

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

PRINTED: 03/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/06/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>
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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 000	INITIAL COMMENTS	F 000		
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 interview, record review and facility policy review, it was determined the facility failed to follow the plan of care for two (2) of four (4) sampled residents.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans-Interdisciplinary, dated 01/08, revealed upon admission the Licensed Nurse initiates a care plan addressing the resident's most immediate needs. The interdisciplinary team educates the resident and responsible party to the care plan and implements the care plan.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 02/08/13 with diagnosis of Diabetes, Status Post Right Above Knee Amputation (AKA). Review of the nursing</p>	F 282	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regis Woods Care &amp; 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."</p>	

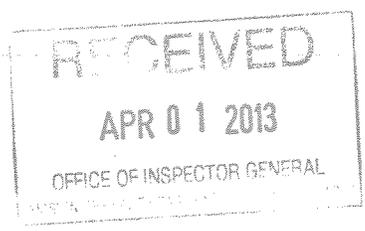
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Executive Director</i>	(X6) DATE <i>3-27-13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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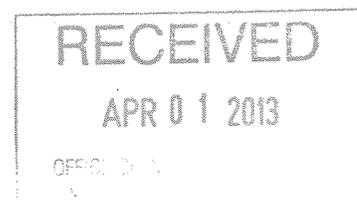
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F 282	<p>Continued From page 1</p> <p>admission assessment, dated 02/08/13, revealed the resident was alert and oriented. Review of the resident's Release From Responsibility for Discharge (AMA) revealed the reason for self-discharge was very poor care. The resident's discharge date was 02/09/13.</p> <p>Review of the Certified Nurse Care Plan, undated for Resident #1, revealed the facility identified the resident to be continent and toileted by use of a bedpan. The facility's Resident Functional Performance Record revealed the resident to be totally dependent with assist of one. The interventions were to provide the resident with a call light within easy reach and to toilet the resident before and after meals and as needed. The resident implemented the use of the call light; however, the staff did not response. The resident had to call a family member and then yell for assistance.</p> <p>Phone interview, on 03/05/13 at 10:00 AM, with Resident #1 revealed the admitting nurse explained the use of the call light and assured it was working properly. The resident stated he activated the call light for assistance with toileting; however, no staff answered the call light and he/she resorted to calling a family member which instructed him/her to yell for assistance.</p> <p>Phone interview, on 03/05/13 at 9:50 AM, with a family member of Resident #1 revealed the resident was admitted to the facility for rehabilitation due to a recent Right AKA amputation. The family member stated she received a call from the resident stating he/she had a episode of diarrhea and no one would answer the call light. The family member stated</p>	F 282	<p><u>F TAG 282:</u></p> <ol style="list-style-type: none"> <li>Resident #1 discharged from the facility on 2-9-13. The care plan for Resident # 3 was updated by a licensed nurse for a raised toilet seat and the bed side commode was discontinued on 3-6-13. RN #1 is no longer employed by the center as of 2-13-13.</li> <li>The Administrator, Director of Nursing and Unit Managers and Assistant Directors of Nursing will complete and document an audit of Care plans for current residents by 4-5-13 to determine that care is provided in accordance with the care plan. Any concerns identified will be corrected at that time.</li> <li>The Director of Nursing, Staff Development Coordinator and the Assistant Directors of Nursing will re-educate licensed nurses to the care plan policy and guidelines for initiating and updating care plans and providing care in accordance with the care plan by 4-5-13. A post test was completed to determine staff understanding 4-5-13.</li> <li>The Director of Nursing, Unit Managers and Assistant Director of Nursing will document an audit of 10 care plans per week x 4 weeks, 10 per month x 2 months and 10 per quarter x 2 quarters to determine that care is being provided in accordance with the care plan. Any concerns identified will be corrected at that time. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x3</li> </ol> <p>months and then at least quarterly x2 for further review and recommendation.</p> <ol style="list-style-type: none"> <li>Completion date 4-6-13</li> </ol>		



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F 282	<p>Continued From page 2</p> <p>to the resident to scream in the hallway for assistance. The family member stated they immediately drove to the facility and upon entering the resident's room observed a CNA had just started to assist the resident. The family member stated the resident was removed from the facility and care would be provided at home.</p> <p>Interview, on 03/06/13 at 5:20 AM, with (CNA) #1 revealed call lights are to be answered by every employee. She stated when a CNA was on break, another CNA along and the nurse were notified to monitor if a resident needed anything. She continued to state the CNA worksheet informed the staff on the needs of the residents.</p> <p>Interview, on 03/06/13 at 5:30 AM, with Registered Nurse (RN) #2 revealed call lights are to be answered by all employees and if you are unable to assist the resident the employee should tell the CNA or nurse that the resident was in need of assistance.</p> <p>Phone interview, on 03/06/13 at 8:00 AM, with the Weekend Supervisor LPN #1 revealed on 02/09/13 Resident #1's family member entered the facility very upset wanting to talk to the Director of Nursing. He stated he and the family member entered the resident's room and the CNA (not the resident's assigned CNA) was beginning to clean the diarrhea off of the resident. He stated the resident had been waiting about 25-30 minutes. (the time was based on the family member's cell phone log and the time the family member arrived to the facility).</p> <p>Phone interview, on 03/06/13 at 8:40 AM, with RN #1 revealed she was caring for Resident #1 on</p>	F 282			



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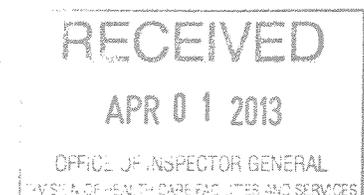
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F 282	<p>Continued From page 3</p> <p>02/09/13. She stated remembering passing morning medications and sitting at the nurse's area attempting to complete paper work. She further stated while at the nurses desk she heard the call light going off; however, she did not acknowledge the call light. She stated she was unaware the resident's CNA had left the unit, until the weekend supervisor (LPN #1) and the resident's family member arrived to the unit. She continued to state the CNAs are mainly responsible for answering the call lights,. She continued to state she should have been more attentive to the call light.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 01/30/13, with diagnoses of Weakness, Anemia and Hypertension. Review of the 02/12/13 Admission Minimum Data Set (MDS) assessment revealed the resident to have no cognitive impairments and was determined to be interviewable. In addition, the facility identified the resident as extensive assistance of one with toileting. Review of the comprehensive care plan revealed the resident had a bedside commode near the bed.</p> <p>Observation during initial tour, on 03/05/13 at 11:30 AM and at 1:15 PM and on 03/06/13 at 5:30 AM and 10:30 AM, revealed no bedside commode in Resident #3's room.</p> <p>Interview, on 03/06/13 at 05:20 AM, with CNA #1 revealed she was unaware the resident needed a bedside commode.</p> <p>Interview, on 03/06/13 at 10:35 AM, revealed he/she had never had a bedside commode.</p>	F 282			



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F 282	Continued From page 4 He/She further stated a bedside commode could be useful especially at night.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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 interview and record review, it was determined the facility failed to provide toileting assistance for one (1) of four (4) sampled residents. The facility failed to answer the call light in a timely manner for a dependent resident resulting in the resident lying in diarrhea for and extended period of time. Resident #1.  The findings include:	F 309		



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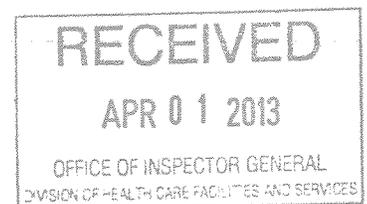
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F 309	<p>Continued From page 5</p> <p>The facility did not provide a policy in regards to care and services or call lights.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 02/08/13 with diagnosis of Diabetes, Status Post Right Above Knee Amputation (AKA). Review of the nursing admission assessment, dated 02/08/13, revealed the resident was alert and oriented. Review of the resident's Release From Responsibility for Discharge (AMA) revealed the reason for self discharge was very poor care. The resident's discharge date was 02/09/13.</p> <p>Phone interview, on 03/05/13 at 9:50 AM, with a family member of Resident #1 revealed the resident was admitted to the facility for rehabilitation due to a recent Right AKA amputation. The family member stated she received a call from the resident stating he/she had an episode of diarrhea and no one would answer the call light. The family member stated to the resident to scream in the hallway for assistance. The family member stated they immediately drove to the facility and upon entering the resident's room observed a CNA had just started to assist the resident. The family member stated the resident was removed from the facility and care would be provided at home.</p> <p>Interview, on 03/05/13 at 1:05 PM, in Resident #2's room revealed staff mostly at night and on weekends take awhile to answer the call light. He/She further stated the Certified Nursing Assistance (CNA) would come into the room and turn off the call light stating they would return in a moment; however, most of the time the CNA will</p>	F 309	<p><u><b>F TAG 309:</b></u></p> <ol style="list-style-type: none"> <li>1. Resident #1 discharged from the facility on 2-9-13. RN #1 is no longer employed by the facility as of 2-13-13.</li> <li>2. The Administrator, Director of Nursing and Unit Managers and Assistant Directors of Nursing will interview current residents with a BIM score of 8 or greater to determine resident satisfaction with the timeliness of staff response to call lights. This will be completed 4-5-13. Any concerns identified will be addressed at that time.</li> <li>3. The Director of Nursing, Staff Development Coordinator and Assistant Directors of Nursing will re-educate nursing, therapy, housekeeping, dietary, activity, social services and administrative staff to the expectation that all staff respond to call lights and that call lights are answered timely as of 3-29-13. A post test was completed 4-5-13 to determine understanding.</li> <li>4. The Director of Nursing, Unit Managers and Assistant Directors of Nursing will complete and document 15 call light response time audits per week to include 3 on each shift times 4 weeks, 15 per month for 3 months and 15 per quarter x 2 quarters. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x4 months and then at least quarterly x2 for further review and recommendation.</li> <li>5. Completion date 4-6-13</li> </ol>		

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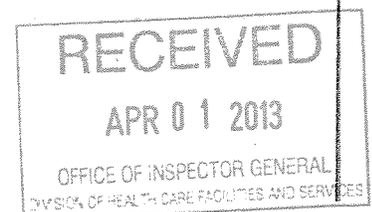
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F 309	Continued From page 6 forget and not return.  Interview, on 03/05/13 at 3:15 PM, in Resident #3's room revealed staff do not answer call lights mainly on the night shift and weekend shift. The resident stated due to his/her body size it was very difficult to lift his/her legs onto the bed. The resident continued to state at night there had been occasions after activating the call light of having to wait up to an hour for help.  Interview, on 03/06/13 at 5:20 AM, with CNA #1 revealed call lights are to be answered by every employee. She stated when a CNA was on break another CNA along and the nurse was notified to monitor if a resident needed anything. She stated the call light responder which was located on top of the nurse's counter allowed staff to see the room number and the amount of time the call light had been on. She continued to state the only way the call light responder would stop the time was by actually entering the room and turning off the call light.  Interview, on 03/06/13 at 5:30 AM, with Registered Nurse (RN) #2 revealed call lights are to be answered by all employees and if you are unable to assist the resident the employee should tell the CNA or nurse that the resident was in need of assistance. She stated when a CNA left the floor another CNA and the nurse were informed so the residents could be effectively covered.  Phone interview, on 03/06/13 at 8:00 AM, with the Weekend Supervisor LPN #1 revealed on 02/09/13 Resident #1's family member entered the facility very upset wanting to talk to the	F 309			



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F 309	<p>Continued From page 7</p> <p>Director of Nursing. He stated he and the family member entered the resident's room and the CNA (not the resident's assigned CNA) was beginning to clean the diarrhea off of the resident. He stated the resident had been waiting about 25-30 minutes. (the time was based on the family member's cell phone log and the time the family member arrived to the facility).</p> <p>Attempted phone interviews with CNA #3 and #4, on 03/06/13 at 08:15 AM and 08:17 AM, were unsuccessful and messages were left to return the call.</p> <p>Phone interview, on 03/06/13 at 8:40 AM, with RN #1 revealed she was caring for Resident #1 on 02/09/13. She stated remembered passing morning medications and sitting at the nurse's area attempting to complete paper work. She further stated while at the nurses desk she heard the call light going off; however, she did not acknowledge the call light. She stated she was unaware the resident's CNA had left the unit, until the weekend supervisor (LPN #1) and the resident's family member arrived to the unit. She continued to state the CNAs are mainly responsible to answering call lights. She continued to state she should have been more attentive to the call light.</p> <p>Interview, on 03/06/13 at 12:05 PM, with the Director of Nursing (DON) RN#3 revealed it was the responsibility of every employee to answer call lights and ensure the resident's safety. She continued to state the system for CNA's and staff when leaving the unit was to notify another staff member and the unit nurse.</p>	F 309			



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F 309	Continued From page 8 Interview, on 03/06/13 at 12:45 PM, with the Administrator revealed he immediately came into the facility upon notification of the incident with Resident #1. He further stated the system breakdown was not understanding the importance of customer service.	F 309		

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OFFICE OF ASSISTANT SECRETARY  
DIVISION OF MEDICAL SERVICES

Office of Inspector General

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N 000	INITIAL COMMENTS	N 000		
N 194	<p>902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. 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 interview, record review and facility policy review, it was determined the facility failed to follow the plan of care for two (2) of four (4) sampled residents.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans-Interdisciplinary, dated 01/08, revealed upon admission the Licensed Nurse initiates a care plan addressing the resident's most immediate needs. The interdisciplinary team educates the resident and responsible party to the care plan and implements the care plan.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 02/08/13 with diagnosis of Diabetes, Status Post Right Above Knee Amputation (AKA). Review of the nursing admission assessment, dated 02/08/13, revealed the resident was alert and oriented. Review of the resident's Release From Responsibility for Discharge (AMA) revealed the reason for</p>	N 194	<p><u>N Tag 194:</u></p> <ol style="list-style-type: none"> <li>Resident #1 discharged from the facility on 2-9-13. The care plan for Resident # 3 was updated by a licensed nurse for a raised toilet seat and the bed side commode was discontinued on 3-6-13. RN #1 is no longer employed by the center as of 2-13-13.</li> <li>The Administrator, Director of Nursing and Unit Managers and Assistant Directors of Nursing will complete and document an audit of Care plans for current residents by 4-5-13 to determine that care is provided in accordance with the care plan. Any concerns identified will be corrected at that time.</li> <li>The Director of Nursing, Staff Development Coordinator and the Assistant Directors of Nursing will re-educate licensed nurses to the care plan policy and guidelines for initiating and updating care plans and providing care in accordance with the care plan by 4-5-13. A post test was completed to determine staff understanding 4-5-13.</li> <li>The Director of Nursing, Unit Managers and Assistant Director of Nursing will document an audit of 10 care plans per week x 4 weeks, 10 per month x 2 months and 10 per quarter x 2 quarters to determine that care is being provided in accordance with the care plan. Any concerns identified will be corrected at that time. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x3 months and then at least quarterly x2 for further review and recommendation.</li> <li>Completion date 4-6-13</li> </ol>	

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

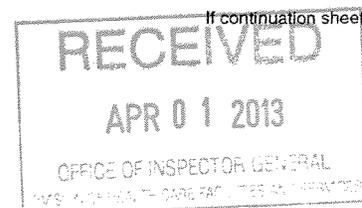
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APR 01 2013 If continuation sheet 1 of 8

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES

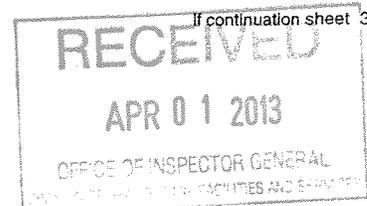
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100503</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 194	Continued From page 1  self-discharge was very poor care. The resident's discharge date was 02/09/13.  Review of the Certified Nurse Care Plan, undated for Resident #1, revealed the facility identified the resident to be continent and toileted by use of a bedpan. The facility's Resident Functional Performance Record revealed the resident to be totally dependent with assist of one. The interventions were to provide the resident with a call light within easy reach and to toilet the resident before and after meals and as needed. The resident implemented the use of the call light; however, the staff did not response. The resident had to call a family member and then yell for assistance.  Phone interview, on 03/05/13 at 10:00 AM, with Resident #1 revealed the admitting nurse explained the use of the call light and assured it was working properly. The resident stated he activated the call light for assistance with toileting; however, no staff answered the call light and he/she resorted to calling a family member which instructed him/her to yell for assistance.  Phone interview, on 03/05/13 at 9:50 AM, with a family member of Resident #1 revealed the resident was admitted to the facility for rehabilitation due to a recent Right AKA amputation. The family member stated she received a call from the resident stating he/she had a episode of diarrhea and no one would answer the call light. The family member stated to the resident to scream in the hallway for assistance. The family member stated they immediately drove to the facility and upon entering the resident's room observed a CNA had just started to assist the resident. The family member stated the resident was removed from	N 194			



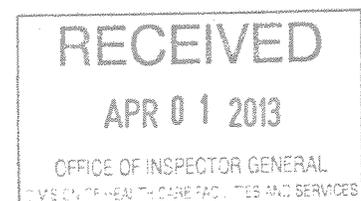
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100503</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 2  the facility and care would be provided at home.  Interview, on 03/06/13 at 5:20 AM, with (CNA) #1 revealed call lights are to be answered by every employee. She stated when a CNA was on break, another CNA along and the nurse were notified to monitor if a resident needed anything. She continued to state the CNA worksheet informed the staff on the needs of the residents.  Interview, on 03/06/13 at 5:30 AM, with Registered Nurse (RN) #2 revealed call lights are to be answered by all employees and if you are unable to assist the resident the employee should tell the CNA or nurse that the resident was in need of assistance.  Phone interview, on 03/06/13 at 8:00 AM, with the Weekend Supervisor LPN #1 revealed on 02/09/13 Resident #1's family member entered the facility very upset wanting to talk to the Director of Nursing. He stated he and the family member entered the resident's room and the CNA (not the resident's assigned CNA) was beginning to clean the diarrhea off of the resident. He stated the resident had been waiting about 25-30 minutes. (the time was based on the family member's cell phone log and the time the family member arrived to the facility).  Phone interview, on 03/06/13 at 8:40 AM, with RN #1 revealed she was caring for Resident #1 on 02/09/13. She stated remembering passing morning medications and sitting at the nurse's area attempting to complete paper work. She further stated while at the nurses desk she heard the call light going off; however, she did not acknowledge the call light. She stated she was unaware the resident's CNA had left the unit, until the weekend supervisor (LPN #1) and the	N 194		



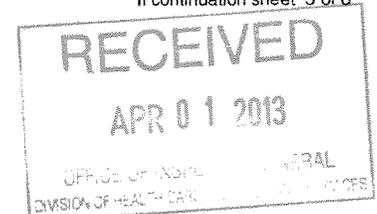
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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION C</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	<p>Continued From page 3</p> <p>resident's family member arrived to the unit. She continued to state the CNAs are mainly responsible for answering the call lights,. She continued to state she should have been more attentive to the call light.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 01/30/13, with diagnoses of Weakness, Anemia and Hypertension. Review of the 02/12/13 Admission Minimum Data Set (MDS) assessment revealed the resident to have no cognitive impairments and was determined to be interviewable. In addition, the facility identified the resident as extensive assistance of one with toileting. Review of the comprehensive care plan revealed the resident had a bedside commode near the bed.</p> <p>Observation during initial tour, on 03/05/13 at 11:30 AM and at 1:15 PM and on 03/06/13 at 5:30 AM and 10:30 AM, revealed no bedside commode in Resident #3's room.</p> <p>Interview, on 03/06/13 at 05:20 AM, with CNA #1 revealed she was unaware the resident needed a bedside commode.</p> <p>Interview, on 03/06/13 at 10:35 AM, revealed he/she had never had a bedside commode. He/She further stated a bedside commode could be useful especially at night.</p> <p>Interview, on 03/06/13 at 12:05 PM, with the Director of Nursing (DON) RN#3 revealed it was the responsibility of every employee to answer call lights and ensure the resident's safety. She continued to state the system for CNA's and staff when leaving the unit was to notify another staff member and the unit nurse. She stated the care</p>	N 194		



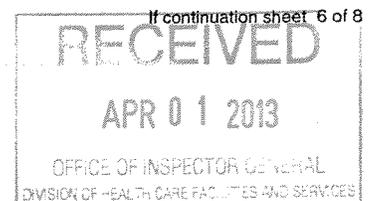
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
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N 194	Continued From page 4 plan was updated by the interdisciplinary team along with unit mangers.	N 194		
N 199	902 KAR 20:300-8 Section 8. Quality of Care  Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident shall receive services 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 interview and record review, it was determined the facility failed to provide toileting assistance for one (1) of four (4) sampled residents. The facility failed to answer the call light in a timely manner for a dependent resident resulting in the resident lying in diarrhea for and extended period of time. Resident #1.  The findings include:  The facility did not provide a policy in regards to care and services or call lights.  Review of the clinical record for Resident #1 revealed an admission date of 02/08/13 with diagnosis of Diabetes, Status Post Right Above Knee Amputation (AKA). Review of the nursing admission assessment, dated 02/08/13, revealed the resident was alert and oriented. Review of the resident's Release From Responsibility for Discharge (AMA) revealed the reason for self	N 199	<u>N Tag 199:</u>  1. Resident #1 discharged from the facility on 2-9-13. RN #1 is no longer employed by the facility as of 2-13-13.  2. The Administrator, Director of Nursing and Unit Managers and Assistant Directors of Nursing will interview current residents with a BIM score of 8 or greater to determine resident satisfaction with the timeliness of staff response to call lights. This will be completed 4-5-13. Any concerns identified will be addressed at that time.  3. The Director of Nursing, Staff Development Coordinator and Assistant Directors of Nursing will re-educate nursing, therapy, housekeeping, dietary, activity, social services and administrative staff to the expectation that all staff respond to call lights and that call lights are answered timely as of 3-29-13. A post test was completed 4-5-13 to determine understanding.  4. The Director of Nursing, Unit Managers and Assistant Directors of Nursing will complete and document 15 call light response time audits per week to include 3 on each shift times 4 weeks. 15 per month for 3 months and 15 per quarter x 2 quarters. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x4 months and then at least quarterly x2 for further review and recommendation.  5. Completion date 4-6-13	



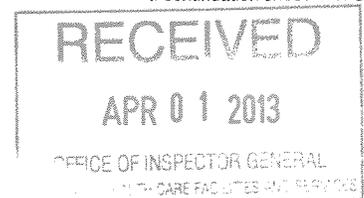
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
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N 199	<p>Continued From page 5</p> <p>discharge was very poor care. The resident's discharge date was 02/09/13.</p> <p>Phone interview, on 03/05/13 at 9:50 AM, with a family member of Resident #1 revealed the resident was admitted to the facility for rehabilitation due to a recent Right AKA amputation. The family member stated she received a call from the resident stating he/she had an episode of diarrhea and no one would answer the call light. The family member stated to the resident to scream in the hallway for assistance. The family member stated they immediately drove to the facility and upon entering the resident's room observed a CNA had just started to assist the resident. The family member stated the resident was removed from the facility and care would be provided at home.</p> <p>Interview, on 03/05/13 at 1:05 PM, in Resident #2's room revealed staff mostly at night and on weekends take awhile to answer the call light. He/She further stated the Certified Nursing Assistance (CNA) would come into the room and turn off the call light stating they would return in a moment; however, most of the time the CNA will forget and not return.</p> <p>Interview, on 03/05/13 at 3:15 PM, in Resident #3's room revealed staff do not answer call lights mainly on the night shift and weekend shift. The resident stated due to his/her body size it was very difficult to lift his/her legs onto the bed. The resident continued to state at night there had been occasions after activating the call light of having to wait up to an hour for help.</p> <p>Interview, on 03/06/13 at 5:20 AM, with CNA #1 revealed call lights are to be answered by every employee. She stated when a CNA was on break</p>	N 199		



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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 199	<p>Continued From page 6</p> <p>another CNA along and the nurse was notified to monitor if a resident needed anything. She stated the call light responder which was located on top of the nurse's counter allowed staff to see the room number and the amount of time the call light had been on. She continued to state the only way the call light responder would stop the time was by actually entering the room and turning off the call light.</p> <p>Interview, on 03/06/13 at 5:30 AM, with Registered Nurse (RN) #2 revealed call lights are to be answered by all employees and if you are unable to assist the resident the employee should tell the CNA or nurse that the resident was in need of assistance. She stated when a CNA left the floor another CNA and the nurse were informed so the residents could be effectively covered.</p> <p>Phone interview, on 03/06/13 at 8:00 AM, with the Weekend Supervisor LPN #1 revealed on 02/09/13 Resident #1's family member entered the facility very upset wanting to talk to the Director of Nursing. He stated he and the family member entered the resident's room and the CNA (not the resident's assigned CNA) was beginning to clean the diarrhea off of the resident. He stated the resident had been waiting about 25-30 minutes. (the time was based on the family member's cell phone log and the time the family member arrived to the facility).</p> <p>Attempted phone interviews with CNA #3 and #4, on 03/06/13 at 08:15 AM and 08:17 AM, were unsuccessful and messages were left to return the call.</p> <p>Phone interview, on 03/06/13 at 8:40 AM, with RN #1 revealed she was caring for Resident #1 on</p>	N 199			



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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4604 LOWE RD LOUISVILLE, KY 40220</b>		
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N 199	<p>Continued From page 7</p> <p>02/09/13. She stated remembered passing morning medications and sitting at the nurse's area attempting to complete paper work. She further stated while at the nurses desk she heard the call light going off; however, she did not acknowledge the call light. She stated she was unaware the resident's CNA had left the unit, until the weekend supervisor (LPN #1) and the resident's family member arrived to the unit. She continued to state the CNAs are mainly responsible to answering call lights. She continued to state she should have been more attentive to the call light.</p> <p>Interview, on 03/06/13 at 12:05 PM, with the Director of Nursing (DON) RN#3 revealed it was the responsibility of every employee to answer call lights and ensure the resident's safety. She continued to state the system for CNA's and staff when leaving the unit was to notify another staff member and the unit nurse.</p> <p>Interview, on 03/06/13 at 12:45 PM, with the Administrator revealed he immediately came into the facility upon notification of the incident with Resident #1. He further stated the system breakdown was not understanding the importance of customer service.</p>	N 199			

