

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

PRINTED: 09/04/2013
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 08/22/2013
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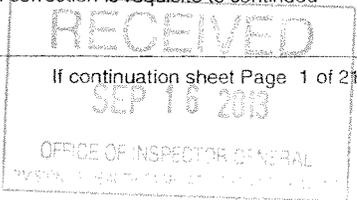
NAME OF PROVIDER OR SUPPLIER REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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F 000	INITIAL COMMENTS	F 000		
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of a facility document on rooms identified as homelike or non-homelike and review of the facility's policy titled Personal Property, and a letter provided to families upon a resident's admission, it was determined the facility failed to provide a homelike environment in eight (8) of twenty-seven (27) resident rooms on the Solana Unit, a locked unit within the facility. The rooms identified were Rooms 401, 403, 412 B, 420 A and B, 422 A and B, 426, 429 B and 431 A. This is a repeat deficiency from 2011 and 2012.</p>	F 252	<p>"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 exists, 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 252</p> <p>1.) Room's 401, 403, 412b, 420 A and B, 422A and B, 426, 429B and 431B have been made to have a homelike environment by adding additional pictures placed at a height visible to residents in the bed or a wheelchair, picture frames on nightstands and other individualized items for the resident currently residing in the bed or room by josh Schindler on 9-13-13</p> <p>2.) The Administrator and Assistant Administrator completed an audit of current resident rooms to determine that each room reflected a Homelike environment with no other rooms identified from on 9-6-13.</p>	
	<p>The findings include:</p> <p>Review of the facility's policy titled Personal</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 9/11/13
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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.



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F 252	<p>Continued From page 1</p> <p>Property: Patient's, Revised 04/01/03, revealed the resident had the right to keep and use his/her personal property, including some furnishings and clothing, as long as there was enough space at the facility and other residents were not inconvenienced. The purpose of the policy was noted as protecting the resident's right to retain his/her personal belongings and preserve the resident's individuality and dignity. The policy did not address residents and/or families who were unable or did not provide items to preserve individuality.</p> <p>Review of the facility's audits, dated 06/18/12, identified the homelike and non-homelike resident rooms in which four (4) rooms on the Solana Unit had been identified as not being homelike.</p> <p>Review of a facility letter provided to family members during the admission process of the resident to the facility, undated, revealed families were encouraged to bring in personal items for the resident and if unable, to notify the facility and the facility would accommodate. However, when families did not provide items for a homelike environment or if the resident had no family, the facility did not create an environment in the resident's room which emphasized individualization.</p> <p>Observation, on 08/21/13 beginning at 12:15 PM, of resident rooms on the Solana Unit (a Dementia Unit) revealed the following: Room 401 had a television set and a clock on the wall, there were no other items present, Room 403 had a single picture on the wall and no personal items present,</p>	F 252	<p>3.) The Assistant Administrator, Director of Admissions, Maintenance Director, Director of Nursing, Nurse Practice Educator, and Unit Managers were educated to the Homelike Environment assessment process and re-educated to the expectation that if a residents family is unable to provide personal items to create a homelike environment in the residents room that the facility will facilitate pictures and other items to personalize the room and create a homelike environment by the Administrator on 9-29-13 The Director of Admissions, Unit Manager or Administrator/Administrator assistant will complete and document a Homelike Environment assessment of newly admitted resident rooms within the first week of admission to ensure that a homelike environment is provided by the facility if the residents family is unable.</p> <p>4.) The Administrator, Maintenance Director, and/or Guest services director will complete weekly audits of current resident rooms to determine that the room provides a homelike environment weekly x4 weeks and then monthly for 2 months and then Quarterly for 3 quarters. Any concerns identified will be addressed at that time. A summary of findings will be submitted monthly x12 months to the Performance Improvement Committee by the Administrator for further review and recommendation.</p> <p>5.) Completion Date: 9-30-13</p>	
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DIVISION OF HEALTHCARE SERVICES

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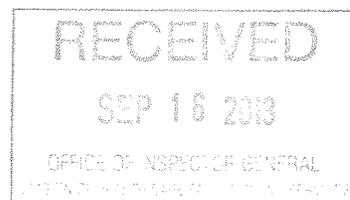
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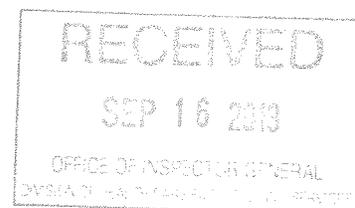
F 252	<p>Continued From page 2</p> <p>Room 412 B contained no family pictures or personalization, a facility provided picture on the wall was above the level for the resident to see in his/her wheelchair or while in bed, Room 420 A had a metal sun on the wall and a single small stuffed bear on the night stand and 420 B was void of anything personal except for a single stuffed animal on the bed, Room 422 A had nothing personal in the room and 422 B had a doll on the bed and no other items, Room 426 A had no personal items in the room except a chair, Room 429 B had no personal items or personal pictures and Room 431 A contained a bed and night stand, nothing personal. In addition, all the resident rooms listed did not contain items or pictures that would connect the residents to the past or items to connect them to who they were in the present.</p> <p>Interview, on 08/22/13 at 10:42 AM, with Licensed Practical Nurse (LPN) #2 revealed pictures were important to keep demented/Alzheimer's residents connected to today, their past and their families. She stated residents still liked to see those things. She revealed pictures represent reminders to the resident of who they were and their family. She stated residents like to see those things. She revealed a homelike room was a room that contained things from home, things the resident liked. While in Room 127 B, LPN #2 revealed the room was not homelike because this particular resident was aware of his/her surroundings and the resident needed to feel like he/she was home and not in a hospital. LPN #2 pointed out the only picture, which was provided by the facility, on the wall was hung too high for the resident to see while in a wheelchair and the picture was on a wall not seen from the resident's</p>	F 252		
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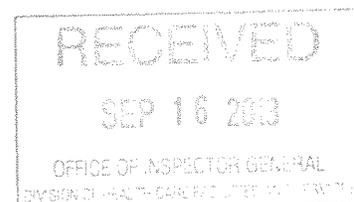
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F 252	<p>Continued From page 3 bed.</p> <p>Interview, on 08/22/13 at 1:20 PM, with the Activities Director for the Solana Unit revealed a homelike room had personal items from the resident's own home. She gave the example of pictures, a bedspread and little odds and ends. She stated it was very important to have a homelike room and not just a room with four (4) walls.</p> <p>Interview, on 08/22/13 at 1:30 PM, with Certified Nursing Assistant (CNA) #2 revealed a homelike room for a resident would have personal items from their house to make it more homey, the things the resident remembered. She revealed it was not homelike to have just a bed and a facility provided picture in the room. CNA #2 revealed it was important to have a homelike room because it helped bring the resident back to something they may remember because the residents on the unit had a degenerative disease taking their memories from them.</p> <p>Interview, on 08/22/13 at 11:04 AM, with Assistant Director of Nursing Registered Nurse (RN) #2 revealed personal belongings, photos or cards the family brought in made a room homelike. She stated it was important to have a homelike environment so the resident would have reminders of their life, things to spark memories, something familiar for the resident to form a connection. RN #2 revealed there were rooms on the Solana Unit that were not homelike. She revealed the lack of rooms presenting homelike had been brought up and her unit was addressing</p>	F 252		



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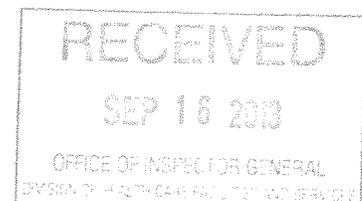
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F 252	Continued From page 4 the concern. It was not revealed in what venue the resident rooms had been discussed. RN #2 revealed the Activity person was trying to come up with crafts the residents could do to help make their rooms more homelike. In looking at Room 422 A, RN #2 revealed the room looked institutionalized; bare, cold and sterile.	F 252		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain resident equipment in a clean sanitary manner for one (1) of the six (6) facility residents utilizing a lap buddy. The facility failed to clean a heavily soiled lap buddy utilized by Resident #9 for three (3) consecutive days. The findings include: Interview with the Director of Nursing (DON), on 08/22/12 at 2:45 PM, revealed there was no facility policy for cleaning or maintaining resident equipment in a clean sanitary manner. Review of Resident #9's clinical record revealed the facility admitted the resident on 12/03/11 with diagnoses of Dementia, Depression, and Hypertension. The facility completed an Annual MDS, dated 01/14/13, and assessed the resident as requiring an activity lap buddy due to	F 253	F253 1.) The lap buddy for Resident #9 was cleaned on 8-22-13 by the Unit Manager. 2.) The Assistant Directors of Nursing completed an audit of resident lap buddies used by current residents on 8-23-13 to determine that the lap buddy was clean. No other concerns were identified. 3.) The Unit mangers, for each unit, updated the Wheelchair and walker cleaning schedule to include the cleaning of lap buddies on 9-6-13. The Nurse Practice Educator and, Assistant Directors of Nursing re-educated the licensed nurses and nursing assistants to the revised Wheelchair, walker and lap buddy cleaning schedule and the expectation that lap buddies are to be cleaned after meals and when visibly soiled as of 9-29-13 with a post test completed.	



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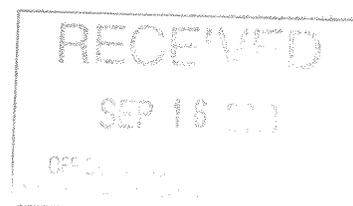
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F 253	<p>Continued From page 5 decreased safety awareness.</p> <p>Observation of Resident #9, on 08/20/13 at 1:38 PM, 2:48 PM, and 4:46 PM; 08/21/13 at 7:44 AM, 9:05 AM, 11:40 AM, 1:30 PM, 3:00 PM, 4:30 PM; and 08/22/13 at 1:10 PM, revealed the resident's lap buddy was soiled with a brown crusty substance.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 08/22/13 at 1:14 PM, revealed the resident's lab buddy appeared to have dried food residue. The CNA revealed she did not clean the lap buddy's and did not know who was responsible or when they should be cleaned. The CNA revealed the resident was known to frequently put things in their mouth and had chewed on some of the activities attached to the lap buddy. The CNA revealed the condition of the lap buddy did look bad and could cause infections for the resident.</p> <p>Observation of CNA #3, on 08/22/13 at 1:23 PM, revealed the CNA took the lap buddy up to the nursing station and showed the Unit Manager for NF 2. The CNA cleaned the lap buddy with a Sani Wipe easily removing all debris from the lap buddy.</p> <p>Interview with the NF 2 Unit Manager, on 08/22/13 at 1:24 PM, revealed everyone was responsible to monitor the cleanliness of resident equipment. The Unit Manager revealed the lap buddy's should be cleaned with the wheelchairs and after meals. The Unit Manager revealed she had not told unit staff specifically when they should be cleaned, but thought it was on the wheelchair cleaning list.</p>	F 253	<p>4.) The Director of Nursing, Assistant Directors of Nursing and/or Unit Managers will complete an audit lap buddies for current residents to determine that lap buddies are clean 3x per week for 4 weeks, weekly for 4 weeks and then monthly for 10 months. Any concerns will be addressed when identified. The Director of Nursing or Assistant Director of Nursing will submit a summary of findings to the monthly Performance Improvement Committee monthly x12 months for further review and recommendation.</p> <p>5.) Completion Date: 9-30-13</p>		



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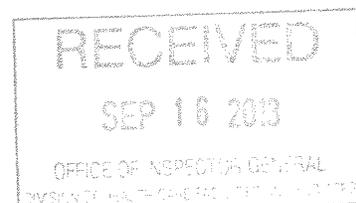
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F 253	<p>Continued From page 6</p> <p>Review of the Wheelchair cleaning list, dated 08/19/13, revealed assigned walkers and wheelchairs are to be cleaned, as well as any that are observed as soiled. No mention of lap buddy's was listed on the cleaning list.</p> <p>Continued interview with the Unit Manger revealed it was her expectation that all staff would monitor the cleanliness of resident equipment, including lap buddy's and clean as necessary. However, the Unit manager revealed she did not do anything to assure the staff were aware of this expectation and stated there was no system in place to monitor the cleanliness of the lap buddy's.</p> <p>Interview with the DON, at 08/23/13 at 2:45 PM, revealed there was no system to monitor and clean the resident's lap buddy's. The DON revealed staff should be watching all resident equipment, but had not followed up to ensure this was being done</p>	F 253		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,</p>	F 280	<p>F280</p> <p>1.) The care plan for Resident #16 was revised on 8-22-13 by the unit manager to integrate individualized hospice interventions for identified focus areas as indicated on the resident's hospice plan of care integrated with inter disciplinary care plans.</p>	



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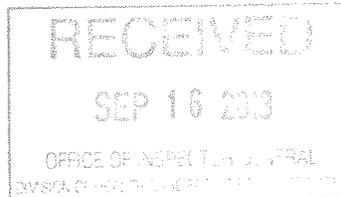
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F 280	<p>Continued From page 7</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy titled Care Plan-Interdisciplinary, it was determined the facility failed to revise the plan of care to reflect the integrated care provided by Hospice for one (1) of twenty-five (25) sampled residents, Resident #16.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Care Plan-Interdisciplinary, undated, revealed it was the policy of the facility to develop an individualized plan of care for each resident utilizing the information gathered during each assessment. In addition, the policy stated the Interdisciplinary Team (IDT) reviewed each care plan at least quarterly with updates as necessary.</p> <p>Record review for resident #16 revealed the facility admitted the resident on 01/20/13 with diagnoses of Failure to Thrive, Alzheimer's Disease, Dementia with Behaviors, Depressive Disorder, Cognitive Communication Deficit and Convulsions. The facility obtained an order for hospice care on 06/15/13 and signed by the physician on 06/18/13. On 06/21/13, the</p>	F 280	<p>2.) The Director of Nursing and Assistant Directors of nursing completed an audit of current residents receiving hospice services to determine that the residents facility care plan was integrated with the individualized approaches as indicated on the hospice care plans on 9-6-13. No other concerns identified.</p> <p>3.) The Assistant Director of Nursing met with hospice on 9-5-13, Hospice will provide an individual binder to be kept at nurses' station to inform staff of services rendered by hospice. The Nurse Practice Educator and Assistant Directors of Nursing educated nurses to the Hospice binder kept at the nursing stations and re-educated licensed nurses to integrate residents hospice care plan with the facility care plan upon admission, quarterly, or with significant changes in the residents status as of 9-29-13 with a posttest completed.</p>	



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F 280	Continued From page 8 Minimum Data Set (MDS) Nurse completed a Significant Change in Condition MDS assessment for Resident #16. The mental status of Resident #16 was unable to be determined, the resident could not complete the interview. Review of the plan of care for Resident #16 revealed a Focused area that identified Resident #16 required Hospice care due to the terminal condition of Senile Dementia with Delirium. The initiation date was 06/14/13 and the revised date was 06/27/13. The goals listed were cares would be coordinated between the Hospice agency and the nursing center and the resident would be kept comfortable. The interventions were as follows: contact hospice agency for any change in condition; encourage visitors; evaluate for pain; honor advanced directives and notify Hospice for any status changes and to request orders. Continued review of the plan of care for Resident #16 revealed thirteen (13) identified focused areas with no intervention noted to include Hospice, other than to notify Hospice for any status changes and to request orders. Those focused areas included: feelings of sadness, emptiness or anxiety; negative feelings of self; decreased activity; self care deficit; urinary incontinence; and staff assistance with feeding. Hospice performed these interventions in addition to the facility staff. The care between Hospice and the facility were not coordinated on the care plan. The care plan did not address the care Hospice provided to the resident which was in addition to what was on the care plan. The care plan interventions only involved facility staff. Observation, on 08/22/13 at 8:20 AM, revealed	F 280	4.) The Director of Nursing, Assistant Directors of Nursing, and or Unit Managers will audit the care plans of residents with hospice to determine that the facility care plan integrates the individualized hospice interventions for identified focus areas and the hospice binders weekly for 4 weeks and monthly x 2 months and then quarterly x 3 quarters. Any concerns will be addressed when identified. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing or Assistant Director of Nursing monthly x12 months for further review and recommendation. 5.) Completion Date: 9-30-13	



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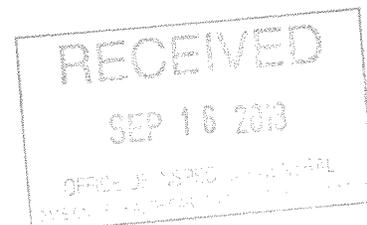
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280	<p>Continued From page 9</p> <p>Resident #16 in his/her bed crying. A partially eaten breakfast tray was on an overbed table near the bed. A hospice Certified Nursing Assistant (CNA) sat next to the bed in a chair. The CNA was observed asking the resident if he/she would care for anything else to eat. Resident #16 continued to cry. The CNA rubbed the arm, then held the hand of Resident #16, comforting him/her. The CNA asked the resident if he/she would like to try to go for a walk.</p> <p>Interview, on 08/22/13 at 9:02 AM, with the Hospice CNA revealed her role with Hospice for Resident #16 was to do his/her care which included changing briefs, bathing, feeding, nail care, putting lotion on the resident, checking his/her feet, peri-care, socializing with the resident and comforting the resident. She stated she was to supplement the care provided by the facility, give the extra care, not to do the care of Resident #16 instead of the facility doing the care.</p> <p>Interview, on 08/22/13 at 9:40 AM, with the Director of Nursing (DON) revealed Hospice had attended the Quarterly or Significant Change in Condition care plan meetings in the past. It was not stated if Hospice had been involved in the care plan update when Resident #16 was placed in Hospice.</p> <p>Interview, on 08/22/13 at 10:20 AM, with the MDS Nurse revealed the notation of notify Hospice was a general intervention and did not imply integration of Hospice care with the Activities of Daily Living (ADLs) for Resident #16. She revealed she did attend the IDT meetings to review care plans. She stated Hospice had not given any input into the facility nursing care plan as Hospice had their own care plan. However,</p>	F 280		
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F 280	Continued From page 10 review of the binders for the comprehensive care plans did not reveal any evidence of a Hospice developed care plan for Resident #16.	F 280		
F 282 SS=D	<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 review of the facility's policy, it was determined the facility failed to ensure staff implemented a care plan approach related to removing a restraint during meal service for one (1) of twenty-five (25) sampled residents (Resident #18). In addition, the facility failed to ensure the sensor pad was in place while in bed for One (1) of twenty-five (25) sampled residents, (#18).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plan-Interdisciplinary, effective 01/08, revealed the Interdisciplinary Team (IDT) included measurable objectives to meet residents needs. The IDT implements the care plan.</p>	F 282	<p>F282</p> <ol style="list-style-type: none"> 1.) The Unit Manager validated that Resident #18's lap buddy was removed for the evening meal and that the bed alarm was in place when the resident was in bed on 8-22-13. 2.) The Assistant Directors of Nursing and unit managers completed an audit of current residents and their care plans to determine that interventions are implemented as indicated on the residents' plan of care on 9-13-13. Any concerns were corrected when identified. 3.) The Nursing Practice Educator and Assistant Directors of Nursing re-educated licensed nurses and nursing assistants of the expectation that care plan interventions are implemented as indicated on the residents' plan of care as of 9-29-13 with a post-test completed. 	
	Review of the medical record for Resident #18 revealed the facility admitted the resident on 08/16/12 with diagnoses of Dementia, Lumbago, and Osteoporosis. Review of the Comprehensive Care Plan revealed the facility had implemented			



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F 282	<p>Continued From page 11</p> <p>the use of a lap buddy on 03/20/13. Interventions for the lap buddy were: lap buddy while up in the wheelchair; check every thirty (30) minutes; and release every two (2) hours for meals, activities, toileting and activities of daily living. The facility added interventions for the sensor pad to the bed at all times, on 06/07/13, as a result of a fall from the bed with no injury. On 06/16/13 the facility added to the care plan that the resident had a history of crawling out of the bed and lying or scooting on the fall mats.</p> <p>Observation, on 08/21/13 at 8:26 AM, revealed Resident #18 sitting in the wheelchair at the table. A staff was feeding the resident. The lap buddy remained in place and was not removed. Continued observation at 8:36 AM revealed the lap buddy remained on Resident #18 during breakfast.</p> <p>Observation, on 08/21/13 at 12:21 PM, revealed Resident #18 sitting up in the wheelchair at the dining table with the lap buddy in place. Continued observation revealed at 12:35 PM LPN #4 was feeding Resident #18 while the lap buddy remained in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 08/22/13 at 2:15 PM, revealed she did not remember if the lap buddy was removed on 08/21/13 at lunch when she was feeding the resident. She stated the resident was pushed up to the table. She stated she was not sure if the lap buddy was to be removed or not.</p> <p>Observation, on 08/22/13 at 9:30 AM, 10:30 AM and 12:45 PM, revealed Resident #18 was found in the bed with the sensor pad not in place; however, it was found hanging behind the</p>	F 282	<p>4.) The Director of Nursing, Unit managers, and/or Assistant Directors of Nursing will complete an audit of 10 resident and their care plans weekly for 4 weeks and then monthly for 2 months and then quarterly for 3 quarters to determine that care plan interventions are implemented as indicated. Any concerns will be addressed when identified. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing or Assistant Director of Nursing monthly x12 months for further review and recommendation.</p> <p>5.) Completion Date 9-30-13</p>	
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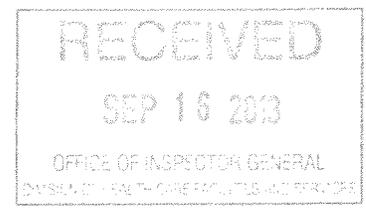
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F 282	Continued From page 12 headboard. Interview, on 08/22/13 at 12:45 PM, with Registered Nurse #5 revealed she believed the sensor pad should have been under Resident #18, but needed to check the care plan. She proceeded to check the care plan for Resident #18 and said it was on the care plan, but the Certified Nursing Assistant (CNA) had changed the bed and forgot to put it back on. Interview, on 08/22/13 at 1:10 PM, with CNA #4 revealed she stated the sensor pad should have been under Resident #18, but she took it off when she changed the bed. She stated it was used to alert staff when the resident was moving around a lot in the bed and was at risk of falling out of bed. Interview with Registered Nurse (RN) #4, on 08/22/13 at 2:25 PM, revealed restraints were to be removed if directed by the residents care plan. She stated the lap buddy should have been removed for meals for Resident #18. She stated the restraints should be removed to promote comfort and dignity. She stated in regards to the sensor pad not being in place, that it should have been, to alert staff if the resident was moving around in the bed.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1.) Resident #19 Wheelchair Brake extension was repaired on 8-22-13 by Maintenance Director. 2.) The Maintenance Director completed audit of all wheel chairs to determine any needed repairs on 9-6-13 with no other concerns identified.	



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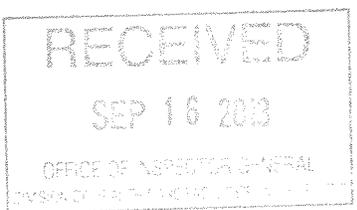
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F 323	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record, and review of the facility's policy, it was determined the facility failed to ensure the environment was free of hazards for one (1) of twenty-five (25) sampled residents, Resident #19. The facility staff failed to ensure the bare metal tips of the extended brake handles, of Resident #19 were protected with caps for three days</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Preventive Maintenance: General, revised 06/01/07, revealed preventative maintenance would be scheduled on equipment.</p> <p>Review of the facility's policy regarding Routine Maintenance, revised 06/01/07, revealed areas of the facility would have an area designated for maintenance work orders which would be collected and completed by the maintenance department.</p> <p>Interview, on 08/22/13 at 10:22 AM, with the Director of Nursing (DON) revealed the facility did not have a policy or schedule for the maintenance of resident wheelchairs. She stated the third shift staff cleaned the wheelchairs, with designated wheelchairs cleaned each night. The DON stated if a wheelchair needed repair the staff should list it on the maintenance log in order for the maintenance department to be aware of the needed repair.</p> <p>Review of the facility's wheelchair cleaning</p>	F 323	<p>3.) The Nurse Practice Educator and Assistant Directors of Nursing re-educated licensed nurses, nursing assistants, activity, therapy and dietary staff to report any equipment including wheelchairs in need of repair by documenting on the Maintenance Log that is kept at each nursing station as of 9-29-13 The Maintenance Director will audit wheel chairs for current residents to determine and complete any needed repairs monthly and will check the Maintenance log for requested repairs 5 days per week and make necessary repairs.</p> <p>4.) The Maintenance Director will audit wheelchairs and the maintenance log monthly to determine any need for repairs and that the maintenance log is utilized by each unit weekly for 4 weeks, monthly for 2 months and then quarterly for 3 quarters. Any repair needs identified will be addressed at that time. The Maintenance Director will submit a summary of findings to the Performance Improvement Committee for further review and recommendation.</p> <p>5.) Completion Date: 9-30-13</p>	
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F 323	<p>Continued From page 14</p> <p>schedule revealed Resident #19's wheelchair was cleaned by facility staff on Monday, 08/19/13.</p> <p>Observations, on 08/20/13 at 8:08 AM, 08/21/13 at 11:28 AM, and on 08/22/13 at 8:10 AM, 8:41 AM, 9:15 AM, and 10:30 AM, of Resident #19 revealed the resident in a wheelchair with extended brake handles with exposed metal ends. The brake handles protruded out from, and beyond, the wheelchair and did not have tips or other type of protective covering. The resident was observed to use the extended brakes and self-propel in the wheelchair.</p> <p>Continued interview with the DON, on 08/22/13 at 2:24 PM, revealed if the tips were missing when the wheelchair was cleaned Monday night, the maintenance log should have been completed.</p> <p>Review of Resident #19's clinical record revealed the facility admitted the resident on 01/14/10 with diagnoses of Dementia with Behaviors, Muscle Weakness, and Osteoarthritis. The facility assessed the resident with a Quarterly Minimum Data Set (MDS), on 06/15/13, as cognitively impaired with a Brief Interview Mental Status (BIMS) score of seven (7). Review of the comprehensive care plan for Resident #1 revealed the resident care plan for falls included re-education of the resident for proper wheelchair brake placement.</p> <p>Interview with Resident #19, on 08/21/13 at 11:28 AM, revealed he/she used the brake handles as part of the wheelchair. The resident stated the handles did not have the rubber on them and hurt his/her hands to use them. Resident #19 stated he/she needed the brakes and wanted the handles to be fixed.</p>	F 323		

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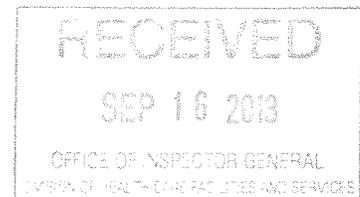
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F 323	<p>Continued From page 15</p> <p>On 08/22/13 at 1:02 PM, interview with Certified Nurse Assistant (CNA) #6 revealed the third shift staff was responsible to clean the residents' wheelchairs. She stated there was a schedule to clean each wheelchair in the facility twice a week. The CNA indicated Resident #19 had the extended brakes for a while, and the protective tips had been missing a long time. She stated if the wheelchair needed repair she would report it to the nurse, who would then complete a maintenance request. The aide stated she had not reported the missing brake handle covers to the nurse or completed a work order or maintenance request. She stated CNAs did not complete work orders, only the nurses on the unit did them. The CNA stated without the protective covers on the extended brake handles the resident could injure his/her hand, or injure someone else if the resident's wheelchair bumped into them.</p> <p>Interview with Registered Nurse (RN) #6, on 08/22/13 at 1:06 PM, revealed she did not work on the unit with Resident #19 and was not aware the extended brakes did not have a protective cover. She stated if a resident's wheelchair needed repair, then a work order or a note in the maintenance log would need to be completed. The RN stated without the protective tips on the wheelchair, Resident #19 could harm someone if the wheelchair ran into them.</p>	F 323		
	<p>Interview, on 08/22/13 at 1:18 PM and 2:00 PM, with Certified Occupation Therapy Assistant (COTA) revealed Resident #19 had been discharged from Physical Therapy and Occupational Therapy in May 2013, and discharged from Speech Therapy in July 2013.</p>			



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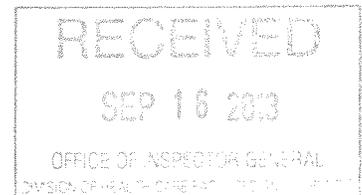
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F 323	<p>Continued From page 16</p> <p>She stated each resident was screened quarterly by therapy, regardless if the resident was currently receiving therapy. The COTA indicated Resident #19 was not due to be screened until this month and had not yet been assessed since being discharged from therapy. She stated when the resident was last assessed by therapy, Resident #19 could self-propel in the wheelchair. She also stated the resident needed the extended brake handles as they were easier for the resident to see due to poor vision. The COTA indicated the therapy department did not maintain extra tips for the handles and maintenance would be responsible for the repair of the brake handles. She indicated the therapy department did keep tennis balls on hand for residents who needed them with assistive devices.</p> <p>On 08/22/13 at 1:27 PM, interview with the Unit Manager (UM) RN #4 revealed all staff were responsible to ensure resident wheelchairs were in good repair. The UM stated if the CNA discovered the protective tips missing from the brake handles, the aide should have reported it to the nurse and complete the maintenance log for repair. She stated the CNAs were responsible to clean the wheelchairs on a rotating schedule. The UM indicated without the protective covers on the handles, Resident #19 could cut him/herself, or cause others to fall.</p> <p>Interview, on 08/22/13 at 1:46 PM, with the Maintenance Director revealed Resident #19's wheelchair brake handles needed protective tips; however, there were none in stock at the facility nor any on order. He stated he was advised by the Administrator this morning to repair the handles. He indicated he had not received a work order or maintenance request to repair the</p>	F 323		
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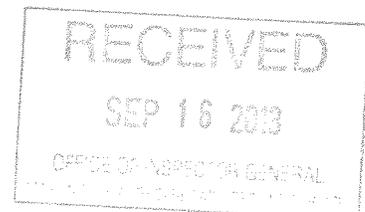
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F 323	Continued From page 17 handles. The Maintenance Director also stated he was not aware how long the protective tips had been missing. On 08/22/13 at 2:08 PM, interview with the Assistant Director of Nursing (ADON) revealed the exposed metal on Resident #1's brakes was discovered in the morning by the Administrator. He stated the extended handles were protruding out from the wheelchair and missing the protective tips. The ADON stated the CNAs were responsible to clean the wheelchairs and the nurses were responsible to complete the maintenance log for any requests for repairs. He indicated he received a list of wheelchairs that had been cleaned by the aides and followed up to check the wheelchairs. Interview with the Administrator, on 08/22/13 at 2:42 PM, revealed he was not aware how long the tips had been missing from Resident #19's wheelchair. He stated anyone on staff should have reported the brake handles needed repair when the tips were discovered missing. The Administrator stated without the tips the brake handles were unsafe and the resident could cut him/herself.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1.) The Dietary Manager discarded 23 sandwiches from the tray in the refrigerator on 8-20-13.	



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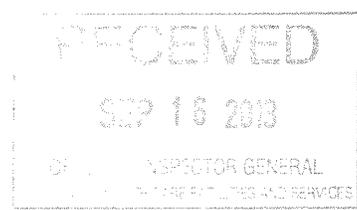
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F 371	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was stored under sanitary conditions. Observation on the initial tour found twenty-three (23) of twenty-three (23) sandwiches stored in the refrigerator were not dated or labeled.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Food Storage-Cold, effective 07/08, revealed the designated Nutrition Service Director or Cook would ensure all food items were stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. However, the policy did not specify how the Dietary staff were carry out this task.</p> <p>Observation, on 08/20/13 at 8:20 AM, found twenty-three (23) half sandwiches of peanut butter and jelly, ham, and chicken sandwiches were stored on a tray in the refrigerator unlabeled and undated.</p> <p>Interview, on 08/20/13 at 8:30 AM, with the Dietary Manager revealed the sandwiches should have been labeled and dated when they were made up the day before.</p>	F 371	<p>2.) The Dietary manager completed an audit of food storage areas including the refrigerator to determine that food items were dated as labeled as appropriate on 8-20-13. No other concerns identified.</p> <p>3.) The Dietary manager re-educated the dietary staff on proper food storage including dating and labeling prepared or opened food items as of 9-29-13 with a post-test completed.</p> <p>4.) The Dietary manager, Administrator and or Assistant Administrator will complete an audit of kitchen including the refrigerator to determine that food is stored appropriately including that prepared items are dated and labeled weekly for 4 weeks, monthly for 2 months and quarterly for 3 quarters. Any concerns will be addressed when identified. The Dietary Manager or Administrator will submit a summary of findings to the Performance Improvement Committee monthly x12 months for further review and recommendation.</p> <p>5.) Completion Date: 9-13-13 <i>9-30-13</i></p> <p><i>changed per phone call w/admin 9/23/13 MZ</i></p>	
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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		
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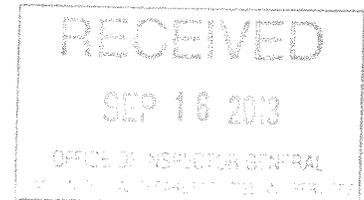
PRINTED: 09/04/2013
FORM APPROVED
OMB NO. 0938-0391

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 08/22/2013
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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(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
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F 441	<p>Continued From page 19</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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:</p>	F 441	<p>F441</p> <p>1.) LPN#1 was reeducated on infection control policy on 8-21-13. Resident #22 was assessed by a licensed nurse utilizing the Definitions of Infections in Long Term Care criteria to determine evidence of infection related to improper hand washing with no changes in condition noted on 8-21-13.</p> <p>2.) Current residents with G-tubes and Tracheostomies were assessed by licensed nursing staff utilizing the Definitions of Infections in Long Term Care criteria to determine evidence of infection related to improper hand washing on 9-13-13.</p> <p>3.) The Nurse Practice Educator re-educated licensed nurses and nursing assistants on the infection control policy including hand washing expectations with a post-test completed as of 9-29-13.</p>	
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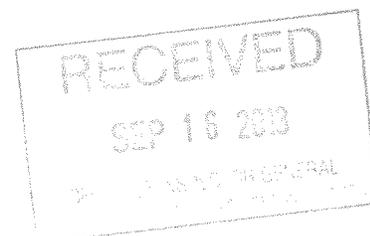
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F 441	<p>Continued From page 20</p> <p>Based on observations, interviews, and record review, it was determined the facility failed to provide a sanitary environment for one (1) of twenty-five (25) sampled residents. LPN #1 failed to wash her hands during treatments and medication administration before and after glove changes for Resident #22.</p> <p>The findings include:</p> <p>Review to the facility's Infection Control Policy, revised 03/01/08, revealed, hands should be washed before direct contact with a patient, after contact with a patient, and after removing gloves.</p> <p>Observations, on 08/21/13 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #22's room, put on non-sterile gloves, checked the gastric tube (g-tube), administered medications and changed her gloves to sterile gloves to suction the residents tracheostomy. She removed the sterile gloves, replaced them with non-sterile gloves and added medication to a nebulizer for a pulmonary breathing treatment. There were four (4) opportunities for the LPN to wash her hands.</p> <p>Interview with LPN #1, on 08/21/13 at 9:40 AM, revealed the LPN was knowledgeable of the current Infection Control Standards as they related to hand washing. In addition, she stated she knew she was to wash her hands before putting on gloves and again when the gloves were removed.</p>	F 441	<p>4.) The Nurse Practice Educator, Assistant Directors of Nursing, and/or the Director of Nursing will complete and document care observations with 5 licensed nurses to determine that Infection control practices including hand washing expectations are implemented appropriately 3 times per week for 4 weeks, monthly for 2 months and then quarterly for 3 quarters. Any concerns will be addressed when identified. A summary of findings will be submitted to the Performance Improvement Committee by the Director of Nursing or Nurse Practice Educator monthly x12 months for further review and recommendation.</p> <p>5.) Completion Date: 9-30-13</p>	
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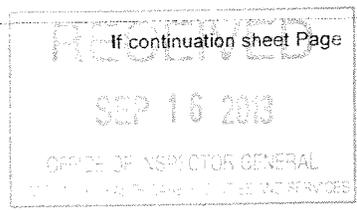
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978, 1980, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system; hydraulically designed.</p> <p>GENERATORS: (2) Type II generators; (1) 30KW and (1) 125KW, fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 08/20/13. Regis Woods Care and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p>	K 000		
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<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 9/11/13</i>
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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.



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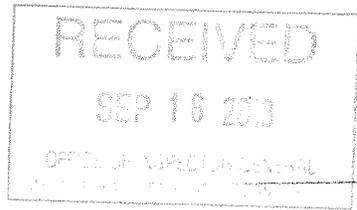
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K 000	Continued From page 1	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility has one-hundred and eighty-six (186) certified beds and the census was one-hundred and sixty-four (164) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 08/20/13 at 10:55 AM, with the Maintenance Supervisor revealed the door to the Clean Utility Room located near the Time</p>	K 029	<p>K 029</p> <ol style="list-style-type: none"> 1.) A Self- Closing device was placed on the clean utility room doors located near the time clock on the Personal Care Unit and near the Solana Nurses Station on 9-5-13 by the Maintenance Director. 2.) The Maintenance Director completed audit of doors in facility to determine what doors are in need of self-closures on 9-6-13. The Maintenance Director installed self-closure devices on 9-5-13 to required areas. 3.) The Administrator re-educated the Maintenance Director to the requirements for Protection of Hazards in accordance with NFPA standards on 9-6-13. 	



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K 029 Continued From page 2
Clock in the Personal Care Unit did not have a self-closing device installed on the door.

Interview, on 08/20/13 at 10:55 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for the Clean Utility Room door to be equipped with a self-closing device.

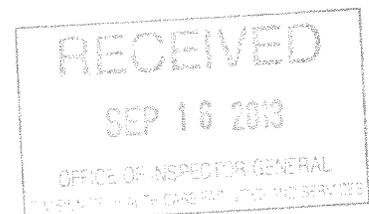
2. Observation, on 08/20/13 at 11:03 AM, with the Maintenance Supervisor revealed the door to the Clean Utility Room located near the Solara Nurses Station did not have a self-closing device installed on the door.

Interview, on 08/20/13 at 11:03 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for the Clean Utility Room door to be equipped with a self-closing device.

Reference:
NFPA 101 (2000 Edition).
19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the

K 029 4.) The Maintenance Director will audit doors in the center to determine that requirements are met in the Protection of Hazards that will include the use of self-closing devices weekly for monthly for 3 months and then quarterly for 3 quarters. Any concerns will be corrected when identified. The Maintenance Director will submit a summary of findings to the Performance Improvement Committee monthly x12 months for review and further recommendation.

5.) Completion Date: 9-29-13



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K 029	Continued From page 3 following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke	K 045	K 045 1.) Alternative Electric Company installed 2 bulbs in the exterior egress light fixtures on 9-11-13. 2.) The Maintenance Director conducted audit of the exterior of the building on 9-6-13 to determine the number of exterior egress light fixtures and notified Alternative Electric Company.	



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K 045

Continued From page 4
compartments, all residents, staff and visitors. The facility has one-hundred and eighty-six (186) certified beds and the census was one-hundred and sixty-four (164) on the day of the survey. The facility failed to provide the required illumination outside an exit for discharge.

The findings include:

Observations, on 07/20/13 between 10:18 AM and 2:23 PM, with the Maintenance Supervisor revealed all of the exterior egress light fixtures, did not have exterior egress lighting to provide the required illumination level for each exit discharge. The exits were equipped with a light fixture with only one bulb.

Interviews, on 07/20/13 between 10:18 AM and 2:23 PM, with the Maintenance Supervisor revealed he was not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs.

Reference NFPA 101 (2000 edition)

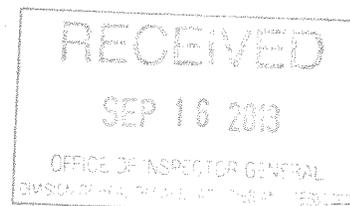
19.2.8 Illumination of Means of Egress.

Means of egress shall be illuminated in accordance with Section 7.8.

7.8 ILLUMINATION OF MEANS OF EGRESS
7.8.1 General.
7.8.1.1*
Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and

K 045

- 3.) The Administrator re-educated the Maintenance Director to the NFPA standard regarding the Illumination requirements for means of egress on 9-6-13.
- 4.) Maintenance Director will audit exterior egress to determine appropriate illumination of means of egress weekly for 4 weeks, monthly for 2 months and quarterly for 3 quarters. Any concerns will be addressed when identified. A summary of findings will be submitted to the Performance Improvement Committee by the Maintenance Director monthly x12 months for further review and recommendation.
- 5.) Completed Date: 9-29-13



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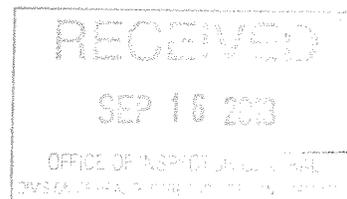
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K 045 Continued From page 5
passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.
7.8.1.2
Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.
7.8.1.3*
The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.
7.8.1.4*
Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2

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K 045 Continued From page 6
ft-candle (2 lux) in any designated area.

K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Smoking regulations are adopted and include no less than the following provisions:

(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.

(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.

(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.

(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4

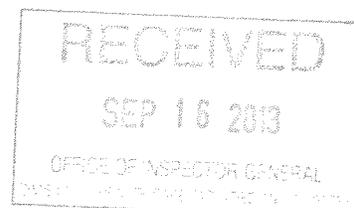
K 045

K 066

K 066

- 1.) Housekeeping office was locked by the Maintenance Director on 8-20-13 and is no longer in-service. The extinguished cigarettes were removed from outside the door of Room 302 by Maintenance Director on 8-22-13. The Housekeeping Supervisor was re-educated on 8-20-13 by the Administrator to the smoking policy including smoking only in designated smoking areas. The ash container was emptied 8-20-13 by maintenance Director.
- 2.) The Maintenance Director conducted audit of the exterior grounds on 9-6-13 to determine compliance with the smoking policy including smoking only in designated smoking areas and proper use or ash containers. No other concerns were identified.
- 3.) The Maintenance Director and Nurse Practice Educator re-educated nursing, dietary, housekeeping, laundry, therapy, activity and administrative staff to the smoking policy including smoking only in designated smoking areas and proper use of ash containers as of 9-29-13 with a post-test completed.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure their smoking policy was followed in the designated smoking area for Residents and Staff, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility has one-hundred and



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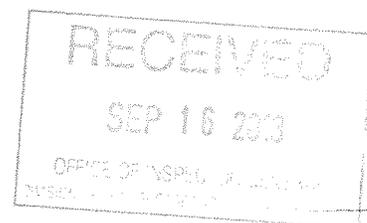
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K 066	<p>Continued From page 7</p> <p>eighty-six (186) certified beds and the census was one-hundred and sixty-four (164) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 08/20/13 at 10:15 AM, with the Maintenance Supervisor revealed the concrete patio outside of the exterior door from Room 302, the Housekeeping Supervisor's Office, was being used as an unauthorized smoking area. Extinguished cigarettes were located in a pile directly outside of the door. There were no approved ashtrays or a fire extinguisher available for usage.</p> <p>Interview, on 08/20/13 at 10:15 AM, with the Maintenance Supervisor revealed he was not aware of smoking being done outside of the designated smoking area.</p> <p>2. Observation, on 08/20/13 at 10:46 AM, with the Maintenance Supervisor revealed the facility was not following their smoking policy in the designated exterior courtyard smoking area for Residents and Staff. The designated smoking area was equipped with two (2) fire extinguishers, two (2) fire blankets and an ash container with a self-closing lid. However, the ash container was used to discard empty cigarette packs and a full, plastic trash bag next to the container was filled with discarded paper products and an abundance of cigarette butts.</p>	K 066	<p>4.) The Maintenance Director will audit the facility grounds including the smoking area weekly for 4 weeks, monthly for 2 months and quarterly for 3 quarters to determine compliance with the smoking policy including smoking only in designated areas and proper use of ash containers. Any concerns will be addressed when identified. The Maintenance Director will submit findings to the Performance Improvement Committee monthly x12 months for further review and recommendation.</p> <p>5.) Completion Date: 9-30-13</p>	
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	<p>Interview, on 08/20/13 at 10:46 AM, with the Maintenance Supervisor revealed he was not aware of the smoking policy not being followed in the designated smoking area.</p>			
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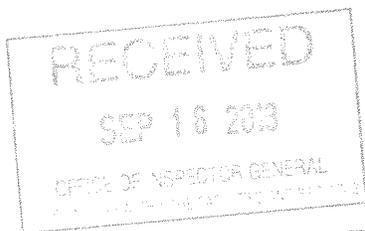
PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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K 066	<p>Continued From page 8</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited.</p> <p>Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p>	K 066		
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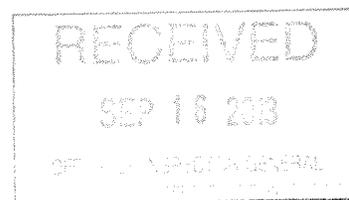
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER

REGIS WOODS

STREET ADDRESS, CITY, STATE, ZIP CODE
4604 LOWE RD
LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 9	K 066		
K 147 SS=D	Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Subject: Alert: Smoking Safety in Long Term Care Facilities NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, approximately forty (40) residents, staff, and visitors. The facility has one-hundred and eighty-six (186) certified beds and the census was one-hundred and sixty-four (164) on the day of the survey. The findings include: 1. Observation, on 08/20/13 at 11:33 AM, with the Maintenance Supervisor revealed medical equipment (a mini-nebulizer) was plugged into a power strip located in Resident Room 231. Interview, on 08/20/13 at 11:33 AM, with the Maintenance Supervisor revealed he was aware of the requirements for the usage of power strips; however, he was not aware of medical equipment being plugged into a power strip located in Resident Room 231.	K 147	K 147 1.) Maintenance Director removed power strip from Room 231 and 232 on 8-20-13. 2.) Maintenance Director completed an audit of resident rooms for power strip usage completed on 8-22-13. Any concerns were addressed when identified. 3.) The Maintenance Director and Nurse Practice Educator re-educated nursing, dietary, therapy, housekeeping, laundry, and administrative staff on the use of power strips as of 9-29-13 with a post- test completed.	



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NAME OF PROVIDER OR SUPPLIER REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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K 147

Continued From page 10

2. Observation, on 08/20/13 at 11:37 AM, with the Maintenance Supervisor revealed medical equipment (a mini-nebulizer, an oxygen concentrator and the resident 's bed) were plugged into a power strip located in Resident Room 232.

Interview, on 08/20/13 at 11:37 AM, with the Maintenance Supervisor revealed he was aware of the requirements for the usage of power strips; however, he was not aware of medical equipment being plugged into a power strip located in Resident Room 232.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D
Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 147

4.) The Maintenance Director will audit current resident rooms weekly for 4 weeks, monthly for 2 months and then quarterly for 3 quarters to determine power strip usage. Any concerns will be addressed when identified. The Maintenance Director will submit a summary of findings to the Performance Improvement Committee monthly x12 months for further review and recommendation.

5.) Completion Date: 9-30-13

