

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

PRINTED: 02/12/2015
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 01/29/2015
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	F 000			
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of the facility's policy, it was determined the facility failed to ensure staff respected the privacy of residents by knocking on doors before entering for one (1) of twenty-one (21) sampled residents (Resident #18) and eight (8) of nine (9) unsampled residents (Unsampled Residents A, B, C, D, E, F, G, and H) and failed to ensure staff knocked on doors to seven (7) of seven (7) rooms (Rooms 215, 216, 217, 219, 221, 227 and 229) during meal tray pass. Staff was already inside residents' rooms as they knocked or said knock knock and entered, or staff failed to knock at all to gain the residents permission to enter.</p> <p>The findings include: Review of the facility's policy regarding Resident Privacy Rights, dated 09/01/13, revealed the policy did not address staff requesting permission</p>	F 241	<p>"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."</p> <p>F 241</p> <p>I. Resident #18, unsampled resident's A, B, C, D, E, F, G, & H and the resident's in rooms 215, 216, 217, 218, 219, 221, 227, & 229 were evaluated on 2/16/15 by the Director of Nursing and Social Service Director to determine areas of concerns with dignity and respect including knocking on doors and waiting on residents permission before entering the room. No areas of concern were identified.</p>		

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

TITLE

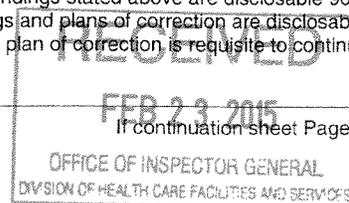
(X6) DATE

Shane Garrett

Administrator

2/20/15

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.

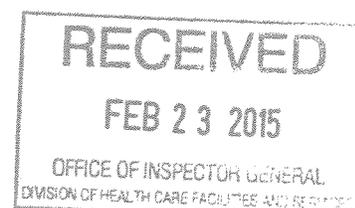


MP

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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

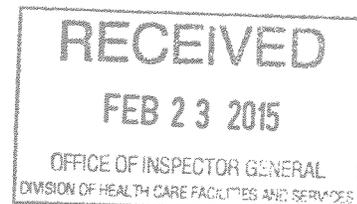
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 241	<p>Continued From page 1 to enter a residents room.</p> <p>Interview during the Quality of Life, Group Meeting, on 01/27/15 at 2:30 PM, revealed Resident #18 and Unsampled Residents A, B, C, D, E, F, G, and H present at the group meeting voiced concerns the staff did not knock or seek permission prior to entering their rooms.</p> <p>Observation of lunch, on 01/28/15 at 12:31 PM, on the 200 unit, revealed staff delivered food trays to residents eating in rooms 215, 216, 217, 219, 221, 227, and 229 without knocking or seeking permission to enter the room. Staff was also noted to be inside the rooms when they actually knocked on the door. In addition, staff was observed stating knock knock as they entered resident rooms without actually knocking.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 01/28/15 at 12:21 PM, revealed she had received education regarding the privacy of residents which included knocking and seeking permission prior to entering a resident's room. She stated she did not realize she was already inside the room prior to knocking. She indicated residents were used to this routine; however, the room was their home and she had been educated about this.</p> <p>Interview with CNA #9, on 01/28/15 at 1:58 PM, revealed she could not remember if she knocked on the doors during tray pass on 01/28/15 at 12:21 PM. She stated she had received education regarding resident privacy rights and sometimes was so busy that she forgot to knock. She stated the room was the resident's home and privacy was important to the residents.</p>	F 241	<p>2. All residents of the facility have the potential to be affected. The Director of Nursing, Social Services Director and Unit Managers completed observations on 2/16/15/during resident care and meal service to determine that staff knocked on doors and awaited resident permission before entering the room. No concerns were identified.</p> <p>3. All staff, including Nursing, Dietary, Housekeeping, Maintenance, Activities and Administration were re-educated by 2/21/15 by the Nurse Practice Educator on Resident Rights to include ensuring privacy by knocking on the resident's door and gaining permission to enter. A post-test was provided by the Nurse Practice Educator to determine competency of education provided. All new employees will be educated by the Social Services Director on Resident Rights to include ensuring privacy by knocking on the resident's door and gaining permission to enter during new hire orientation. The Nurse Practice Educator will provide re-education to Nursing Staff with annual competencies and/or when an issue is identified with Resident Rights to include ensuring privacy by knocking on the resident's door and gaining permission to enter.</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

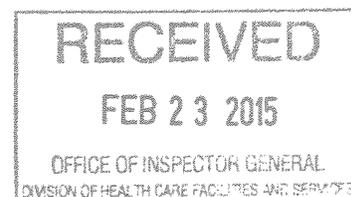
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 241	Continued From page 2 Interview with CNA #11, on 01/28/15 at 1:43 PM, revealed she forgot to knock or seek permission to enter prior to entering a resident's room. She stated she had received education regarding resident's right to privacy. She stated you could not walk in to a residents' rooms unannounced as this was their home. Interview with Licensed Practical Nurse (LPN) #6, on 01/28/15 at 1:22 PM, revealed permission was requested prior to entering a resident's room. He stated sometimes you knocked as you were entering and did not wait for a reply. He revealed he sometimes forgot to knock when in a hurry; however, he was educated to knock or ask for permission to enter a resident's room as the room was the resident's home. Interview with the Director of Nursing, on 01/29/15 at 3:20 PM, revealed the nursing staff were educated to respect residents' privacy which included knocking and receiving permission to enter a resident's room.	F 241	The Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, and Unit Managers, Nursing Supervisor and/or designee will complete rounds 7 days a week for four weeks then weekly for a month, then monthly for four months observing resident care and meal service to observe that staff knocked on doors and awaited the resident's permission to enter. Areas of concern will be corrected when found. 4. The Director of Nursing will submit the findings to the monthly Performance Improvement Committee for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Dietitian, Maintenance and Activity Director.		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to provide resident specific activities	F 248	5. Date of compliance 2/21/2015 <i>2-22-15 per D. Grant</i> F248 1. On 01/30/15 Resident #8's Activity Care Plan was updated by the Activity Director to reflect the residents' personal need for sensory stimulation to include but not limited to music, group activities, television, church, smell and color stimulation such as colored balloons or flowers. Activity Director was provided	<i>by PB 2-26-15</i>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

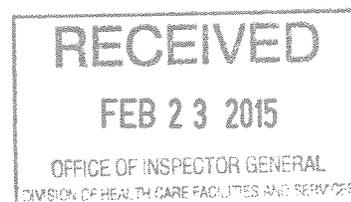
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 248	<p>Continued From page 3</p> <p>for one (1) of twenty-one (21) sampled residents, Resident #8. The facility assessed Resident #8 as needing Sensory Stimulation (activities which stimulate the five (5) senses, site, smell, taste, touch and hearing) three (3) times a week which was not provided consistently.</p> <p>The findings include:</p> <p>Review of the Recreation Services Policies and Procedures, revised 07/01/14, revealed regularly scheduled programs would be provided to all residents who were not able to tolerate or preferred not to participate in group activities. Scheduled interventions must meet the individual's recreational needs and occur in accordance with state regulations.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident on 11/19/10, with a diagnoses of Infantile Cerebral Palsy, Abnormal Posture and Anomaly of the Upper Limb.</p> <p>Review of Resident #8's Minimum Data Set (MDS), Annual Assessment, dated 09/15/14, revealed the facility assessed the resident with a Basic Interview for Mental Status (BIMS) score of ninety-nine (99), which meant the resident was not interviewable. Review of the Staff Assessment of Daily and Activity Preferences, dated 09/10/14, revealed Resident #8 enjoyed listening to music, being around animals such as pets, doing things with groups of people, participating in favorite activities, spending time outdoors and participating in religious activities or practices.</p> <p>Review of Resident #8's Recreation Quarterly Progress Note, dated 12/04/14, revealed</p>	F 248	<p>reeducation by the Administrator on 2/17/15 regarding need to provide resident #8 sensory stimulation as per care plan and need to document refusals or reason for non-participation.</p> <p>2. All residents of the facility have the potential to be affected. The Activity Director reviewed all current activity care plans for individualized programs and participation log. No other residents were identified.</p> <p>3. On 02/6/15 the Activity Director and both assistants were re-educated on the Activity policy to ensure that all residents who have limited tolerance or prefer not to participate in group programs have consistent and individualized recreation opportunities by the Regional Activity Coordinator including sensory stimulation and programs provided as per care plan with refusals or reasons for non-participation documented.. A post-test was given by the Administrator on 2/17/15 to determine competency.</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

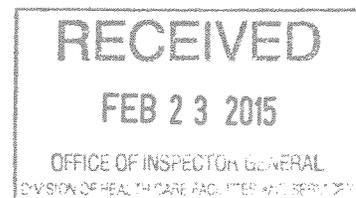
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 248	<p>Continued From page 4</p> <p>Resident #8's most frequently attended groups were entertainment; social events; sing a long; and, church singing. The Resident would participate in an individual program of Sensory Stimulation three (3) times a week.</p> <p>Review of the January 2015 Activity Calendar, for the date of 01/27/15, revealed Bible Study at 10:00 AM; Price is Right at 11:00 AM; Nifty Nails at 1:45 PM; Resident Council at 2:30 PM; Parachute Ball at 3:00 PM; Cards and Puzzles at 4:00 PM; and, News and Music at 5:00 PM.</p> <p>Observation of Resident #8, on 01/27/15 at 11:28 AM (Price is Right at 11:00 AM), 1:27 PM, 2:01 PM and 4:30 PM (cards and puzzles at 4:00 PM) and 5:10 PM (news and music at 5:00 PM), revealed Resident #8 in his/her room with no activities taking place and no staff in the room providing sensory stimulation.</p> <p>Review of the January 2015 Activity Calendar, for the date of 01/28/15, revealed Arts/Crafts at 10:00 AM; Price is Right/Cards at 11:00 AM; Dice at 2:00 PM; Country Music at 3:00 PM; and, Puzzles/Television at 4:00 PM.</p> <p>Observation of Resident #8, on 01/28/15 at 10:15 AM (arts/crafts at 10:00 AM), 11:15 AM (Price is Right at 11:00 AM), 12:20 PM, 1:40 PM, 3:00 PM (country music at 3:00 PM) and 3:30 PM, revealed Resident #8 in his/her room, with no activities taking place and no staff in the room providing sensory stimulation.</p> <p>Interview with the Recreational Assistant, on 01/29/15 at 12:52 PM, revealed the Sensory Program was a program that provided touch and feel, memory, music and visual sensations to the</p>	F 248	<p>The Administrator and/or Activity Director will perform 5 audits weekly of the personalized activities to determine that resident refusals and or participation are documented on the residents' activity log with appropriate intervention and follow up by the activity staff 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.</p> <p>4. The Administrator will submit a summary of the findings to the monthly Performance Improvement Committee monthly x6 months for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary</p> <p>5. Date of compliance 02/21/15</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

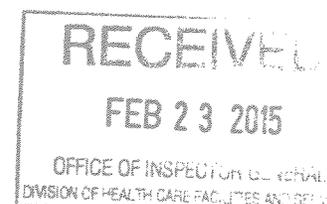
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 248	<p>Continued From page 5</p> <p>residents. The Recreational Assistant stated she tried to provide Sensory Programing on Mondays, Wednesdays and Fridays. If the residents were asleep she would try to come back the next day to provide the sensory activity. The Recreational Assistant stated if she observed a resident in the room doing no activity, she would try to provide some type of stimulation. The Recreational Assistant stated the Director of Recreations provided Sensory Stimulation to the resident on Wednesday 01/28/15. She stated the Sensory Stimulation lasted from about fifteen (15) to twenty (20) minutes. The Recreation Assistant stated she tried to document when a refusal or a decline from the resident occurred. She stated she had not taken Resident #8 to any groups or provided Sensory Stimulation to Resident #8 on 01/27/15 and 01/28/15.</p> <p>Review of the Recreational Assistant's notes revealed Resident #8 was not provided any activities on 01/27/15 and 01/28/15. No documentation of refusals were noted.</p> <p>Interview with the Director of Recreations, on 01/29/15 at 1:19 PM, revealed she did not complete a Sensory activity with Resident #8 on 001/28/15. The Director of Recreations stated if she completed an activity with a resident she would document the activity and notify the Recreation Assistant of the activity. The Director of Recreations stated she would like to see some documentation completed by staff if there was some attempt at completing an activity. The Director of Recreations stated she may have not explained clearly to her Assistants about what items she completed on Wednesday, 01/28/15.</p> <p>Interview with the Administrator, on 01/29/15 at</p>	F 248		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

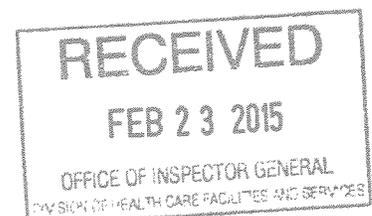
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 248	Continued From page 6 2:30 PM, revealed Resident #8 had behaviors and if he/she was stimulated to much the resident would become loud and during the music activity Resident #8 had been known to sing loudly and it interrupted the other residents during the music activity. The Administrator stated she supervised the Activity Department and would expect the staff to document if there was an attempt to complete an activity with a resident. The Administrator stated she monitored the performance improvement of the Activity Department weekly by making observations of the Activity Department and had not identified any concerns.	F 248			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 1. Resident #14's care plan was re-evaluated by the Director of Nursing on 1/29/15 and updated to reflect current care needs including the C-diff infection and symptoms. 2. All residents of the facility with infections have the potential to be affected. The Director of Nursing, Social Services Director and Unit Mangers re-evaluated the care plans for all current patients with infections to ensure proper precautions were care planned on 1/30/15. There were no areas of concern identified.		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

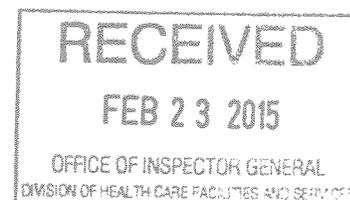
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 279	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy on Care Plans, it was determined the facility failed to develop a comprehensive care plan for one (1) of twenty-one (21) sampled residents. Resident #14 had Clostridium Difficile infection (C. Diff) and the facility failed to develop a care plan to address the infection and Contact Precautions on the comprehensive care plan.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, dated 04/15/02, revealed the facility must develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's nursing, medical, mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Review of the clinical record for Resident #14 revealed the facility admitted the resident on 06/24/11 with diagnoses of Dementia, Hypertension, Depressive Disorder and Peripheral Vascular Disease. The facility assessed the resident using the Minimum Data Set (MDS), on 11/04/14, with a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident was cognitively intact. The stool specimen collected and sent to the laboratory on 07/25/14 and 12/10/14, revealed the resident had positive results for C. Diff.</p> <p>Review of the Comprehensive Care Plan for Resident #14, revealed there was no evidence to show the facility addressed the resident's</p>	F 279	<p>3. The Director of Nursing and Social Services Director were re-educated by the Administrator on 1/30/15 regarding ensuring care plans are developed which include measurable objectives and timetables to meet the resident's nursing, medical, mental, and psychosocial needs that are identified in the comprehensive assessment. A post-test was given by the Administrator on 1/30/15 to determine competency of the education provided. The Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Unit Managers, Nursing Supervisor, and/or Social Services Director will review 5 resident care plans weekly for 4 weeks then monthly times 5 months to ensure necessary measurable objectives and timetables to meet the resident's nursing, medical, mental, and psychosocial needs including infections that are identified. Areas of concern will be corrected when found.</p> <p>4. The Director of Nursing will submit the findings to the monthly Performance Improvement Committee for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Maintenance and Activity Director.</p> <p>5. Date of compliance 2/21/2015</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

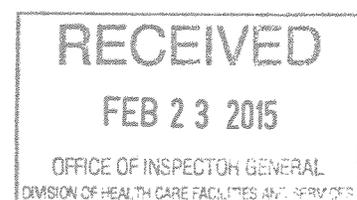
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 279	Continued From page 8 infection with C. diff and resulting placement in Contact Precautions. Observation of Resident #14, on 01/29/15 at 11:00 AM, revealed the resident was outside in the court yard, smoking a cigarette. Interview with the Director of Nursing (DON), on 01/29/15 at 4:00 PM, revealed Resident #14's care plan should have been developed to address the C. diff infection, symptoms, Contact Precautions and medications being used.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280	F280 1. Resident #4 care plan was reviewed and revised by the Registered Dietician on 2/9/15 to address current weight loss interventions with measurable objectives to meet the resident's needs and goals. 2. All residents of the facility have the potential to be affected. Facility audit of all current care plan interventions for residents with significant weight loss/gain was completed on 2/9/15 by the Registered Dietician. Areas of concern were corrected when identified.		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

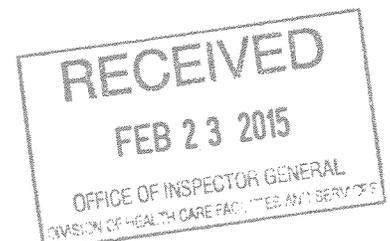
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twenty-one (21) sampled residents, (Resident #4). Resident #4 sustained a significant weight loss of 25.8 pounds, a 16.4% weight loss from 7/06/14 through 01/06/15; however, the facility failed to revise the residents Comprehensive Care Plan to address the actual weight loss.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, revised 01/02/14, revealed the purpose of the care plan was to provide necessary care and services to attain or maintain the patients highest practical physical, mental, and psychosocial well being. The Comprehensive Care Plan is reviewed and revised a minimum of quarterly and as needed to reflect responses to care and changing needs and goals. The Care Plan must be customized to each individual patient needs.</p> <p>Review of the facility's policy regarding Customers at Risk meeting, effective 04/01/03, revealed residents identified as actually or potentially at risk for decline in function are consistently addressed in an interdisciplinary context until they have improved or stabilized. Residents at risk may include: new admissions; nutritional risk with significant unanticipated weight loss or gain; infection; skin breakdown; behaviors; and, falls. The Customers at Risk meeting is conducted on a weekly basis with the Dietician attending at least once a month to</p>	F 280	<p>3. The Registered Dietician was re-educated by the Clinical Nutrition Director on 2/9/15 and The Director of Nursing was re-educated on 1/29/15 by the Manager of Clinical Operations on ensuring the Comprehensive Care Plan is revised to provide necessary care and services to attain or maintain the patients' highest practical physical, mental, and psychosocial well-being. A post-test was given by the Manager of Clinical Operations on 2/18/15 to determine competency.</p> <p>The Registered Dietician will review and monitor the weights report weekly and monthly recorded by the nursing staff weekly for 4 weeks then monthly for 5 months. Residents who are identified as "at risk" will be evaluated by the Dietician with recommendations to the Clinical at Risk Team and corrective action will be completed upon discovery including revision of the care plan if indicated.</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

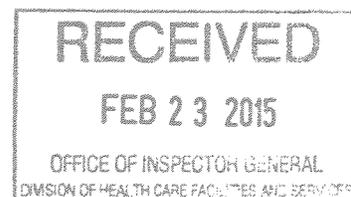
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 10</p> <p>review residents at nutritional risk. Documentation for each weekly meeting must include resident information; a participant roster; and, minutes. Each discipline is responsible for completing medical record documentation on identified residents during or immediately after the meeting.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 06/04/10 with diagnoses of Dementia, Congestive Heart Failure and Cerebrovascular Disease. Review of the Annual MDS (MDS)Assessment completed 04/03/14 revealed the facility assessed the resident's cognition, using the Brief Interview for Mental Status (BIMS) score, at four (4), severely impaired, and independent with supervision for eating. Review of the 01/07/15 Quarterly MDS Assessment revealed the facility assessed Resident #4's cognition at three (3), severely impaired, using the BIMS Assessment. The facility assessed the resident as requiring extensive assistance with staff assist for eating.</p> <p>Review of the weight summary for Resident #4 revealed the resident was started on weekly weights on 07/06/14 with a weight of 157.2 pounds. On 01/27/15 the facility weighed the resident and was found to be 129.1 pounds.</p> <p>Review of the Dietician's Nutritional Progress Notes for Resident #4, dated 10/13/14, revealed the resident had a weight loss of 10.7% in 180 days. The Dietician documented the resident ate in the dining room and suggested an increase in appetite stimulate. On 12/08/14 the Dietician documented a 13.7% weight loss in 180 days, with recommendation to continue the current plan. On 01/12/15 the Dietician documented a 16.4% wight loss in 180 days related to</p>	F 280	<p>4. All findings will be submitted to the monthly Performance Improvement Committee for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Maintenance and Activity Director.</p> <p>5. Date of Compliance 2/21/15.</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

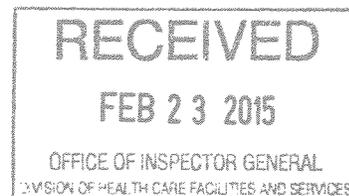
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 11</p> <p>hospitalization (12/11-17/14) and decreased appetite. On 01/15/15 the Dietician documented a 30 day review weight of 131.4 and would continue to follow and monitor intake and weight. On 01/27/15 the Dietician documented a weight loss with a weight on 01/27/15 of 127.1 pounds. She recommend continue with current plan and the addition of a house supplement three times a day.</p> <p>Review of the Comprehensive Care Plan for Resident #4 revealed the Focus was Nutritional Status and a diagnosis of Dementia. The care plan was initiated on 04/01/14. The resident was able to make needs known and agreeable to current interventions. The resident was able to feed self and eats in room per the resident's choice. The Goal listed was no significant weight change, 5% in 30 days, or 10% in 180 days. Continued review revealed the last update for interventions was on 09/29/14 for an appetite stimulant per order. The care plan did not address that the resident ate in the dining room or the addition of house supplements added on 01/27/15.</p> <p>Interview, on 01/29/15 at 1:17 PM, with Licensed Practical Nurse #4 revealed the Dietician completed the Nutrition Care Plan.</p> <p>Interview, on 01/29/15 at 2:00 PM, with the Dietician revealed she assessed residents upon admission, created the Comprehensive Care Plan and made changes if there was a diet change or new interventions. She stated she felt the Focus documented on the Care Plan for Resident #4 was accurate except the resident had been going to the dining room of late. She stated she did not feel she needed to make any</p>	F 280		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

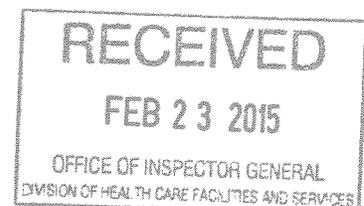
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 280</p> <p>F 282 SS=D</p>	<p>Continued From page 12 other changes based on the documented oral intake from nursing.</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 review, it was determined the facility failed to follow the Activity Care Plan for one (1) of twenty-one (21) residents, Resident #8. The activity staff failed to followed Resident #8's group and sensory stimulation activities as care planned.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, revised 01/02/14, revealed a comprehensive individualized care plan would be developed by the interdisciplinary team for each resident. The care plan would include measurable objectives to meet the resident's needs and goals as identified by the assessment process.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident on 11/19/10, with diagnoses of Infantile Cerebral Palsy, Abnormal Posture and Anomaly of the Upper Limb.</p> <p>Review of Resident #8's Minimum Data Set (MDS), annual assessment, dated 09/15/14,</p>	<p>F 280</p> <p>F 282</p>	<p>F282</p> <p>1. On 2/2/15, 2/3/15 and 2/4/15 resident #8 was assisted to Musical Entertainment, Bible Study and Moving to Music in the Activity department by the Activity Assistant to fulfill the goals as written in the Care Plan for group programing through musical programs and social parties for stimulation.</p> <p>2. All residents of the facility have the potential to be affected. The Activity Director reviewed all current care plans to assess that written objective goals were being met through recreational programing with observation of participation on 2/17/15. No other concerns were identified.</p> <p>3. On 2/17/15 the Activity Director and both assistants were re-educated on following the written plan of care for resident participation in activities to attain or maintain the patients' highest practical physical, mental, and psychosocial well-being by the Administrator. A post-test was given by the Administrator on 2/17/15 to determine competency of education.</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

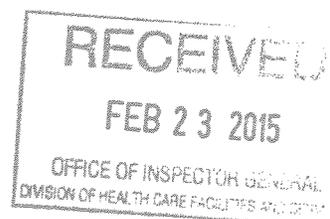
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 13</p> <p>revealed the facility assessed Resident #8 as enjoying listening to music; being around animals such as pets; doing things with groups of people; participating in favorite activities; spending time outdoors; and, participating in religious activities or practices.</p> <p>Review of Resident #8's Activity Care Plan, revised 07/23/14, revealed the facility determined Resident #8 required the stimulation of group programs. The goals for Resident #8 was for the resident to accept being assisted to group programs of potential interest such as musical programs and social parties for stimulation. The interventions for Resident #8 was to assist and encourage Resident #8 to attend group programs such as socials and musical programs; Observe the resident for responses to programming stimulation; and, to provide one to one programs for sensory stimulation.</p> <p>Review of the January 2015 Activity Calendar, for the date of 01/27/15, revealed Bible Study at 10:00 AM, Price is Right at 11:00 AM, Nifty Nails at 1:45 PM, Resident Council at 2:30 PM, Parachute Ball at 3:00 PM, Cards and Puzzles at 4:00 PM and News and Music at 5:00 PM.</p> <p>Observation of Resident #8, on 01/27/15 at 11:28 AM, 1:27 PM, 2:01 PM and 4:30 PM and 5:10 PM, revealed Resident #8 in his/her room no activities presented and no staff in room providing sensory stimulation.</p> <p>Record review of the January 2015 Activity Calendar, for the date of 01/28/15, revealed Arts/Crafts at 10:00 AM, Price is Right/Cards at 11:00 AM, Dice at 2:00 PM, Country Music at 3:00 PM and Puzzles Television at 4:00 PM.</p>	F 282	<p>The Administrator and/or Activity Director will perform 6 audits weekly of the personalized activities to determine that resident refusals and or participation are documented on the residents' activity log with appropriate intervention and follow up by the activity staff for three times a week for two weeks, weekly for two months, and then monthly x 4 months. Any concerns identified will be addressed at that time.</p> <p>4. The Activity Director will submit a summary of the findings to the monthly Performance Improvement Committee for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Dietician, Maintenance and Activity Director.</p> <p>5. Date of compliance 02/21/15</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

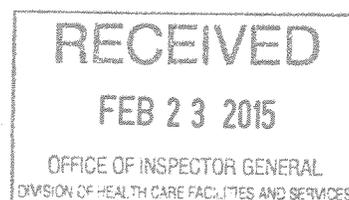
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 14 Observation of Resident #8, on 01/28/15 at 10:15 AM, 11:15 AM, 12:20 PM, 1:40 PM, 3:00 PM and 3:30 PM, revealed Resident #8 in his/her room, no activities presented or staff in room providing sensory stimulation. Interview with the Recreational Assistant, on 01/29/15 at 12:52 PM, revealed she did not take Resident #8 to activities or provide Sensory Stimulation for the days of 01/27/15 through 01/28/15. The Recreational Assistant stated she did not initiate or complete the care plans for residents. The Recreational Assistant stated she did provide activities for Resident #8 and thought the Director of Recreations completed the Sensory Stimulation activity with Resident #8 on 01/28/15. The Recreational Assistant stated she did not follow the care plan for Resident #8 if the activities were not provided. Interview with the Director of Recreations, on 01/29/15 at 1:19 PM, revealed she did not provide sensory stimulation to Resident #8 on 01/28/15 and felt she needed to communicate better with her staff. The Director of Recreations stated she initiated, updated and completed the activity care plans and felt that the care plan was not followed because the activities were not provided as outlined. She stated she felt the staff were providing activities to the residents, but the communication could have been better between her and her staff.	F 282			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

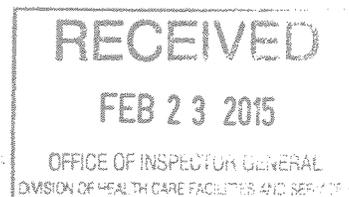
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 15 resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow their policy and ensure residents maintained their body weight for one (1) of twenty-one (21) sampled residents (Resident #4). Resident #4 sustained a significant weight loss of 25.8 pounds resulting in a 16.4% in six months from 7/06/14 through 01/06/15 without consistent assessment until the resident's weight was stable.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Nutrition Care Process, revised 05/05/13, revealed residents were assessed upon admission and routinely thereafter to assure each resident received timely, individualized and consistent nutrition. The Dietician completed additional assessments for residents of further concern. Residents with a nutritional concerns were to be monitored at least monthly.</p> <p>Review of the facility's policy regarding Customers at Risk meetings, effective 04/01/03, revealed residents identified as actual or potential</p>	F 325	<p>F325</p> <p>1. Resident #4 was assessed by the Dietician, Therapy and Licensed Nurse for current nutritional status and weight change with new orders written on 01/30/15 for a house supplement, Protein powder TID, Regular with thin liquids diet, along with ice cream with meals. Staff will encourage resident to initiate intake, alternate solids and liquids and take small bites and sips. Resident was re-weighed on 2/2/15 by licensed nurse showing a weight gain. The Registered Dietician revised the care plan with the centers current interventions on 2/9/15. The meal consumption record was reviewed and validated by the Charge Nurse and or Unit Manger during all 3 meals beginning on 2/2/15 for 7 days to determine accuracy. No further areas of concern were identified.</p> <p>2. All residents of the facility have the potential to be affected. A review of current resident's weight and meal intake forms was completed by the Registered Dietician to determine acceptable parameters of nutritional status. Residents identified during review were re-assessed by the Registered Dietician with recommendations made and the Physicians were notified by the Director of Nursing on 2/9/15.</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

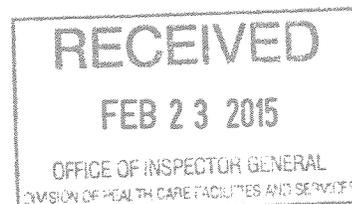
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 16</p> <p>risks for decline in function were consistently addressed in an interdisciplinary context until they improved or stabilized. Residents at risk may include: new admissions; nutritional risk with significant unanticipated weight loss or gain; infection; skin breakdown; behaviors; and, falls. The Customers at Risk meeting is conducted on a weekly basis with the Dietician attending at least once a month to review residents at nutritional risk. Documentation for each weekly meeting must include: resident information; a participant roster; and, minutes. Each discipline is responsible for completing medical record documentation on identified residents during or immediately after the meeting.</p> <p>Review of the clinical record for Resident #4, revealed the facility admitted the resident on 06/04/10 with diagnoses including Dementia, Congestive Heart Failure and Cerebrovascular Disease. Review of the annual Minimum Data Set (MDS) assessment completed 04/03/14 revealed the facility assessed Resident #4's cognition using the Brief Interview for Mental Status with a score at four (4), severely impaired, and independent with supervision for eating. Review of the 01/07/15 Quarterly MDS Assessment revealed the facility assessed Resident #4's cognition at a three (3), severely impaired, using the BIMS Assessment. The facility assessed the resident as requiring extensive assistance of staff for eating.</p> <p>Review of the Weight Summary for Resident #4 revealed the resident was started on weekly weights on 07/06/14 with a weight of 157.2 pounds. On 01/27/15, the facility weighed the resident at 129.1 pounds, a loss of 21.8 pounds.</p>	F 325	<p>3. All current staff including, Nursing, Dietary, Housekeeping, Maintenance, Activities and Administration were re-educated by the Nurse Practice Educator by 2/21/15 regarding the centers tool to identify and report change of condition to the Charge Nurse in order to complete an assessment. Nurses and certified nursing assistants were provided reeducation also regarding the need to document accurate food intake on the meal intake form. All findings are reported to the Director of Nursing to make recommendations to the Registered Dietician.</p> <p>The Director of Nursing/licensed nurses will observe meal intake for residents at nutritional risk to determine accuracy of documentation on the meal intake form daily times 2 weeks then 3 times per week times 2 weeks then as determined by the monthly Performance Improvement committee with corrective action if indicated at the time of occurrence.</p> <p>The Registered Dietician will review and monitor the weights report weekly and monthly recorded by the nursing staff weekly for 4 weeks then monthly for 5 months. Residents who are identified as "at risk" will be evaluated by the Dietician with recommendations to the Clinical at Risk Team monthly.</p>	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

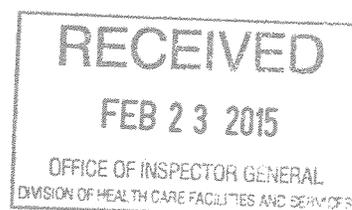
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 17</p> <p>Review of the Dietician's Nutritional Progress Notes, dated 10/13/14, revealed the resident was seen per the September weight report. The resident's October weight was 149.2 pounds, a significant weight loss of 10.7% in 180 days from April's weight of 167.1 pounds. The resident is receiving a regular liberalized diet with 88% of meals consumed. The resident eats in the dining room and is able to feed self and make needs known. The resident denied the need for additional intervention. However, the facility assessed the resident as a BIMS of a three (3). Snacks are offered three times a day. Medications were reviewed and included Remeron 7.5 milligrams. She suggested an increase in Remeron to 15 MG.</p> <p>Continued review of the Nutritional Progress notes revealed no evidence of an assessment in November, 2014. The Progress Note dated 12/08/14 stated the December weight was 138.1 pounds, a 13.7% decrease from the June weight of 160.1 pounds. The resident was receiving a regular liberalized diet with adequate oral intake per the nursing documentation. Remeron 15 mg began on 11/12/14. The weight loss was related to variable intakes. She recommend to continue the current treatment and she would follow. On 01/12/15 the Dietician documented in the Nutritional Progress Notes a January weight of 131.4 pounds, a significant weight loss of 16.4 % in 180 days. The resident was receiving a regular liberalized diet with 64% of meals consumed and the resident ate in the dining room. The weight loss was related to a December hospitalization and decreased appetite. An appetite stimulant was started 12/31/14. The resident is 103% of Ideal Body Weight. On 01/15/15, the Dietician documented on the Nutritional Progress Note,</p>	F 325	<p>4. All findings will be submitted to the monthly Performance Improvement Committee for review and further recommendation, which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Maintenance and Activity Director.</p> <p>5. Date of Compliance 2/21/15.</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

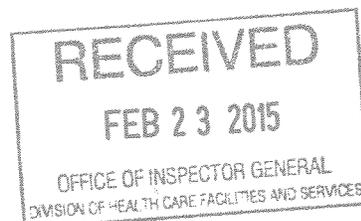
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 18</p> <p>67% of meals consumed, the resident was able to feed self, ate in the dining room, and denied need for additional intervention. However, the facility had assessed the resident with a BIMS of three (3). The response section of the notes stated to continue dietary supplements.</p> <p>Review of the Nourishment List, dated 01/28/15, revealed Resident #4 was not on the list to receive any snacks or nourishments.</p> <p>Review of the Nutritional Care Recommendations completed by the Dietician revealed no recommendations for the month of November for Resident #4 and the resident was receiving Remeron for the months of September, October and December 2014. No new recommendations were made until 01/28/15.</p> <p>Review of the Physician Orders for Resident #4 revealed House Supplements three (3) times a day were ordered on 01/28/15.</p> <p>Review of the meal intake for Resident #4 for the month of January revealed the resident ate 50% to 100 % of each meal and refused a bedtime snack. On 01/27/15, staff documented the resident ate 100% of lunch.</p> <p>Observation, on 01/27/15 at 12:56 PM, revealed Resident #4 was eating lunch in his/her room. The resident was eating the dessert. The plate still had a fish sandwich, corn and mashed potatoes on it. The resident did not eat any other food on the tray. Interview at this time with the resident revealed the resident would say "I don't know or I'm not sure" during the conversation.</p> <p>Observation, on 01/28/15 at 8:00 AM, revealed</p>	F 325		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

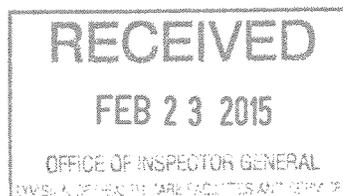
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 19</p> <p>Resident #4 was in the dining room eating breakfast. The resident was noted to eat very slowly.</p> <p>Observation, on 01/28/15 at 12:40 PM, revealed Resident #4 was eating in the dining room. The resident ate all the the ice cream first.</p> <p>Observation, on 01/29/15 at 8:20 AM, revealed Resident #4 in the dining room eating breakfast. The resident was cutting up the toast with a fork and knife.</p> <p>Observation, on 01/29/15 at 1:10 PM revealed Resident #4 eating in the dining room. The resident did state he/she was done eating when questioned by staff. The resident ate about 50% of lunch and the nurse documented this amount on the meal card.</p> <p>Interview, on 01/29/14 at 8:35 AM, with Certified Nurse Aide (CNA) #4 revealed she had worked at the facility for over two (2) years. She stated she had provided care for Resident #4 on a regular basis. She stated the resident generally only eats about 50 % of meals and eats very slowly.</p> <p>Interview, on 01/29/15 at 1:17 PM, with Licensed Practical Nurse (LPN) #4 revealed she worked on the unit where Resident #4 resided. She stated she entered the weights in the computer and if she noticed a weight loss she would ask about it and make a recommendation. She stated she usually depended on the Dietician to over see residents who had weight loss and make recommendations. She stated Resident #4 did not eat 100% of lunch on Tuesday, 01/27/15 and did not know why staff documented incorrectly on the meal intake form. She stated she had</p>	F 325		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

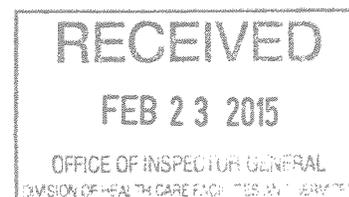
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	<p>Continued From page 20</p> <p>completed audits on meal intakes about a month ago and had no issues. She stated she did not document the audit. She stated Resident #4 was not interviewable and could not hold a total conversation. She stated she was unsure if the resident would let them know if he/she was hungry.</p> <p>Interview, on 01/29/15 at 2:00 PM, with the Dietician revealed she was responsible to assess residents upon admission and monitor nutritional status for stability of resident in the facility. She stated when residents had weight loss she would recommend food first. She stated the next recommendation would be an appetite stimulant before supplements. She stated for residents with weight loss she documented a monthly note of the current intake, medications and any change in the residents status. She acknowledged she failed to put Resident #4 on the weight loss tracker for November and that was the reason there was no documentation in the medical record. She stated she probably should have recommended supplements for Resident #4 before 01/28/15, but just missed it. She stated she believed Resident #4 was receiving a labeled snack three (3) times a day and that was her mistake Resident #4 was not on the list. She stated the potential complication of weight loss was a decline in health status.</p> <p>Interview, on 01/29/14 at 3:30 PM, with the Director of Nursing revealed she had identified an issue with weight loss at the beginning of January 2015 and had talked to LPN #4 about weight loss, but they had not had a chance to put an action plan in place yet. She stated she had not talked with the Dietician about weight loss because she was a corporate employee and the Administrator</p>	F 325		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

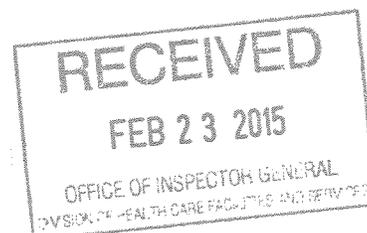
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 325	Continued From page 21 was her supervisor.	F 325		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	F441 1. Resident #7, #12 and #15 were assessed by a licensed nurse on 1/29/15 to determine any signs of infection or adverse effects with no concerns identified. The Director of Nursing was re-educated by the Manager of Clinical Operations to the Infection Control Policy including hand washing, precautions, and proper use of gloves. A post-test was given by the Manager of Clinical Operations on 1/29/15 to determine competency of the education. CNA #3, LPN #3, LPN #5 and LPN #6 were then reeducated by the Director of Nursing to the Infection Control Policy including hand washing procedures and the use of gloves on 1/29/15. LPN #3, LPN #5, CNA #4 and the Activity Assistant were reeducated by the Director of Nursing to the Infection Control Policy including hand washing procedures and the use of PPE equipment on 1/29/15. A post-test was given by the Director of Nursing on 1/29/15 to determine competency of the education.	



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

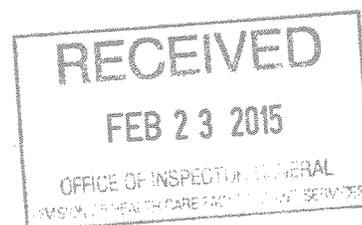
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 22</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure infection control practices were followed by staff for three (3) of twenty-one (21) sampled residents (Residents #7, #12 and #15). A Certified Nursing Assistant (CNA #3), Licensed Practical Nurse (LPN #6) and the Director of Nursings (DON) were observed entering Resident #12's room and LPN #3 and LPN #5 were observed entering Resident #15's Contact Precaution Rooms without the use of Personal Protective Equipment (PPE). The facility failed to ensure LPN #1 practiced safe infection control guidelines during a skin inspection for Resident #7, the nurse went from soiled to clean areas without handwashing or changing gloves.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Contact Precautions, dated 10/01/13, revealed the precautions would be used in addition to Standard Precautions when caring for a resident</p>	F 441	<p>LPN #1 was observed by the Director of Nursing on 1/29/15 for infection control practices during a skin inspection to ensure compliance. No further concerns were identified.</p> <p>2. All residents of the facility have the potential to be affected. A review of all current residents including observation of staff was completed by Director of Nursing and Unit Managers to determine any adverse effects from infection control practices regarding hand washing, standard and contact precautions, and the use of gloves on 1/29/15. No concerns were identified.</p> <p>3. All current staff, including Nursing, Dietary, Housekeeping, Maintenance, Activities and Administration have been re-educated by the Director of Nursing and Unit Manager as of 1/29/15 on the Infection Control Practices including hand washing, standard and contact precautions and appropriate use of gloves. A post-test was given by the Director of Nursing on 1/29/15 to determine competency of the education.</p>		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

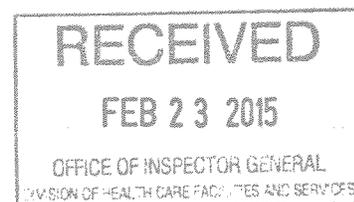
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR 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 23</p> <p>who was colonized or infected with microorganisms that would be transmitted by direct contact or indirect contact with environmental surfaces in resident care areas to reduce the risk of transmission. Staff must use barrier precautions when entering the room. They must wear gown and gloves.</p> <p>Review of the facility's policy regarding Hand Washing, dated 10/01/13, revealed hand hygiene practices were maintained by all the facility's personnel. This included hand washing with soap and water when hands were visibly soiled and the use of alcohol based hand rubs for routine decontamination in clinical situations to reduce the transmission of pathogenic microorganisms. When washing hands with soap and warm water, the staff was to wet their hands, apply soap to hands and rub hands vigorously for at least 15 to 20 seconds covering all surfaces of the hands and fingers. The staff was to rinse hands with warm water and dry thoroughly with a disposable towel. Then the staff was to use a disposable towel to turn off the faucet.</p> <p>1. Observation of Resident #12, on 01/27/15 at 1:10 PM, revealed the resident was in a room with an opened door and a metal box attached to the outside of the door. The box contained disposable gloves, gowns and masks. There was no sign attached to indicated the purpose of the box or the resident for which it was intended.</p> <p>Review of the clinical record for Resident #12, revealed the facility admitted the resident with diagnoses of Lung and Brain Cancer, Urinary Tract Infection with Vancomycin Resistance Enterococcus (VRE), Depression and Vascular Dementia. The facility completed an admission</p>	F 441	<p>The Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator Unit Managers, and/or the Nursing Supervisors will conduct infection control rounds daily for two weeks, weekly for two months, and then monthly for 3 months to determine compliance with infection control policies and procedures including hand washing practices, standard and contact precautions and glove use. Areas of concern will be corrected when identified.</p> <p>4. Results of rounds will be reported to the facility monthly Performance Improvement Committee for six months for further review and recommendation, which includes the Administrator, Director of Nursing, Assistant director of Nursing, Nurse Practice Educator, Medical Director, Social Service Director, Dietary Manager, Dietician, Maintenance and Activity Director.</p> <p>5. Date of Compliance is 2/21/15</p>



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

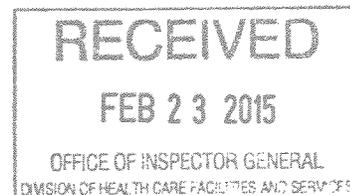
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 24</p> <p>Minimum Data Set (MDS) assessment on 12/01/15 which revealed the resident was not intact cognitively and required extensive assistance with care needs. The resident was incontinent of bladder and had a colostomy. The resident required a tube feeding related to aspiration on all levels of food intake. The resident was on Contact Precautions related to a urinary tract infection with VRE. The resident was receiving antibiotics for the infection.</p> <p>Observation of Resident #12, on 01/27/15 at 2:12 PM, revealed LPN #6 and CNA #3 entered the room without personal protective equipment (PPE). They wore no gloves or gowns. When LPN #6 left the room, CNA #3 was seen placing a blanket over Resident #12. Both employees left the room without washing their hands. Both staff reentered the room at 2:21 PM and closed the door. Neither staff member was gloved or gowned.</p> <p>Interview with CNA #3, on 01/28/15 at 3:46 PM, revealed she did not know what kind of infection Resident #12 had. She stated she was not planning to provide the resident with any care when she entered the room several times. She stated she had touched the resident's bedding without gloves or gowns on. She stated she was not sure what the policy was regarding infection control or contact precautions. She stated she did get a little training by the facility. She stated bacteria could be transmitted to other residents if infection control was not followed.</p> <p>Interview with LPN #6, on 01/28/15 at 4:40 PM, revealed it was not necessary to wear a gown and gloves when entering a Contact Precautions room as he did not plan to provide the resident</p>	F 441		



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

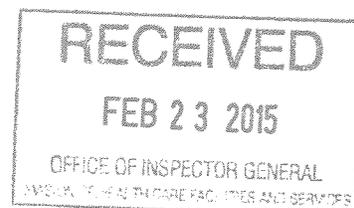
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 25</p> <p>with care. He stated he was not sure what microorganism the resident had, but thought it was VRE in the urine and the resident was incontinent of bladder. He stated he received training on contact precautions from the facility at some unknown point in the past.</p> <p>Observation of Resident #12, on 01/28/15 at 7:20 AM, revealed the DON entered the resident's room without PPE. She was observed leaving the room without hand washing. She stopped at a medication cart and looked through a medication administration record and had not washed her hands.</p> <p>Interview with the Director of Nursing (DON), on 01/29/15 at 12:28 PM, revealed contact precautions were not being followed by most of the nursing staff even though training had been provided. She stated no one supervised staff to ensure procedures were followed. She indicated infection could spread with staff not following the procedures. She stated she was not sure how isolation practices got away from the policy except that staff think if you do not touch anything, you can go in contact precautions without PPE.</p> <p>2. Observation of Resident #15, on 01/29/15 at 10:35 AM, revealed a box that contained isolation supplies hung on the outside of the resident's door to his/her room. There was a sign on the box that said to see the nurse before entering.</p> <p>Review of the clinical record for Resident #15,</p>	F 441			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

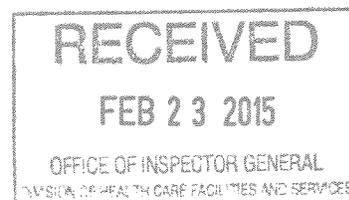
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 26</p> <p>revealed the facility admitted the resident on 02/13/13 with diagnoses of End Stage Renal Disease, Blindness, Unspecified Psychosis, Congestive Heart Failure, and Peripheral Neuropathy. Review of the quarterly Minimal Data Set (MDS) assessment completed on 01/09/15, revealed the facility assessed the resident as requiring extensive assistance with toileting and personnel hygiene and assessed the resident as cognitively intact.</p> <p>Further review of the clinical record for Resident #15, revealed he/she had a stool specimen that tested positive for Clostridium difficile infection (C. diff) on 01/07/15. Resident #15 was prescribed Vancomycin 250 milligrams for one (1) month. On 01/22/15, the Vancomycin was discontinued due to the resident's complaint of an upset stomach. The resident was prescribed Flagyl 500 milligrams three times a day for seven (7) days for the C. Diff infection.</p> <p>Continued observation, on 01/29/15 at 10:35 AM, revealed LPN #3 and LPN #5 entered the resident's room without donning PPE. LPN #3 placed the resident's reacher device on the bed and then rested her left hand on the foot of the bed as she conversed with the resident. LPN #3 and LPN #5 did not wash their hands before they exited the resident's room.</p> <p>Interview with LPN #3, on 01/29/15 at 10:40 AM, revealed PPE was to be donned before entering the room of a resident on contact precautions. She stated she should have donned PPE before she entered Resident #15's room. LPN #3 stated she thought the resident's isolation had ended. She stated she had received training on Contact</p>	F 441			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

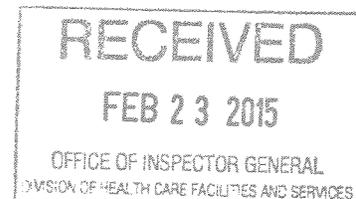
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 27 Precautions from the facility.</p> <p>Interview with LPN #5, on 01/29/15 at 11:15 AM, revealed Resident #15 had been on Contact Precautions for over a week for the diagnosis of C. Diff. LPN #5 stated gloves should have been donned before entering the resident's room and a gown worn if direct patient care was to occur. LPN #5 stated she should have donned gloves prior to entering the resident's room. She further stated infection control in-services were done annually and she was trained on precautions.</p> <p>Observation of Resident #15, on 01/29/15 at 10:41 AM, revealed CNA #4 entered the resident's room without donning PPE and closed the door.</p> <p>Interview with CNA #4, on 01/29/15 at 10:45 AM, revealed she entered the resident's room and assisted the resident to the restroom. CNA #4 stated the staff was to go to the nurse to find out what PPE to use. CNA #4 stated infection control training was done about every other month by the Director of Nursing (DON) or the supervisor. She stated she received training on Contact Precautions from the facility.</p> <p>Observation of Resident #15, on 01/29/15 at 11:21 AM, revealed the Recreation Assistant was in the room speaking to the resident. The Recreation Assistant did not have on PPE. The Recreation Assistant did not wash his hands before he exited the resident's room.</p> <p>Interview with the Recreation Assistant, on 01/29/15 at 11:25 AM, revealed he was aware that the box on Resident #15's door indicated Contact Precautions. He stated he should have put on a mask prior to entering the room. At this point, the interview was terminated related to him becoming upset.</p>	F 441			



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

PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

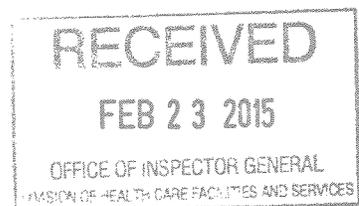
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER REGENCY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE 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 28</p> <p>Interview with the DON, on 01/29/15 at 3:30 PM, revealed staff were required to don gloves and gown prior to entering the room of a resident on Contact Precautions. The DON stated in-services for infection control were done at least yearly. She further stated staff practices should have mirrored the facility's policy and procedure.</p> <p>3. Review of Resident #7's Clinical Record revealed the facility admitted the resident on 02/18/13, with diagnoses of Down's Syndrome, Feeding Difficulties, Peripheral Vascular Disease and Cardiac Dysrhythmias.</p> <p>Observation of LPN #1 performing a skin assessment on Resident #7, on 01/27/15 at 1:35 PM, revealed LPN #1 washed her hands and donned clean gloves. LPN #1 then removed an old gastric tube dressing. LPN #1 then moved the resident on to his/her side and checked the resident's coccyx by moving the gluteal folds. LPN #1 then assessed the resident's back and left ear with the same contaminated gloved hands. LPN #1 then removed her contaminated gloves and washed her hands.</p> <p>Interview with LPN #1, on 01/28/15 at 3:53 PM, revealed she did not remember moving from the resident's coccyx to the resident's back and ears with the same contaminated gloved hands. LPN #1 stated Escherichia Coli (E-coli) was found in the coccyx area that could be spread to other parts of the body. LPN #1 stated they wash their hands to prevent the spread of infection. LPN #1 stated she had completed a competency check off for infection control with no concerns identified.</p>	F 441		



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

PRINTED: 02/12/2015
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 01/29/2015
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 29 Interview with the Unit Manager, on 01/29/15 at 1:58 PM, revealed there had been some hand hygiene and infection control training provided in the last several months. The Unit Manager stated when a nurse moved from dirty to clean areas of the body, the nurse removed their gloves and washed their hands. The Unit Manager stated by LPN #1 not removing her gloves she could have cross contaminated and spread E-coli, Clostridium Difficile (C-diff), and/or Methicillin Resistant Staphylococcus Aureas (MRSA) Interview with the Director of Nursing (DON), on 01/29/15 at 1:42 PM, revealed LPN #1 should have changed her gloves and washed her hands when going from dirty to clean areas of the body. The DON stated she encouraged the staff to wash their hands. The DON stated she was the Infection Control Nurse and educated staff on infection control upon hire and if they noticed any areas of concern. The DON stated there were also quarterly competencies to be completed on the computer and they wash their hands to prevent the spread of infection.	F 441			



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

PRINTED: 02/03/2015
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 01/28/2015
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: Two (2) Type II generators, one (1) 55 KW and one (1) new 125 KW, installed in July of 2014. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 01/28/15. The facility was found not to be 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 one-hundred and five (105) 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

Maureen Harrett

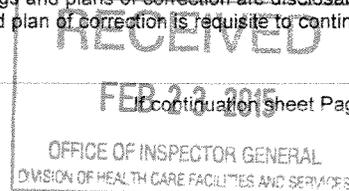
TITLE

Administrator

(X6) DATE

2/20/15

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.



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

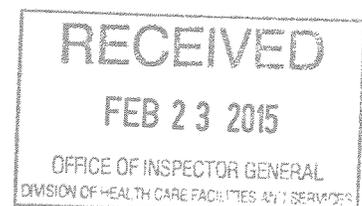
PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

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 01/28/2015
--	---	---	---

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
--------------------	--	---------------	---	----------------------

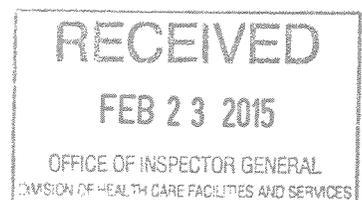
K 000	Continued From page 1 Fire)	K 000		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review of the automatic sprinkler system, it was determined the facility failed to maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the five (5) smoke compartments, all residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was one-hundred and five (105) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the automatic sprinkler system, on 01/28/15 at 12:22 PM, with the Maintenance Director revealed the five (5) year internal pipe inspection for the automatic sprinkler system was past due. The previous internal pipe inspection was performed on 08/05/09 and was over five (5) months past the five (5) year time period required for an internal pipe inspection.</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. The automatic sprinkler system was identified as past due for the five year internal pipe inspection as of 01/28/15. The internal test was completed by outside Sprinkler Contractor on 2/18/15 with no concerns noted. 2. All residents of the facility have the potential to be affected. On 1/28/15 the Maintenance Director conducted an external visual inspection of the sprinkler pipes. No areas were identified to be affected. 3. The Administrator, Maintenance Director and Maintenance Assistant were re-educated on the requirements to maintain the sprinkler system to include the five year internal pipe inspection to identify corrosion or leaks accordance with NFPA 25 Life Safety Code by the Regional Property Manager on 1/30/15. 	



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

PRINTED: 02/03/2015
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 01/28/2015																				
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 062	<p>Continued From page 2</p> <p>Interview, on 01/28/15 at 12:24 PM, with the Maintenance Director revealed he relied on his outside Sprinkler Contractor to ensure the system was inspected, tested and maintained in accordance with NFPA standards.</p> <p>The census of one-hundred and five (105) was verified by the Administrator on 01/28/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/28/15.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Activity</th> <th>Frequency</th> <th>Reference</th> </tr> </thead> <tbody> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td></td> </tr> </tbody> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly		K 062	<p>A post-test was given to measure knowledge of required testing on the sprinkler system on 2/17/15 by the Administrator.</p> <p>4. The Maintenance Director or Maintenance Assistant will monitor the sprinkler system annual tests and record findings using Maintenance audit tool monthly for 6 months then yearly to ensure the five year internal inspection is completed timely. Any concerns will be corrected when identified. The Maintenance Director will report findings in the monthly Performance Improvement Committee for three months for further review and recommendation to include the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, Medical Director, Dietary Manager, Dietician, Social Service Director, Maintenance and Activity Director.</p> <p>5. Date of compliance 2/21/15</p>
Item	Activity	Frequency	Reference																				
Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2																				
Control valves	Inspection	Weekly/monthly	Table 9-1																				
Alarm devices	Inspection	Quarterly	2-2.6																				
Gauges (wet pipe systems)	Inspection	Monthly																					



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

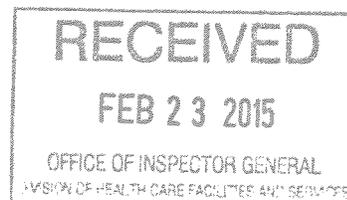
PRINTED: 02/03/2015
FORM APPROVED
OMB NO. 0938-0391

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 01/28/2015
--	---	---	---

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 062	<p>Continued From page 3</p> <p>2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather)</p> <p>2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1</p>	K 062		
-------	---	-------	--	--



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

PRINTED: 02/03/2015
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 01/28/2015
--	--	--	--

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
--------------------	--	---------------	---	----------------------

--	--	--	--	--

