

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

PRINTED: 01/08/2013
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 12/20/2012
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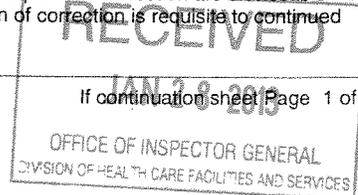
NAME OF PROVIDER OR SUPPLIER REGENCY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
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F 000	INITIAL COMMENTS A recertification health survey was initiated on 12/18/12 and concluded on 12/20/12 with a Life Safety Code survey initiated and concluded on 12/19/12 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey was initiated on 12/18/12 and concluded on 12/20/12. The Division of Health Care substantiated the allegation; however, no related deficiencies were cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency 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." F155 1. Resident #4 and her responsible party were educated by RN supervisor on 12/20/12 and then the responsible party was re-educated on 12/31/12 by RN supervisor on risk of not getting out of bed. Resident #10 was educated by RN supervisor on 12/30/12 on the risks of not getting out of bed. Resident #10 who is alert and oriented requested that her responsible party not be educated.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to advise and/or educate residents and/or their family of consequences which may occur due to the resident's refusal to get out of bed for two (2) of nineteen (19) sampled residents and four (4) unsampled residents. Resident #4 and Resident #10. The findings include: Review of the facility's policy regarding	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deane Harrett, NHA TITLE: X Administrator (X6) DATE: 1/25/13

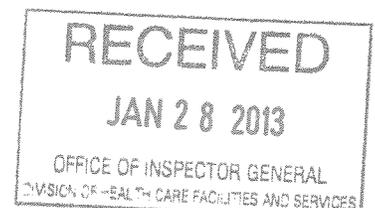
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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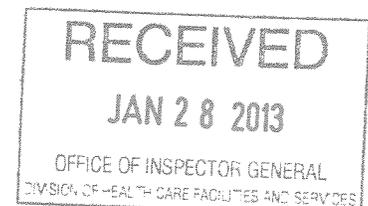
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F 155	<p>Continued From page 1</p> <p>Education-Resident/Family, effective 01/08, revealed the Interdisciplinary Team (IDT) would initiate identification of the educational needs of the resident and/or the family. The policy also stated the IDT documentation would reflect the progress and completion of the teaching/learning process. The policy had an Attachment A, which was the Interdisciplinary Health Education Record.</p> <p>Record review for Resident #10 revealed an admission date of 03/13/09 with diagnoses of Osteoarthritis, Coronary Artherosclerosis, Unspecified Hereditary and Idiopathic Peripheral Neuropathy, Depressive Disorder, Anxiety State, Esophageal Reflux, Hearing Loss, Essential Hypertension and Alzheimer's Disease. The facility assessed Resident #10 as being non-interviewable with a score of three (3) on the Brief Inventory of Mental Status screening tool, dated 09/05/12. Review of the nursing notes for the last one year revealed Resident #10 refused to participate in certain cares and refused to get out of bed. On 12/04/12 Resident #10 refused assist to the bathroom or bedpan and remained in bed. On 10/22/12 and 10/24/12 the resident refused to swish medication in his/her mouth as ordered by the physician. On 08/17/12 the resident refused to turn in bed, and on 08/16/12 the resident refused evening medications. There were no entries of education for the resident or his/her family related to the refusals. The Care Notes for five (5) of the last seven (7) meetings of the IDT referenced Resident #10 not getting out of bed; however, no plan was directed at teaching the family or the resident about the consequences of not getting out of bed or leaving the room.</p>	F 155	<p>Unsampled resident A was educated on 1/14/13 by the Unit manager, unsampled resident B was educated on 12/30/12 by the RN supervisor, unsampled resident C was educated on 12/30/13 by the RN supervisor and unsampled resident D was educated on 1/14/13 by the Unit Manager on risks of refusal of care and services.</p> <p>2. Nursing staff were asked to provide names of any resident that they have knowledge of that have had any type of refusal as of 1/18/13 by Director of Nursing, Assistant Director of Nursing and nursing supervisors. Additionally, MDS listing has been run for E0800=1,2,3 (resists care) and for G010B1=7,8 (transfers rarely or not occurring) was reviewed by the Director of Nursing on 12/28/12 to determine residents with refusals and need for education to the risks of those refusals. All identified residents and/or responsible parties as indicated have been educated by licensed nurses on the potential risk(s) of refusal as of 1/18/13.</p>		



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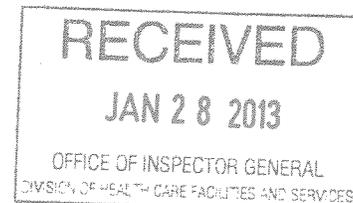
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F 155	Continued From page 2 Observation, on 12/18/12 during the tour of the facility at 2:07 PM, revealed Resident #10 was in bed. Additional observations on 12/18/12 at 4:00 PM and 5:00 PM revealed Resident #10 remained in bed in his/her room. Continued observations on 12/19/12 at 8:30 AM, 11:25 AM, 2:05 PM, and 2:45 PM revealed Resident #10 was in bed. Interview, on 12/18/12 at 2:15 PM, with Licensed Practical Nurse (LPN) #2 during the tour of the facility revealed Resident #10 did not ever get out of bed. Resident #10 was observed in bed at that time. Continued interview revealed there had not been a behavioral assessment completed on Resident #10. She stated there was not a process in place to review behaviors such as the refusal to get out of bed other than allow the resident to refuse. LPN #2 revealed she was aware of the contractures to the feet of Resident #10. There were no notes in the chart by nursing or the IDT that addressed the contractures. Interview, on 12/18/12 at 4:20 PM, with the daughter of Resident #10 revealed Resident #10 had become bed ridden since becoming a resident at the facility. She revealed her parent did not do anything and refused to get out of bed. The daughter stated her parent had refused to take a shower which involved getting out of bed. She stated she just gave up wanting her parent to have a shower and had told the facility her parent could have a bed bath. The daughter did not indicate she had been told or educated regarding any consequence which may occur due to her parent not getting out of bed or leaving the room.	F 155	3. Nursing staff were re-educated by the Director of Nursing, the Assistant Director of Nursing and/or the nursing supervisor as of 1/18/13 on residents right to refuse and the facility's responsibility to educate resident and/or responsible party on potential risks of those refusals. Licensed nurses completed a post test to determine competency with the provided education by the Director of Nurses, Assistant Director of Nurses, Unit Manager or Nursing Supervisor as of 1/27/13. 4. The Director of Nursing, the Assistant Director of Nursing, the Unit Managers and/or the Nursing Supervisors will monitor resident refusals and education and document findings and actions taken on audit tool weekly x12 weeks and then monthly x3 months to determine that resident/responsible party education of risks associated with the refusals has been completed.. Any concerns identified will be corrected at that time. Results of audits will be presented to the facility Performance	



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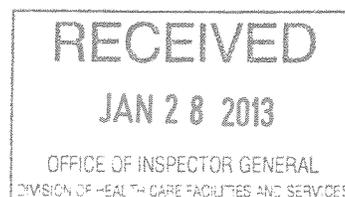
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F 155	Continued From page 3 Interview, on 12/20/12 at 8:55 AM, with Certified Nursing Assistant (CNA) #1 revealed Resident #10 liked to relax in bed and preferred all meals in bed. CNA #1 was unaware the feet of Resident #10 had contracted in a downward position, even though CNA #1 did care for Resident #10. CNA #1 could not recall the last time Resident #10 had been out of bed during his shift. CNA #1 revealed he had not been trained to educate residents about the consequences of their choices, such as never getting out of bed. Interview, on 12/20/12 at 9:35 AM, with LPN #1 revealed Resident #10 had the right to stay in bed. She stated she would encourage the resident to get out of bed because it was important to mingle with others to not get depressed. She revealed the consequences to a resident for not getting out of bed were depression, bed sores and/or contractures. Interview, on 12/20/12 at 11:15 AM, with the MDS Nurse #1 revealed the facility was obligated to meet the needs of the resident who made the choice to not get out of bed. She revealed she was not aware the facility was responsible to educate the resident and/or their family about the consequences of their choices if the choice was one not in the best interest of the resident. Interview, on 12/20/12 at 11:40 AM, with the Director of Nursing revealed the facility provided care to Resident #10 based on what the resident desired. She stated the staff was aware to notify someone on staff (did not state who) of the resident's refusals and/or of a change in the resident's condition. She stated the staff viewed what was going on with Resident #10 as an	F 155	Improvement Committee by Director of Nursing and Assistant Director of Nursing monthly for six months for further review and recommendation. 5. Completion date: 1/28/13		



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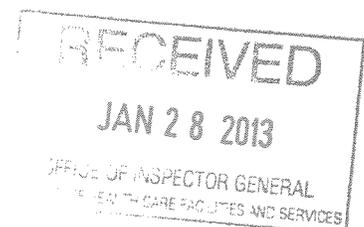
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F 155	<p>Continued From page 4</p> <p>ongoing plan of care; even though the IDT did not address Resident #10 not getting out of bed or the contractures to both feet.</p> <p>Observation of Resident #4, on 12/17/12 at 2:00 PM, 3:00 PM, 4:00 PM, and 4:30 PM, revealed the resident was abed at those times. In addition, observation of Resident #4 on 12/18/12 at 8:10 AM, 8:30 AM, 9:00 AM, 10:00 AM, 11:00 AM, 12:15 PM, 2:00 PM, 3:00 PM and 3:30 PM revealed the resident remained in bed.</p> <p>Record review for Resident #4 revealed a readmission date of 11/05/12 with diagnoses of Diabetes, Pressure Ulcers and Vascular Wounds. The facility assessed Resident #4 as being interviewable with a score of 10 on the Brief Inventory of Mental Status screening tool dated 11/26/12. Review of the physical therapy evaluation notes, dated 11/20/12, revealed Resident #4 had bilateral lower extremity contractures placing the resident at increased risk for skin breakdown and pneumonia with a good rehabilitation potential. The physical therapy evaluation notes also revealed the resident was to be gotten out of the bed with a lift due to the resident's immobility and was to use a Geri-chair when out of the bed. Review of nursing notes dated/timed: 11/27/12 at 2:00 PM; 11/30/12 at 5:00 PM; 12/3/12 at 11:00 AM; and 12/6/12 at 2:00 PM; revealed Resident #4 refused to get up out of the bed.</p>	F 155		



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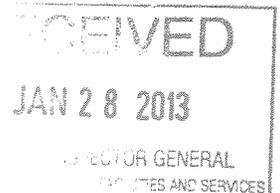
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F 155	Continued From page 5 Interview with Registered Nurse (RN) #2, on 12/19/12 at 4:30 PM, revealed a resident who exhibited refusal of care in regards to getting out of the bed should have been educated as to the consequences of that refusal. She stated she had not seen any nursing documentation of resident education regarding refusal of getting out of the bed for Resident #4. She further revealed a consequence of Resident #4's refusal to get out of the bed could be worsening of skin breakdown. Interview with the Director of Nursing (DON), on 12/20/12 at 2:05 PM, revealed the facility was not absolved of responsibility if a resident refused necessary care and treatment such as getting out of the bed. She stated the facility policy was to educate the resident/family with care needs and document that education to reflect progress and completion of the education. She stated she did not find any documentation of education to Resident #4 regarding the consequences of refusal to get out of the bed.	F 155		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 1. The nurses notes from 12/19/12 thru 1/16/13 were reviewed for Residents # 7 and #10 by licensed nurse on 1/19/13 with no adverse affects identified related to food handling. A physical assessment completed by the Assistant Director of Nursing on 1/14/13 with no adverse effect from food handling identified. Resident #6 was discharged on 12/27/12.	



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F 371	<p>Continued From page 6</p> <p>by:</p> <p>Based on observation and interview, it was determined the facility failed to serve food in a sanitary manner. The facility staff touched resident foods with their bare hands. One Certified Nursing Assistant (CNA) touched Resident #7's bread and Resident #10's snack cake. Another CNA touched Resident #6's bread and crackers.</p> <p>The findings include:</p> <p>The facility did not provide a policy for tray service or tray set-up for residents.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 12/20/12 at 3:15 PM revealed staff should not use bare hands when handling food and should wear gloves.</p> <p>Interview, on 12/20/12 at 4:00 PM, with the Director of Nursing (DON) revealed gloves should be used if touching food.</p> <p>Observation, on 12/20/12 at 11:50 AM, in the restorative dining room revealed CNA #4 opened a package of bread for Resident #7, removed the bread from the package with his/her bare hands and placed the bread on the resident's plate. Additional observation of CNA #4, on 12/20/12 at 12 Noon, revealed she opened a snack cake for Resident #10, removed the cake from the wrapper with bare hands and then placed it on the resident's plate.</p> <p>Observation in the main dining room, on 12/20/12 at 12:05 PM, revealed CNA #5 removed Resident #6's bread from the package with bare hands and</p>	F 371	<p>2. A review of nurses notes from 12/19/12 thru 1/16/13 for current residents was completed by licensed nurse on 1/19/13 to determine any adverse effects from food handling. No concerns were identified.</p> <p>3. Nursing, dietary, therapy, Social Services, Activities, housekeeping, and administrative staff were re-educated by the Director of Nursing, the Assistant Director of Nursing and/or the nursing supervisor as of 1/18/13 on the need to distribute and serve food under sanitary conditions including the prohibition from handling the resident's food with bare hands. Nursing, dietary, therapy, Social Services, Activities, housekeeping, and administrative staff completed post test to determine competency with the provided education by the Director of Nursing, Assistant Director of Nursing, Nursing Supervisors and/or Unit Managers as of 1/27/13.</p>	



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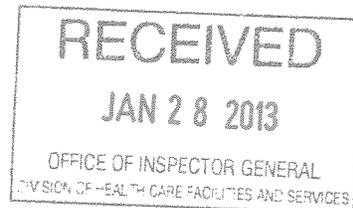
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F 371	Continued From page 7 placed it on the resident's plate. Then CNA #5 opened the same resident's package of crackers, removed the crackers with bare hands and placed them on the resident's plate. Interview, on 12/20/12 at 12:15 PM, with CNA #4 revealed she usually used bare hands to assist residents with tray set up, including removing food from wrappers, with bare hands. The aide stated she was trained by another aide during orientation to serve food in this manner and not to use gloves or tongs. CNA #4 stated there was a risk of spreading infection to the residents by touching their food with bare hands. On 12/20/12 at 12:20 PM, interview with CNA #5 revealed she was trained to use gloves when removing food from wrappers. The aide stated another CNA trained her during orientation to use gloves when handling food. CNA #5 stated using bare hands to handle food could spread infection to the residents. Continued interview with the Assistant Director of Nursing (ADON), on 12/20/12 at 3:15 PM, revealed she would not want anyone touching her food and it did not make the residents feel at home to have staff touch their food. The ADON stated touching food with bare hands could cause infection. Continued interview, on 12/20/12 at 4:00 PM, with the Director of Nursing (DON) revealed touching food with bare hands could spread infection and she would not want anyone touching her food.	F 371	4. The Director of Nursing, the Assistant Director of Nursing, the Unit Managers, Nursing Supervisors and/or the Department Managers will observe dining service and snack service to monitor for proper handling of food and document findings and actions taken on an audit tool. These observations will occur daily for two weeks, three times a week for two weeks, weekly x4 weeks and then monthly for 4 months. Lack of compliance will be immediately corrected and will result in re-education and/or disciplinary action as indicated. Results of these observations will be presented to facility Performance Improvement Committee by the Director of Nursing or Assistant Director of Nursing monthly for six months for further review and recommendation. 5. Completion date: 1/28/13	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		



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F 441	Continued From page 8 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	F441 1. The nursing notes from 12/19/12 thru 1/16/13 were reviewed for Resident #10 and unsampled residents B, C and D by licensed nurse on 1/19/13 to determine any signs of infection or adverse effects with no concerns identified. The ice chest was cleaned by nursing staff on 12/22/12, 12/29/12, 1/5/13, 1/12/13, and 1/15/13. The medication cart used by RN #1 and it's contents were cleaned by a licensed nurse on 1/15/13. Between 12/19/12 and 1/15/13 medication carts were cleaned at least weekly by licensed nurses. RN #1 was re-educated by Nursing Supervisor on 12/19/13 on hand washing. RN #1 was re-educated by Director of Nursing on 12/26/12 to the Infection Control Policy including hand washing procedures and the use of gloves. RN#1 has received disciplinary action for lack of compliance with infection control policies and procedures by Director of Nursing on 1/9/13. RN#1 was observed by the RN supervisor for	

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JAN 28 2013

DIRECTOR OF INSPECTOR GENERAL
CENTERS FOR MEDICARE FACILITIES AND SERVICES

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

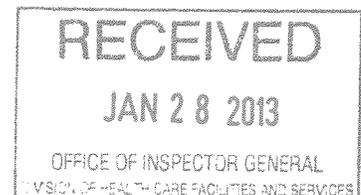
PRINTED: 01/08/2013
FORM APPROVED
OMB NO. 0938-0391

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 12/20/2012
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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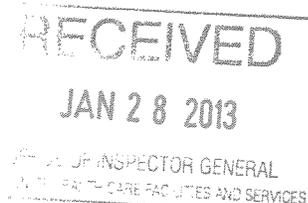
F 441	<p>Continued From page 9</p> <p>by: Based on observations, interviews, and review of the Center for Disease Control (CDC) Guidelines and facility policy review, it was determined the facility failed to have an effective infection control program in regards to hand washing for one (1) of nineteen (19) sampled residents and three (3) of four (4) unsampled residents. During the medication pass facility staff licked their fingers while administering medications to Unsampled residents B, C and D and failed to wash their hands. The facility staff obtained ice from the ice chest without performing hand hygiene. In addition, nursing staff used improper hand hygiene during a skin assessment for Resident #10.</p> <p>The findings include:</p> <p>Review of the CDC's guidelines revealed hand hygiene was necessary after glove removal because hands could become contaminated through small defects in gloves from the outer surface of gloves used during removal. CDC guidelines stated hand hygiene should be performed immediately after gloves were removed. The CDC recommends changing gloves when going from dirty to clean area.</p> <p>Review of the facility's policy regarding Hand Washing, dated 7/1/06, revealed hand washing is a vigorous, brief rubbing of all surfaces of the hands with lathered soap, followed by rinsing under a stream of water. Hand washing should be done before and after direct patient care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of nosocomial infections. Also, hand</p>	F 441	<p>infection control practices during medication pass on 1/9/13 and again on 1/14/13 to ensure compliance with infection control practices. No further concerns were identified.</p> <p>2. A review of nursing notes from 12/19/12 thru 1/16/14 of current residents was completed by the licensed nurse on 1/19/13 to determine any adverse effects from infection control practices regarding hand washing. No concerns were identified.</p> <p>3. Licensed nurses and nursing assistants have been re-educated by the Director of Nursing, the Assistant Director of Nursing and/or the nursing supervisor as of 1/18/13 on Infection Control practices including hand washing and appropriate use of gloves. Licensed nurses and nursing assistants completed post test to determine competency with provided education by the DNS, ADNS, Unit Manager and/or Nursing Supervisor 1/27/13 with no further concerns identified.</p>	
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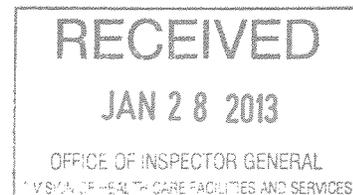
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F 441	<p>Continued From page 10</p> <p>washing is to be performed before and after giving personal care to patients and or self. If gloves are worn for a procedure, hands are to be washed after removal.</p> <p>Observation of the medication pass, on 12/19/12 from 8:35 AM to 9:00 AM, revealed:</p> <p>1. Registered Nurse (RN) #1 obtained medications, dispensed the medications in the medication cup, entered into the room of Unsampld Resident D, obtained a blood glucose reading and administered the medications to the resident, without wearing gloves or washing hands.</p> <p>2. Further observation of RN #1 revealed, the continuous licking of her fingers at the medication cart while preparing for the next medication pass to Unsampld Resident C. Continued observation of RN #1 revealed she entered the room of Unsampld Resident C, applied a Lidoderm patch to both of the resident's knees and administered an oral medication without washing her hands. Further observation revealed RN #1 removed the lid from the resident's thermo ice cup, proceeded down the hallway to the ice chest, used the ice scoop and obtained ice for the resident without ever washing her hands.</p> <p>3. Continued observation of RN #1 revealed she licked her fingers at the medication cart while preparing the medication pass to Unsampld Resident B. Further observation of RN #1 revealed she entered the room of Unsampld Resident B, administered Arulastine nose spray along with several medications which were crushed in applesauce.</p>	F 441	<p>4. The Director of Nursing, the Assistant Director of Nursing, the Unit Managers and/or the Nursing Supervisors will conduct and document infection control rounds and findings daily for two weeks, three times a week for two weeks, weekly for two months and then monthly x3 months to determine compliance with infection control policies and procedures including hand washing practices and glove use. Non compliance will be immediately rectified and will result in disciplinary action or re-education as indicated. Results of rounds will be reported to facility Performance Improvement Committee by the Director of Nursing or Assistant Director of Nursing monthly for six months for further review and recommendation.</p> <p>5. Completion date: 1/28/13</p>	



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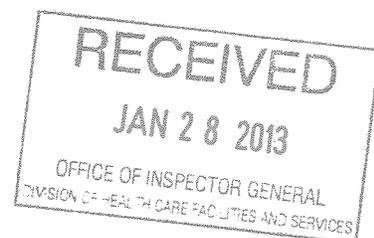
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F 441	<p>Continued From page 11</p> <p>4. Additional observation, on 12/19/12 at 4:30 PM, revealed Registered Nurse (RN) #1 engaged in the skin assessment of Resident #10. During the assessment RN #1 assessed the buttocks of the resident, touching the resident with her gloved hands. RN #1 then moved up to the head of Resident #1 touching the hair of the resident while wearing the same gloves. Upon completion of the assessment, RN #1 removed her gloves, did not wash her hands and touched the hands of Resident #10. RN #1 walked out of the room of Resident #10 without washing her hands.</p> <p>Interview with RN #1, on 12/19/12 at 5:00 PM, revealed the facility provided annual training regarding proper hand washing. She further stated hand washing should be performed before and after resident contact to prevent the spread of germs. She continued to state medication pass was so busy she forgot to perform hand washing. She stated she was unaware of the consistent licking of her fingers, and stated hand washing should be performed after any touching of a staff's personal area, and before and after resident contact to prevent the spread of germs to the residents.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 12/20/12 at 4:30 PM, revealed she was responsible for the infection control program. She further stated the facility provided in-services on hand washing on an annual basis. The ADON stated hand washing should be done before and after resident contact and before using the ice machine. She stated if a staff member touched any part of their body, for example, their mouth, hand washing should be done. The ADON stated the importance of hand</p>	F 441		



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F 441	Continued From page 12 washing was to prevent the spread of infection.	F 441		



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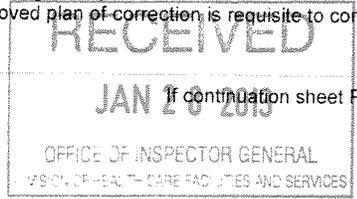
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III, unprotected construction.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet and dry sprinkler system.</p> <p>GENERATOR: Type II 55KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/19/12. Regency Care and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and ten (110) certified beds and the census was ninety-four (94) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>“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 for the deficiency.”</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Yvonne Harrett, NHA* TITLE: *X Administrator X* (X6) DATE: *1/25/2013*

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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K 000 Continued From page 1
Fire)

K 000

Deficiencies were cited with the highest deficiency identified at F level.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

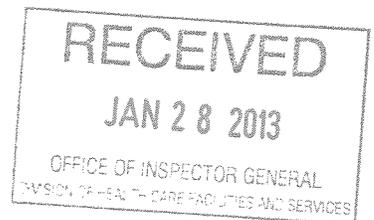
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029

K 029

1. The facility Maintenance Director installed a self-closing devise to the Dry Storage Room door located in the kitchen and the West Soiled Utility Room #2 on 12/19/12.
2. On 12/19/12 Maintenance Director inspected all fire walls and doors in the facility to determine compliance with NFPA 101 Life Safety Code Standard including the presence of self-closing devices on other doors as required. No other areas were identified.
3. The Maintenance Director and Housekeeping Manager were re-educated on the requirements for Protection of Hazards in accordance with NFPA standards by the Administrator on 01/10/2013.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-four (94) on the day of the survey. The facility failed to ensure doors were equipped with functional self-closing devices and failed to ensure the staff was knowledgeable of the requirement.



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K 029 Continued From page 2
The findings include:

Observation, on 12/19/12 at 9:05 AM, with the Maintenance Director revealed the door to the Dry Storage Room, located in the Kitchen, was not equipped with a self-closing device.

Interview, on 12/19/12 at 9:05 AM, with the Maintenance Director revealed the door to the Dry Storage Room had never been equipped with a self-closing device, but was always closed and latched. He was not aware of the door being required to have a self-closing device.

Observation, on 12/19/12 at 10:20 AM, with the Maintenance Director and Housekeeping Manager revealed the door to the West Soiled Utility Room #2 had the arm on the door 's self-closing device removed and would not function as required to automatically close.

Interview, on 12/19/12 at 10:20 AM, with the Maintenance Director and Housekeeping Manager revealed they were not aware of the self-closing device on the door not functioning properly.

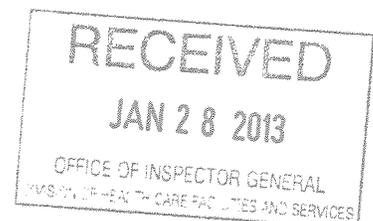
Reference:
NFPA 101 (2000 Edition).

19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided

K 029

4. The Administrator or Maintenance Director will monitor fire walls and record findings using maintenance audit tool on weekly rounds x4 weeks and then monthly x5 months to determine compliance with Protection of Hazards including self-closing devices on doors as indicated in the NFPA standards. Findings will be reported to the Performance Improvement Committee by the Maintenance Director, monthly times 6 months for review and further recommendation.

5. Date of compliance
1/28/2013



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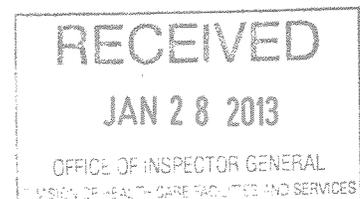
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K 029	Continued From page 3 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and review of the facility's sprinkler testing record, it was	K 062	K 062 1. The gauge on the sprinkler risers identified as not being calibrated or replaced within the past five years, was serviced and replaced on 1/04/13 by Brown Sprinkler Company.	



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K 062 Continued From page 4
determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-four (94) on the day of the survey. The facility failed to ensure gauges on the sprinkler risers were calibrated or replaced within the past five (5) years and failed to ensure the staff was knowledgeable of the requirement.

The findings include:

Observation and record review, on 12/19/12 between 10:30 AM and 1:00 PM with the Maintenance Director and Housekeeping Manager revealed the facility failed to provide documentation that the gauges on the sprinkler risers had been calibrated or replaced within the past five (5) years.

Interview, on 12/19/12 between 10:30 AM and 1:00 PM with the Maintenance Director and Housekeeping Manager revealed they were not aware the gauges on the sprinkler risers had to be calibrated or replaced once every five (5) years.

Reference: NFPA 25 (1998 Edition).

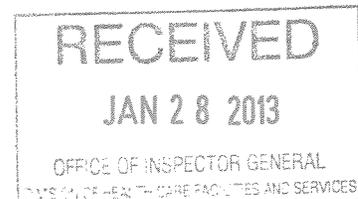
2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of

K 062

2. The Maintenance Director inspected all remaining gauges on 12/19/12 to determine that a five year calibration or replacement has occurred. No other concerns identified.

3. The Maintenance Director and Housekeeping Manager were re-educated on 01/10/13 on maintaining the sprinkler system in according with life safety code NFPA 25 including the requirement that gauges on the sprinkler riser are either calibrated or replaced every 5 years by the Administrator.

4. The Maintenance Director and/or Administrator will inspect, test and provide general maintenance to the sprinkler systems including determining that gauges on the sprinkler riser are either calibrated or replaced within 5 years during weekly rounds and record findings using maintenance audit tool on weekly rounds x4 weeks and then monthly x5



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K 062	<p>Continued From page 5</p> <p>sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference</p> <p>Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2</p> <p>Control valves Inspection Weekly/monthly Table 9-1</p> <p>Alarm devices Inspection Quarterly 2-2.6</p> <p>Gauges (wet pipe systems) Inspection Monthly 2-2.4.1</p> <p>Hydraulic nameplate Inspection Quarterly 2-2.7</p> <p>Buildings Inspection Annually (prior to freezing weather) 2-2.5</p> <p>Hanger/seismic bracing Inspection Annually 2-2.3</p> <p>Pipe and fittings Inspection Annually 2-2.2</p> <p>Sprinklers Inspection Annually 2-2.1.1</p> <p>Spare sprinklers Inspection Annually 2-2.1.3</p> <p>Fire department connections Inspection Table 9-1</p> <p>Valves (all types) Inspection Table 9-1</p> <p>Alarm devices Test Quarterly 2-3.3</p> <p>Main drain Test Annually Table 9-1</p> <p>Antifreeze solution Test Annually 2-3.4</p> <p>Gauges Test 5 years 2-3.2</p> <p>Sprinklers - extra-high temp. Test 5 years 2-3.1.1</p> <p>Exception No. 3</p> <p>Sprinklers - fast response Test At 20 years and every 10 years</p>	K 062	<p>months. The Maintenance Director will submit a summary of findings to the Performance Improvement monthly times 6 months for further review and recommendations.</p> <p>5. Date of compliance 1/28/2013.</p>	
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OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

PRINTED: 12/21/2012
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2012
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 RAYDALE DR LOUISVILLE, KY 40219
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K 062 Continued From page 6 thereafter
2-3.1.1 Exception No. 2
Sprinklers Test At 50 years and every 10 years thereafter
2-3.1.1
Valves (all types) Maintenance Annually or as needed Table 9-1

K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-four (94) on the day of the survey.

The findings include:

Observation, on 12/19/12 at 9:50 AM, with the Maintenance Director revealed the hydrocollator (containing hot water) located within the Physical Therapy Department, was not plugged into a ground fault circuit interrupter (GFCI) outlet as required in wet areas.

K 062

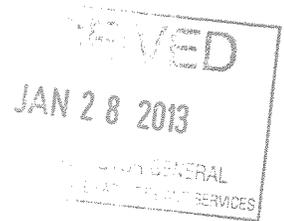
K 147

K 147

1. On 12/19/12 the hydrocollator located in the Physical Therapy Department was unplugged. The outlet was replaced by the Maintenance Director on 12/19/12 with a (GFCI) outlet as in accordance with NFPA 70. Extension cord being used by resident in room 223 was removed on 12/19/2012. The family and resident were educated by Maintenance Director regarding usage of extension cords on 2/19/2012.

2. The Maintenance Director completed an audit of the facility and inspected all remaining outlets requiring ground fault circuit interrupter (GFCI) outlet as required in wet areas as well as looked for additional use of extension cords on 12/19/2012. No other concerns identified.

3. The Maintenance Director and Housekeeping Manager were re-educated regarding



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K 147 Continued From page 7

Interview, on 12/19/12 at 11:05 AM, with the Maintenance Director revealed he was not aware of the hydrocollator being plugged into a standard electrical outlet.

Observation, on 12/19/12 at 11:05 AM, with the Maintenance Director and Housekeeping Manager revealed an extension cord was being used to power a Christmas tree located in Resident Room 223.

Interview, on 12/19/12 at 11:05 AM, with the Maintenance Director and Housekeeping Manager revealed they were aware of the use of extension cords being prohibited and indicated the resident's family had provided the Christmas decorations and acknowledged the need to be cautious during the Holiday Season.

Reference: NFPA 99 (1999 edition)
3-3.2.1.2 D

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

K 147

maintaining electrical wiring and equipment in accordance with NFPA 70, National Electrical Code on 1/10/2013 by the Administrator including outlets to be used in wet areas and the use of extension cords in the center by the Administrator. Nursing, Housekeeping and Therapy staff were educated by the Maintenance Director on 01/14/2013.

4. The Maintenance Director and or Housekeeping Manager will conduct weekly facility rounds and record findings using maintenance audit tool on weekly rounds x4 weeks and then monthly x5 to determine that electrical equipment is plugged into appropriate outlets and that no extension cords are in use. The Maintenance Director will submit summary of findings to the Performance Improvement monthly times 6 months for further review and recommendations.

5. Date of compliance 1/28/2013.

