

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/05/2012
--	--	--	---



NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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  An abbreviated survey (KY #18404) was initiated on 05/24/12 and concluded on 06/01/12 to determine the facility's compliance with federal requirements. KY #18404 was found to be unsubstantiated.  The abbreviated survey (KY #18404) was reopened and (KY #18580) was initiated on 07/02/12 and concluded on 07/05/12. KY #18404 was substantiated with related deficiencies and KY #18580 was unsubstantiated with no deficiencies.	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Regency Care &amp; Rehabilitation Center</b> 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 facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p><b>F246</b></p> <p>1. The call light for Residents #3,12,13, 14, 16, 18 and 20 were placed within reach of the residents by the Activities Assistant and Admissions Director on 7/5/12.</p> <p>2. An audit of current residents that included rounds has been conducted on 7/5/12 by the Activities Assistant and Admissions Director to determine call lights were within reach. Any call lights found out of reach were repositioned to be within reach of the resident by a licensed nurse.</p>	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the residents right to receive services in a facility with reasonable accommodation of individual needs for one resident (#3), in the selected sample of 9 and six residents (#12, #13, #14, #16, #18 and #20) not in the selected sample, related to call lights. Observations revealed the facility failed to ensure call lights were kept within reach of Residents #3, #12, #13, #14, #16, #18 and #20.	F 246		07/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve McQuilley</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/25/12</i>
---	-------------------------------	-----------------------------

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.

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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 246	Continued From page 1  Findings include:  An interview with the Director of Nursing (DON), on 07/04/12 at 3:00 PM, revealed the facility did not have a specific policy and procedure related to call lights.  1. A record review revealed the facility admitted Resident #16 on 05/02/06 with diagnoses to include Head Injury, Delusional Disorder, Tracheostomy, Paranoid Schizophrenia, Cataract, and Quadriplegia and Quadriparesis.  A review of the Comprehensive Care Plan for "Self Care Deficit", dated 04/29/10, revealed staff was to provide total assistance for care, mechanical lift and assistance of two (2) for transfers.  Observations on 07/02/12 at 4:50 PM, on 07/04/12 at 9:00 AM and 1:20 PM, and on 07/05/12 at 8:30 AM, revealed the call light for Resident #16 was on the floor and under the head of the bed.  Interviews with Licensed Practical Nurse (LPN) #2 and LPN #4, on 07/04/12 at 3:00 PM and 4:15 PM respectively, revealed Resident #16 was able to use a call light.  2. A record review revealed the facility admitted Resident #18 on 05/12/06 with diagnoses to include Dementia, Osteoporosis, Hypothyroidism, Chronic Airway Obstruction, Hypertension, Peripheral Vascular Disease, and Hyperpotassemia.	F 246	3. Licensed Nurses and Nursing Assistants will be provided re-education by the Assistant Director of Nursing, Nursing Supervisor, Unit Manager or Charge Nurse on accommodation of needs including resident call system by 7/30/12.  4. The Assistant Director of Nursing, Shift Supervisors, Unit Managers and Charge Nurses will audit by completing an observation of at least 10% of current residents to determine needs are accommodated including call lights are in reach. These audits will occur across various shifts and weekdays and weekends. Audits will be conducted daily for two weeks, weekly for six weeks and monthly for one month. Results of the audits will be presented to the facility Performance Improvement Committee for three months and thereafter as indicated by results of audit.		

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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 246	<p>Continued From page 2</p> <p>A review of the Comprehensive Care Plan for "Potential for Decline in Self Care Ability", dated 01/14/10, revealed interventions for staff to supervise/assist with activities of daily living (ADLs) as needed, and to ensure call light was within reach of the resident.</p> <p>Observations on 07/02/12 at 4:54 PM, on 07/03/12 at 12:20 PM, on 07/04/12 at 9:04 AM and 1:24 PM, and on 07/05/12 at 8:34 AM revealed Resident #18's call light was under the bed and not within reach of the resident.</p> <p>An interview with Resident #18, on 07/04/12 at 1:24 PM, revealed the resident didn't know if he/she could get to the light or not.</p> <p>An interview with LPN #3, on 07/04/12 at 3:30 PM, revealed Resident #18 can use the call light but is starting to decline so staff must ensure the call light is within reach of the resident and remind the resident to use the call light.</p> <p>3. A record review revealed Resident #3 was admitted to the facility on 06/13/12 with diagnoses to include Dementia with Behavioral Disturbance and Muscle Weakness.</p> <p>A review of the Comprehensive Care Plan for Risk for Falls, dated 06/13/12, revealed an intervention for staff to place call light within easy reach of the resident.</p> <p>Observations, on 07/02/12 at 4:00 PM and on 07/03/12 at 3:00 PM, revealed Resident #3 was in a wheelchair at bedside with the call light attached to the quarter side rail of the bed out of the resident's reach.</p>	F 246			

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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 246	Continued From page 3  4. A record review revealed Resident #12 was admitted to the facility on 09/09/12 with diagnoses to include Dementia with Behavioral Disturbance and Huntington's Chorea.  A review of the Comprehensive Care Plan for Self Care Deficit, dated 12/17/09, revealed an intervention for staff to ensure the call light was placed in reach of the resident and for staff to answer immediately.  Observations, on 07/02/12 at approximately 4:05 PM and on 07/03/12 at 12 noon, revealed Resident #12 was sitting in a wheelchair beside the bed and the call light was on the floor between the headboard and the wall. Further observation on 07/05/12 at 8:40 AM revealed Resident #12 was in the wheelchair at the foot of bed and the call light was attached to the quarter side rail out of the resident's reach.  Interview with LPN #2, on 07/04/12 at 3:00 PM, revealed Resident #12 was able to use the call light.  5. A record review revealed Resident #13 was admitted to the facility on 03/14/08 with diagnosis to include Psychosis, Dementia with Behavioral Disturbance and Knee Joint Replacement.  A review of the Comprehensive Care Plan for Self Care Deficit, dated 12/08/09, revealed an intervention for staff to ensure call light was placed within reach of the resident and to answer immediately.  Observations on 07/02/12 at 4:15 PM and on	F 246			

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 246	Continued From page 4 07/03/12 at 12:05 PM and 1:40 PM revealed Resident #13 was in bed asleep on the left side. The call light was laying on the resident's bedside table out of reach of the resident.  Interview with LPN #2, on 07/04/12 at 3:00 PM, revealed Resident #12 was able to use the call light.  6. A record review revealed Resident #14 was admitted to the facility on 12/28/11 with a diagnosis of Multiple Sclerosis.  A review of the Comprehensive Care Plan for Self Care Deficit, dated 01/09/12, revealed an intervention for staff to ensure call light was within reach of the resident and to answer promptly.  Observations on 07/02/12 at 4:10 PM, on 07/03/12 at 12:10 PM and 07/04/12 at 10:40 AM revealed Resident #14 was laying in bed with the call light in the top drawer of the bed side table out of reach of the resident.  Interview with LPN #2, on 07/04/12 at 3:00 PM, revealed Resident #14 was able to use the call light.  7. A record review revealed Resident #20 was admitted to the facility on 02/21/12 with diagnoses to include Neurofibromatosis, Impaired Mobility and Decreased Vision.  A review of the Comprehensive Care Plan for Self Care Deficit, dated 11/28/11, revealed an intervention for staff to ensure call light within reach of resident and to answer promptly.	F 246		

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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 246	<p>Continued From page 5</p> <p>Observations on 07/02/12 at 4:00 PM and on 07/03/12 at 12 noon and 1:30 PM, revealed Resident #20 was in the wheelchair at bedside with the call light wrapped around the assistive bed rail under the bedspread out of the resident's reach.</p> <p>Interview with Resident #20's family member, on 07/02/12 at 12 noon, revealed Resident #20 was able to use the call light if it was in reach and close to the resident's hand as the resident's eyesight was poor.</p> <p>Interview with LPN #2 and LPN #3, on 07/04/12 at 3:00 PM, 3:30 PM respectively, revealed Resident #20 can use the call light as long as the call light was right by the resident because the resident was going blind.</p> <p>Interviews with Registered Nurse (RN) #1, LPN #1, LPN #2, LPN #3 and LPN #4 on 07/04/12 at 2:00 PM, 3:00 PM, 3:30 PM and 4:00 PM respectively, revealed everyone was responsible for ensuring call lights were within reach of each resident at all times. The licensed staff revealed they make rounds and observe when passing medications to ensure the call lights were within reach of the residents.</p> <p>Interviews with Certified Nurse Aide (CNA) #1, CNA #2, CNA #3 and CNA #4 on 07/05/12 at 8:50 AM, 9:00 AM, 9:35 AM and 9:45 AM respectively, revealed call lights should be within reach of the residents at all times.</p> <p>Interview with the Director of Nursing (DON), on 07/05/12 at 1:30 PM, revealed she expected the nurses, nursing assistants, and anyone else who</p>	F 246			

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 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 246	Continued From page 6 enters the residents' rooms to ensure call light was within reach of the resident.	F 246			
F 280 SS=E	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 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.  This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and facility policy and procedure review, it was determined the facility failed to ensure the resident and resident's family or resident's legal representative had the opportunity to participate in the development of the comprehensive care plan, for three residents (#1, #5 and #6) in the selected sample of 9 and three residents (#10, #11, and #20) not in the selected sample.	F 280	<b>F280</b> 1. Resident #5 has been asked by the Activities Director or Activities Assistant on 7/11/12 if she would like to have a care plan meeting. Resident #5's family member or legal representative has also been asked by the Social Services Director via mailing on 7/11/12 if he/she would like to have a care plan meeting. The care plan meeting has been scheduled for 8/1/12.  Resident #6 has been asked by the Activities Director or Activities Assistant on 7/11/12 if she would like to have a care plan meeting at this time. Resident #6's family member or legal representative has also been asked by the Social Services Director via mailing on 7/11/12 if he/she would like to have a care plan meeting. The care plan meeting is scheduled for 8/1/12.  Resident #10 and resident's sister and daughter participated in a care plan meeting on 7/18/12.  Resident #11 and resident's daughter participated in a care plan meeting on 7/11/12.	07/30/12	

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219		
(X4) IO 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 280	Continued From page 7  Findings include:  A review of the facility's Care Plan Interdisciplinary policy and procedure, dated 01/08, revealed the interdisciplinary team educates the resident/responsible party to the care plan and encourages residents and families to participate in care plan conferences (Attachment A). A review of Attachment A revealed a form titled Interdisciplinary Attendance Log with boxes for resident or family to sign if present at care plan meeting.  1. A record review revealed the facility admitted Resident #5 on 10/31/10 with diagnoses to include Left Hip Fracture, Repeat Urinary Tract Infections, Iron Deficiency Anemia, Hypertension, Diabetes, and Colostomy.  A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/26/12, revealed the facility assessed Resident #5's cognition as cognitively intact.  A review of the Care Meeting Notes, dated 01/27/12 to 07/02/12, revealed there was no evidence the resident or family was invited to the care plan meetings and record review revealed there was no evidence of the Interdisciplinary Care Plan Attendance  An interview with Resident #5, on 07/04/12 at 1:15 PM, revealed the resident had no knowledge of care plan meetings and the resident stated "that must be something new".  2. A record review revealed the facility admitted	F 280	Resident #1 was discharged from the facility on 1/23/12.  Resident #20 has been asked by the Activities Director or Activities Assistant on 7/10/12 if she would have a care plan meeting at this time. Resident #20's family member or legal representative has also been asked by the Social Services Director via mailing on 7/11/12 if he/she would like to have a care plan meeting at this time. The care plan meeting has scheduled for 7/29/12.  2. Each current interviewable resident was asked by the Activities Director or Activity Assistant on 7/10/12 & 7/11/12 if he or she would like to have a care plan meeting scheduled. The family member or legal representative for all current residents who have one has been asked this question by the Social Services Director via mailing on 7/11/12. For those desiring a care plan meeting, a meeting has been scheduled.  3. The Social Services Director was re-educated by the Administrator on 7/10/12 that residents and their family/responsible party are offered an invite to Care Plan meetings to provide the opportunity to participate in the development of a comprehensive care plan.		

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 RAYDALE DR LOUISVILLE, KY 40218		
(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 280	<p>Continued From page 8</p> <p>Resident #6 on 04/15/08 with diagnoses to include Diabetes Type I, Osteoarthritis, Congestive Heart Failure, Long Term Use of Anticoagulants, Hypothyroidism, Chronic Kidney Disease, and Morbid Obesity.</p> <p>A review of the quarterly MDS assessment, dated 05/07/12, revealed the facility assessed Resident #6 cognition as cognitively intact.</p> <p>A review of the Care Meeting Notes, dated 01/03/12-07/02/12, revealed there was no evidence the resident or family was invited to the care plan meetings and record review revealed there was no evidence of the Interdisciplinary Care Plan Attendance Log.</p> <p>An interview with Resident #6, on 07/03/12 at 12:10 PM, revealed a family member visits every day and stated the facility used to have care plan meetings when the resident was first admitted but doesn't have them anymore.</p> <p>3. A record review revealed the facility admitted Resident #10 on 02/01/12 with diagnoses to include Senile Dementia, Muscle Weakness, Difficulty Walking, and Cognitive Communication Deficit.</p> <p>A review of the quarterly MDS assessment, dated 04/11/12, revealed the facility assessed Resident #10 as cognitively intact.</p> <p>An interview with Resident #10, on 07/04/12 at 9:55 AM, revealed he/she nor a family member had ever been invited to the care plan meetings.</p>	F 280	<p>4. The Administrator or Director of Nursing will audit records of 10% of current residents scheduled for Care Plan meeting to determine documentation of invitation and status of participation by resident and family member weekly for four weeks, and monthly for two months. Results of the audits will be presented to facility Performance Improvement Committee meeting monthly for three months and thereafter as indicated by the results of the audits.</p>		

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 9 4. A record review revealed the facility admitted Resident #11 on 05/22/12 with diagnoses to include Pain Thoracic Spine, Abnormal Gait, and Muscle Weakness.  A review of the initial MDS assessment, dated 05/24/12, revealed the facility assessed Resident #11 as cognitively intact.  A review of the Care Meeting Notes, dated 05/12/12-07/02/12, revealed there was no evidence the resident or family was invited to the care plan meetings and record review revealed there was no evidence of the Interdisciplinary Care Plan Attendance Log.  An interview with Resident #11's family member, on 07/02/12 at 4:25 PM, revealed he/she had never been invited to a Care Plan meeting but would like to attend. The family member stated he/she was in the facility every day and would be free to come to a Care Plan meeting at any time.  5. A record review revealed Resident #1 was admitted to the facility on 10/15/10 with diagnoses to include Acute Venous Embolism and Thrombus, Non-Psychotic Mental Disorder with Organic Brain Damage, Bipolar Disorder and Hypothyroidism. An interview with Resident 1's sons revealed they were never invited to a care plan meeting for Resident #1.  A review of the Social Workers Notes, dated 10/15/10-1/08/12, and the Care Meeting Notes, dated 10/18/10-01/08/12, revealed no evidence Resident #1's family was invited to the the care plan meetings or a phone conference was held with the family related to Resident #1's care.	F 280			

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 10</p> <p>Further review revealed there was no evidence of an Interdisciplinary Attendance Log.</p> <p>6- A record review revealed Resident #20 was admitted to the facility on 02/21/12 with diagnoses to include Congenital Abnormality of the Spine and Neurofibromatosis.</p> <p>An interview with Resident #20's family member, on 07/02/12 at 5:20 PM, revealed Resident #20 was admitted in February 2012. She stated she had not been invited to a care plan meeting since the resident was admitted. She stated "I guess it might be because I'm here everyday".</p> <p>A review of the Social Workers Notes and Care Meeting Notes, dated 02/21/12-07/02/12, revealed no evidence Resident #1's family was invited to the the care plan meetings or a phone conference was held with the family related to Resident #1's care. Further review revealed there was no evidence of an Interdisciplinary Attendance Log.</p> <p>An interview with the Director of Nursing, on 07/05/12 at 1:52 PM, revealed the Social Worker is responsible for sending out letters to the families to invite to care plan meeting. She was not sure how the residents were invited.</p> <p>An interview with the Social Worker, on 07/05/12 at 10:16 AM, revealed letters were sent to the families to invite them to care plan meetings. She stated she conducted phone conferences for those who can not come in. The Social Worker revealed she usually documents in the Social Workers notes when family is invited and if attended care plan meeting or not. In addition,</p>	F 280			

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

PRINTED: 07/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/05/2012
NAME OF PROVIDER OR SUPPLIER  REGENCY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 11 she revealed she keeps a list which indicates who she did phone conferences with.  An interview with the Administrator, on 07/05/12 at 1:55 PM, revealed he is responsible for ensuring the Social Worker performs her duty to invite families and residents to care plan meetings. He stated the Social Worker was supposed to call and ask the residents' families to come to the care plan meetings and it should be documented in the Social Worker notes. He stated the only time a letter is sent out is when the family lives outside the driving area. He was not aware the Social Worker had no evidence that families and residents were called and invited to care plan meetings.	F 280			