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

PRINTED: 11/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard Health survey was initiated on 10/18/11 and concluded on 10/20/11 and Life Safety Code survey was conducted on 10/18/11 with deficiencies cited at the highest scope and severity of an "F". An abbreviated survey was conducted on 10/20/11 investigating Complaint KY17205 . The Division of Health Care unsubstantiated the allegation due to lack of evidence.	F 000	**"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency 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 the deficiency."**	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156	F156 (1) The signage regarding how to apply and receive Medicare and Medicaid Benefits was posted near the front lobby by the Maintenance Director on 11/7/11. (2) No residents were affected. Any residents requesting information on Medicare or Medicaid benefits were directed to the Social Services Designee or the Business Office Manager for details. Additionally, the Medicare and Medicaid benefits are included in the facility admission packet.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X [signature]	X Administrator X	12/6/11

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

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F 156	Continued From page 1 the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance	F 156	(3) Social Service Director was re-educated by the Administrator regarding required Medicaid/Medicare postings on 11/4/11. (4) The Administrator or Social Services Director will audit the area where the required Medicare/Medicaid posters are hanging as required monthly x 3 months to ensure they are posted. The results of the audit will be submitted to Performance Improvement Committee for three (3) months by the Administrator or Social Services Director for review and further recommendation. (5) Date of Compliance: 11/19/11	

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F 156	Continued From page 2 directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to post the required signage notifying residents and visitors how to apply and receive Medicare and Medicaid benefits. The findings include:	F 156		

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F 156	Continued From page 3 A policy on required signage was not provided by the facility. Observation during the environment tour, on 10/20/11 at 10:00 AM, revealed the required Medicare and Medicaid signage notifying residents and visitors how to apply for, and receive benefits was not posted in the facility. Interview with the Administrator, on 10/20/11 at 2:45 PM, revealed he was aware Medicare and Medicaid signage was required, but did not notice the signage was not posted in the facility. The Administrator revealed there was no monitoring system in place to ensure the required signage was posted in the facility	F 156		
F 253 SS=E	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, review of the maintenance annual work plan, and review of the Housekeeping policy, it was determined the facility failed to: 1. maintain safe and functional resident room doors for four (4) of the fifty-three (53) resident rooms; 2. the facility failed to maintain safe resident entryways in three (3) of the fifty-three (53) resident rooms; 3. The facility failed to maintain safe, sanitary functional resident bathrooms in four (4) of the fifty-three	F 253	F253 (1) The doors for rooms #122, 123, 125, & 223 were sanded smooth of rough edges on 11/9/11 by the Maintenance Director. The door stops in resident rooms 218, 219 & 222 were removed on 10/19/11 by the Maintenance Director. The sink in room 120 was replaced on 11/8/11 by the Maintenance Director. The sink vanity and missing vanity facing in room 126 was repaired on 11/9/11 by the Maintenance Director. In bathroom room 229, the baseboard tile was repaired and the wall was painted on 11/9/11 by the Maintenance Director. The toilet in room 215 was repaired on	11/19/11

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F 253	Continued From page 4 (53) resident rooms; 4. the facility failed to maintain safe sanitary floors on two (2) of the two (2) nursing units; 5. the facility failed to maintain a safe and functional outdoor courtyard. The findings include: Review of the facility's policy titled Housekeeping, which was not dated, revealed the nursing center was maintained in a clean and sanitary condition with a written schedule for cleaning and decontamination appropriate to the area. Review of the facility's maintenance annual work plan, which was not dated, revealed a facility exterior inspection was to be performed weekly, a facility inspection for the strength and integrity of all grab bars was to be completed every three months. 1. Observation during initial tour, on 10/18/11 at 8:32 AM, revealed resident rooms #122, #123, and #125 had entry room doors with rough, chipped, and splintered edges. Observation of room #223, on 10/19/11 at 4:30 PM, revealed the entry room door with cracked and splintered sharp edges. Interview with the Maintenance Director, on 10/20/11 at 2:00 PM, revealed resident doors were checked weekly. The Maintenance Director revealed there was no auditing tool or list that was kept, to indicate which room doors were in need of repair. He further revealed the doors had a potential to injure the residents and cause skin tears. 2. Observation of the West Hall, on 10/19/11 at	F 253	10/20/11 by the Maintenance Director. The tile in rooms 123, 126, and on West hall outside the shower room was repaired on 11/7/11 by the Maintenance Director. The side walk ramp leading off the patio from the outdoor courtyard was repaired on 11/7/11 by the Maintenance Director. The pipe extending out of the ground next to the sidewalk of the patio area was removed on 10/20/11 by the Maintenance Director. (2) The Maintenance Director completed a facility-wide observation audit on 11/08/11 to identify other environmental concerns. (3) The Environmental Services Supervisor and the Maintenance Director were re-educated by the Administrator on 11/4/11 on utilizing an auditing tool for rounding of the facility to record and identify any concerns and to complete work orders for repairs made.	

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F 253	Continued From page 5 4:30 PM, revealed resident rooms #218, #219, and #222 with a metal doorstop attached to the floor approximately 6 inches from the wall at the entryway of the room. Interview with the Maintenance Director, on 10/19/11 at 2:00 PM, revealed he was not aware of the doorstops on the floor and had not noticed them during his rounds. He further revealed the door stops were removed from the other rooms and did not know why they had been left. He stated a potential for residents to trip and fall over the door stops on the floor. 3. Observation during the initial tour, on 10/18/11 at 8:32 AM, revealed room #120 with a crack in the sink extending from the faucet to the outer edge of the sink. Continued observation, on 10/18/11 at 8:32 AM, revealed room #126 with the sink vanity chipped and the facing removed, exposing the compressed wood along the outer edge. Observation of room #229, on 10/19/11 at 4:30 PM, revealed a bathroom with missing baseboard tile, and white colored wall patching to the left of the commode. Observation of room #215, on 10/20/11 at 9:28 AM, revealed a commode filled with stool and urine, when flushed the water rose all the way to the top and slowly seeped down; however, it did not empty the total contents. Interview with the Maintenance Director, on 10/20/11 at 2:00 PM, revealed he was not aware of the problems with rooms 120, 126, and 215. He stated no one had reported these issues and did not notice during rounds. He further revealed room 229 had the wall repaired but was not able to say when the work was completed or last	F 253	(4) The Maintenance Director, Environmental Services Supervisor and/or the Administrator will complete an audit weekly x 4 weeks, then monthly times two months to identify services necessary to maintain a sanitary, orderly and comfortable environment. A summary of the audits will be submitted by the Administrator to the Performance Improvement Committee monthly x 3 months for review and further recommendation. (5) Date of Compliance: 11/19/11	

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F 253	Continued From page 6 worked on. The Maintenance Director was not able to provide a work order or a request. Concurrent interview with the Director of Housekeeping, on 10/20/11 at 2:00 PM, revealed the areas of concern could not be properly cleaned and could pose a potential problem with infection. She further revealed she was not aware of the issues. 4. Observation during initial tour of room #123, on 10/18/11 at 8:32 AM, revealed cracked and chipped tile with missing pieces at room entryway. Continued observation of room 126, on 10/18/11 at 8:32 AM, revealed cracked tile at the entryway to room. Observation of the West Hall, on 10/19/11 at 4:30 PM, revealed cracked tile with missing pieces outside the shower room. Concurrent interview with the Director of housekeeping and the Maintenance Director, on 10/20/11 at 2:00 PM, revealed the floor could not be cleaned as well as it should be and the areas needed to be replaced. They further revealed they were not aware of the tile condition and did not notice it during rounds. 5. Observation of the outdoor courtyard, on 10/19/11 at 4:20 PM, revealed the sidewalk ramp leading off from the patio was cracked and depressed leaving an approximate 4 inch elevation difference. An elevated and angled pipe was extending out of the ground approximately one foot next to the sidewalk off from the patio area. Interview with the Maintenance Director, on 10/20/11 at 2:00 PM, revealed the pipe was part	F 253		

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F 253	Continued From page 7 of the sprinkler hose and should not be sticking up out of the ground. The Maintenance Director revealed he had not noticed the broken ramp or the pipe during rounds, but stated he had not been looking for potential hazards in the courtyard and had only been looking at the cleanliness. He further revealed he did not have a rounding tool or auditing tool that was being utilized while making the facility rounds. The Maintenance Director revealed both the pipe and the broken concrete ramp could potentially be a trip hazard for the residents. Continued interview with the Maintenance Director, revealed he was not able to locate any work orders/request, or evidence of repair work for 2011. He stated all work orders are submitted on paper, but he was not currently able to locate them or explain the system that was in place to report or show completion of facility work. Interview with the Administrator, on 10/20/11 at 2:45 PM, revealed he made rounds daily and wrote down items in need of repair on the work order sheet. The Administrator further revealed he monitored the maintenance log books; however, had not monitored the work orders or repair forms to see that they had been completed. The administrator stated there was no tool in place for rounding and recording of problems identified during rounds.	F 253		
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	F 309	F309 (1) A long-sleeve sweater was placed on Resident #4 on 10/18/11 by the Unit Manager. Resident #4's Care Plan interventions and physician orders were reviewed and implemented.	

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F 309	Continued From page 8 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician orders for one (1) of twenty (20) sampled residents. Resident #4 had an order to wear long sleeves at all times that was not followed. The findings include: Review of the current physicians orders revealed an order for Resident #4 to wear long sleeves at all times. Review of the medical record for Resident #4 revealed the facility admitted the resident on 06/09/11 with diagnoses including Dementia, Alzheimer's, and a History of Falls. Review of the quarterly minimum data set (MDS) assessment, completed on 07/07/11, revealed the facility assessed the resident's cognitive status severally impaired. Review of the Certified Nursing Assistant (CNA) care plan revealed Resident #4 was to wear long sleeves at all times. Review of the Care Plan meeting notes for Resident #4 revealed on 07/19/11 the facility had added an approach to apply Geri sleeves or long sleeves related to skin tears. On 07/26/11 the facility documented Resident #4 sustained a self	F 309	(2) A review of all current resident physician orders and care plan interventions was completed on 10/29/11 by the RN Supervisor and Director of Nursing to ensure implementation. No residents were affected. (3) The nursing staff will be re-educated by the Assistant Director of Nursing, the Charge Nurse or the Unit Manager by 11/18/11 regarding following physician orders and implementing care plan interventions. (4) The Assistant Director of Nursing, the Shift Supervisors and the Unit Managers will audit at least 10 residents to ensure physician orders and care plan interventions are implemented. The audits will occur daily for thirty (30) days, then weekly for thirty (30) days and then monthly for one (1) month. Results of the audits will be submitted to Performance Improvement Committee by the Director of Nursing for three (3) months for further review and recommendation. (5) Date of Compliance: 11/19/11	

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F 309	Continued From page 9 inflicted skin tear by running the wheelchair into a sink. On 09/15/11 the facility documented Resident #4 sustained a skin tear on 09/12/11 by hitting his/her hand on the chair rails. Observation, on 10/18/11 during tour at 8:20 AM, revealed Resident #4 sitting in a wheelchair in his/her room. Both arms were noted to have a Kerlix wrap in place. Observation, on 10/18/11 at 11:20 AM, revealed Resident #4 sitting in the dining room in a wheelchair. The left forearm was wrapped in Kerlix and the right upper arm was wrapped in Kerlix. The resident was wearing a short sleeve shirt. The right lower arm was exposed. At 12:05 PM Resident #4 was sitting up in the wheelchair in the dining room. The resident did not have on long sleeves. Observation of a skin assessment for Resident #4 with the Unit Manager, on 10/19/11 at 11:30 AM, revealed the right upper arm, just above the elbow with a (1) centimeter (cm) crescent shaped skin tear. The left forearm had a three (3) cm by one (1) cm skin tear. Staff reported the left forearm skin tear occurred on 10/13/11 as the result of a fall. The Unit Manager stated they had used Geri sleeves in the past but the resident removed them. Interview with CNA #2, on 10/20/11 at 10:10 AM, revealed she had provided care for Resident #4, and had worked at the facility about one (1) year. She stated she used the CNA assignment sheet to know what the care needs were for the residents. She read the resident needed to wear long sleeves at all times because the resident	F 309		

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F 309	Continued From page 10 "scratches" themselves. Interview with Registered Nurse #1, on 10/20/11 at 10:15 Am, revealed she had worked at the facility for four (4) months. She stated Resident #4 was to wear long sleeves at all times but didn't know why. Interview with the West Unit Manager, on 10/10/11 at 10:20 AM, revealed she acknowledged Resident #4 did not have on long sleeves during tour on 10/18/11 and should have. She stated the resident needs to wear long sleeves to help prevent skin tears if the resident bumps his/her arms. She stated the resident was at an increased risk for infection from skin tears. Interview with a family member, on 10/20/11 at 9:30 AM, revealed the facility had not informed her the resident needed long sleeves. The family member stated if she knew that she would have brought more long sleeves shirts/blouses and removed the short sleeved blouses, as the family did the resident's laundry.	F 309		
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	F 371	F371 (1) The male dietary employees were re-educated on 10/18/11 by the administrator to use beard coverings when preparing and serving food. The male employees initiated and continue to use beard coverings as of 10/18/11. The nursing scheduler was re-educated on 10/18/11 by the administrator not to enter the kitchen without a hair net.	11/19/11

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	185290		10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE AND REHABILITATION CENTER	1550 RAYDALE DR LOUISVILLE, KY 40219

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F 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Staff Attire, it was determined the facility failed to prepare, and serve food under sanitary conditions. Two (2) of two (2) male dietary employees prepared and served foods without beard coverings and one (1) facility employee entered into the kitchen without their hair being confined in hair net or cap. The findings include: Review of the facility's Staff Attire policy dated 07/08, revealed the Nutrition Service Director insured all staff members had their hair confined in a hair net or cap and facial hair properly restrained. Observation of the kitchen during initial tour, on 10/18/11 at 8:20-9:00 AM, revealed the Director of Dietary assisted with the breakfast preparation without any facial hair covered. Further observation during initial tour revealed the nursing scheduler entered the kitchen and obtained a cup of coffee without her hair covered. Observation of the kitchen prior to trayline, on 10/19/11 at 11:15 AM -11:30 PM, revealed the dietary aide placed bread in plastic bags and poured a variety of beverages into cups without his facial hair covered. Further observation during trayline, on 10/19/11 at 11:30 AM-12:45 PM, revealed the Director of Dietary assisted throughout the kitchen with meal service and a dietary aide was positioned at the start of the trayline, both staff members were without facial hair coverings.	F 371	(2) No residents were affected. No complaints of facial hair were reported by any residents or found in any food served by the staff. (3) The Nutritional Services Supervisor was re-educated by the Administrator regarding use of beard coverings and hair nets while in the kitchen on 11/4/11. Dietary staff were re-educated by the Nutritional Services Supervisor regarding beard coverings and hair nets while in the kitchen as of 11/9/11. Facility staff will be re-educated by the Asst. Director of Nursing or the Administrator regarding use of hair nets when entering the kitchen by 11/18/11. 4) The Nutritional Services Supervisor will audit the use of hair nets and beard coverings while in the kitchen weekly for two (2) months, then monthly for one (1) month. The audit findings will be submitted by the Nutritional Services Director to the Performance Improvement committee monthly for (3) three months for review and further recommendations. 5) Date of Compliance: 11/19/11	

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F 371	Continued From page 12 Interview with Nursing Scheduler, on 10/18/11 at 12:00 PM, revealed she had been trained to not enter the kitchen without proper hair covering. She further stated that hair could get into food which was not sanitary. Interview with the Dietary Aide, on 10/20/11 at 1:30 PM, revealed he had been trained on proper covering of facial hair. He further stated the training included, beard covering which was only needed for long, unmanaged beards and that the facility had no beard covers available. He confirmed that even with short beards hair could get into the food or drinks. Interview with the Director of Dietary, on 10/20/11 at 2:00 PM, revealed he was aware of the policy for hair covering and he was responsible for insuring the policy was followed. He further stated, if a beard was well groomed and close to the face, no hair covering was needed. He continued to state, based on the facility policy, all facial hair should be covered to ensure food was prepared and served under sanitary conditions.	F 371		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the maintenance annual work plan, and review of the Housekeeping policy, it was determined the facility failed to maintain safe functional	F 468	F468 (1) The identified hand rails on West Hall and on the wall leading into the common television area were secured on 11/9/11 by the Maintenance Director.	11/19/11

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F 468	Continued From page 13 handrails/grab bars in three (3) of the five (5) resident areas. The findings include: Review of the facility's maintenance annual work plan, which was not dated, revealed a facility inspection for the strength and integrity of all grab bars was to be completed every three months. Observation of the West Hall, on 10/19/11 at 4:30 PM, revealed loose, unsecured handrails/grab bars across from nursing station and by room #224; Observation of the television area, on 10/19/11 at 4:45 PM, revealed a loose handrail on the wall leading into the common television area. Interview with the Maintenance Director, on 10/20/11 at 2:00 PM, revealed he did not think the loose handrails could pose a potential problem to the resident. However, the Maintenance Director revealed the handrails were in need of tightening. He further revealed rounds are completed on the safety and security of the handrails, but did not know when it was last completed. He did not have a rounding tool or auditing tool that was utilized while making the facility rounds. Continued interview with the Maintenance Director, revealed he was not able to locate any work orders/request, or evidence of repair work for 2011. He stated all work orders are submitted on paper, but he was not currently able to locate them or explain the system that was in place to report or show completion of facility work. Interview with the Administrator, on 10/20/11 at 2:45 PM, revealed he made rounds daily and	F 468	(2) The Maintenance Director and Regional Maintenance Director completed a facility-wide audit on 11/3/11 to identify any other unsecured handrails. No additional hand rails were found to be loose. (3) The Maintenance Director was re-educated by the Administrator on 11/4/11 regarding the importance of having secured handrails and monitoring process. Assessing secured handrails will be completed by the Maintenance Director while performing monthly Preventative Maintenance rounds. (4) The Maintenance Director and Administrator will audit the handrails throughout the center monthly for three (3) months. The findings will be submitted by the Administrator to the Performance Improvement Committee monthly for 3 months for further review and recommendation. (5) Date of Compliance: 11/19/11	

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F 468	Continued From page 14 wrote down items in need of repair on the work order sheet. Although the Administrator monitored the maintenance log books; he had not monitored the work orders or repair forms to see that they had been completed. There was no tool in place for rounding and recording of problems identified during rounds.	F 468		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF TYPE OF STRUCTURE: One (1) story, Type III, unprotected. SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 10/18/11. Regency Health and Rehabilitation was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and ten (110) beds and the census was one-hundred (100) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X [signature] TITLE X Administrator X (X6) DATE 11/10/11 12/6/11

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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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0WJL21 Facility ID: 100669 If continuation sheet Page 1 of 4

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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at D level.			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, per NFPA standards. The deficiency had the potential to affect two (2) of the five (5) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility is licensed for one-hundred and ten (110) beds and the census was one-hundred (100) on the day of the survey. The findings include: Observation, on10/18/11 at 11:20 AM, with the Maintenance Director revealed the smoke partition extended above the ceiling, located in	K 025	K025 (1) The smoke partition on the North Hall near the Therapy Room was repaired on 10/20/11 by the Maintenance Director. (2) The Maintenance Director completed rounds of the facility on 10/18/11 and no issues were identified related to smoke barriers. (3) The Maintenance Director was re-educated on 11/4/11 by the Administrator regarding maintaining smoke barriers that would resist the passage of smoke between smoke compartments. Assessing smoke barriers will be completed by the Maintenance Director while performing monthly preventative maintenance rounds. (4) The Maintenance Director will audit the smoke barriers in the facility to ensure barriers will resist the passage of smoke between smoke compartments monthly for three (3) months. The findings will be submitted by the Administrator to the PI Committee for three (3) months for further review and recommendation.	

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K 025	Continued From page 2 the North Hall near the Therapy Room, and had penetrations by newly installed data lines. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 10/18/11 at 11:20 AM, with the Maintenance Director revealed he was unaware of the penetration in the smoke partition. The facility had a policy for contract work performed above the ceiling. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or	K 025	(5) Date of Compliance: 11/19/11	

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K 025	Continued From page 3 2. Be made by an approved device designed for the specific purpose.	K 025		

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