

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

PRINTED: 06/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2012
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER	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) COMPLETE DATE
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F 000	INITIAL COMMENTS A standard and abbreviated survey investigating complaints KY18509 and KY18427 was initiated on 06/12/12 and completed on 06/14/12. The highest scope and severity cited was an "F" with the facility having an opportunity to correct before remedies would be recommended. A Life Safety Code survey was conducted on 06/12/12 and found the facility in compliance with federal Life Safety Code requirements. The Division of Health Care substantiated Complaint KY18509 with deficiencies cited and KY18427 allegation was unsubstantiated.	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." FTAG 166 1. A grievance form was completed on 6-15-12 by the Director of Nursing related to the concern of medication availability and staff handling medications with their bare hands as voiced by the daughter of Resident #21. An investigation was completed by the Director of Nursing on 6-15-12 which determined that the resident had adequate supply of ordered medications. Licensed nurses will be re-educated by the staff development coordinator to infection control practices while passing medications by 7-13-12. The Director of Nursing contacted the daughter of Resident #21 and notified Resident #21 of the Grievance Investigation and resolution on 6-15-12. Both the resident and the residents' daughter voiced satisfaction with the investigation and outcome. 2. A letter was sent to the responsible party for current residents by the Administrator on 7-5-12 to encourage that families contact the Administrator or Social Services staff with any unresolved or new concerns/grievances. The Social Services staff completed interviews 7-6-12 with current cognitively intact residents to determine if they had any unresolved or new concerns/grievances. Any concerns/grievances voiced were documented, investigated and resolved using the Grievance form and process. An observation of medication administration was completed by the Staff Development Coordinator on 6-15-12 to determine Infection Control Practices when handling medications during medication administration for 2 residents per medication cart on each unit. 3. The Regional Director of Clinical Operations re-educated the Administrator, Director of Nurses, Assistant Director of Nurses and Social Services staff regarding	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the grievance record, and review of the facility's policy, it was determined the facility failed to respond or resolve a grievance for one (1) of twenty-three (23) sampled residents (# 21). The facility failed to ensure Resident #21 had adequate medications in the facility. The findings include: Review of the facility's policy and procedure Customer Concerns/Grievances, dated 01/09, revealed the Center Staff will assist a resident,	F 166		

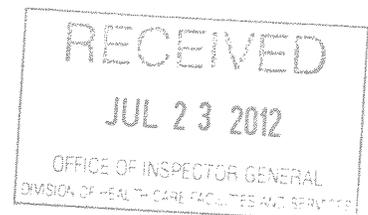
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joshua S. Schuler</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>7-6-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may 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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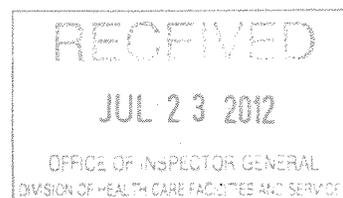
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F 166	<p>Continued From page 1</p> <p>legal representative, other involved family member...who has a concern/grievance to report as needed with a Grievance form completed. This will be forwarded to the Social Services Director, who enters the information on the Grievance log. The grievance will be reviewed and involve other departments as appropriate. The center will investigate the concern, take action, and document the follow up and proposed resolution on the completed grievance form. The Administrator/Designee will inform the individual that filed the concern of the conclusion and corrective action.</p> <p>Review of the clinical record revealed the facility admitted Resident #21 on 12/10/09 with diagnoses of Congestive Heart Failure, End Stage Renal Disease, and Dialysis Dependent.</p> <p>Interview with the daughter of Resident #21, on 06/14/12 at 10:40 AM, revealed she had called the Director of Nursing (DON) about three weeks ago to voice a concern about the facility running out of medication for Resident #21. She also voiced a concern regarding staff handling medication with bare hands. She stated no one from the facility including the DON followed up with her about the grievance.</p> <p>Review of the Grievance record, from January 2012 though June 2012, revealed no evidence of any grievances filed for Resident #21 by the family. The facility provided no documentation of receiving a grievance regarding staff handling of medications with bare hands.</p>	F 166	<p>Grievance process on 7-2-12. Nursing, Dietary, Housekeeping, Laundry, Therapy, Activities, and the Administrative Staff will be re-educated to the Grievance process by the Social Worker and Administrator by 7-13-12. Grievance forms have been posted at each nurses stations and in the lobbies for staff, family and visitors to document grievances. Grievance forms will be reviewed daily by the Social Services staff or Weekend Manager and resolved accordingly.</p> <p>4. The Social Services Director, and or Administrator will complete an interview of 5 cognitively intact residents and then interview the responsible parties for 5 cognitively impaired residents to determine any new or unresolved concerns weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>Completion 7-14-12</p>



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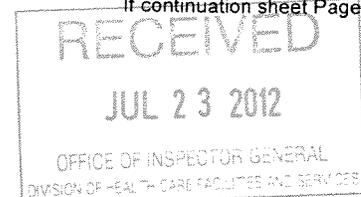
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F 166	Continued From page 2 Interview with the Social Service Director, on 06/14/12 at 4:30 PM, regarding grievances, revealed the person who received the grievance would complete the grievance form. She stated if the grievance was a nursing issue the DON would investigate and follow up. She stated the facility should follow up with the complainant within forty-eight (48) hours. Interview with the DON, on 06/14/12 at 5:15 PM, revealed she had received a complaint over the phone from the daughter of Resident #21 about three weeks ago regarding the resident running out of medication and staff handling of medication with bare hands. She stated she did not complete a grievance form but should have. She stated she investigated the issues and found the resident was not out of medication, as it was in the medication cart when she checked with the nurse. She stated she had talked with the staff about handling medications with bare hands. She stated she did not follow up with the family and she had instructed the nurse to notify the daughter that the medication was in the facility. The DON stated the nurse should have documented in the nurses notes of the notification of the daughter. The DON reviewed the medical record and stated she was unable to find any documentation of the nurse notifying the daughter.	F 166			
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit	F 224			



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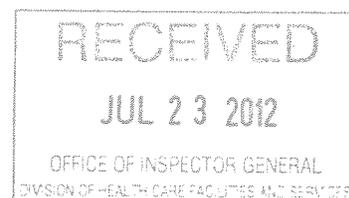
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F 224	<p>Continued From page 3 mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to protect one (1) of twenty-six (26) residents from misappropriation of property. Resident #18's bank card was stolen from the resident's bedside table.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property revealed all residents have the right to be free from misappropriation of their property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Record review revealed the facility admitted Resident #18 on 04/27/12 with diagnoses of Motor Vehicle Accident with After Care for Multiple Traumatic Fractures and Bipolar Disorder. A review of the admission Minimum Data Set (MDS), dated 05/04/12, revealed the facility identified the resident as cognitively impaired.</p> <p>Interview with Resident #18, on 06/12/12 at 11:30 AM, revealed the resident was on pain medication for multiple fractures, from a motor</p>	F 224	<p>F224</p> <p>1. An initial report was made to the Office of Inspector General and Adult Protective Services on 5-31-12 by the Assistant Director of Nursing and the investigation initiated. The Administrator notified the Louisville Metro Police on 5-31-12 who then came to the facility and a police report was filed. The investigation was completed and a final report was submitted to the Office of Inspector General and Adult Protective Services by Assistant Director of Nursing on 5-31-12 that substantiated misappropriation however the center could not determine who took the bank card. The Administrator placed a call to the Detective on 7-5-12 for follow-up with no new information provided. The Police investigation remains ongoing. Resident #18's bank card was replaced and money refunded by the bank on 5-31-12. Resident #18 was provided a locked drawer to his nightstand to secure his personal belongings by Maintenance on 5-31-12 and then on 6-15-12 was provided a lock box..</p> <p>2. A letter was sent to the responsible party for current residents from the Administrator on 7-5-12 to inform them that Lock boxes are available to secure personal items upon request. Current cognitively intact residents will be notified by 7-13-12 by the Administrator, Social Services and/or Activities Directors that Lock boxes are available upon request. Any resident or responsible party that requested a lock box was provided with a lock box at the time of the request by the Maintenance staff. No other</p>



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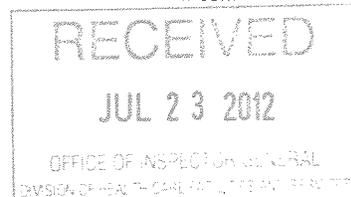
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F 224	<p>Continued From page 4</p> <p>vehicle accident, at the time of admission, and was uncertain if he/she was offered a locked drawer or the opportunity to lock up valuables in the business office when admitted. The resident said he/she discovered the card was missing when he/she received a phone text from the bank informing him/her of multiple charges on the bank card at approximately 5:00 PM on 05/30/12. The resident returned the call to the bank, stopped the charges, and then informed CNA #6 of the missing bank card. The CNA told the resident the facility could not do anything about this until morning, because Management had left for the day. The resident said he/she reported the missing bank card to his/her nurse the next morning.</p> <p>Interview with CNA #6, on 06/14/12 at 3:30 PM, revealed she did not report the missing bank card to anyone at the facility until the next day, 05/31/12 at 3:00 PM. The CNA commented she did not report it to the nurse because the nurse would not know who took it and Management had already left for the day. The CNA said she was trained to report abuse immediately and probably should have told the nurse.</p> <p>Interview with LPN #4, on 06/14/12 at 3:10 PM, revealed the resident had reported to her that the bank card was missing the next morning, on 05/31/12.</p> <p>Interview with the Social Service Director, on 06/14/12 at 4:30 PM, revealed she was uncertain what the Admission Coordinator tells the residents and their families on admission concerning locking up valuables.</p>	F 224	<p>allegations have been reported regarding missing property.</p> <p>3. A letter from the Administrator has been inserted into the facility admission packet to notify newly admitted residents and/or their responsible parties of the availability of lock boxes to secure personal belongings on 7-5-13. The Administrator will provide re-education to the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Admissions and Maintenance Director regarding the availability of lock boxes for residents to secure their belongings by 7-13-12. As of 7-13-12 Nursing and maintenance staff will be provided re-education regarding the availability of lock boxes by the Social Services, Maintenance Director, and Staff Development Coordinator. The Regional Director of Clinical Operations re-educated the Administrator, Director of Nursing, and Assistant Director of Nursing on 7-3-12 to the Abuse Policy and Procedure with particular emphasis on the timely reporting and investigating of any allegation of abuse. Nursing, dietary, therapy, housekeeping, laundry, Social Services, Activities, and Administrative staff will be re-educated to the Abuse Policy with added emphasis and explanation of reporting all allegations timely to their supervisor by the Staff Development Coordinator and Social Services by 7-13-12.</p> <p>4. The Social Services or Admissions Director will contact either the resident or responsible party of 5 newly admitted residents to determine their awareness to the availability of lock boxes for the residents upon request weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>Completion Date 7-14-12</p>		



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F 224	Continued From page 5 Interview with the Director of Nursing (DON), on 06/14/12 at 4:35 PM, revealed the staff was trained to report abuse/neglect immediately. A staff member should never wait twenty (20) hours to report an incident of misappropriation of property or any type of abuse/neglect.	F 224			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and review of the facility's Abuse and Neglect Prohibition Program, it was determined the facility failed to ensure written policies and procedures were implemented regarding reporting misappropriation of property for one (1) of twenty-six (26) residents. Resident #18's bank card was reported missing to CNA #6, who delayed reporting the alleged abuse to administration. Administration delayed investigating the incident. The finds include: Review of the facility's policy regarding Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property revealed the Department Head or designee is responsible to educate employees through orientation and on-going training sessions on reporting and documentation of abuse and neglect and is responsible to investigate allegations of misappropriation of	F 226	F226 1. The Interim Administrator's last day working at the center was on 6-14-12. CNA #6 was re-educated on 5-31-12 by the Assistant Director of Nursing to the Abuse Policy with emphasis on the reporting timely. CNA #6 received disciplinary action for not reporting the allegation of misappropriation timely on 5-31-12 by the Assistant Director of Nursing. An initial report was made to the Office of Inspector General and Adult Protective Services on 5-31-12 by the Assistant Director of Nursing and the investigation initiated. The Administrator notified the Louisville Metro Police on 5-31-12 who then came to the facility and a police report was filed. The investigation was completed and a final report was submitted to the Office of Inspector General and Adult Protective Services by Assistant Director of Nursing on 5-31-12 that substantiated misappropriation however the center could not determine who took the bank card. A call was placed to the detective on 7-5-12 with no new information provided. The Police investigation is on going. Resident #18's bank card was replaced and money refunded by the bank on 5-31-12. Resident #18 was provided a Locking nightstand drawer on 5-31-12 and then on 6-15-12 a lock box was provided to secure his personal belongings by Maintenance. 2. The Administrator and Director of Nursing reviewed any allegations of abuse in the past 30 days on 7-3-12 to determine that allegations were reported and investigated timely. No other concerns were identified.		



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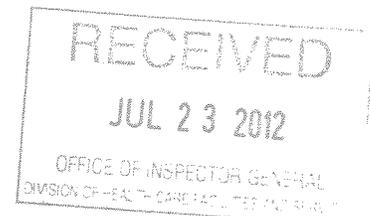
F 226	<p>Continued From page 6 residents' property.</p> <p>Review of the facility's investigation revealed Resident #18 had told CNA #6 that his/her bank card had been stolen and the CNA told the resident he/she should speak with the Assistant Director of Nursing (ADON) the next morning. Review of the facility's investigation revealed the facility did not complete the Staff Event Investigation Interviews until five days after the alleged incident occurred.</p> <p>Interview with CNA #6, on 06/14/12 at 3:30 PM, revealed Resident #18 had reported to her on 05/30/12 at approximately 6:30 PM that his/her bank card was missing. The CNA did not report the missing bank card to anyone at the facility until the next day, 05/31/12 at 3:00 PM. The CNA commented she did not report it to the nurse because the nurse would not know who took it and Management had already left for the day. The CNA said she was trained to report abuse immediately and probably should have told the nurse.</p> <p>Interview with LPN #4, on 06/14/12 at 3:10 PM, revealed the resident had reported to her the next morning, 05/31/12, that the bank card was missing.</p> <p>Interview with the Social Service Director, on 06/14/12 at 4:30 PM, revealed misappropriation of property was abuse, and should have been reported immediately,</p> <p>Interview with the Director of Nursing (DON), on 06/14/12 at 4:35 PM, revealed the staff was trained to report abuse/neglect immediately. A</p>	F 226	<p>3. The Regional Director of Clinical Operations re-educated the Administrator, Social Services, Director of Nursing, and Assistant Director of Nursing on 7-3-12 to the Abuse Policy and Procedure with particular emphasis on the timely reporting and investigating of any allegation of abuse. Nursing, dietary, therapy, housekeeping, laundry, Activities, and Administrative staff will be re-educated to the Abuse Policy with added emphasis and explanation of reporting all allegations timely to their supervisor by the Staff Development Coordinator and Social Services as by 7-13-12.</p> <p>4. The Director of Nursing and/or Administrator will complete an audit of all allegations of abuse to determine that they are reported and investigated timely weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>5. Completion: 7-14-12</p>	
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JUL 23 2012
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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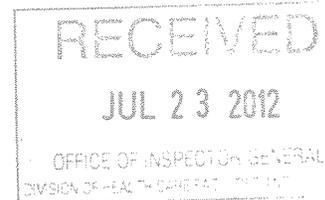
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F 226	Continued From page 7 staff member should never wait twenty (20) hours to report an incident of misappropriation of property or any type of abuse/neglect. Interview with the Interim Administrator (IM), on 06/14/12 at 6:00 PM, revealed an alleged incident of abuse/neglect should be reported immediately to administration. Any staff that has had contact with the alleged victim in the twenty-four (24) hours prior to the incident, should have an investigative interview completed within the next twenty four (24) hours. The Administrator was ultimately responsible to see that abuse was reported and investigated in a timely manner.	F 226		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a homelike environment for thirteen (13) of twenty-six (26) residents. Rooms 113A, 115, 116, 121A, 123, 124B, and 127A, were observed to have a non home-like environment. This is a repeat deficiency. The findings include: The facility revealed there was no policy on	F 252		



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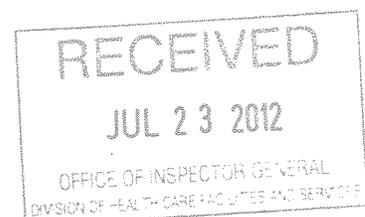
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F 252	<p>Continued From page 8 resident environment.</p> <p>Observations of the facility during the initial tour, on 06/12/12 at 8:00 AM, and on 06/12/12 at 4:45 PM, revealed rooms 113A, 115, 116, 121A, 123, 124B, and 127A were lacking any type of decoration or personal items. Observation, on 06/13/12 at 7:40 AM, of Room 123-B, the room of Resident "D", revealed the resident's room had no pictures on the wall, no personalized items to decorate the room, no television or anything that would make the room present homelike. The resident's presence in the room was the only indicator the room was occupied without going into a closet or drawer.</p> <p>Interview with Resident #6, on 06/13/12 at 2:00 PM, revealed some residents' rooms were bare on the 100 unit and she felt it was sad. She stated she thought many residents were not able to speak for themselves.</p> <p>Interview with Certified Nurse Aides (CNA) #3 and #4, on 06/13/12 at 9:00 AM, revealed the residents in these rooms were confused and they had not noticed that there were no home-like touches in the rooms. They stated the rooms did need some personal touches or decorations to make them home-like.</p> <p>Interview, on 06/14/12 at 7:05 AM, with the Assistant Director of Nursing (ADON) revealed families were encouraged to bring in items to make the resident's room more homelike. The Ambassador's monitor the rooms, which include the physical appearance of the room, she</p>	F 252	<p>F252</p> <p>1. Curtains and a variety of wall hangings (pictures and mirrors) were placed in Rooms 113a, 115, 116, 121a, 123, 124b and 127a. by Maintenance by 7-13-12.</p> <p>2. An audit of all resident rooms was completed on 6-31-12 by the Administrator, Maintenance and Housekeeping to determine that all rooms had a homelike environment. No other concerns were identified.</p> <p>3. The Administrator educated the Director of Admission, Social Services Director, Maintenance Director, and Housekeeping Supervisor on 7-3-12 that residents will be provided with a homelike environment. Resident rooms on NF1 have had an accent wall painted, and resident rooms on NF1, NF2 and Solana have had pictures and mirrors placed to create a homelike environment by maintenance as of 7-13-12. Prior to or upon a residents admission, the Administrator will designate either the Director of Admissions, Social Services or Maintenance Director to determine that the residents room has a homelike appearance by completing a Resident Room Checklist which includes checking resident rooms for a homelike environment (ie pictures, mirrors)..</p> <p>4. The Administrator and or Maintenance Director will audit the rooms of current residents using the Resident Room Checklist to determine that their room has a homelike environment weekly x4 weeks and then monthly x2 months then quarterly x 2. A summary of findings will be submitted to the Performance Improvement Committee monthly x 10 months for further review and recommendation.</p> <p>5. Completion Date: 7-14-12</p>		



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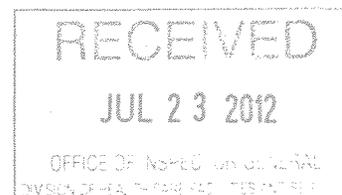
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2012
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F 252	Continued From page 9 revealed. Related directly to Resident "D" she stated "no", the room was not homelike. Interview with the Director of Nursing, on 06/14/12 at 1:00 PM, revealed the rooms on the 400 unit were decorated in 2011 after the facility was cited for resident environment. She stated no other unit rooms were included in the deficiency and therefore no other unit rooms were decorated. She indicated some of the residents in these rooms were homeless prior to admission to the facility and they had no property. She stated the facility would have to make efforts to add decor to the rooms. Continued interview with the DON, on 06/14/12 at 1:45 PM, revealed homelike was how you lived in your home prior to living in the facility. The facility had residents that were indigent. She stated individual preference was what makes one comfortable, the resident comfortable. She revealed the facility had made major improvements to the environment and stated there are rooms that could continue to be improved.	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 review of	F 253		



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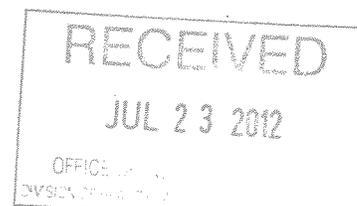
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F 253	<p>Continued From page 10</p> <p>the facility's policy, it was determined the facility failed to maintain a sanitary environment for two (2) of three (3) nursing units. Two rooms on the 200 hall had bed pans and wash basins on the bathroom floor not in bags (Rooms 210 and 224). Two rooms on the 200 hall and two rooms on the 100 hall had rooms with clutter with boxes on the floor preventing cleaning (rooms 229-A, 234, 128 and 129).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Nursing Department Infection control Guidelines, Care of Resident Equipment, dated January 2008, revealed Bedpans, urinals and washbasins care and cleaning include cover and store in the residents' bedside cabinets.</p> <p>Observation, on 06/12/12 at 8:15 AM, revealed in Room 210, the bedpan and the washbasin were on the floor under the sink and not stored in bags. In Room 224 the bath basin was in the bathroom on the floor on top of a clear bag.</p> <p>Observation, on 06/12/12 during the 8:15 AM tour and on 06/14/12 at 2:00 PM, during the sanitation tour, Room 229-A had multiple boxes on the floor and the room was cluttered with personal belongings. Room 234-B had two boxes of personal belongings stored on the floor. Room 128 and 129 was cluttered with multiple personal items stored on the floor.</p> <p>Interview with the Housekeeping Director, on 06/14/12 at 2:00 PM, revealed the facility had several residents who have cluttered rooms and they had reported to nursing and social services.</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> 1. The bed pans and wash basins in rooms 210 and 224 were discarded on 6-14-12 by a licensed nurse and then replaced with new bed pans and wash basins that were covered and stored in the residents' bedside cabinet. Resident rooms 229a, 234, 128 and 129 will have boxes and clutter removed by maintenance and housekeeping by 7-13-12. 2. An audit of the resident rooms and care areas was completed by the Administrator, Maintenance, Director of Nursing, Staff Development Coordinator and the Unit Managers on 7-3-12 to determine that there is a sanitary, orderly, and comfortable interior. Any additional bed pans and washbasins identified were discarded, replaced, and stored appropriately when identified. No other concerns were identified. 3. The Administrator re-educated the Maintenance Director, Director of Nursing, Staff Development Coordinator, Unit Managers, and Housekeeping Supervisor on 7-3-12 that the center will maintain a sanitary, orderly, and comfortable interior with specific examples provided related to bed pan and wash basin storage and clutter. The Staff Development Coordinator and housekeeping supervisor will provide re-education to the nursing, social services, maintenance, and housekeeping staff that the center will maintain a sanitary, orderly, and comfortable environment with specific examples of proper bed pan and wash basin storage in addition to clutter in resident rooms by 7-13-12. 4. The Administrator, Director/Assistant of Nursing, Social Services, and/or Maintenance Director will complete an audit of current resident rooms weekly x4 weeks and then monthly x2 months to determine that a sanitary, orderly and comfortable interior is maintained including appropriate storage of bed pans and washbasins and the presence of clutter. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for review and further recommendation. 5. Completion Date: 7-14-12



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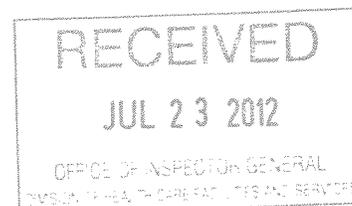
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F 253	<p>Continued From page 11</p> <p>He stated the problem with boxes was it could cause bugs and housekeeping staff cannot clean the room thoroughly when items were stored on the floors.</p> <p>Interview with the Maintenance Director, on 06/14/12 at 2:00 PM, revealed they had made attempts to remove clutter items and the residents scream and yell. He did acknowledge it was a fire hazard and a risk for falls for rooms where there was excessive clutter.</p>	F 253		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced</p>	F 279		



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F 279	<p>Continued From page 12</p> <p>by:</p> <p>Based on observation, interview, review of the facility's policy and review of the clinical record, it was determined the facility failed to develop a comprehensive care plan for one (1) of twenty-six (26) sampled and three (3) un-sampled residents. The facility failed to integrate Hospice care into Resident #3's comprehensive care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plan- Interdisciplinary, dated 01/08, revealed the nurse was to initiate a care plan addressing the resident's most immediate needs upon admission. The Interdisciplinary Team (IDT) develops a comprehensive care plan addressing the resident's most acute problems within twenty-four (24) hours of admission and reviews each care plan at least quarterly and updates as necessary.</p> <p>Review of the clinical record for Resident #3 revealed, the facility admitted the resident on 03/01/12 with diagnoses of Dementia with Behaviors and Chronic Airway Obstruction. The resident was admitted to hospice care on 05/31/12.</p> <p>Review of Resident #3's comprehensive care plan, dated 03/01/12 and revised 06/11/12, revealed Hospice care was mentioned for identified issues of resident nutrition and self-care. However, the facility did not incorporate Hospice care into the resident's comprehensive care plan regarding scope of services or frequency of visits by the hospice nurse, social worker, or chaplain.</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> 1. The care plan for Resident #3 and the 3 un-sampled residents was updated on 7-3-12 by the Interdisciplinary team to integrate Hospice care. 2. An audit of current residents care plan was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers to determine that a comprehensive care plan is in place. Care plans will be updated as necessary by the Interdisciplinary team by 7-13-12. 3. The Interdisciplinary team was re-educated by the Regional Director of Clinical Operations to the Care Plan policy and completing a comprehensive care plan including the integration of hospice care on 7-3-12. Licensed nurses will be re-educated to the Care Plan Policy include the integration of hospice care by 7-13-12 by the Staff Development Coordinator and Clinical Reimbursement Manager. 4. The Clinical Reimbursement Manager, Assistant Director of Nursing and/or Unit Managers will complete <p>an audit of 5 resident care plans (2 residents of which will be under the care of hospice) weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>Completion Date 7-14-12</p>



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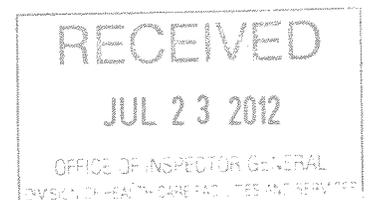
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F 279	Continued From page 13 Interview, on 06/12/12 at 3:10 PM and 06/14/12 at 2:20 PM, with Licensed Practical Nurse (LPN) #7 revealed Resident #3 was receiving Hospice care. The nurse stated the nurses were responsible to update the resident comprehensive care plan when there was a change in the resident condition. Interview, on 06/14/12 at 3:35 PM, with LPN #8 Unit Manager (UM) revealed the nurses were responsible to update the care plans, including incorporating the hospice care plan into the comprehensive care plan. The UM stated once a week the Director of Nursing (DON), UM, MDS Coordinator, and Social Worker met together and reviewed the resident's chart and care plan. The UM stated the nurses were trained in orientation how to complete a resident care plan. On 06/14/12 at 4:53 PM, interview with the DON revealed the nurses were responsible to update resident care plans when a change occurred. The DON stated she was ultimately responsible to ensure resident care plans were revised. She stated not revising the resident's care plan could result in the resident's care not communicated to staff and care may not be provided.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		



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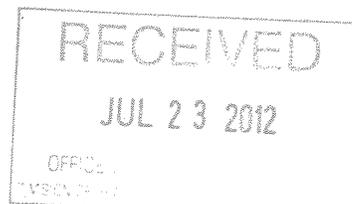
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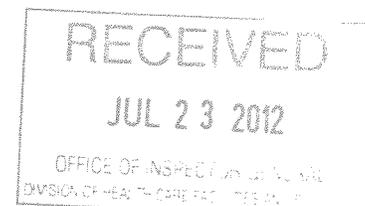
F 280	<p>Continued From page 14 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</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 revise the comprehensive care plan for two (2) of twenty-six (26) sampled residents (Resident #12, #14). The facility planned for Resident #14 to attend activities with his/her mother, also a resident at the facility, however, the resident's mother expired in 01/2012. The facility failed to revise the resident's comprehensive care plan to include interventions to assist with coping with his/her loss. The facility failed to revise the care plan for Resident #12 regarding the discontinuation of a wander guard.</p> <p>The findings include:</p> <p>Observation of Resident #14, on 06/12/12 at 11:15 AM, revealed the resident making fists during the conversation and appearing angry. The resident flailed his/her arms and made angry</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> 1. The care plan for resident #12 and 14 was revised on 7-3-12 by a licensed nurse to reflect the residents' current status. 2. The Assistant Director of Nursing, Unit Managers and Clinical Reimbursement Manager will complete an audit of current resident care plans by 7-13-12 to determine that care plans reflect the residents current status. Any other care plans identified will be updated as necessary by a licensed nurse. 3. The Administrator re-educated the Interdisciplinary team to the Care Planning which included updating the care plan to reflect the residents current status on 7-3-12. The Staff Development Coordinator, Unit Managers, and Clinical Reimbursement Manager will provide re-education to the licensed nurses to the Care Plan process including updating the care plan to reflect the residents current status by 7-13-12. 4. The Director/Assistant of Nursing, Unit Managers, and/or Clinical Reimbursement Manager will audit 5 resident care plans per week x4 weeks and then monthly x2. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation. <p>Completion Date: 7-14-12</p>	
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F 280	<p>Continued From page 15 hand motions.</p> <p>Inter view with Resident #14, on 06/12/12 at 11:00 AM, revealed the resident had anger against the facility whom the resident blamed for the death of his/her mother. The resident stated his/her mother was a resident at the facility and expired. The resident refused to provide any details and stated the facility had been sued. The resident displayed a hostile and loud voice and left the room.</p> <p>Review of the clinical record for Resident #14, revealed the facility admitted the resident on 06/18/10 with diagnoses of Diabetes, Seizure Disorder, Depression, Anxiety and Bilateral Lower Leg Amputations. The facility completed an annual Minimum Data Set assessment on 04/12/12 which revealed the resident was verbally hostile to staff, felt down and depressed, was tired, refused care, threatened staff and fabricated stories regarding staff. The resident experienced pain on a daily basis and required sleeping medication, antidepressants and anti-anxiety medication.</p> <p>Review of the comprehensive care plan, developed by the facility, for Resident #14, revealed no information regarding the death of the resident's mother. The facility was not able to provide any documentation of revising the behavior/mood care plan following the death of his/her mother in January 2012.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 06/13/12 at 9:00 AM, revealed Resident #14 took the loss of his/her mother badly. She stated the resident's behaviors seemed worse and the</p>	F 280		



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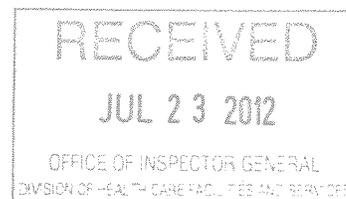
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F 280	<p>Continued From page 16</p> <p>resident was harder to satisfy. She stated she was unable to locate care plan revisions to address the resident's loss.</p> <p>Interview with the Director of Nursing, on 06/14/12 at 5:15 PM, revealed the facility should have revised Resident #14's behavior/mood care plan when the resident's mother expired.</p> <p>Review of the clinical record for Resident #12 revealed the facility admitted the resident on 04/21/08 with a diagnosis of Dementia with Behaviors. The facility conducted a quarterly Minimum Data Set (MDS) assessment on 02/09/12 which revealed the resident was cognitively impaired with a Brief Interview Mental Score (BIMS) of two (2).</p> <p>Review of the comprehensive care plan for Resident #12 revealed the facility identified the resident with a decline in memory and indicated an intervention for the use of a wanderguard. The care plan intervention for a wanderguard was initiated on 12/10/2010 and revised on 05/09/2011, with the most recent review on 02/10/2012.</p> <p>Observation, on 06/12/12 at 11:45 AM, 2:50 PM and 06/13/12 at 8:35 AM, and 4:05 PM, revealed Resident #12 did not have a wanderguard in place.</p> <p>Interview, on 06/14/12 at 2:20 PM, with Licensed Practical Nurse (LPN) #7 revealed Resident #12 was not supposed to have a wanderguard and did not have a wanderguard in place. The LPN stated</p>	F 280		
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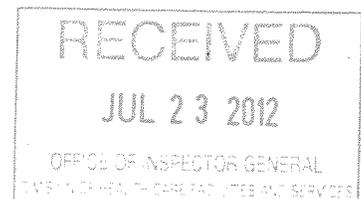
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F 280	<p>Continued From page 17 she did not remember if the resident ever had a wanderguard.</p> <p>Interview, on 06/14/12 at 3:35 PM, with the Unit Manager (UM) LPN #3 revealed the nurses were to update the resident care plans. The UM stated once a week the Director of Nursing (DON), UM, Social Worker, and MDS Coordinator review resident charts to ensure the care plan is updated.</p> <p>On 06/14/12 at 4:35 PM, interview with the DON revealed the nurses were responsible to revise the resident care plan when there was a change in resident condition. The DON stated care plans were reviewed during the care plan conference and care meetings. She stated not updating the care plan would result in resident care not being properly communicated, which would lead to care not being followed through. The DON stated she was ultimately responsible for revision of the care plan.</p>	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 provide care and services in accordance with the Comprehensive Care Plan for three (3) of twenty-six (26) sampled</p>	F 282		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 06/14/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 282	<p>Continued From page 18</p> <p>residents, (#2, #8 and #17). Resident #2 did not receive Restorative Therapy as indicated on the Care Plan. Resident #8 and #17 did not receive assistive devices as indicated on the care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care and Services, revised 01/08, revealed the facility will provide the necessary care and services to maintain the highest level of practicable functioning that will enhance the residents quality of life.</p> <p>1. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 09/10/08 with diagnoses including Cerebral Vascular Accident (CVA), Contractures, Parkinson's Disease and Muscular Wasting. Review of the Comprehensive Care Plan For Resident #2 revealed the resident had limited Range of Motion (ROM) related to muscle weakness with interventions for passive/active ROM to extremities, 10 reps seven (7) days per week initiated on 01/10/12.</p> <p>Review of the Certified Nursing Assistant (CNA) Kardex Report printed 05/21/12 for Resident #2, revealed a Restorative Program was indicated for ROM and eating. No specific orders were written. Review of the Restorative Nursing Program Flow Sheet for the month of June 2012, revealed AROM to bilateral upper extremities, 10 reps 7 days per week. Only six (6) of 11 days were</p>	F 282	<p>F282</p> <p>1. The restorative plan for Resident 2 was revised on 7-5-12 by the licensed nurse as recommended by the Interdisciplinary team. Resident #8 was provided with bed bolsters and fall mats to the floor next to the bed when the resident is in the bed as well as a chair alarm, geri/long sleeves and floating heels on 6-15-12 by a licensed nurse. The care plan for Resident #17 was updated to reflect resident refusal of non-skid socks and hipsters by the licensed nurse on 6-15-12. Resident #17 was provided a perimeter mattress and non-skid strips as per the plan of care by a licensed nurse on 6-15-12.</p> <p>2. The Director and Assistant Director of Nursing, Unit Managers, and/or Clinical Reimbursement Manager will complete an audit of current resident care plans to determine that necessary care and services as indicated on the resident plan of care is in place by 7-13-12. Any other care or services not in place will be provided upon identification.</p> <p>3. The Assistant Director of Nursing, Unit Managers, Staff Development Coordinator and Clinical Reimbursement Manager will be provided re-education to the nursing staff by 7-13-12 on providing care and services as necessary including providing restorative nursing plans and assistive devices. Licensed staff and nursing assistants will be provided re-education to review the care cards and complete the assignment sheets with care and services as planned for each assigned resident and for the licensed nurses to review these with the nursing assistant at the beginning of each shift to determine that the nursing assistant has gathered the necessary information for services to be provided by the Staff Development Coordinator and Unit Managers by 7-13-12.</p> <p>4. The Director/Assistant of Nursing and/or Unit Managers will complete an audit of 5 residents care to determine that care and services are provided according to the plan of care weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>5. Completion Date: 7-14-12</p>



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F 282	<p>Continued From page 19 signed off with Resident #2 receiving ROM.</p> <p>2. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 07/01/05 with diagnoses including Dementia without Behaviors, Lumbago, and Muscle Weakness. Review of the Comprehensive Care Plan for Resident #8 revealed the resident was to utilize assistive devices of bilateral bolsters to bed, fall mats on floor next to bed; potential for skin breakdown with interventions to include: use care when transferring due to residents skin tears easily, geri sleeves or long sleeves to bilateral upper extremities, and float heels while in bed.</p> <p>Observation of the CNA assignment sheets and interview with CNA #7 and CNA #8, on 06/13/12 at 11:00 AM, revealed CNA #7, who was providing care for Resident #8, had worked at the facility for one week and this was her third day on the floor. Her assignment sheet had the residents names and which residents were to receive showers. The assignment sheet was blank regarding assistive devices, Range of Motion, diets or snacks. CNA #8 had worked at the facility for four (4) months and had a hand written piece of paper with notes on the residents she was assigned.</p> <p>Observation, on 06/13/12 at 12:00 PM, revealed Resident #8 sitting up in a wheelchair in the dining room. No tab alarm or foot cradle was on the wheelchair for the resident.</p> <p>Observation, on 06/13/12 at 3:00 PM and 4:00</p>	F 282			



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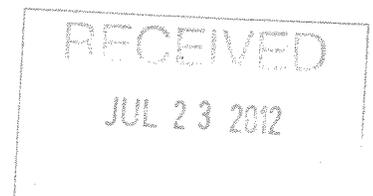
F 282	<p>Continued From page 20</p> <p>PM, revealed Resident #8 in bed. The bed was in low position, no bolsters were on the bed, and the sensor pad was under the resident. Observation at that time revealed the plug that went to the box was missing and the wires were exposed. The resident's heels were not floated off the bed.</p> <p>Observation, on 06/14/12 at 8:20 AM, revealed Resident #8 sitting up in a highback wheelchair in the dining room. There was no tab alarm on the wheelchair or the resident. The resident had on short sleeves and no Geri sleeves.</p> <p>Observation, on 06/14/12 at 8:40 AM, revealed CNA's #9, #10, and #11 did not have assignment sheets regarding the care of the residents.</p> <p>Interview with CNA #10, on 06/14/12 at 8:40 AM, revealed the CNA's make their own assignment sheets out after the nurse makes out the staffing assignment. She stated the CNA's work 6:00 AM to 2:30 PM. She stated they have a blank Nursing Assistant Flow sheet they fill out by looking at the residents Care Kardex they are assigned.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on 06/14/12 at 11:15 AM, revealed she had worked at the facility for three years. She stated the CNA's complete their own assignment sheets based on the Care Kardex after they have received their assignment. She stated she had not looked recently to see if the CNA's were completing the flow sheets. She stated it was</p>	F 282		
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F 282	<p>Continued From page 21</p> <p>important those were completed so the residents received the care they needed, and interventions were put into place and followed. She went on to say, the CNA assigned to Resident #8 on 06/14/12 was a regular staff on that group and was familiar with the residents. She stated the CNA just forgot to put the Geri sleeves on the resident today. In regards to all the other interventions not in place for Resident #8, she stated, that's not good.</p> <p>Interview with the LPN #5, on 06/14/12 at 11:30 AM, revealed the floor nurses should have ensured the CNA work sheets were completed everyday and turned in at the end of the day.</p> <p>Interview with the Director of Nursing (DON), on 06/14/12 at 5:15 PM, regarding the residents that did not get care and interventions per the care plan, revealed the Unit Managers were responsible for the Unit Nurses and CNA's to ensure the residents needs were being meet. She stated if they were not following the Physician orders and care plan interventions they were not providing the care to the residents. She stated the Nurses should allow 5-10 minutes each shift to allow the CNA's to fill out the flow sheets but that must not be getting done.</p> <p>3. Review of the clinical record for Resident #17 revealed the Minimum Data Set (MDS) assessment quarterly update was written on 06/01/12. Resident #17's comprehensive care plan, revealed falls risk interventions that included</p>	F 282		



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F 282 Continued From page 22
a perimeter mattress secured to the bed frame, non-skid strips on the floor at the bedside, non-skid socks, and hipsters for protection.

Observation of Resident #17, on 06/14/12 at 2:30 PM, revealed a perimeter mattress was not in place and affixed to Resident's #17's bedframe and non-skid strips were not in place on the floor at the bedside.

Observation, on 06/14/12 at 11:25 AM, revealed Resident #17 sitting on the bedside of an empty bed in another room on the Solana Unit. The resident was noted to be barefoot.

Observation, on 06/14/12 at 11:50 AM, revealed Resident #17 walking barefoot in the hallway on the Solana Unit.

Interview, on 06/14/12 at 3:15 PM, with LPN #8, Unit Manager (UM), revealed a perimeter mattress had not been on Resident #17's bed since she had been working on the unit, but she thought it would be an ineffective intervention for this resident because Resident #17 did not stay in bed very much. The UM stated she thought the floor in Resident #17's room had recently been deep-cleaned and suggested the non-skid strips may have been removed during the cleaning process, but she was not sure. The UM stated Resident #17 refused to wear non-skid socks and hipsters for protection.

F 282

F 309 SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309

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F 309

Continued From page 23

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to provide the necessary care and services to maintain the highest practical physical well-being for four (4) of twenty-six (26) residents, Residents #1, #7, #15 and #19. The facility failed to obtain blood pressure of Residents #1, #7 and #19 prior to the administration of specific heart medications per physician's orders and failed to record this on the Medication Administration Record (MAR). Resident #15 did not receive medications as ordered by the physician.

The findings include:

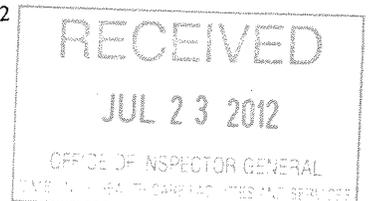
Review of the facility's policy regarding Administration of Medications, Revised 04/01/06, revealed all required vital signs and/or monitoring must be obtained and documented on the MAR before the nursing staff administered the medication. In addition, the policy stated if a dose of routinely scheduled medication was withheld, the nurse was to initial and circle the initials on

F 309

F309

- The blood pressure's for Resident #1, #7, and #19 was taken on 6-14-12 by a licensed nurse that determined the blood pressures were all within acceptable range. The physician for Resident #15 was notified on 6-15-12 by a licensed nurse that the medication was not documented as being administered with no new orders received. Resident #15 has received the medication as of 6-15-12
- The Director of Nursing, Assistant Director of Nursing and Unit Managers completed an audit of the Medication Administration record to determine that blood pressures and appropriate monitoring are obtained prior to administering medications as ordered and that medications are administered as ordered or an explanatory nurses note is in place. Any residents with blood pressures or other monitoring reflected on the Medication Administration Record had a blood pressure taken by a licensed nurse as of 7-3-12. No out of range blood pressures were identified. The physician for any resident with medication not documented as administered or not followed with an explanatory note and intervention was notified with no new orders or negative effects noted as of 7-13-12 by a licensed nurse.
- Licensed nurses will be provided re-education to the Administration of Medications policy including the process of obtaining and documenting any required vital signs and /or monitoring as ordered by the physician before administering the medication and that if a dose of routinely scheduled medication was withheld or not administered, the nurse was to initial and circle the initials on the Medication Administration Record and an explanatory note was placed in either the nurses notes or on the back of the Medication Administration Record by 7-13-12 by the Assistant Director of Nursing, Staff Development Coordinator, Unit Managers, and Clinical Reimbursement Manager.
- The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will audit the Medication Administration records of 5 residents on each unit to determine that blood pressures and other monitoring is completed as ordered by the physician and that any meds not given are reflected by circled initials with a corresponding nurses note explaining why the med was not administered weekly x4 weeks and then monthly x2. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.

Completion Date: 7-14-12



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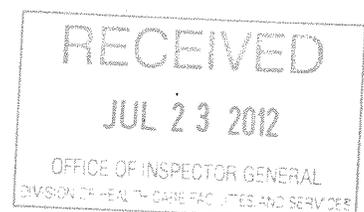
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F 309	<p>Continued From page 24</p> <p>the resident's MAR in the space provided for that dose administered. An explanatory note was then to be placed in the nurse's notes or on the back of the MAR.</p> <p>Record review of the MAR for Resident #1 revealed an order for Metoprolol Succinate 6.25 mg, to be given by mouth every day for paroxysmal atrial fibrillation. Resident #1 had a diagnosis of Atrial Fibrillation and Congestive Heart Failure (CHF). The documentation on the MAR was missing blood pressures for eight (8) out of the first twelve (12) days in June 2012, when the medication was administered.</p> <p>Record review of the MAR for Resident #7 revealed an order for Isosorbide to be given every day for hypertension. Resident #7 had a diagnosis of Angina and CHF. The documentation on the MAR was missing blood pressures for five (5) out of the first twelve (12) days in June 2012, when the medication was administered.</p> <p>Record review of the MAR for Resident #19 revealed an order for Spironolactone 25 mg, to be given by mouth every day for hypertension. Resident #19 had a diagnosis of CHF. The documentation on the MAR was missing blood pressures for nine (9) out of the first twelve (12) days in June 2012, when the medication was administered.</p> <p>Record review of the MAR for Resident #15</p>	F 309		
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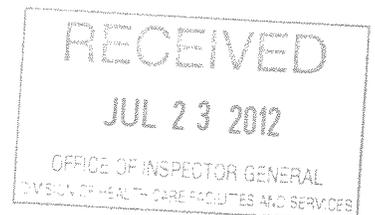
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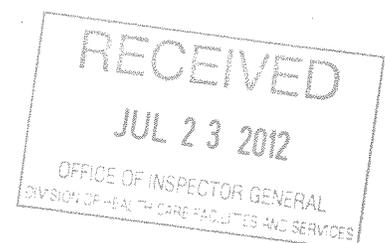
F 309	<p>Continued From page 25</p> <p>revealed an order for Advair Diskus Inhaler twice a day/every day for shortness of air. Resident #15 had a diagnosis of Chronic Airway Obstruction. The MAR revealed the medication was not given to the resident for six (6) consecutive morning doses and two (2) consecutive evening doses during the first eleven (11) days in June 2012, without a documented explanation why the medication was not administered or any physician notification of the medication not being administered or available.</p> <p>Observation, on 06/13/12 during the morning medication pass at 7:20 AM, revealed Registered Nurse #1 administering blood pressure medication to Resident D. A blood pressure was obtained and recorded. However, all spaces on the MAR previous to 06/13/12 remained blank where the blood pressure should have been recorded.</p> <p>Interview, on 06/13/12 at 8:45 AM, with RN #1 revealed the blood pressure, when obtained, was to be charted on the MAR. She stated the blood pressure of Resident D was to be checked every morning and recorded on the MAR and the nurses were responsible to obtain the blood pressure. She revealed because it was a medication for blood pressure was why the blood pressure was to be obtained.</p> <p>Interview, on 06/14/12 at 7:05 AM, with the Assistant Director of Nursing (ADON) revealed if you were to obtain a blood pressure with a medication it would be recorded on the MAR. To</p>	F 309		
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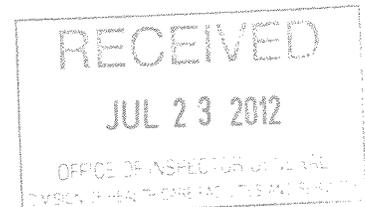
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F 309	<p>Continued From page 26</p> <p>obtain a blood pressure when ordered would be a standard of nursing practice. She revealed failure to do so was failing to follow physician's orders. It was revealed the Unit Managers were to monitor the MARs. The frequency of monitoring the MARs was not indicated, however, it was stated the MARs were monitored more than once a month.</p> <p>Interview, on 06/14/12 at 8:55 AM, with Licensed Practical Nurse (LPN) #13 revealed it was the facility policy to obtain a blood pressure on residents prior to administering blood pressure medication.</p> <p>Interview, on 06/14/12 at 1:45 PM, with the Director of Nursing (DON) revealed the physician sets the parameters for medication administration, such as blood pressure readings. She indicated these parameters were based on the resident's condition and diagnoses and obtained prior to the administration of medications that affect the blood pressure. She revealed the purpose would be to not administer a medication to lower blood pressure when the pressure was already low. She revealed that would cause the resident to "bottom out" their pressure, having it drop too low. Additionally, it was revealed the Unit Managers monitor the MARs twice a week to prevent medication errors that can harm the resident. She revealed if a medication was not in the medication cart, the pharmacy would be contacted to obtain the medication and if a medication was refused, the physician would be notified. Neither contact occurred with the Advair Diskus for Resident #15.</p>	F 309			



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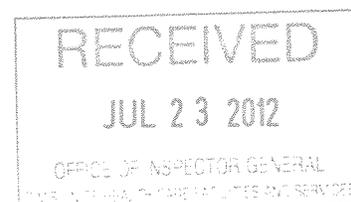
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 27 She stated this "could have" affected the health of the resident by failing to give the medication and charting should have occurred to reflect why the drug was not given.	F 309			
F 323 SS=E	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. 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 the facility was free from accidents and hazards for one (1) of twenty-six (26) sampled and three (3) un-sampled residents. Resident #3 did not have an oxygen (O2) sign posted on the door outside the resident's room. On initial tour of the facility, Room 224 had an unsecured O2 tank in the resident's room, Room 403 had an emergency call cord in the shower wrapped around a grab bar, and Room 429 had an emergency call cord in the bathroom wrapped around the grab bar. The findings include: 1. Observation, on 06/12/12 at 8:40 AM, 11:40 AM, 12:30 PM, 2:45 PM, 3:10 PM, on 06/13/12 at	F 323	F323 1. An Oxygen sign was posted on the door outside of the room of resident #3 by a licensed nurse on 6-14-12. The unsecured oxygen tank in room 224 was removed by the Maintenance staff on 6-12-12. The call cords in room 403 and 429 were unwrapped from around the grab bar on 6-14-12 by a licensed nurse. 2. The Director of Nursing, Assistant Director of Nursing, Maintenance, and Unit Managers completed an audit of current resident call cords and resident doors for appropriate oxygen storage and signage on 6-29-12. Any other call cords determined to be out of reach or inaccessible were made accessible to the resident on 6-29-12. No other hazards were identified. 3. The Administrator re-educated the Director/Assistant Director of Nursing, the Staff Development Coordinator and the Unit Managers on 7-3-12 to preventing accidents and hazards including keeping call lights within reach and accessible to the resident as well as appropriate oxygen storage and the required oxygen signage. The Staff Development Coordinator, Director and Assistant Director of Nursing, and Unit Managers will provide re-education to the staff to preventing accidents and hazards including keeping call lights within reach and accessible to the resident along appropriate oxygen storage and the required oxygen signage by 7-13-12. 4. The Administrator, Maintenance Director, and or Unit Managers will complete an audit of current resident rooms daily x2 weeks, weekly x2 weeks and then monthly x2 months to determine that the center is free of hazards including call lights are accessible and oxygen tanks are secured and the appropriate signage is posted. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation. 5. Completion Date: 7-14-12		



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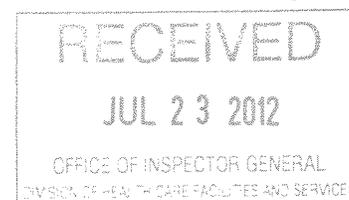
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F 323	<p>Continued From page 28</p> <p>8:45 AM, 11:00 AM, 3:00 PM, and on 06/14/12 8:40 AM and 10:50 AM, revealed Resident #3 did not have an O2 sign posted on the outside of the door to the resident's room.</p> <p>Interview, on 06/14/12 at 10:50 AM, with Certified Nursing Assistant (CNA) #2 revealed there should have been an O2 sign posted at Resident #3's door, per facility policy. The CNA was unaware how long the resident had been receiving O2, and had not noticed there was no O2 sign posted at the door. She stated without an O2 sign at the door, anyone entering the room would not know the resident had oxygen. The CNA stated if there was a fire, or a lit cigarette, there could be an explosion.</p> <p>Interview, on 06/14/12 at 2:20 PM, with Licensed Practical Nurse (LPN) #7 revealed Resident #3 did have an O2 sign posted at the door at one time. The nurse stated sometimes other residents take things off the walls. She stated O2 tanks were explosive and not having an O2 sign on the door would not alert anyone going into the room there was O2 present.</p> <p>2. Observation, on 06/12/12 on initial tour at 8:15 AM, revealed an unsecured oxygen tank cylinder in Room 224.</p> <p>Interview with the Maintenance Director, on 06/14/12 at 2:00 PM, revealed he had no idea the oxygen tank in Room 224 was there until the Life Safety code inspector showed him. He stated the oxygen tank was a hazard if it was unsecured.</p>	F 323		



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F 323	<p>Continued From page 29</p> <p>3. Observation, on 06/12/12 on initial tour at 8:15 AM, revealed a bath emergency cord was wrapped around the handicap bar in the bathroom in Room 429. The cord could not be pulled to alert staff related to being wrapped around the grab bar. The cord remained wrapped during all three (3) days of the survey.</p> <p>4. Observation, 06/14/12 at 2:30 PM, revealed the emergency cord in the shower of Room 403 was wrapped around the handicap bar. The cord could not be pulled to alert staff related to being wrapped around the grab bar.</p> <p>Interview with the Housekeeping Supervisor, on 06/14/12 at 2:30 PM, stated she had observed both cords wrapped around the handicap bar in Rooms 403 and 429. She indicated the cord should not be wrapped around the grab bar because the resident may not reach it if they fell or the cord would not alert staff in case of an emergency.</p> <p>On 06/14/12 at 3:35 PM, interview with LPN #8, Unit Manager (UM) revealed there should have been an O2 sign posted at Resident #3's door. The UM stated the residents on the unit sometimes take things and the O2 sign may have been removed by a resident. She stated everyone was responsible for the O2 sign posted at the resident's door. The UM stated she checks resident rooms on Monday or Tuesday each week when monitoring resident O2 tubing and did not have any documentation of rounds being completed. She stated she was ultimately responsible to ensure the O2 sign was posted at</p>	F 323			



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F 323 Continued From page 30
resident rooms and without the sign it was possible for unsafe chemicals to be in the resident's room with the oxygen.

F 323

Interview, on 06/14/12 at 4:10 PM, with the Director of Nursing (DON) revealed the nursing staff should replace the missing O2 sign and had access to additional signs at all times. The DON stated without the O2 sign posted at the resident's door then anyone going into the room would not be aware of the presence of O2 in the resident's room or the resident's need of O2.

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=E PALATABLE/PREFER TEMP

F 364

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

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 provide residents with a palatable diet. A test tray, requested on 06/13/12, at the lunch meal consisted of meatloaf, corn, mashed potatoes and the alternate meal of pork riblet, potato wedges, and broccoli. The food was bland, the texture was mushy, the taste was unpleasant, and the meals were not visually appealing for one hundred thirteen (113) of one hundred sixty-nine (169) residents receiving a regular diet (including texture modifications).

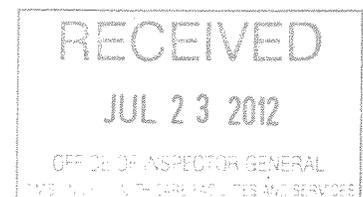
The findings include:

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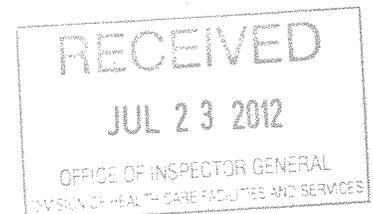
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F 364	Continued From page 31 Review of the facility's policy regarding Food, dated 07/08, revealed food should be prepared by methods that conserve flavor and appearance and that food was palatable and attractive. Additionally, food should be seasoned as acceptable to residents. Review of the Food Committee Minutes revealed the food flavor and appearance had not been satisfactory. The minutes, dated March 28, 2012, identified greens that did not have seasoning, weak coffee, and watered down grits. The minutes, dated May 28, 2012, revealed the chicken soup was salty and bacon was hard. Observation, on 06/13/12 at 12:40 PM, on the one hundred (100) hall of the last tray on the last tray cart revealed the meatloaf tasted soft and bland, the corn had black spots, the mashed potatoes had a salty mushy taste without butter, the riblet did not have flavor, and the broccoli was overcooked, bland, and pale green in color. Interview with the Nutrition Services Director (NSD), on 06/12/12 at 4:30 PM, revealed the facility had a food committee of residents that discussed food options and planned one (1) meal for the first Friday of the month. Interview, on 06/13/12 at 12:40 PM, with the NSD revealed the broccoli did not look like fresh broccoli but was delivered frozen and pale green in color. The NSD stated the broccoli should be greener and had called other facilities several months ago to verify the broccoli was in the same condition at those facilities as well. The NSD stated the other facilities confirmed the condition	F 364	F364 1. The recipe for meat loaf has been revised by the Regional Director of Nutritional Services on 6-15-12. The vegetable vendor has been notified of issues related to the quality of vegetables by Dietary Manager on 6-15-12. 2. The Dietary Manager and/or Cook will complete taste test of food items prepared prior to meal service to determine meal palatability and presentation at each meal beginning 7-5-12. A Resident Council meeting was held on 6-26-12 and the residents were re-educated and encouraged by the Administrator and Dietary Manager to notify the management staff of any concerns with food palatability and presentation for timely review. 3. The Administrator re-educated the Dietary Manager on following recipes and determining that food palatability and appearance are acceptable prior to each meal service on 7-3-12. The dietary staff were re-educated by the Dietary Manager to follow recipes and taste prepared food items to determine that food palatability and appearance are acceptable prior to each meal service on 7-3-12. The Food Committee meeting will be held weekly x4 weeks beginning on 7-6-12 and then monthly to discuss resident satisfaction with food palatability and presentation. 4. The Administrator, Dietary Manager and/or Weekend Manager will sample food items prepared at a minimum of one meal a day to determine food palatability and presentation prior to the meal service daily x14 days and then twice weekly x2 weeks and then at weekly x2 months. The Administrator will attend the Food Committee meeting weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation. 5. Completion Date: 7-14-12		



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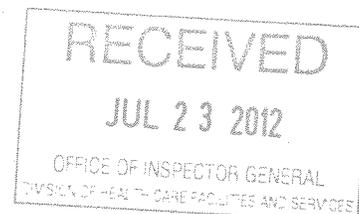
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F 364	Continued From page 32 of the broccoli but the NSD did not contact the food supply company. Additionally, she stated the mashed potatoes needed seasoning, the meatloaf had a soft texture and needed more onion. On 06/14/12 at 2:20 PM, interview with Licensed Practical Nurse (LPN) # 7 revealed the LPN had received complaints from residents about the food. The LPN stated some complaints included food being cold, the food did not look appetizing, and some residents refused to eat due to the quality of the food. The nurse stated residents could have weight loss as a result of not eating. Interview, on 06/14/12 at 4:10 PM, with the Director of Nursing (DON) revealed she tasted the resident's food every now and then, and it needed more seasoning. The DON stated if residents did not eat as a result of the taste of the food, the residents could experience weight loss, or skin breakdown.	F 364			
F 371 SS=F	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 This REQUIREMENT is not met as evidenced by:	F 371			



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F 371	<p>Continued From page 33</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. The deep fryer had food particles floating on the oil surface, resident refrigerators were not monitored for appropriate temperatures, and a male cook with a beard was observed preparing food without the beard being contained. These practices affected all residents who received oral nutrition.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Food, dated 07/08, revealed food should be prepared in a sanitary manner and served at proper temperatures.</p> <p>Review of the facility's policy regarding Staff Attire, dated 07/08, revealed staff were to have facial hair properly restrained.</p> <p>The facility did not provide a policy on cleaning the kitchen equipment. A cleaning schedule revealed the deep fryer was last cleaned on Tuesday 06/05/12.</p> <p>1. Observation, on 06/12/12 at 8:10 AM, of the kitchen during the facility tour revealed the deep fryer had food particles floating on the oil's surface.</p> <p>Interview, on 06/12/12 at 8:10 AM and 4:30 PM and 06/14/12 at 3:15 PM, with the Nutrition Services Director (NSD) revealed the deep fryer was scheduled for cleaning once a week on Tuesday night by the night shift staff. The NSD stated the deep fryer had not been used on</p>	F 371	<p>F371</p> <p>1. The oil in the deep fryer was discarded on 6-12-12 and the deep fryer was cleaned on 6-15-12 by the Dietary Manger. The temperature of the refrigerator belonging to Resident #11 was checked and recorded on a temperature log by a licensed nurse on 6-15-12 and determined to be within acceptable range in temperature. The male cook received disciplinary action by the Dietary Manager on 7-5-12 for not following policy of wearing a beard restraint.</p> <p>2. The oil in the deep fryer was discarded on 6-12-12 and then the deep fryer was cleaned on 6-15-12 by the Dietary Manger. Current dietary staff are wearing beard guards as appropriate as of 6-14-12. Each resident with a refrigerator had temperature logs put in place and temperatures checked and logged as of 7-6-12 by a licensed nurse. All resident refrigerators were found to be within acceptable temperature range.</p> <p>3. The Dietary Manager and Administrator revised the cleaning schedule for equipment in kitchen on 7-6-12. The Administrator re-educated the Dietary Manger on 7-6-12 to Food Sanitation procedures including the importance of wearing hair nets including beard guards, discarding used oil after it's use and maintaining sanitary equipment. The Dietary Manager re-educated the dietary staff to Food Sanitation procedures including discarding oil after use, the cleaning schedule and how to clean equipment, and the necessity of wearing beard guards while in the kitchen on 7-3-12. Licensed nurses and nursing assistants will be provided re-education by the Staff Development Coordinator by 7-13-12 regarding the responsibility of nursing staff to check resident refrigerator temperatures and document the temperatures on the log daily.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, Weekend Manager and/or Unit Managers will review the temperature logs for resident refrigerators daily x7 days and then weekly x10 weeks. The Administrator and/or Dietary Manager will complete weekly audits for 4 weeks, monthly for 3 months to determine that equipment is sanitary and that dietary staff are wearing beard guards as appropriate. A summary of findings will be submitted to the Performance Improvement Committee for further review and recommendation.</p> <p>5. Completion Date: 7-14-12</p>		



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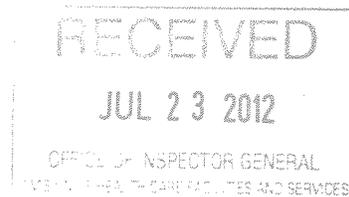
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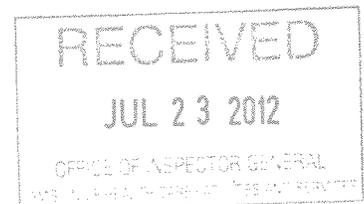
F 371	<p>Continued From page 34</p> <p>Tuesday and was not usually used on Tuesdays. She stated there was not a policy for cleaning the equipment in the kitchen, only a cleaning schedule. The NSD also stated if the deep fryer was not clean there could be bacteria and the residents could become sick.</p> <p>2. Observation, on 06/12/12 at 8:40 AM, 11:40 AM, 3:20 PM, and on 06/13/12 at 8:45 AM and 3:25 PM, revealed Resident # 11 had a personal refrigerator in her room. The refrigerator did not have a log for monitoring temperature.</p> <p>On 06/14/12 at 10:35 AM, interview with the Nutrition Services Director (NSD) revealed the facility ambassadors were responsible to check the resident refrigerator temperatures. The NSD stated the dietary department did not check the temperatures and did not keep a log of the resident refrigerator temperatures.</p> <p>Interview, on 06/14/12 at 2:20 PM, with Licensed Practical Nurse (LPN) # 7 revealed the night shift nursing staff were responsible to check the resident refrigerator temperatures and the monitor log should be taped to the refrigerator. The LPN stated if the temperatures were not checked the refrigerator temperature could be out of range and the resident could get food poisoning.</p> <p>Interview, on 06/14/12 at 3:35 PM, with LPN #8, the Unit Manager (UM), revealed the night shift staff were to check the temperature of the residents' refrigerators. The UM stated temperatures should be checked every night, signed, and dated and the monitoring log should hang on the front of the refrigerator. The UM</p>	F 371		
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F 371	<p>Continued From page 35</p> <p>stated if the log was missing it should be replaced and temperatures continued to be monitored. She stated a missing log was not an excuse for not monitoring the refrigerator temperatures. The UM stated she monitors the temperature logs every morning by going in and out of resident rooms. She stated there was not a formal monitoring system and she did not document that checking the logs had been completed.</p> <p>On 06/14/12 at 4:10 PM, interview with the Director of Nursing (DON) revealed the nursing staff was responsible to monitor resident refrigerator temperatures and the facility had designated ambassadors for residents. The DON stated the ambassadors were responsible to ensure the resident refrigerators had temperature logs and were being monitored. She stated the ambassadors were responsible to document the temperature if they find the monitor logs had not been completed for that day. The DON stated anyone who noticed the monitor log was missing was responsible to replace the log. She stated if the temperatures were not checked and were out of range, the food could spoil.</p> <p>3. Observation, on 06/14/12 at 3:15 PM, revealed a male cook with a beard preparing food in the kitchen without a beard restraint.</p> <p>Interview, on 06/14/12 at 3:15 PM, with the NSD revealed male staff with a beard were to wear a beard restraint. The NSD stated hair could fall into the residents food without a beard restraint in place.</p> <p>Interview, on 06/14/12 at 3:18 PM, with the Cook revealed his beard should have been contained in</p>	F 371		



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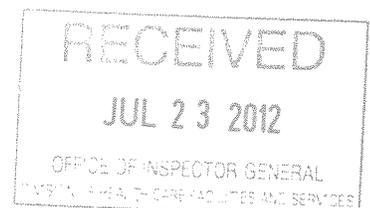
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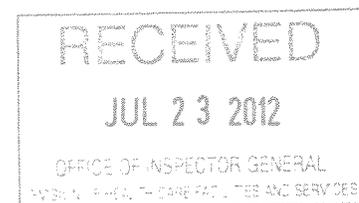
F 371	Continued From page 36 a beard restraint. The cook stated he had been trained to wear a beard guard and monitoring the use of beard guards was conducted by anyone who noticed a beard without a beard covering. He stated without the beard cover hair could fall into the food.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls; and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		



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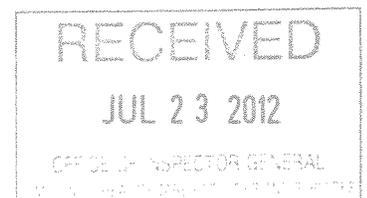
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2012
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F 431	<p>Continued From page 37 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Medication Storage, October 15, 2005, it was determined the facility failed to store medications separately based on their route of administration. Nasal sprays, eye drops, suppositories, injectable and oral medications were found intermingled in the medication carts on three (3) of three (3) nursing units.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding The Medication Storage, October 15, 2005, states medications for internal use were to be stored separately from medications for external use.</p> <p>Observation, on 06/13/12 at 8:25 AM, of the middle medication cart on the 200 Wing revealed oral medications stored together with inhalers and eye drops. Also sub-lingual medications were stored with injectable medications.</p> <p>Observation, on 06/13/12 at 8:30 AM, of the 200 Wing Rehab Medication cart revealed inhalers stored with injectable medication.</p> <p>Observation, on 06/13/12 at 8:40 AM, of the Back Hall 100 medication cart revealed eye drops, inhalers and injectable medications, stored together.</p>	F 431	<p>F431</p> <ol style="list-style-type: none"> 1. The 200 wing middle medication cart and Rehab medication cart, the front and back hall 100 medication carts, the 200 wing middle hall and rehab medication carts were re-organized to provide separate storage for medications based on their route of administration on 6-31-12 by the Unit managers and Staff Development Coordinator. The 200 medication cart was cleaned on 6-15-12 by the Unit Manager. The employee handbag was removed from the Solana unit medication cart on 6-13-12 by the licensed nurse. The trash receptacle on the Solana treatment cart was emptied of trash, cleaned and then lined with a trash bag on 6-13-12 by a licensed nurse. The glucometers on Solana were checked by a licensed nurse and recorded on a Glucometer Calibration log on 6-13-12 and determined to be within acceptable range. 2. Each medication and treatment cart on units have been re-organized to store medications separately based on route of administration and cleaned both on the interior and exterior of the carts by the licensed nurses on 6-31-12. The Glucometer logs on each unit were audited by the Director of Nursing on 7-3-12 to determine that calibration checks were completed. Any other glucometers without the appropriate calibration check was checked and documented on a Glucometer Calibration Log with no calibrations identified outside of normal range on 6-31-12 by a licensed nurse. 3. The Staff Development Coordinator and Unit Managers will provide re-education to the licensed nurses to the Medication Storage Policy, the Nursing Cleaning Schedule that includes cleaning and organization of medications on a weekly basis and Glucometer Calibration checks schedule and documentation by 7-13-12. 4. The Director of Nurses, Assistant Director of Nurses and or Unit Managers will complete an audit of each medication cart, treatment cart, and Glucometer Log weekly x4 weeks and then monthly x2 months to determine that medications are stored appropriately, the carts are clean and that Glucometer machines are calibrated and documented on the Glucometer Calibration Log as appropriate. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further recommendation and review. 	



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F 431	<p>Continued From page 38</p> <p>Observation, on 06/13/12 at 8:50 AM, of the Front Hall 100 medication cart revealed inhalers, injectable medications, eye drops, nasal sprays and suppositories all stored together without any form of divider.</p> <p>Interview, on 06/13/12 at 8:25 AM, with Licensed Practical Nurse (LPN) #2 revealed medications were stored all together because the medications did not fit in other places on the cart. She stated she had not been in-serviced on the storage of medication and thought the purpose to store medications separately was more for organization. She revealed the wrong medication could be given by storing medications together.</p> <p>Interview, on 06/13/12 at 8:30 AM, with LPN #13 revealed she was the Rehab Unit Manager and had never had to work the medication cart. In addition, had not been in-serviced on the storage of medication. She revealed if eye drops were stored together with nasal sprays, the wrong medication could be used on the resident.</p> <p>Interview, on 06/13/12 at 8:40 AM, with Registered Nurse (RN) #1 revealed she had not been in-serviced on the storage of medication but did know medications were to be stored separately because they were not administered by the same route.</p> <p>Interview, on 06/13/12 at 8:50 AM, with LPN #3 revealed she did not know a reason to store medications separately based on route of administration. She voiced she was sure she had been in-serviced on the storage of medication.</p> <p>Interview, on 06/14/12 at 7:05 AM, with the</p>	F 431		



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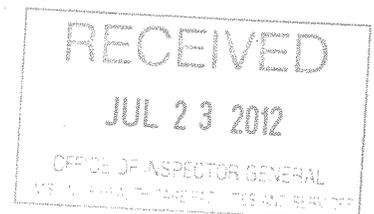
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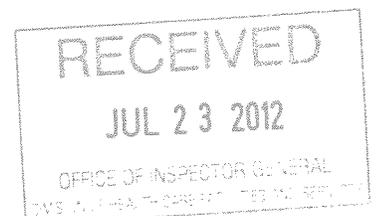
F 431	<p>Continued From page 39</p> <p>Assistant Director of Nursing (ADON) revealed the reason for the separation of medication was to prevent a medication error. She did not know who monitored the medication carts. She was unsure if there had been an in-service on the separation of medications.</p> <p>Interview, on 06/14/12 at 1:45 PM, with the Director of Nursing (DON) revealed the staff had been in-serviced on the medication carts and the storage of medications. In addition, it was the Unit Managers who were responsible to monitor the medication carts. She revealed the purpose of separating the medications by route of administration was to prevent a medication error which could harm the resident.</p> <p>Observation, on 06/13/12 at 8:10 AM, on the 200 hall revealed oral medications, eye drops, and inhalers were stored in the same compartment in a drawer on the 200 hallway's medication cart. This same medication cart was visibly soiled as evidenced by a large amount of dark sticky tape residue on top of the attached hand sanitizer and other black marks on the exterior surfaces of the cart.</p> <p>Interview, on 06/13/12 at 8:20 AM, with LPN # 2 revealed the oral medications, eye drops, and inhalers were stored in the same compartment on the medication cart because there was not enough space in the other drawers to store the medications separately. LPN # 2 stated she had not been educated by the facility to separate orals, eye drops, and inhalers. LPN # 2 stated the problem with storing medications administered by different routes in the same compartment of the drawer would be the</p>	F 431		
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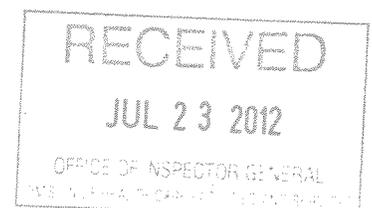
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F 431	<p>Continued From page 40 medications would not be organized.</p> <p>Observation, on 06/13/12, at 8:25 AM, on the Solana unit revealed an employee's handbag was stored in the bottom drawer of the medication cart.</p> <p>Observation, on 06/13/12 at 8:30 AM, on the Solana unit revealed the glucometer calibration log was not available for review.</p> <p>Observation, on 06/13/12 at 3:15 PM, on the Solana unit revealed a treatment cart with an attached trash receptacle that was unlined and half filled with trash.</p> <p>Interview, on 06/13/12 at 8:40 AM, with LPN # 8 Unit Manager (UM) revealed the night shift staff was responsible for calibrating the glucometers and recording the results in the glucometer log. Night shift was also responsible for reporting any glucometer malfunctions to the day shift nurses. The UM stated she was ultimately responsible for ensuring the glucometer calibrations were performed and results were recorded in a log book. The UM stated the potential problem was without a system to consistently monitor the accuracy of the glucometers, staff could not ensure the accuracy of the blood glucose measurements performed on the residents.</p> <p>Interview, on 06/14/12 at 5:15 PM, with the Director of Nursing (DON) revealed external and internal medications, administered by different routes, should not be stored together and she was concerned an employee stated space was an issue that caused this improper storage. Employees' personal items should not be stored</p>	F 431	



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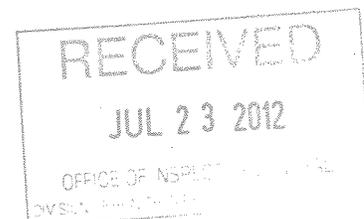
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F 431	Continued From page 41 in medication or treatment carts, and she expected all medication and treatment carts to be clean at all times.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441			



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F 441	Continued From page 42 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and review of the facility's policy, it was determined the facility failed to develop and maintain an infection control program to prevent the spread of bacteria and disease. The facility implemented reverse isolation (protecting the resident from contamination from others) on a resident, however, the facility failed to ensure staff entering the room wore the appropriate personal protective equipment (PPE). Licensed Practical Nurses (LPN) and Certified Nurse Aides (CNA) delivered care to residents without hand washing for five (5) of twenty-six (26) sampled residents (Residents #3, 5, 9, 11 and 12). In addition, the facility failed to ensure Residents #3, #7, A and B were not using oxygen equipment that was contaminated. The facility additionally failed to change Resident #16's oxygen tubing since 05/25/12. The findings include: Review of the facility's policy and procedure regarding Respiratory Care Services and Oxygen Therapy, undated, revealed the types of oxygen delivery devices, to include nasal cannula and nebulizers, but did not include how the equipment, when not in use, was to be stored.	F 441	F441 1. CNA #5 was re-educated to follow isolation precautions and given disciplinary action on 6-15-12 by the Unit Manager related to not following reverse isolation precautions. The oxygen and or nebulizer mask/tubing for Residents #3, 7, 16, A & B was discarded and replaced by a licensed nurse on 6-14-12 and stored in a bag if not in use. Residents #3, 5, 9, 11, and 12 were assessed on 6-15-12 by a licensed nurse with no signs of infection noted. 2. The oxygen and mini neb masks and tubing for current residents was discarded, replaced, and stored in a bag if not in use by a licensed nurse on 6-15-12. The Infection Log was reviewed for the past 30 days to determine any infection trends, with no trends identified. An observation was completed on 7-3-12 by the Director of Nursing to determine staff adherence to isolation precautions during care with no concerns identified in following isolation precautions. 3. The Staff Development Coordinator and Unit Managers will provide re-education to nursing staff to the Respiratory Care Services and Oxygen Therapy policy including the storage of oxygen tubing and nebulizers in a plastic bag when not use and the Infection Control Procedures including hand washing and reverse isolation procedures by 7-13-12. Licensed nurses will be re-educated by the Assistant Director of Nursing and the Staff Development Coordinator that oxygen and nebulizer tubing will be changed by the licensed nurses routinely as indicated in the Respiratory Care Services and Oxygen therapy policy and documented on the Treatment Administration Record by 7-13-12. 4. The Infection Control nurse, Director of Nursing, and/or Assistant Director of Nursing will complete an audit of 5 residents with oxygen or nebulizer equipment, 5 residents on isolation precautions and 5 nursing staff for proper hand washing practices weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for review and further recommendation. 5. Complete: 7-14-12.		



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F 441	<p>Continued From page 43</p> <p>Interview with the Director of Nursing, on 06/14/12 at 3:40 PM, revealed the staff were to wear a gown to protect the resident from any bacteria they have on their uniform when providing reverse isolation care to residents.</p> <p>1. Observation of the 100 wing, on 06/13/12 at 12:15 PM, revealed staff entering a room with an isolation cart parked outside the door. The resident's meal tray was delivered and set up after staff cleared the overbed table of multiple personal items and moved the table to a chair for the resident.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 06/13/12 at 12:30 PM, revealed the resident received reverse isolation and needed to be protected from other peoples' germs. She stated she should have worn a gown over her uniform as she had been providing care for other residents all morning. She stated she probably had germs on her uniform and could have spread them in the resident's room.</p> <p>2. Observation, on 06/12/12 on initial tour at 8:15 AM, revealed Resident #16 had oxygen tubing and mini-neb mask dated 05/25/12 and not in a bag. In addition, unsampled Residents A and B had disposable mini-neb equipment not stored in a bag.</p> <p>Interview with LPN #12, on 06/14/12 at 11:15 AM, revealed she never checked the dates on the oxygen tubing because it was a contracted service. She stated if it was not changed regularly it could increase the risk for infection for the residents using the equipment.</p>	F 441			

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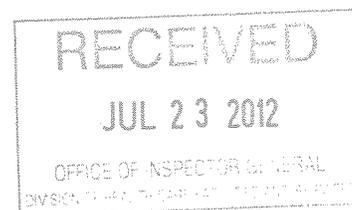
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F 441	Continued From page 44 Interview with the LPN #5, on 06/14/12 at 11:30 AM, revealed they had a contract person who came in weekly and changed out the tubing for oxygen dependent resident or residents on mini-nebs. She stated the person came on different days and could not be sure the tubing was changed every week as stated in the facility policy. She stated someone else oversees the contracted employee to ensure they are performing the services. She was unaware the tubing for Resident #16 was dated 05/25/12. 3. Observation, on 06/12/12 during the tour of the facility which began at 8:30 AM, revealed in Room 201-2, a nebulizer mask and a nasal cannula with tubing placed on a chair, both uncovered and undated. Observation, on 06/12/12 at 11:30 AM, revealed in Room 201-2 a nebulizer mask next to a resident in bed, uncovered and undated. Droplets were noted in the reservoir. A walker with wheels had an oxygen tank attached with oxygen tubing and nasal cannula wrapped around the handle of the walker uncovered and undated. Continued observation revealed in Room 121-2, a Bi-Pap face mask sitting out uncovered. Observation, on 06/12/12 at 11:35 AM, in the room of Resident #7 revealed a nebulizer mask sitting out on the side table uncovered and undated. Observation, on 06/12/12 at 4:30 PM, in the room of Resident #7 revealed a nebulizer face mask	F 441			



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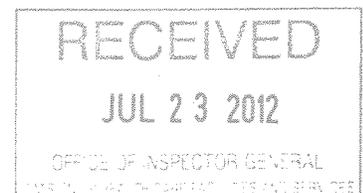
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F 441	<p>Continued From page 45</p> <p>sitting out uncovered. The reservoir contained droplets that were present from the previous treatment. In addition, a urinal was hanging on the edge of the garbage can.</p> <p>Interview, on 06/14/12 at 2:25 PM, with Licensed Practical Nurse (LPN) #13 revealed oxygen tubing with nasal cannula and nebulizer masks were to be rolled up and stored in a bag. This was to prevent cross contamination, keep out dust and dirt, and not make a respiratory illness worse, she revealed. She stated she had been in-serviced on the storage of respiratory equipment.</p> <p>4. Observation, on 06/12/12 at 8:40 AM, 11:40 AM, and 06/13/12 at 8:45 AM, and 4:30 PM, revealed Resident #3 had oxygen (O2) tubing that was not dated and nebulizer tubing dated 05/25/12.</p> <p>Observation, on 06/12/12 at 8:40 AM and 11:40 AM, revealed Resident #3's O2 tubing lying on the oxygen concentrator uncovered and nebulizer tubing lying on the nightstand uncovered.</p> <p>Interview, on 06/13/12 at 4:30 PM, with Licensed Practical Nurse (LPN) #7 revealed O2 tubing should be dated and stored in a bag. The LPN stated the facility contracts out for respiratory care and the respiratory company does not come to the facility each week. She stated the tubing should be changed weekly by the night shift nurse and Resident #3's O2 tubing and nebulizer tubing should be thrown away. The LPN stated outdated tubing could spread germs and the resident was at risk of infection.</p>	F 441		



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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	
F 441	Continued From page 46 Interview, on 06/14/12 at 3:35 PM, with LPN #8 Unit Manager (UM) revealed O2 tubing should be changed once per week, dated, and stored in bags. The UM stated the respiratory company the facility contracted with did not change the tubing which should be changed by the night shift staff on the weekends. She stated she monitored the tubing had been changed on Mondays, checking room to room. The UM stated she did not document monitoring of the tubing. She stated not dating or changing the tubing, and not storing the tubing in a bag could spread infection to residents. On 06/14/12 at 4:10 PM, interview with the Director of Nursing (DON) revealed the nurses were responsible to monitor, change and date O2 and nebulizer tubing and to store tubing in a plastic bag. The DON stated O2 and nebulizer tubing should be changed weekly, per policy, and there was a serious issue with tubing that was dated 05/25/12. Continued interview, on 06/14/12 at 4:10 PM, with the DON revealed hands should be washed after removing a soiled dressing and when gloves are changed. The DON stated not washing hands could spread infection. 5. Observation, on 06/14/12 at 3:05 PM and 3:25 PM, revealed Licensed Practical Nurse (LPN) #7 did not wash or sanitize her hands before conducting a skin assessment for Resident #3 and Resident #11. Observation, on 06/14/12 at 3:05 PM, 3:25 PM, and 4:05 PM, revealed LPN #7 did not wash	F 441			



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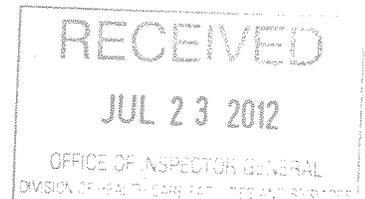
PRINTED: 06/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 47</p> <p>hands when changing gloves during skin assessments for Resident #3, Resident #11, and Resident #12. During the assessment for each resident, the LPN assessed the resident's buttocks, changed gloves, and then assessed the resident's ears and/or mouth. Additionally, when the LPN washed her hands after completing skin assessments to each resident she turned the faucet off with her bare hands.</p> <p>Interview, on 06/14/12 at 4:25 PM, with LPN #7 revealed she should have washed her hands prior to conducting resident skin assessments, after assessing a dirty body area, and during each glove change. The LPN stated she had been trained by the facility and had completed a skills check off for hand washing and was trained to pull the paper towels to turn off the faucet. She stated not washing hands and turning off the faucet with bare hands had the potential to spread germs.</p> <p>On 06/14/12 at 3:35 PM, interview with LPN #8 UM revealed hands should be washed before providing resident care and between glove changes. The UM stated she casually monitored weekly by walking around the unit. She stated she had not observed any issues with hand hygiene.</p> <p>Observation, on 06/13/12 at 3:25 PM, during a dressing change for Resident #11 revealed LPN #7 did not wash her hands after removing a soiled dressing, after cleaning the resident's wound, and after completing the resident's treatment.</p> <p>Interview, on 06/14/12 at 4:30 PM, with LPN #7</p>	F 441		

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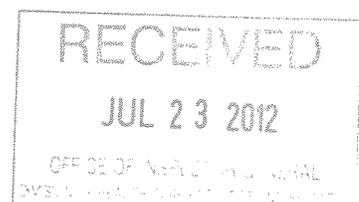
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 48</p> <p>revealed hands should be washed whenever gloves were changed, after touching a dirty body area, and after providing resident care. The LPN stated she had been trained by the facility and she should have washed her hands due to the potential to spread infection and transmit bacteria.</p> <p>6. Observation, on 06/13/12 at 10:20 AM, revealed LPN #7 failed to wash her hands upon entering Resident #5's room, and before performing the skin assessment for this resident. After the skin assessment was completed LPN #7 removed her gloves but did not wash her hands before leaving Resident # 5's room. CNA #2 did not wash her hands upon entering Resident #5's room, or after assisting LPN #7 with turning and positioning this resident during the skin assessment.</p> <p>Observation, on 06/13/12 at 10:40 AM, revealed LPN #7 failed to wash her hands upon entering Resident # 9's room, and before performing the skin assessment for the resident. During the skin assessment LPN #7 assisted Resident # 9 with putting on his/her shoe so he/she could stand during a portion of the assessment. LPN #7 touched the soles of Resident # 9's shoes with her gloved hands, but did not remove her gloves, wash her hands, and don clean gloves before continuing with the skin assessment where she touched Resident #5's back, buttocks, and peri area.</p> <p>Interview, on 06/14/12 at 1:45 PM, with LPN #7 revealed she should have washed her hands when she entered Resident #5's room, before she donned gloves to perform the skin</p>	F 441			



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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 06/14/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 49</p> <p>assessment, and after she completed Resident #5's skin assessment. LPN #7 stated the problem with not washing her hands before and after giving resident care would be the potential for the spread of infection to Resident #5, other residents, or staff members. LPN #7 stated her most recent hand washing inservice occurred about two (2) months ago.</p> <p>Interview, on 06/14/12 at 2:00 PM, with LPN #8 Unit Manager revealed she expected direct care givers to wash their hands before and after performing resident care, even if gloves were worn. Further, direct care staff should remove gloves, wash their hands and don clean gloves any time their gloves become contaminated during resident care.</p>	F 441		



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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2012
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978, 1980, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Four (4) 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 06/12/12. Regis Woods Care and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.