care. She stated that Therapy had in-serviced on Range Of Motion for this resident and she provided 10 repetitions on each extremity on the three days she works.</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure that residents with a limited range of motion receive appropriate treatment and services to increase range of motion or prevent further decrease in range of motion for one (1) of twenty-eight (28) sampled residents. Resident #6 had interventions on the care plan to include Range of Motion during care, and staff did not consistently provide services to Resident #6.</p> <p>The findings include:  A review of the medical record for Resident #6</p>	F 318	<p><b>F-318</b></p> <ol style="list-style-type: none"> <li>1. The CNA care card for resident # 6 was been updated on 5/29/10 to include ROM with care to ensure that services are provided.</li> <li>2. Residents with limited range of motion have been identified and reviewed on 6/17/10 by DNS/Therapy Program Manager, (TPM), by utilizing MDS 2.0, physician orders, care plans, and CNA care plans to ensure they receive appropriate treatment and services as needed to prevent further decrease in range of motion.</li> <li>3. Nursing staff were re-educated before 6/25/10 by the SDC regarding performing active and passive range of motion to increase/prevent decrease in range of motion. The care plan and CNA care cards of residents identified with limited range of motion will include passive/active range of motion as an intervention.</li> <li>4. The Unit Managers will monitor range of motion weekly x 3 months to ensure that programs are implemented a planned. A summary of weekly</li> </ol>	



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

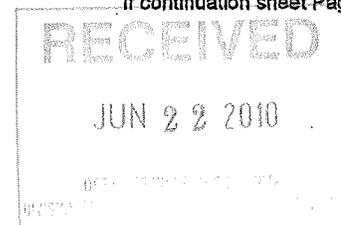
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/27/2010
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	Continued From page 6	F 318			
	<p>revealed an admission date of 07/23/09 with diagnoses including; Traumatic Brain Injury, convulsions, and pressure wounds. The annual Minimum Data Set (MDS) assessment dated 08/05/09 and Quarterly MDS dated 05/07/10 revealed Resident #6 had a cognition level of 3, severely impaired. The medical record revealed the resident was in a "semi-vegetative state". The MDS assessment revealed Resident #6 had a functional limitation of range of motion on both sides to all extremities with full loss.</p> <p>Observation of Resident #6 on 05/25/10 at 11:45am revealed the resident was on a Dermafloat air mattress. The resident's eyes were open but the resident did not respond to verbal stimuli. There were fall mats on both sides of the bed. The resident had contractures to the arms, hands, wrists, legs, and feet. There were no splints in place.</p> <p>Observation of Resident #6 on 05/26/10 at 2:00pm revealed the resident in bed. Staff were assisting the resident. Resident #6 had a helmet in place that was worn when the resident was up in a chair. The resident had stiffness to all extremities. There was no observation of range of motion by the facility staff.</p> <p>A review of the care plan for Resident #6 revealed an intervention to apply splints as ordered, initiated on 07/23/09. Another intervention initiated on 07/23/09 stated, remove the splints for care and check the skin, and further intervention identified on the Care Plan dated 07/23/09 was to do active/passive range of motion during care. The nurse aide care plan initiated on 03/20/10 did not include splint application, but did have hand roll checked. The</p>		<p>reviews will be reported to the Performance Improvement Committee monthly X 3 months for review to ensure sustained compliance.</p> <p>5. Date of Compliance 6/26/2010</p>		



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

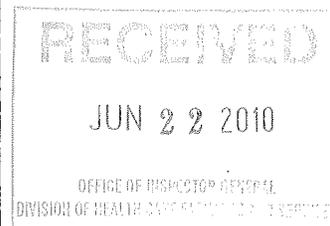
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/27/2010
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	Continued From page 7	F 318			
	<p>nurse aide care plan did not contain information that included active/passive range of motion during care.</p> <p>An Interview with Licensed Practical Nurse #4 on 05/27/10 at 7:30am revealed that Resident #6 did not wear any splints or rolls to the hands.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 05/27/10 at 8:15am revealed she believed that Resident #6 wore splints to the legs for two (2) hours a day. She also stated that as far as she knew the resident did not get range of motion. The CNA stated the Therapy Department in-services the staff on range of motion for the residents.</p> <p>An interview with the Assistant Director of Nursing (ADON), who was previously the Unit Manager for the 100 hall, on 05/27/10 at 3:30pm, revealed she did attend the Care Plan meetings. She stated they went over the resident's problems and goals but did not go over each intervention. She stated that the nurse who took the order off should have reviewed the care plan for updates. The ADON also stated that they started using a new system this year in which the MDS staff are putting care plan revision in the new computer system. She continued to say they are bringing the 24 hour reports to the care plan meetings, and any new orders written on the resident is reviewed there. The ADON stated that the splints for Resident # 6 were discontinued because they were causing skin problems. The ADON was unaware the intervention for range of motion for Resident #6 during care was not on the CNA care plan. The ADON stated the Therapy Department did in-services with the CNA's to ensure they were educated on Restorative Range of Motion. The</p>				



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

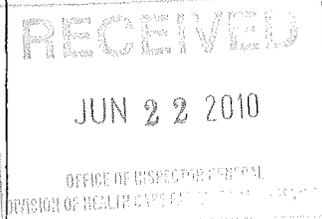
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/27/2010
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
<del>F 318</del>	<del>Continued From page 8</del>	<del>F 318</del>			
F 334 SS=E	<p>ADON stated it is important that the interdisciplinary care plans and CNA care plans be updated to ensure the residents are receiving the care they need.</p> <p>A review of the Therapy notes revealed there had been training sessions regarding positioning, adaptive equipment, and range of motion for Resident #6 in August, September, and October of 2009.</p> <p>Interview with CNA #2 on 05/27/10 at 3:15pm revealed she was aware Resident #6 was to get range of motion during care. She stated that Therapy had in-serviced on Range of Motion for this resident and she provided 10 repetitions on each extremity on the three days she works.</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that –</p> <ul style="list-style-type: none"> <li>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</li> <li>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</li> <li>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</li> <li>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:             <ul style="list-style-type: none"> <li>(A) That the resident or resident's legal</li> </ul> </li> </ul>	F 334	<p><b>F-334</b></p> <p>1. The families and doctors for resident #1, 6, 11, and 13 were notified on 6/16/10 that Flu Vaccines had not been administered as recommended for the 2009 Flu Season. When notified via telephone, the POA for resident #13 stated that the Flu vaccination had been given to resident in October 2009 while in hospital. Residents #6 and #22 were administered the Pneumococcal vaccine on 6/16/10. Resident #7 was discharged on 6/10/10. The POA for resident #13 stated Resident had been given the Pneumococcal vaccine by family physician in 2008.</p> <p>2. A review of resident vaccination consent forms and MAR's will be completed on 6/18/10 to identify potential residents affected. The attending physician's and families will be notified and vaccines administered accordingly.</p>		



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(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 334	Continued From page 9	F 334	<p>3. The Infection Control Nurse and licensed nurses have been re-educated to the facility Immunization Program on 6/25/10 by SDC. An immunization binder has been developed to store resident Flu and Pneumococcal Vaccination information and to be maintained by the Infection Control nurse.</p> <p>4. A review of immunization consents and administration will be completed by the DNS/ADNS monthly X 3 months. Findings will be reported to the Performance Improvement Committee monthly X 3 months for review to ensure sustained compliance.</p> <p>5. Date of Compliance 6/26/2010</p>		
	<p>representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative</p>				



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/27/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>
---	---

(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 334	Continued From page 10	F 334		
-------	------------------------	-------	--	--

refuses the second immunization.

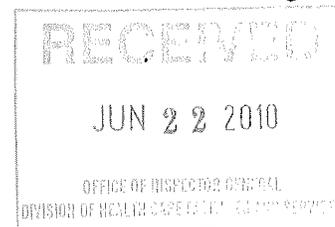
This REQUIREMENT is not met as evidenced by:  
Based on record review and interview it was determined the facility failed to ensure each resident was offered and received, as desired, an Influenza (Flu) and Pneumococcal (Pneumovax) vaccine. Residents #1, #6, #11, and #13 had signed consents for the influenza vaccine but did not receive the vaccine. Residents #6, #7, #13, and #22 had signed consents for the Pneumococcal vaccine but did not receive the vaccine.

The findings include:

Review of the medical record for Resident #1 revealed an admission date of 04/25/09. The record revealed a signed consent for the influenza vaccine. The vaccination record for Resident #1 revealed the resident did not receive the influenza vaccine.

Review of the medical record for Resident #6 revealed an admission date of 07/23/07. There was a signed consent form for the resident to receive the Flu and Pneumovax vaccine. Review of the vaccination record revealed no documentation of either vaccine administered. The facility staff were unable to locate any documentation that the resident had received either vaccine.

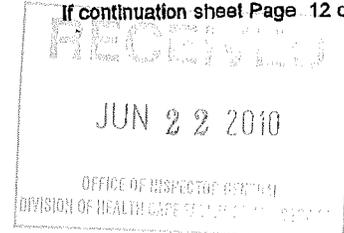
A review of the medical record for Resident #7



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

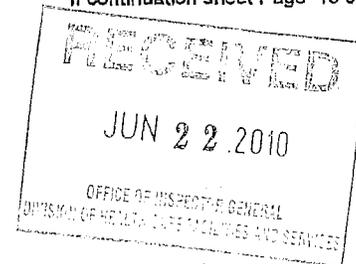
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4804 LOWE RD LOUISVILLE, KY 40220</b>		
(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 334	Continued From page 11	F 334			
	<p>revealed an admission date of 02/27/10. There was a signed consent form for the resident to receive the Flu and Pneumovax vaccine. However, review of the vaccination record revealed no documentation of either vaccine administered. The facility staff were unable to locate any documentation that the resident had received either vaccine.</p> <p>Review of the medical record for Resident #11 revealed an admission date of 01/25/08. The medical record revealed a signed consent for the annual Flu vaccine. However, there was no documentation in the medical record that Resident #11 received the Annual Flu vaccine.</p> <p>Review of the medical record for Resident #13 revealed an admission date of 01/14/10. There was a signed consent form on the medical record for the resident to receive the Flu and Pneumovax vaccine. However, there was no documentation in the medical record that the resident received either vaccine.</p> <p>Review of the medical record for Resident #22 revealed an admission date of 02/27/10. The medical record revealed a signed consent for the Pneumovax vaccine but there was no documentation that the resident received the Pneumovax vaccine.</p> <p>An interview with the Director of Nursing (DON) on 05/27/10 at 3:00pm revealed that the nurses working the units do the admissions and are responsible to ensure the vaccines and TB skin test are transcribed to the medication record; and given in a timely manner. The DON could not explain why the vaccines were not given. When the surveyor asked if the Infection Control</p>				



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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 12	F 334			
F 425 SS=D	<p>Coordinator was monitoring the immunization program per facility policy, she stated she would. The Infection Control Coordinator was out of town and unable to be reached for an interview during the standard survey.</p> <p>An interview with the Assistant Director of Nursing (DON), formally the Unit Manager, on 05/27/10 at 3:30pm revealed all the nurses, including herself, are educated on vaccine administration and documentation. She also stated that the Unit Managers do audits on all new admissions for assessments and review the vaccine records. She could not give a reason as to how these vaccines were missed.</p> <p>Facility policy on the Immunization Program implemented in January 2008 revealed the Infection Control Coordinator is responsible for the immunization program. The policy also stated there would be ongoing audits to validate compliance.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>	F 425	<p><u>F-425</u></p> <p>1. Resident #17's Xanax is currently available and has been administered consistently since 5/17/10. The resident had no adverse effects. Resident #23 no longer resides at this facility.</p> <p>2. A review of MAR's/ medication carts was completed 6/24/10 by the DNS/ADNS/UM to ensure that</p>		



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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/27/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(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 425	Continued From page 13  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide doses of medication to two (2) of twenty-eight (28) sampled residents. Nine (9) doses of a scheduled medication (Xanax 0.25mg) were not provided to Resident #17. The facility failed to administer a stat pain medication (Oxyfast) to Resident #23 in a timely manner.  The findings include:  Record review of Resident #17's medication administration record (MAR) revealed that a scheduled medication, Xanax 0.25mg twice a day, was not given between the dates of 05/12/10 through 05/16/10. Each date revealed circled signatures to verify that Xanax was not given. Record review of Resident #17's diagnoses revealed Parkinson's disease, tremors and anxiety.  Interview with Licensed Practical Nurse #2 (LPN) on 05/27/10 at 2:25pm revealed that her signature was documented on the 13th and 14th of Resident #17's MAR, with an initial and circle. LPN #2 stated that when she signs her name and circles it, it means the medication is not given. She revealed that she did not notify the MD because during report she learned that the	F 425	medications are available and being administered as ordered.  3. Nurses were re-educated on 6/25/10 by the SDC on the steps to take when a medication is not available. A binder is located at each nurse's station to track communications with the pharmacy and medication delivery. A copy of a quick reference guide on handling missing medications was placed in the front of each MAR on 6/16/10 for staff reference.  4. All MAR's will be reviewed weekly X 4 weeks, then monthly X 3 months by the ADNS to ensure that medications are being given as ordered. A summary of findings will be reported to the Performance Improvement committee monthly X 3 months for review to ensure sustained compliance.  5. Date of Compliance 6/26/10		

RECEIVED  
JUN 28 2010

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

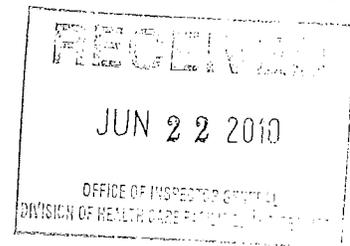
PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  05/27/2010
--	--	--	--

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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

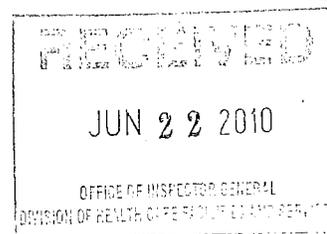
F 425	Continued From page 14	F 425		
	<p>previous nurse called the physician. LPN #2 further stated that she called the pharmacy, but the pharmacy kept asking for a prescription. She stated that there have been issues with the pharmacy not bringing medications in a timely manner and she did notice Resident #17's tremors got worse during the week no Xanax was given.</p> <p>Interview with LPN #1 on 05/27/10 at 3:15pm revealed that when a medication is missing staff are to document in the tracker and log system. She further stated that when it was revealed to her that the Xanax was missing, she did not document in the tracker or the log system. LPN #1 stated that when you see an initial circled it means the medication was not given.</p> <p>Interview with RN #2 on 05/27/10 at 2:45pm revealed that her signature was documented on the 13th of May on Resident #17's MAR. She stated when she circles her initials it means that the medication was not given and that she was not familiar with the system.</p> <p>Interview with Unit Manager of the 200 hall on 02/27/10 at 11:09am revealed that nurses should not circle their initials when a medication is not available. The nurse should first call the doctor to obtain an order to hold medication or do whatever the doctor likes. The nurse must also check the Emergency Drug Kit (EDK) for drug availability. They are not to borrow from other residents or skip doses of medication. She further stated she was not aware that Resident #17 had missed five (5) days of medication.</p> <p>Interview with Director of Nursing on 05/27/10 at 3:45pm revealed there were issues with</p>			



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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 15	F 425			
	<p>prescriptions not being signed by doctors. The facility was working closely with doctors and pharmacists to get the prescription issue resolved. She was made aware of the Xanax not being administered for five (5) days after the occurrence.</p> <p>Record review of Resident #23's medical records on 05/27/10 revealed the resident was admitted to the facility on 06/03/09 with diagnoses of Alzheimer's Dementia with Behavioral Disturbances, Explosive Personality, Edema, and Acute Venous Embolism. The Resident was initially evaluated by Hospice on 02/26/10.</p> <p>Continued record review revealed that Resident #23 had a MD order written on 02/26/10 at 7:30pm for Oxyfast Concentrate five (5) milligrams to be administered stat. The Resident did not receive the ordered medication until 02/27/10 at 5:45pm.</p> <p>Interview with LPN #5 on 05/27/10 at 1:45pm revealed normal stat delivery times for a medication is usually one to three hours during normal working hours. She stated she relied on the incoming nurse to follow up with the pharmacy to obtain the stat medication. She had not notified the Director of Nursing with the problem of obtaining the medication. The physician had not been notified that the Resident had not received the stat Oxyfast per order.</p> <p>Record review of Resident #23's nursing notes dated 02/27/10 at 5:00am revealed that neither the physician nor the Director of Nursing had been notified that the Resident had not received a stat Oxyfast medication.</p>				



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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 16	F 425			
	<p>Interview with the Director of Nurses (DON) on 05/27/10 at 5:20pm revealed the LPN should have notified the doctor as well as the DON when the stat medication could not be obtained in a timely manner from the pharmacy.</p> <p>Review of the facility's policy on 05/27/10 titled Medication Shortages/Unavailable drugs dated December 2006 stated: If an emergency delivery is unavailable; the facility nurse should contact the attending physician to obtain orders or directions.</p> <p>Interview with the Pharmacy Consultant on 05/27/10 at 5:05pm revealed that just because a prescription has not been obtained by the pharmacy, does not mean the pharmacy will not fill the medication. The facility should have called the pharmacy to have the medication delivered. The Pharmacy Consultant further stated that she was not aware the facility was having issues with receiving medication late.</p> <p>Interview with the General Manager of the pharmacy service on 05/27/10 at 5:12pm revealed they receive orders from a licensed staff member. They do not refuse to send medications if there is a valid chart order. They had some issues with communication with the facility. They also keep a record of every time they are notified by the facility.</p> <p>The Long Term Care Facility's Pharmacy Services and Procedures Manual Policy dated December of 2006 revealed that if an order is not received, a facility designee should check for a communication slip indicating: (1) back orders; (2) ordered-too-soon notifications; (3) drug-drug interactions; (4) formulary changes; or (5) any</p>				

If continuation sheet Page 17 of 20  
**RECEIVED**  
JUN 22 2010  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 06/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

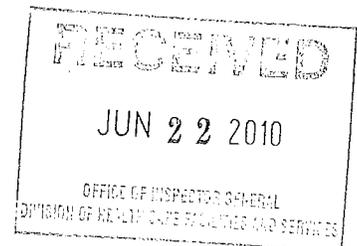
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/27/2010
--	--	--	--

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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 425	Continued From page 17	F 425		
-------	------------------------	-------	--	--

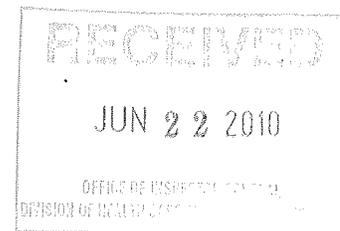
F 520 SS=E	<p>other communication explaining the reason a medication or item was not delivered. The facility should contact the Pharmacy if the facility is not clear as to the reason for the missing items or medications. The facility should document any delivery discrepancies (e.g., item received in error, labeling error, etc.)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was</p>	F 520	<p><u>F-520</u></p> <ol style="list-style-type: none"> <li>The Immunization Program will be added to the monthly agenda for Performance Improvement Program.</li> <li>Residents residing in the center have the potential to be affected.</li> <li>Re-education will be held by the SDC by 6/18/10 with department heads to review the Performance Improvement Program. Administrator will compare the immunization binder to the report from the SDC to ensure sustained compliance.</li> <li>The SDC will be responsible for reporting, tracking/trending for the Immunization Program at the monthly Performance Improvement Committee meeting to take any further action if needed to ensure compliance is sustained. The administrator will compare the immunization binder to the report from the SDC to ensure sustained compliance.</li> <li>Date of Compliance 6/26/10</li> </ol>	
---------------	--	-------	--	--



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

PRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 18  <del>determined the facility failed to develop and implement appropriate plans of action in the Quality Assurance Committee (QAC) to correct an identified quality deficiency related to administering Purified Protein Derivative (PPD) to all residents upon admission and annually thereafter.</del>  The findings include:  Record review for Resident's #2, #5, #14 and #22 on 05/26/10 revealed no documentation of PPD having been administered timely or at all.  Interview with the Director of Nursing (DON) on 05/26/10 at 2:00pm revealed she had a log showing residents' names, dates of PPD having been given, and dates PPD's were read, but these were all in her handwriting. No names of nurses were on this log that had administered or read the PPD's. The DON explained the information on the log was obtained from various sources, i.e. Medication Administration Records, immunization sheets found in notebooks on the nursing units, and the residents' records in different places. The DON further explained her audit of records was in response to a plan of action developed in the QAC which was in direct response to last year's survey Statement of Deficiencies regarding PPD administration.  Interview with the Assistant Director of Nursing (ADON) on 05/27/10 at 3:30pm, revealed that all of the nurses are educated on PPD administration and documentation. She also stated that the Unit Nursing Managers do audits on all new resident admissions for completed assessments and review of vaccine records. She could not give a reason as to how these PPD's	F 520			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/10/2010  
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  05/27/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 19 <del>were missed or were not given timely.</del>  Interview with the Director of Nursing (DON) on 05/27/10 at 3:45pm revealed the nurses working on the units, who do the admission assessments, are responsible to ensure the PPD skin tests are administered timely and transcribed to the medication record. The DON could not give a reason as to how these skin tests were missed or not given timely. The DON stated the Infection Control Coordinator was monitoring the immunization program per facility policy but no evidence of this was provided. The DON stated the Infection Control Coordinator was out of town and unable to be reached for an interview during the standard survey. When asked if the Infection Control Coordinator was monitoring the immunization program, the DON stated she would.  Review of the facility policy on the Immunization Program implemented in January 2008 revealed the Infection Control Coordinator was responsible for monitoring the immunization program. The policy also stated there would be ongoing audits to validate compliance.  Interview with the Administrator on 05/27/10 at 4:00pm revealed the Statement of Deficiencies from last year's survey was discussed in each QAC with identified problems addressed with an action plan. She stated a plan was developed for assurance of PPD administration per regulation and to her knowledge the plan was implemented. She acknowledged the plan would need to be revised, implemented, and monitored for compliance.	F 520			



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

PRINTED: 06/15/2010  
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/03/2010
--	--	--	--

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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000		
K 062 SS=E	<p>A Life Safety Code survey was initiated and conducted on 06/03/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an E.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/17/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25, 1999 Edition.</p> <p>The findings to include:</p> <p>A tour of the facility conducted 06/03/10 at 10:30am, revealed ten (10) sprinkler heads in the kitchen and three (3) sprinkler heads on the Light House porch were stained with a brown green substance.</p> <p>An Interview with the Administrator and Maintenance Director, on 06/03/10 at 10:35am, revealed they were unaware of the build-up on the sprinkler heads.</p>	K 062	<p><b><u>K062</u></b></p> <ol style="list-style-type: none"> <li>The 10 sprinkler heads in the kitchen and the 3 sprinkler heads on the Light House porch have were repaired on 6/3/10.</li> <li>Residents residing in the center have the potential to be affected. The Maintenance Director did a complete inspection of the centers' sprinkler heads on 6/7/10 and 6/8/10 to assess for corrosion, none were identified.</li> </ol>	



JUL 08 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 6-24-2010

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.

JUN 24 2010



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

PRINTED: 06/15/2010  
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/03/2010
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 1  Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1 <sup>+</sup> Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	<p>3. The Maintenance Director will check sprinkler heads throughout the facility during monthly Preventative Maintenance rounds to ensure that sprinkler heads are free of corrosion.</p> <p>4. The Maintenance Director will bring copies of the monthly Preventative Maintenance rounds to include sprinkler head inspections to the monthly Performance Improvement Committee meeting to ensure that compliance is sustained.</p> <p>5. Date of Compliance: 6/25/10</p>	

JUL 08 2010

