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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 11/17/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated and concluded on 11/17/11 to investigate KY17407 and KY17282. The Division of Health Care substantiated the allegation for KY17282 as verified by the evidence. Federal deficiencies were cited. The allegation for KY16407 was unsubstantiated due to lack of sufficient evidence. Therefore, no regulatory violations was identified.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Regis Woods Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide care in a manner that would enhance dignity for one (1) of four (4) sampled residents. Resident #4 did not receive showers as scheduled and the facility failed to assist the resident of removal of facial hair according to the resident's preference. The findings include: Review of the facility's policy for care and services, with date of January 2008, revealed the facility was to provide care and services to accommodate each resident's individual needs	F 241	F241 1. Resident #4 received a shower and shave on 11/17/2011 by the Unit Manager. 2. An audit was completed on current residents from 11/18 to 11/22/2011 by the Director of Nursing, Assistant Director of Nursing and Unit Managers and any residents determined to not have documented showers were given another shower the same day it was identified by the assigned nursing staff. 3. The nursing staff will be re-educated by the Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing on dignity and respect of individuality, with focus on showers and grooming by 12/15/2011. Resident care plans will be audited for resident preferences with bathing and grooming by the Director of Nursing,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Joseph Hewitt	X Administrator	X 12/8/2011

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

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 and preferences. Observation of Resident #4 during the Group meeting, conducted on 11/17/11 at 7:00 PM, revealed the resident had a heavy growth of facial hair and wore a knit toboggan covering the hair. Interview with the resident, during the group meeting, revealed the resident had not received the regular scheduled shower on Tuesday (11/15/11). The resident stated he/she had not received a shower for over a week. In addition, the resident stated he/she had not been shaved for several weeks and the heavy growth of facial hair was itching and made the resident feel bad. The resident revealed he/she needed assistance with shaving because the resident had neuropathy in both hands and could not hold a razor anymore. The resident stated it was their preference not to have a beard. The resident indicated he/she had put on clean clothes daily but felt dirty without a shower. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/31/11 with diagnosis of Diabetes with neuropathy. Review of the most recent MDS (minimum data set) assessment, dated 09/06/11, revealed the facility assessed the resident to have no cognition deficit, no mood or behaviors exhibited, vision was moderately impaired, and was independent with dressing and personal hygiene (including shaving). The facility assessed the resident to require set up assistance with bathing. However, interview with the MDS coordinator, on 11/17/11 at 8:00 PM, revealed the resident required more assistance with bathing than setup. The facility assisted the resident in washing his/her back and	F 241	Assistant Director of Nursing and Unit Managers by 12/15/11 with documented resident preferences related to hygiene. 4. The Assistant Director of Nursing will assess, via observation and resident interview, 6 residents (3 alert and oriented and 3 not alert and oriented) and documentation once a week for three months to ensure completion of showers and grooming to maintain dignity and respect for individuality. A summary of the audit findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Assistant Director of Nursing monthly times three months for further review and recommendation. 5. Date of compliance 12/16/2011.	

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185301		C 11/17/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 feet and the resident required assistance with shaving. Continued review of the clinical record revealed no documented evidence the resident had ever refused a bath or shaving. Review of the care plan, dated 06/21/11, revealed a goal for the resident to have a neat, clean, well groomed appearance. Interventions developed were for baths/showers to be given as scheduled and provide assistance with grooming needs: comb hair; wash face and hands; oral hygiene; and shaving as needed. Refer to F312. Review of the shower schedule for NF-2 (the wing where Resident #4 resided) revealed the facility had scheduled Resident #4 for showers on Tuesdays and Fridays. Continued review of the shower records revealed no evidence Resident #4 received a shower/bath on Friday, 11/04/11, Tues. 11/07/11, Friday 11/11/11, and Tues. 11/15/11. Shave men and women with shower was written on the shower schedule. Interview with NF-2 nurse manager, on 11/17/11 at 7:45 PM, revealed he was unaware the resident had not received a shower this week. The resident told the nurse manager he/she did not want to cause trouble but would really like a shower because the resident felt dirty. In addition, the resident rubbed his/her face and requested a shave. Review of the shower log revealed no documented evidence the shower was given. The nurse manager revealed he had not reviewed the shower log to ensure all showers were given. He indicated that was the responsibility of the ADON (Assistant Director of Nursing). Interview with the ADON, on 11/17/11 at 5:05 PM	F 241		

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185301		C 11/17/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 and 8:35 PM, revealed she had implemented a new shower program about three weeks ago. She indicated she was responsible for oversight of the new program and would monitor for completion of showers. However, she revealed she had been absent due to illness and had not reviewed the November forms for completion. She stated the staff was to initial the new form and the shower schedule too. She searched for the forms to indicate Resident #4 had received scheduled showers on the above dates; however, she could not find evidence the showers had been given. She stated nobody had monitored the forms in her absent.	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's shower tracking records, it was determined the facility failed to provide necessary services to maintain good personal hygiene for two (2) of four (4) sampled residents. The facility failed to provide assistance with bathing and shaving for Resident #2 and #4. The findings include: The facility could not provide a policy and procedure specific for showers, shaving, and	F 312	F312 1. Resident #2 received his scheduled shower on 11/22/11 and Resident #4 received a shower and shave on 11/17/2011 by the Unit Manager. The Administrator and Director of Nursing spoke with both residents on 12/1/2011 and both residents voiced satisfaction with their shower schedule and both residents confirmed they are receiving showers. 2. An audit was completed on current residents from 11/18 to 11/22/2011 by the Director of Nursing, Assistant Director of Nursing and Unit Managers and any residents determined to not have documented showers were given another shower the same day it was identified by the assigned nursing staff. The shower schedule has been reviewed and revised by the Assistant Director of	

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
CABINET FOR HEALTH AND FAMILY SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 4 personal hygiene. 1. Observation of Resident #4 during the Group meeting, conducted on 11/17/11 at 7:00 PM, revealed the resident had a heavy growth of facial hair and wore a knit toboggan covering the hair. Interview with the resident, during the group meeting, revealed the resident had not received the regular scheduled shower on Tuesday (11/15/11). The resident stated he/she had not received a shower for over a week. In addition, the resident stated he/she had not been shaved for several weeks and the heavy growth of facial hair was itching and made the resident feel bad. The resident revealed he/she needed assistance with shaving because the resident had neuropathy in both hands and could not hold a razor anymore. In addition, it was revealed the facility locked the shower room and the residents cannot enter without staffs' assistance. The resident stated he/she did not want a beard and would like to have the facial hairs removed. The resident indicated they had put on clean clothes daily but felt dirty without a shower. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/31/11 with diagnoses of Diabetes with neuropathy. Review of the most recent MDS (minimum data set) assessment dated 09/06/11 revealed the facility assessed the resident to have no cognition deficit, no mood or behaviors exhibited, vision was moderately impaired, and was independent with dressing and personal hygiene (including shaving). The facility assessed the resident to require set up assistance with bathing. However, interview with the MDS coordinator, on 11/17/11 at 8:00 PM, revealed the resident required more	F 312	Nursing on 11/18/2011 according to the residents preferences for two or more showers per week. The licensed nurse assigns showers daily to the Certified Nursing Assistants. 3. During the clinical morning meeting the Director of Nursing, Assistant Director of Nursing and Unit Manager will review ADL books and previous day assigned showers and bed baths per the resident's preference for validation that showers or bed baths were given. The nursing staff were re-educated by the Assistant Director of Nursing on showers, hair and nail care on 11/23 through 11/30/11 related to the importance of following the resident shower schedule and documenting accordingly. 4. The Assistant Director of Nursing will assess, via observation and resident interview, 6 residents (3 alert and oriented and 3 not alert and oriented) and documentation once a week for three months to ensure completion of showers and grooming to maintain dignity and respect for individuality. A summary of the audit findings will be submitted to the Performance Improvement Committee by the Assistant Director of Nursing. During monthly Resident Council, for the next 3 months, residents will be asked if showers or bed baths per their preference are being given on the dates assigned by nursing. Any resident voicing concern that showers or bed	

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 5 assistance with bathing than setup. The facility assisted the resident in washing his/her back and feet and the resident required assistance with shaving. Continued review of the clinical record revealed no documented evidence the resident had ever refused a bath or shaving. Review of the care plan dated 06/21/11 revealed a goal for the resident to have a neat, clean, well groomed appearance. Interventions developed were for baths/showers to be given as scheduled and provide assistance with grooming needs: comb hair; wash face and hands; oral hygiene; and shaving as needed. Review of the shower schedule for NF-2 (the wing where Resident #4 resided) revealed the facility had scheduled Resident #4 for showers on Tuesdays and Fridays. Continued review of the shower records revealed no evidence Resident #4 received a shower/bath on Friday, 11/04/11, Tues. 11/07/11, Friday 11/11/11, and Tues. 11/15/11. Shave men and women with shower was written on the shower schedule. Interview with NF-2 nurse manager, on 11/17/11 at 7:45 PM, revealed he was unaware the resident had not received a shower this week. He spoke with the resident and the resident told the nurse manager he/she had not received the regular scheduled shower on Tuesday, 11/15/11 because the facility was working (painting) in the resident's room. The direct care staff had told the resident they could not give the shower because of the maintenance work. However, the resident does not have a shower or tub in the resident's room and would have to go to the main shower room on the unit. The resident told the nurse manager he/she did not want to cause trouble but	F 312	bath were not given by nursing will be communicated to nursing management (Director of Nursing, Assistant Director of Nursing and Unit Manager) by the Activity Director and added to a grievance form by the Activity Director. Social Services will track and trend all grievances related to ADL care and submit to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) monthly times three months for further review and recommendation. 5. Date of compliance 12/16/2011.	

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 6 would really like a shower because the resident felt dirty. In addition, the resident rubbed his/her face and requested a shave. The nurse manager stated the direct care staff should document on the shower schedule if the shower was given. Review of the shower log revealed no documented evidence the shower was given. The nurse manager revealed he had not reviewed the shower log to ensure all showers were given. He indicated that was the responsibility of the ADON (Assistant Director of Nursing). 2. Observation of Resident #2 during the initial tour of the facility, on 11/17/11 at 4:30 PM, revealed the resident was clean and shaved. Interview with the resident revealed he/she had received a shower today; however, the resident stated he/she should have received the shower on Tuesday, 11/15/11. The resident stated he/she sometimes goes for two weeks without a shower and said, "The staff gives showers whenever they want to". The resident's daughter was visiting at the time of the observation and she validated the resident did not always get the scheduled showers. She further stated she had found the resident dirty and without a shower upon some visits. Review of the clinical record revealed the facility admitted Resident #2 on 02/18/10. Review of the most recent MDS assessment dated 10/17/11 revealed the facility assessed the resident to have no cognition impairment, mood or behaviors. The MDS assessment revealed the resident required extensive assist with dressing, bathing, and personal hygiene. Review of the care plan dated 10/17/11 a goal for the resident to have a neat, clean, well groomed appearance. The	F 312		

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 interventions were to provide showers/baths per schedule and as needed. The facility would provide assistance with bathing and grooming needs. Review of the shower schedule revealed the facility placed Resident #2 on the Tuesday/Friday shower schedule. Review revealed no documented evidence Resident #2 received a shower/bath on Tuesday 11/08/11, Friday 11/11/11, and Tuesday 11/15/11. Interview with the ADON, on 11/17/11 at 5:05 PM and 8:35 PM, revealed she had implemented a new shower program about three weeks ago. The new program utilized a small skin booklet the direct care staff carries with them and when a shower is given, a skin assessment is conducted too. The staff must initial completion of the shower and turn the form into the charge nurse. The nurse initials the shower was given and forwards the forms to me. She indicated she was responsible for oversight of the new program and would monitor for completion of showers. However, she revealed she had been absent due to illness and had not reviewed the November forms for completion. She stated the staff was to initial the shower schedule too. She searched for the forms to indicate Resident #2 and #4 had received scheduled showers on the above dates; however, she could not find evidence the showers had been given. She stated nobody had monitored the forms in her absent. Review of the grievance log for the last three months revealed on 08/01/11 a resident stated she/he had not received their scheduled shower. On 10/18/11 during the October resident council	F 312		

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 meeting, two residents stated they had not received their showers as scheduled. The action taken by the facility was to implement a new shower form and have the nurse assistant and the nurse to initial completion of the shower. Interview with the Administrator, on 11/17/11 at 8:45 PM, revealed he reviewed all resident council meeting concerns. The new shower system was implemented due to the residents' complaints of not getting showers. The ADON was placed over the program and track the progress. He stated the ADON would have done audits and presented information to the QAPI meeting scheduled for next Tuesday, 11/22/11. The administrator stated there were two ADONs and someone should have monitored the program while one was out sick.	F 312		

RECEIVED
DEC 8 - 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES