DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED	
	185301 NAME OF PROVIDER OR SUPPLIER					C 05/22/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
REGIS W	DODS							
					DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FC	000				
	Abbreviated Survey of concluded on 05/22/2 were investigated. O investigations, thirty-t were unsubstantiated The complaints were KY30690, KY30779, KY30912, KY31028, KY31158, KY311028, KY31158, KY31028, KY31393, KY31479, KY31624, KY 32510, KY32856, KY33006, KY32856, KY33006, KY32856, KY33006, KY32856, KY33006, KY32856, KY33006, KY32856, KY33006, KY3224, and KY3322 Additionally, twenty-fi were substantiated w However, fifteen (15) complaints occurred p 11/12/2020 compliant Re-Certification surve without deficiencies of complaints without deficiencies of complaints withou	2021. Sixty (60) complaints ut of the sixty (60) wo (32) of the complaints I without deficiencies cited. KY30554, KY30637, KY 30800, KY30877, KY31037, KY31103, KY31172, KY31179, KY31324, KY31378, KY31480, KY31486, KY32710, KY32779, KY33105, KY33159, 264. ve (25) of the complaints ith deficiencies cited. out to the twenty-five (25) prior to the facility's ce date for the last ey, thus will be substantiated eficiencies cited were KY31310, KY31311, KY31528, KY 31588, KY31722, KY32178, and KY33015. omplaints were ficiencies cited. Due to iance, complaints that 11/12/2020 compliance date cation survey were also aints were KY31095, KY32708, KY33007,						

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

TITLE

(X6) DATE

PRINTED: 07/16/2021

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	E, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 000	The facility admitted F with the primary diagr and additional diagno Episodes, Anxiety Dis with Delusions, Deme Disturbance, and Adju Record review reveal history of resident-to- Continued review reve 10/28/2020 slapped of 10/25/2020 Resident and that resident scra face; and on 10/02/20 resident down resultin suffering a fracture. F documented evidence utilized person center the resident or reduce including pacing, intru- space and verbal or p at others. Interviews with staff re of the underlying caus behaviors, unaware o stressors, and were n centered interventions reduce expression or Interview with the Mer revealed the facility fa Rounds per policy.	KY33789, and KY33888. Resident #21 on 01/01/2020 hosis of Alzheimer's Disease ses included Depressive corder, Psychotic Disorder entia without Behavioral ustment Disorder. ed Resident #21 had a resident altercations. ealed on 03/24/2021 and other residents; on #21 patted a resident's face of the Resident #21 in the 20 Resident #21 pushed a ng with the other resident Further review revealed no e the facility developed or ed interventions to support e the expressions/distress usion of others' personal ohysical behaviors directed evealed they were unaware ses of the resident's responses to	F	000		ILIENUY)		
	five (5) resident-to-res	sident altercations involved in ; Resident #16 kicked						

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 Continued From page 2 F 000 Resident #15; Resident #11 hit Resident #10; Resident #19 stepped on the foot of Resident #20; and Resident #21 pushed Resident #61 down. The facility admitted Resident #31 on 05/10/2013 with diagnoses including Alzheimer's, Psychotic disorder with delusions, and Adjustment disorder with Depressed Mood. Review of the care plan revealed the resident would cheek and spit out medications and was a hoarder. Staff interviews revealed they were aware Resident #31 was a hoarder and was infatuated with medication cups. Observations during the survey revealed Resident #31's unlocked cabinet/dresser drawer contained twenty-two (22) medication cups. Four (4) of the cups had thirty-seven and a half (37.5) assorted medications; eleven (11) of the medications were not prescribed to Resident #31. The medications included blood pressure medications, anti-depressants, antacids, a urinary retention medication, an anti-fungal, a diuretic, and an antibiotic; some of which were not prescribed to Resident #31. Immediate jeopardy was identified on 05/07/2021 and determined to exist on 03/27/2021. Immediate Jeopardy was identified in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, (F600) Free from Abuse and Neglect at a scope and severity (S/S) of "K", 42 CFR 483.21 Comprehensive Resident Centered Care Plans, (F658) Services Provided Meet Professional Standards at a S/S of "J", and 42 CFR 483.40 Behavioral Health Services, (F740) Behavioral Health Services at a S/S of "J". The facility was notified of the Immediate Jeopardy on 05/07/2021.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/16/2021

-						FORM	07/16/2021 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PROVIDER OR SU	PPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WOODS				604 LOWE ROAD OUISVILLE, KY 40220			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 Continued F			F 000				
Agency (SS immediate j immediate j and was de Immediate , 42 CFR 483 Centered C Comprehen Timing and 483.35 Nurs Nursing Sta Administrati Governing R Resident Re S/S of a "J" Activities, a notified of th Actual harm Pharmacy S Unnecessat of a "G". Additional d 42 CFR 483 Rights/Exer Reasonable Needs/Prefe Grievances Freedom fre Exploitation Services, (F Review, at a The facility Allegation of	A) identifi eopardy v eopardy v termined f Jeopardy v 3.21 Comp are Plans sive Care Revision, sing Servi ff, at a S/S on, (F835 Body at a ecords-Ide a a S/S of a was also Services (I ry Psycho eficiencie 8.10 Resic cise of Rig e Accomm erences a , at a S/S on Abuse ,42 CFR 4 730) Nurs a S/S of a provided a f Complia	t a S/S of "E", and (F585) of a "D", 42 CFR 483.12 , Neglect, and 483.35 and Nursing se Aide Performance					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS			604 LOWE ROAD OUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	the Immediate Jeopar 05/20/2021, as allege 05/22/2021, with rema Scope and Severity o develops and implem- and the facility's Qual to ensure compliance	e Survey Agency determined rdy had been removed on rd, prior to exit on aining non-compliance at a f a "G" while the facility ents a Plan of Correction ity Assurance (QA) monitors with systemic changes.	F 000				
F 550 SS=D	§483.10(a) Resident I The resident has a rig self-determination, an access to persons an	(2)(b)(1)(2) Rights. ght to a dignified existence, id communication with and	F 550				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's ity must protect and					
	access to quality care severity of condition, or must establish and m practices regarding tra	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					
		right to exercise his or her f the facility and as a citizen					

Event ID: ODNZ11

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		185301	B. WING			0	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 550	Continued From page	9 5	F	550	0		
	resident can exercise	cility must ensure that the his or her rights without n, discrimination, or reprisal					
	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.						
	by: Based on observatio and review of the faci determined the facility were treated in a digr	is not met as evidenced n, interview, record review, lity's policy it was y failed to ensure residents ified manner for one (1) of npled residents (Resident					
		-					
	The findings include:						
	Rights Under Federal revealed the facility s (resident) with respect each resident in a material	s policy, OPS206 Resident Law revised 03/01/2018, hould treat each patient and dignity and care for nner and in an environment nance or enhancement of					

Facility ID: 100503

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	incorporate the patient choices into care. The patient's individuality is his/her input. The fact promote the rights of it Review of the facility's Changes Based on Lo Community Risk," rev revealed a resident "Me strongly discouraged resident decided to le Executive Director (C reviewed the Resident resident and family m resident. The resident supply of disposable supon returning to the placed on "Observation Review of the facility's Leaves of Absence (L dated 11/08/2020, rev the residents and family ment Further review revealed discouraged from leave potential risks during is leave for any reason of necessary the following and family member w explanation of the risk potential consequence resident would be pro Agreement" and would by both the resident and	nd self-worth. They should nt's goals, preferences, and ey should recognize each as well as honor and value cility should protect and the resident. s policy titled, "Guidance ower (but Not Zero) rised on 03/29/2021, eave of absence" was during the pandemic. If a ave, the Center ED) or a designated leader ave, the Center ED) or a designated leader to Outing Agreement with the ember escorting the nt would be provided with a standard face masks and facility the resident would be on Status." s policy titled, "Review of the COA) during the Pandemic," vealed the facility expected hily members would inquire of leaving the facility to go nbers for part of the day. ed residents were strongly ving the facility despite the the day or for overnight other than medically ing would apply: the resident ould be provided an k of leaving the facility and	F 550				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION			SURVEY DLETED
		185301	B. WING			-		22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	revealed the facility w with a single, disposa each day that the resi the facility. Record review reveal Resident #1, on 11/23 of Quadriplegia, Hype disorder, Adjustment stress disorder, Chro Anxiety disorder, Chro Four (4) pressure ulco Dependence. Review of the Annual dated 01/27/2021, rev Resident #1 with a Br Status (BIMS) score of determined he/she wa Review of Resident # 03/16/2021, revealed Social Services. Per that the Center Execu (him/her) that (he/she weekends anymore w by the Center Nurse B could leave the facility resident across the ha days, but (he/she) can revealed the designat action on the resident Review revealed the of received the grievanc undated "resolved" da revealed the box was explanation related to	I record. Continued review rould provide the resident ble standard facemask for ident would be away from ed the facility admitted 8/2018, with the diagnoses ertension, Bipolar Two (2) disorder, Post-traumatic nic Respiratory Failure, onic pain syndrome, Stage er, and Nicotine Minimum Data Set (MDS), vealed the facility assessed ief Interview for Mental of fifteen (15) and as interviewable. 1's Grievance Form, dated the concern was reported to review, the "resident stated utive Director informed e) could not leave on vhen (he/she) was informed Executive (CNE) (he/she) y. The resident reported a all went home for three (3) n't anymore." Further review ted department to take t's concern was the CED. CED signed off having e on 03/16/2021 with an ate. Continued review checked "no" without an	F	550				

Facility ID: 100503

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	1				FORM OMB NC	D: 07/16/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION			SURVEY LETED
		185301	B. WING			_		22/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	policy related to the "I was discussed with the revealed the CED me face and was signed 03/19/2021. Review of the "Reside dated 08/24/2020, reve planned to leave the faction transported by family appointment or other companions were required advance about the date outing, follow proper in practices, meet at the facility, wear a mask at of the outing, adhere practices, avoid large hand hygiene procedus sign and their family ri- agreed to these condu- Review of Resident # revealed the resident agreement on 11/24/2 Observations, on 04/2 revealed Resident #1 music. The resident of sweats, without odor, wheelchair. Further of resident was able to u Interview with Reside PM, revealed he/she he/she had a choice for further revealed he/she	<ul> <li>vance/concern was that the Leave of Absence" policy of resident. Further review st with the resident face to off as resolved on</li> <li>ent Outing Agreement,"</li> <li>vealed that when a resident facility accompanied and or friend for a medical outing, the resident and any juired to: notify the facility in may, time, and duration of nfection prevention</li> <li>effont entrance to the at all times for the duration to social distancing gatherings, and follow good ures. The resident had to member/friend saying they itions.</li> <li>1's Outing Agreement and family signed the 2020.</li> <li>22/2021 at 2:45 PM, in his/her room listening to was groomed in gray sitting in an electric observation revealed the</li> </ul>	F	550				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
			4	604 LOWE ROAD			
REGIS WO	JODS		L L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	explanation. The resilike he/she was being The resident said that leave the facility, under administration, but no He/she further reveale allowed to leave the fa another resident leave over the weekend. T Centers for Disease O (CDC) guidelines did could not leave the fa Interview with Reside approximately 3:00 Pl given permission by th family. He further rev residents could not leave their family. Interview with the Soc on 05/07/2021 at 6:19 told" by Resident #1 t allowed to go out on o her knowledge, no on facility. Further interv the CNE who told her unapproved leave and (14) day quarantine. not aware of any polic residents from leaving on information that was Per interview, the resi was not an "issue" un board. The SSD state and his/her grievance the facility should hav	ave the facility without an ident stated that he/she felt held against his/her will. t they had been able to er the previous w, they could not leave. ed other residents were acility as he/she saw e to visit his/her loved ones the resident said that the Control and Prevention not say that the residents cility. nt # 47, on 05/20/2021 at M, revealed he/she was he CNE to visit his/her realed he/she was not aware ave the building to visit with cial Service Director (SSD), D PM, revealed she was "just hat Resident #47 was butings. She stated that to re was allowed to leave the riew revealed she talked to the was now on a fourteen The SSD stated she was	F 550				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING _				( 05//	C 22/2021
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		-
				46	504 LOWE ROAD			
REGIS WC	005			LC	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	PM, revealed that Rea non-compliant and matransferred from center choices he/she made refused to stay in his/ wear his/her mask wh facility. The CNE stat lot of time with the res happy and address his that Resident #1 would and would not quaran resident was currently "quarantined." The C would put other reside he/she leave the facilit the CNE revealed she visit with his/her famile the rules and quarant She further revealed the resident's "leave of discouraged the resid facility, but the policy/ resident that he/she of depend on CDC guide Interview with the CEI PM, revealed that he residents from going of	E, on 05/11/2021 at 5:05 sident #1 was very anipulative and had er to center because of . She stated the resident her room and would not ien moving about in the red Social Services spent a sident trying to keep him/her s/her concerns. She stated d not stay in his/her room, tine, but acknowledged the r in a private room and was NE stated Resident #1 ents at jeopardy, should ty. Continued interview with a allowed Resident #47 to y as the resident "followed" ined when he/she returned. he facility's policy related to of absence" strongly ents from leaving the guidance did not state the ave to visit family or go out she has never told the ould not go out, that it would elines. D, on 05/11/2021 at 5:20	F 5	550		EFICIENCY)		
	time was his reasonin residents from going l	umbers being high at the g for strongly discouraging nome, adding, "I have to ' The CED stated he had a sident #1 and other						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		185301	B. WING				<u>)</u> 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	-	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550 F 558 SS=E	guidance, residents s was a medical necess the CED stated he co recommendations/gui was not letting anyon COVID positivity rate stated he was afraid F had possible COVID quarantine when he/s Reasonable Accomm CFR(s): 483.10(e)(3)	ng. He said per all the hould not go out unless it sity. However, per interview, uld not locate such idance. He said the facility e out until the County's went down. The CED Resident #1 would go out, exposure, and not she got back. odations Needs/Preferences	F 550 F 558				
	services in the facility accommodation of respresences except we endanger the health of other residents. This REQUIREMENT by: Based on observation and review of the facility residents' needs in a eighty-seven (87) san #15, #22, #53, #84 ar revealed five (5) of eig call lights were not an Observations reveale up to thirty (30) minut units with no staff avait the hall. Interviews we not enough staff to me residents on the units revealed they have to answer their call lights	sident needs and hen to do so would or safety of the resident or is not met as evidenced n, interview, record review, lity's policy it was y failed to accommodate timely manner for five (5) of npled residents (Residents nd #87). Observations ghty-seven (87) residents' nswered timely. d call lights were activated es for two (2) of three (3) iilable for long periods on vith staff revealed there was eet the needs of the					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
REGIS WO	ODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558		e 12 meetings and was noted in	F 55	8			
	the grievance log.						
	The findings include:						
	Daily Living (ADL's)," revealed the purpose resident's highest phy	was to maintain the					
	facility must provide th	he necessary care and					
		resident's abilities do not care included hygiene,					
		bathing, dressing, grooming,					
	06/01/2016, revealed included to maintain a	elivery Care Process, dated basic prevention of injury an intact skin surface. o provide adequate peri-care					
		ons, and to provide pressure					
	call lights within their	s policy, "Call Lights," evealed residents will have reach at all times and staff l lights and communications					
		s policy, "Accommodation of 8/2016, revealed the facility environment.					
	job description, revise	ed Nursing Assistant (CNA) ed 11/23/2020, revealed all ights in a timely manner.					
	Review of the Reside	nt Council minutes, dated					

Facility ID: 100503

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D PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 05/22/2021		
AME OF PR	ROVIDER OR SUPPLIER		4604	EET ADDRESS, CITY, STATE, ZIP COD I LOWE ROAD JISVILLE, KY 40220	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 558	facility about the cond to the call light. The f response to the repor review revealed on 12 received notification of continued concern ab lights in a timely man Review of the facility's 12/10/2020, revealed the late AM and noon audited day shift, the call documented as tw twenty-three (23) sec 12/16/2020, the audit 7:45 AM for the 200 H (2) (NF2). The audito call lights were activa audit, the Auditor note (10), fifteen (15), twer minutes of observed of noted in the comment nurse manager and s without attempts to re- finish of the audit obs revealed the Auditor r acknowledged or resp Continued audit revie- two (2) observations of response of thirteen ( minutes; and on 01/2 revealed thirty-two (32 call light on the day sl	the residents notified the bern of staff's slow response facility did not document a ted concern. Continued 2/04/2020, the facility of the Resident Council's bout staff not answering call ner. s Call Light Audit, dated staff audited the 400 Hall in . On 12/14/2020, staff 300, and 400 Halls, with a welve (12) minutes and onds to respond. On or observed from 7:00 AM to Hall Nursing Floor (NF) two or noted four (4) residents' ted. At the conclusion of the ed response times of ten nty (20), and twenty-five (25) call lights. The Auditor t section of the audit that the taff remained at the desk espond from the start to the ervation. Further review noted no one on the unit ponded to the call lights. w revealed on 01/26/2021, on the day shift with staff's 13) and seventeen (17)	F 558				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 07/16/2021 ORM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3)	3 NO. 0938-0391 DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE .	
REGIS WO	OODS			4 LOWE ROAD		
				UISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 558	Time," dated 04/02/20 audited call light respective clinical staff. Further monitored for "various different residents. The longest wait time of el- of the 04/06/2021 audited audited "various times the longest wait time of Continued review of the revealed the facility audited time of twelve (12) mit facility's audits did not shift, time of activation unit, activity on unit, in staff, and resident cer the audit and resident Further review of the Notes, dated 04/19/20 council's concerns ind response to call lights included to complete hallways to ensure staff Observation, on 04/20 revealed the facility's heard while standing and they became loud Agency Surveyor app station. Continued of staff sat in the NF2 nut	2/17/2021, revealed nical staff members vice. s audit "Call Light Answer D21, revealed clinical staff onse times by administrative review revealed the staff is times" for fifteen (15) he audit revealed the leven (11) minutes. Review dits revealed the facility s" for eight (8) residents with of ten (10) minutes. he 04/13/2021 audits, udited eight (8) residents' times" with the longest wait inutes. However, the t provide specific times, n and response, staff for neterview with resident or nsus for the unit the day of ts' needs on the unit. facility's Resident Council D21, revealed the resident cluded staff's lack of timely s. The facility's response call light audits for unit aff's timely response.	F 558			

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	-					FORM	D: 07/16/2021
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-		C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	identified herself as L (LPN) #3. Review of 'monitor' unit (an elect the room call bell activ activated and located revealed room 204 ac minutes prior to arrivat the NF2 nurse's static Licensed Practical Nu desk, and various fac call light handset whice without staff response observations revealed responded to room 20 room 204. The facility thirty-nine (39) minute policy, staff response 1. Record review rever Resident #84 to room the diagnoses of Park failure, and Major Dep of the Quarterly Minin 03/14/2021, revealed resident's cognitive pa Interview for Mental S scored fifteen (15) wh interviewable. The fa as a two (2) person et mobility, toileting, hyg breakdown.	Nurse and the other staff icensed Practical Nurse the centralized call light tronic box which identified vated and length of time at the nurse's station) ctivated the call light five (5) al. Further observation at on revealed observations of urse (LPN) #3 sitting at the ility staff walking past the ch continued to alarm e to room 204. Continued d at 11:25 AM, LPN #3 04. Resident #84 resided in y's response time was es. According to the facility's should be immediate. ealed the facility readmitted a 204, on 03/07/2021, with kinson's Disease, Heart oression Disorder. Review num Data Set (MDS), dated the facility assessed the atterns with the Brief Status (BIMS). The resident atterns with the Brief Status (BIMS). The resident atterns vie assist for bed giene, and at risk for skin	F 558				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	604 LOWE ROAD		
REGIS WO	DODS			L	OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	manner the residents pain, lay in urine, and pressure. Further inte- had looked at the mod Agency Surveyor arri- 'hit' the call light often staff would answer the passed and the LPN of to be addressed. LPN completed in-services customer services, ar required sessions. Record review reveal attendee to the facility response. Further re- and reviewed the faci 02/13/2021. Howeve LPN did not follow the completing the educa observed on 04/20/20 Resident #84 was not the time, on 04/20/20 2. Interview with Resi 11:50 AM, revealed h for himself/herself and revealed he/she had moved the call light of reach, and he/she con activate it for help. The waited a long time for or they did not answe time could be thirty (3) staff to respond. The activated the call light	id not respond in a timely might get hurt, fall, have I have skin breakdown from erview revealed the LPN nitor before the State Survey ved. She stated the resident a, and she figured another e light. However, time decided the call light needed N #3 revealed the facility s for call light response, nd she had attended all ed LPN #3 signed as an y's in services for call light view revealed she received lity's call light policy, on r, observations revealed the e facility's policy after tion and policy review as 021 at 11:25 AM. t available for interview at	F	558			

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		MEDICAID SERVICES					D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		· · ·	SURVEY
			A. DOILDIN	<u> </u>			С
		185301	B. WING				/22/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, C	CITY, STATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD	40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOUL EFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 558	interview revealed he	e/she believed staff moved	F 5	58			
the call light on purpose so he/si request help because they knew requested help often and it incor staff. Resident #53 further revea		e they knew he/she and it inconvenienced the					
		o people when they asked					
	Resident #53, on 01/ of Chronic Obstructiv (COPD), Glaucoma,	ed the facility re-admitted 29/2019 with the diagnoses e Pulmonary Disease and history of falls. Review , dated 03/07/2021, revealed					
	the facility did not ass cognitive pattern. How resident revealed the questions factually, a	sess for the resident's wever, interview with the resident answered nd was oriented to self, care					
	the resident as an ex hygiene and a limited mobility, assist for toi	ngs. The facility assessed tensive one person assist for l one person assist for bed leting, transfer, and ed review record revealed the					
	facility care planned t falls with the interven	tion to have the call bell in close proximity at all times					
	revealed the NF2 call 215's call light was a	I/23/2021 at 9:55 AM, I light monitor showed room ctivated for 12 minutes. ed Resident #22 resided in					
	no staff was observed no staff observed in t #3 exited a resident's	oservation revealed initially d at the nurse's station and he hallway. At 9:58 AM, LPN s room, walked into the					
	into the Center Nurse At 10:06 AM, an unkr	wed the monitor, and walked Executive's (CNE) office. nown staff deactivated room rvation revealed the resident					

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CENTER STATEMENT C	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				FORM OMB NO (X3) DATE	D: 07/16/2021 // APPROVED 0. 0938-0391 SURVEY PLETED	
		185301		B. WING			С		
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA		05/	22/2021	
	CONDERVOR SOLT ELER				604 LOWE ROAD				
REGIS WO	DODS				OUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 558	waited twenty-one (21 per the facility's policy Record review reveals Resident #22, on 09/1 the diagnoses of Morl and Bipolar. Review 03/25/2021, revealed resident's cognitive pa of Mental Status score determined the reside facility assessed the r extensive assist for be limited assist for toilet ambulation. Interview with Reside 1:00 PM, revealed he the bathroom. The res regularly responded at (60) minutes. 4. Observation, on 04 revealed the call light Care Unit (TCU) was nine (9) minutes and ten (10) minutes and with no visible staff or addition, no staff was 400 Hall. Continued of staff exited room 321 the call light for room observation revealed minutes there was no Staff from other units residents. However, ti call lights. Observatio room 324's light was of	1) minutes, which was not /. ed the facility re-admitted 17/2020, to room 215 with bid Obesity, Viral Hepatitis, of the Quarterly MDS, dated the facility assessed the atterns with a Brief Interview e of fifteen (15) and ent was interviewable. The resident as a two (2) person ed mobility, and one person ting, transfer, and nt #22, on 04/21/2021 at //she called for assistance to sident revealed staff as late as thirty 30 to sixty //26/2021 at 10:07 AM, monitor for the Transitional activated for room 323 for 9 seconds; and room 324 at fifty-seven (57) seconds	F	558					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	immediately. Record review reveals Resident #15, on 12/0 the diagnoses of Para Hypertension. Review dated 03/04/2021, rev for cognitive patterns fifteen (15). Resident interviewable. The fac as a two (2) person et mobility, transfer, hyg review revealed the re medication on an "as Interview with Reside 10:41 AM, revealed th hours for pain medicat the last weekend he/s hours for response to shift, since admission resident stated that st would say that they con needs of other reside staff at the bedside. F when he/she called for was at a scale of six ( time he/she received reached eight and a h stated that long wait t the call light was com 5. Record review rever	es and room 324 was utes. According to the vas to respond to call lights ed the facility re-admitted 07/2020, to room 323 with aplegia, Septicemia, and v of the Quarterly MDS, vealed the facility assessed with the BIMS' score of #15 was determined to be cility assessed the resident xtensive assist for bed iene, toileting. Further esident received pain needed" (PRN) basis. Int #15, on 04/26/2021 at e/she waited over two (2) tion on a day shift, within she waited over three (3) the call light on the third on Easter weekend. The aff, both nurses, and aides, build not respond due to the nts which required two (2) further interview revealed or medication, his/her pain 6) out of (10) and by the pain relief the pain had ualf (8 $\frac{1}{2}$ ). The resident imes for staff's response to mon.	F 558				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	≥ 20	F	558				
	03/18/2021, revealed Resident #87's concerresponse times. Record facility admitted Resid with the diagnoses of Dysreflexia, and Neur Review of the Quarter (MDS), dated 05/12/2 assessed for cognitive Interview for Mental S fifteen (15) and detern interviewable. The fact included the use of a and bed mobility require maximum assist. In a always incontinent of Record review reveals Resident #87, on 03/0 of Paraplegia, Autono Neuralgia. Review of Set (MDS), dated 05/ assessed for cognitive Interview for Mental S fifteen (15). The facility be interviewable. The assessment included	rly Minimum Data Set 2021, revealed the facility e patterns with the Brief Status (BIMS) with a score of mined the resident was cility's mobility assessment wheelchair; and, transfers uired two (2) person ddition the resident was bowel. ed the facility admitted 03/2021, with the diagnoses omic Dysreflexia, and the Quarterly Minimum Data 12/2021, revealed the facility e patterns with the Brief Status (BIMS) with a score of ity assessed the resident to						
	was always incontined Interview with Reside 12:04 PM, revealed h light, on 04/26/2021, i bath. The resident sta	ist. In addition, the resident nt of bowel. ent #87, on 05/14/2021 at le/she had activated the call in the AM to start his/her ated that long wait times for Il lights was normal. The						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/16/2021 FORM APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			MB NO. 0938-0391 x3) DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
			460	4 LOWE ROAD		
REGIS WO	DODS		LO	UISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 558	the aides refused to a Resident #87 stated h changed, and had wa The resident stated h and the Social Worke However, the residen did not change. Conti resident revealed stat until 1:00 AM and he/ connect to the station staff did not attach the addition, he/she state on his/her phone whe refused to come into 1 stated the wait time w he/she reported this to (Administrator). Resid want to answer his/he considered him/her di he/she just wanted to and receive the care 1 Review of Resident # 03/18/2021 at 5:53 PI call light was on, and the resident reported change and became w Worker completed a g Interview with LPN #4 revealed the Transitio acute cases which co rehabilitation needs, r illnesses, and transitio and for new residents The LPN revealed on assigned to the unit.	e told the Social Worker that come into the room. ne/she needed a brief lited a long time for staff. e/she became emotional, r wrote up a grievance. t stated call light response nued interview with the ff left him/her up in the chair she had to call the facility to to contact staff because e call light to his/her chair. In d to have initiated the timer en one aide worked who his/her room. The resident vas three (3) hours and o the director lent #87 stated staff did not er call light because they ifficult. The resident stated be treated like a human he/she needed to get better. 87 Progress Note, dated M, revealed the resident's Social Services responded, he/she needed a brief very emotional. The Social grievance form. 4, on 04/26/2021 at 1:18 PM, mal Care Unit (TCU) Hall for uld include residents with	F 558			

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	S FOR MEDICARE &					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY
			A. BUILDING	3		
		185301	B. WING			С
	ROVIDER OR SUPPLIER	105501		STREET ADDRESS, CITY, STATE, ZIP CO		5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			4604 LOWE ROAD	DE	
REGIS WO	DODS			LOUISVILLE, KY 40220		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 558	Continued From page	- 22	F 55	8		
		the floor. The LPN stated	1 00			
	0	ok up to thirty (30) minutes,				
		f the floor, and they could				
		bells. The LPN stated staff				
	was supposed to com	ne help from other hallways.				
		could not hear call bells from				
		tated acceptable response				
		ided five (5) to seven (7)				
		venty (20) to thirty (30)				
		or residents, and this could				
		all because they become ated the call bell (call light)				
	-	e line for help. The LPN				
	stated because she h					
		en could not get her duties				
	completed by the end	-				
		N #4 stated she had voiced				
	her concerns to the s	cheduler and to the director.				
	However, no changes	s had been made to the				
		evealed she attended the				
		y the facility for call bell				
		ations. However, the LPN				
		meet the policy's (facility's)				
	expectations.					
	Observation on 05/0	5/2021 at 4:15 PM, revealed				
		<sup>-</sup> 2 alarmed and showed				
		#84's room, activated for 15				
		nds. While the module				
	alarmed staff sat at th	ne desk or charted. Staff				
		N #3 and Certified Nursing				
		Continued observation				
	revealed the CNA did	•				
		addressed a phone call,				
	reviewed the monitor					
	therapists and asked					
	thoropicto antono d	and 204 line - and frame				
	-	om 204. Upon exit from staff identified themselves				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_\_ С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 558 Continued From page 23 F 558 Therapist Assistant (PTA). The call light was deactivated at 4:19 PM. The wait time totaled 19 minutes and 30 seconds, which was not in accordance with the facility's policy. Interview with the OT and PTA. on 05/05/2021 at 4:19 PM, revealed LPN #3 asked them to respond to the room to inquire what the resident needed. They stated the resident needed to be repositioned because he/she reported burning skin to his/her thigh. The therapist stated they repositioned the resident to the right side, propped the resident with pillows, covered him/her, and made sure the resident's items were within reach. Continued interview revealed Resident #84 required two (2) people for extensive assistance with all care needs. They stated resident care was a team effort. Interview with Resident #84, on 05/05/2021 at 4:20 PM, revealed he/she needed to be turned and had waited a while before the two (2) staff came in his/her room. Resident #84 revealed it was the first time the therapists came in to turn him/her. The resident revealed staff always take a long time to answer the call bell. Interview with LPN #3, on 05/05/2021 at 4:22 PM, revealed the LPN worked to complete resident charts and guessed she did not hear the call bell. However, the LPN revealed she was sitting next to the call module with the alarm next to her. LPN #3 stated Resident #84 required extensive assistance for his/her care needs, which could require extensive time. She stated she needed to get the charts completed on the residents. The LPN stated this was the reason she asked the therapists to answer the call light. Interview related to the posted communication which stated

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 07/16/2021

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 558 Continued From page 24 F 558 timely response was at least within five (5) minutes, LPN #3 stated if the module which read 15 minutes, Resident #84's call bell was not responded to in a timely fashion. Interview with CNA #37. on 05/20/2021 at 2:40 PM, revealed staff answered call lights immediately. The CNA revealed the residents used the light for safety to prevent falls, skin breakdown, and to call for help. CNA #37 stated anyone could answer the call light and they should be answered at least less than five (5) minutes. Interview with CNA #38, on 05/20/2021 at 2:47 PM, revealed staff answered call lights in a timely manner. The CNA revealed timely meant within fifteen (15) minutes. The CNA revealed the residents called for help to prevent falls, and for staff to assist them with care which the residents could not do by themselves. CNA #38 further stated when staff did not answer call lights immediately residents become impatient and tried to do the task on their own and could hurt themselves if they fell. Interview with the Unit Manager (UM), on 05/20/2021 at 4:05 PM, revealed facility staff checked on residents frequently and answered call lights timely. The UM revealed timely meant within 15 minutes. Further interview revealed when call lights went unanswered residents could attempt to do a task on their own which could result in a fall and injury, because they lost patience. The UM stated the units had residents who frequently pushed the call light for staff. However, the UM did not identify an issue with staff's response; response times greater than 15 minutes; and, staff at the desk while call lights

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & M					FORM	07/16/2021 APPROVED 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
	185301	B. WING			C 05/22	2/2021	
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	, ZIP CODE			
		40	604 LOWE ROAD				
REGIS WOODS		L	OUISVILLE, KY 40220				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE	
revealed the UM cond as official observational findings of excessive v Interview with the Cen- on 04/26/2021 at 11:50 was adequately staffed expected staff to help the 300 and 400 halls stated staff had not co- not being able to comp call lights because of s Further interview with 9 9:15 AM, revealed she October 2020. She sta ensure staff provided to the residents. The CNI were initiated with com- staff were slow to resp initiated them in late 20 stated normal call wait twelve (12) minutes. S Center Executive Direc he requested more au- revealed she gave an February 2021 when et long wait times, but the stated the in-service in lights and staff's expect answer call lights first second. The CNE stat ensure all residents co- and staff responded to followed policy. She st floors adequately to m answer call lights. She	Inse. Continued interview ucted spot audits, as well al audits without significant wait times. Iter Nurse Executive (CNE), 0 AM, revealed the facility d. The CNE revealed she each other, and staff from to help the TCU. The CNE ime to her with concerns of olete their tasks or answer staffing. Ithe CNE, on 05/05/2021 at e came to the facility in ated her role included to best practice and care to E stated call light audits inplaints from residents that bond to call lights and she 020 and early 2021. She it times was ten (10) to othe revealed when the new ctor (CED) came in March, dits of call lights. She in-service to staff in earlier audits revealed some ey were not excessive. She included the policy for call ctations which included to and to do paper work ed she expected staff to build reach their call light,	F 558					

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					1 APPROVED . 0938-0391
VIDER/SUPPLIER/CLIA	· /		(X3) DATE SURVEY COMPLETED		
185301	B. WING	_	C 05/22/2021		
	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	40	604 LOWE ROAD			
	L	OUISVILLE, KY 40220			
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
nimal. She revealed visors to monitor , she did not provide is with directions to he revealed 3 hours wait times who did not want to thermore she stated om the supervisors The CNE further uld not be accurate documented call light audits were nee (QA). 05/2021 at 10:00 facility March 2021. , observations s' stations and with call lights sidents' call lights sidents' call lights sit at the desk or t response. He several days and goals, and view revealed the necountable for the residents, i.e. took care of the d the facility's goals lity to less paper ed the staff required in with the hiring of a her revealed the nic system to run e stated he initiated staff's pattern, and	F 558				
	AD SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER: 185301 DF DEFICIENCIES PRECEDED BY FULL IFYING INFORMATION) Free most residents nimal. She revealed rvisors to monitor , she did not provide is with directions to he revealed 3 hours wait times who did not want to thermore she stated com the supervisors The CNE further build not be accurate documented call light audits were here (QA). 0/05/2021 at 10:00 facility March 2021. /, observations es' stations and with call lights sidents' call lights sit at the desk or t response. He several days and goals, and view revealed the accountable for the residents, i.e. took care of the d the facility's goals lity to less paper ed the staff required in with the hiring of a her revealed the onic system to run e stated he initiated staff's pattern, and to address call	VIDER/SUPPLIER/CLIA       (X2) MULTIPLE         TIFICATION NUMBER:       A. BUILDING         185301       B. WING         185301       B. WING         2       ID         PREFICIENCIES       ID         PRECEDED BY FULL       PREFIX         TAG       F 558         See most residents       ID         nimal. She revealed       rag         visors to monitor       she did not provide         Is with directions to       re revealed         3 hours wait times       who did not want to         thermore she stated       rom the supervisors         The CNE further       rould not be accurate         documented       call light audits were         roce (QA).       V/05/2021 at 10:00         facility March 2021.       /, observations         si' stations and       with call lights         sidents' call lights       sit at the desk or         t response. He       several days and         goals, and       view revealed the         uccountable for       the facility's goals         lity to less paper       ed the staff required         m with the hiring of a       ter revealed the         onic system to run       e stated he init	viber/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         185301       B. WING         185301       B. WING         185301       B. WING         185301       STREET ADDRESS, CITY, ST. 4604 LOWE ROAD LOUISVILLE, KY 40220         DF DEFICIENCIES :PRECEDED BY FULL IFYING INFORMATION)       ID PREFIX (EACH CORREC CROSS-REFEREN ICACH CORREC CROSS-REFEREN ICACH CORREC CROSS-REFEREN ICACH CORREC CROSS-REFEREN IS with directions to the revealed 3 hours wait times who did not twant to thermore she stated com the supervisors The CNE further fuld not be accurate documented call light audits were not (QA).         v/05/2021 at 10:00 facility March 2021. , observations is' stations and with call lights sidents' call lights sist at the desk or t response. He several days and goals, and view revealed the iccountable for the residents, i.e. took care of the d the facility's goals lity to less paper id the staff required in with the hiring of a her revealed the inic system to run e stated he initiated staff's pattern, and	WIDERSUPPLIERCLIA THFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING       185301     B. WING       185301     B. WING       2010     STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220       2011     PREFIX PRECEDED BY FULL PREFIX     PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       2011     PREFIX TAG     CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       2012     PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       2013     PREFIX TAG     F 558       2014     PREFIX (CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)     DEFICIENCY)       2015     PREFIX (CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)     DEFICIENCY)       2014     PREFIX TAG     F 558       2015     PREFIX (CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       2016     PREFIX (CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       2017     PREFIX (Station sto ther revealed cocumable for the residents, i.e. took care of the d the facility goals lity to less paper d the staff required the mic system to run a stated he initiated staff's pattern, and	WIDERRUPPLENCLA THFICATION NUMBER       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DUE COMP         185301       B. WING       (C) 057         185301       B. WING       (C) 057         2000       STREET ADDRESS, CITY, STATE, ZIP CODE       4604 LOWE ROAD LOUISVILLE, KY 40220       (C) 057         DF DEFICIENCIES       ID PREPIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)       (C) 057         ere most residents nimal. She revealed       F 558       (C) 057         is with directions to ere revealed       F 558       (C) 057/2021 at 10:00 facility March 2021. (, observations sidents' call lights sidents' call lights' sidents' calll

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE	E, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 558 F 585 SS=D	they could not resolve he reviewed the comp identify that the audits second and third shift sections of what the co- interview. He stated he call light audit was ad information for QA. He expected staff to follow the residents. Grievances CFR(s): 483.10(j)(1)-( §483.10(j) Grievances §483.10(j)(1) The resi grievances to the faci- that hears grievances reprisal and without fe reprisal. Such grievan respect to care and the furnished as well as the furnished, the behavior	of the resident's request if a it. However, he revealed bleted call audits and did not a had not been completed on ; had not completed the care need was; or resident's ne could not answer if the equate to provide owever, he revealed he w facility policy and care for (4) S. ident has the right to voice lity or other agency or entity without discrimination or car of discrimination or nees include those with eatment which has been hat which has not been	F	585				
	facility must make pro	ident has the right to and the ompt efforts by the facility to e resident may have, in paragraph.						
		lity must make information ance or complaint available						
		lity must establish a sure the prompt resolution rding the residents' rights						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
			A. BUILDING	3		С		
		185301	B. WING			5/22/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/22/2021		
				4604 LOWE ROAD				
REGIS WO	DODS			LOUISVILLE, KY 40220				
(X4) ID	) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORREC							
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 585	Continued From page	e 28	F 58	35				
		agraph. Upon request, the						
		copy of the grievance policy						
	to the resident. The g							
	include:							
		individually or through						
		t locations throughout the						
	facility of the right to f							
	,	in writing; the right to file						
		usly; the contact information						
	-	ial with whom a grievance						
		is or her name, business email) and business phone						
	, <b>,</b>	e expected time frame for						
		v of the grievance; the right						
		cision regarding his or her						
	grievance; and the co							
	-	with whom grievances may						
	be filed, that is, the p	ertinent State agency,						
		Organization, State Survey						
		ng-Term Care Ombudsman						
		n and advocacy system;						
	(ii) Identifying a Griev							
	-	eeing the grievance process,						
	-	g grievances through to their						
		any necessary investigations ining the confidentiality of all						
		ed with grievances, for						
		of the resident for those						
		l anonymously, issuing						
	-	cisions to the resident; and						
	-	e and federal agencies as						
	necessary in light of							
		king immediate action to						
		tial violations of any resident						
	بالمربح المراجع والقرم الأوارين الاواريجان		1			1		
	right while the alleged	d violation is being						
	investigated;	d violation is being 483.12(c)(1), immediately						

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 185301		A. BUILDING		CON	COMPLETED	
		B. WING		0	C 5/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	=	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTED BY FULL       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHORED AND ACTION)       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APP DEFICIENCY)				SHOULD BE	(X5) COMPLETIO DATE
F 585	abuse, including injur and/or misappropriati anyone furnishing ser provider, to the admir as required by State I (v) Ensuring that all w include the date the g summary statement of the steps taken to inv summary of the pertir regarding the residen as to whether the grie confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat accordance with State of the residents' rights or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issue decision. This REQUIREMENT by: Based on interview, for	ies of unknown source, on of resident property, by rvices on behalf of the histrator of the provider; and aw; vritten grievance decisions grievance was received, a of the resident's grievance, restigate the grievance, a nent findings or conclusions t's concerns(s), a statement evance was confirmed or not ctive action taken or to be s a result of the grievance, en decision was issued; e corrective action in e law if the alleged violation s is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement I law enforcement agency or any of these residents' of responsibility; and ence demonstrating the s for a period of no less than ance of the grievance	F 585			
	by: Based on interview, facility's policy review facility failed to follow failed to follow-up with	record review, and the r it was determined the the grievance process and h residents regarding the ns to resolve grievances for				

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	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-	( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page	9 30	F 585				
	it was the policy of the patient (resident) or p the right to express a fear of restraint, interf discrimination, or repr assure prompt receip patient/representative Review of the Grievan revised 03/01/2018, m included information m Review of the second documentation of the and signature of persi- investigation. The res- section, included if re- resolved, and how the addition, the lower se signature of the perso- the signature of the perso- the signature of the perso- the signature of the in- complaint. Review of Resident # 03/16/2021, revealed Social Services. Per- that the Center Execu- informed (him/her) tha on weekends anymor informed by the Center (he/she) could. The re- across the hall went h (he/she) can't anymoi the designated depar- resident's concern was	evised 07/01/2019, revealed e facility to ensure that any atient representative has grievance/concern without erence, coercion, isal in any form and to t and resolution of grievance/concern. nce/Concern Report Form, evealed the top section egarding the complaint. section revealed investigation, actions taken, on that completed the solution section, the last solved, follow-up if not e facility reported. In ction included a line for the on completing the form with dividual that filed the 1's Grievance Form, dated the concern was reported to review, the "resident states tive Director (CED) at (he/she) could not leave e when (he/she) was er Nurse Executive (CNE) esident reported the resident tome three (3) days, but re." Further review revealed tment to take action on the is the CED. Further review ned off having received the					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	box was checked "no' related to the question confirmed." Additiona grievance/concern wa the "Leave of Absence the resident. Further met with the resident off as resolved on 03/ Review of the facility's Leaves of Absence (L dated 11/08/2020, rev the residents and fam about the possibility of home with family men Further review revealed discouraged from leave potential risks during leave for any reason of necessary the followin and family member w explanation of the risk potential consequence resident would be pro Agreement" and woul by both the resident a escorting the resident the resident's medical Review of the "Resided dated 08/24/2020, rev plans to leave the Cel transported by family appointment or other companions were req	tinued review revealed the "without an explanation n, "Was grievance/concern ally, the resolution of the as that the policy related to e" policy was discussed with review revealed the CED face to face and was signed (19/2021. s policy titled, "Review of the .OA) during the Pandemic," realed the facility expected uily members would inquire of leaving the facility to go nbers for part of the day. ed residents were strongly ving the facility despite the the day or for overnight other than medically ng would apply: the resident ould be provided an to of leaving the facility and es. Additionally, the vided the "Resident Outing d be reviewed and signed and family member who was and it would be placed in I record. ent Outing Agreement," vealed that when a resident net raccompanied and or friend for a medical outing, the resident and any uired to: notify the Center in ty, time, and duration of nfection prevention	F 585				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	of the outing, adhered practices, avoid large hand hygiene procedu- sign and their family m agreed to these condi Review of Resident # revealed the resident agreement on 11/24/2 Record review reveale Resident #1, on 11/23 of Quadriplegia, Hype disorder, Adjustment of stress disorder, Chror Anxiety disorder, Chror Anxiety disorder, Chror Four (4) pressure ulce Dependence. Review of the Annual dated 01/27/2021, rev Resident #1 with a Br Status (BIMS) score of determined he/she wa Observations, on 04/2 revealed Resident #1 music. The resident wa sweats, without odor, wheelchair.	At all times for the duration to social distancing gatherings, and follow good ures. The resident had to nember/friend saying they tions. 1's Outing Agreement and family signed the 2020. ed the facility admitted 8/2018, with the diagnoses ertension, Bipolar Two (2) disorder, Post-traumatic nic Respiratory Failure, onic pain syndrome, Stage er, and Nicotine Minimum Data Set (MDS), vealed the facility assessed ief Interview for Mental of fifteen (15) and as interviewable. 22/2021 at 2:45 PM, in his/her room listening to vas groomed in gray	F 585				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page	33	F 585				
	on 05/07/2021 at 6:19						
	÷	as allowed to leave the riew revealed she was not					
		nat prevented the residents ty,only relied on information					
	that was given to her Director (CED). Per i	by the Center Executive nterview, she would					
	normally assist with the however, the CED was	ne grievance process; anted to handle Resident					
	#1's grievance. She f	further stated the resident's					
	-	elated to leaving the facility colved, with an explanation ent.					
		nter Nurse Executive (CNE) 5 PM, revealed that for the					
	grievance process the	e grievance goes to the SSD and distributes them to the					
	person responsible fo	as told they go straight to					
	the CED with Resider	nt #1's grievances. The					
	he/she could not leav	never told Resident #1 that ethe facility. She stated					
		hat it would depend on Control and Prevention					
		ased upon grievance policy eceive a resolution to their					
	PM, revealed that he	D, on 05/11/2021 at 5:20 strongly discouraged out for anything other then					
	medical necessities. noncompliance and C	He said with Resident #1's COVID-19 positivity numbers					
	-	ent to not leave facility. He					
	said he had a convers	sation with Resident #1 and					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05//	22/2021
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585 F 600	did talk about the grie Assurance and Perfor said that when decidin resolved they talked w resident though it had resolved. The CED s grievances within twe Continued interview re #1's grievance was ad Free from Abuse and	leaving. He said that they vance in QA/QAPI (Quality mance Improvement). He ng if a grievance has been vith the resident and if the been resolved, then was tated he liked to resolve the nty-four (24) hours. evealed he felt like Resident ddressed.	F 585 F 600				
SS=K	Exploitation The resident has the ineglect, misappropriation as defined exploitation as defined used by the includes but is not limic corporal punishment, any physical or chemic treat the resident's methods \$483.12(a) The facility	involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or					
	by: Based on interview, r the facility's policy, it v failed to have an effect	is not met as evidenced record review, and review of was determined the facility ctive system to ensure om physical abuse for					

Facility ID: 100503

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
			A. DOILDIN			С
		185301	B. WING			5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
REGIS WO	2006			4604 LOWE ROAD		
REGIS WC	5053			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	NN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	e 35	F 6	500		
		ghty-seven (87) sampled				
		2, Resident #3, Resident #8,				
	Resident #9, Resider					
		ent #13, Resident #15,				
		ent #19, Resident #20, ent #25, Resident #26,				
		ent #25, Resident #20, ent #37, Resident #38,				
	Resident #45, Reside					
		ent #85 and Resident #86.				
		wenty-four (24) residents				
	resided on the Memo	ry Care Unit (MCU).				
	The facility admitted	Resident #61 to the facility's				
		Unit), on 12/17/2019 with a				
		unspecified Dementia				
		sturbance. Additionally, the				
		ed with Adjustment Disorder				
		l, on 06/16/2020, as his/her Record review revealed on				
	10/02/2020, Residen					
	hospital for an evalua	ation related to a				
		Itercation, involving physical				
		was diagnosed with a				
		al Humerus (long bone of ident occurred during the				
		ice, however, the State				
		) did not have documented				
	evidence the facility r	eported the incident.				
	1 Interviews with sta	ff, who witnessed the				
		Resident #21 and Resident				
		at approximately 5:30 PM,				
	revealed Resident #6	51 was in a group activity in				
		d became tearful, had a				
		exited the common area				
		ng his/her room. Staff nt cry, leave the common				
		rds his/her room, which was				
	adjacent to the comm					1

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	and continued to cry. #21 was pacing/walkin and approached Resi (Resident #21's) door an argument and yelle Resident #21 shoved Resident #61 to lose I #61 fell backwards int to the floor, landing or Further interview with Resident #21 had a h and irritability. Contin Resident #61 exhibit p MCU (hallway, comm residents' rooms). Th physical and verbal al resident's personal sp 2. Record review and #85 and Resident #86 MCU. Resident #85 h as yelling out and Resi behaviors such as con resistive to care. On struck Resident #85 w shared room. Subsect on 04/25/2021 the nut bruising and swelling hand. Orders were of x-ray results showed a in the hand) fracture. 3. Closed record revie and Resident #52 wer of the Memory Care L at approximately 12:5	ay of Resident #21's room Subsequently, Resident ing up and down the hallway dent #61 at his/her way. Resident #21 initiated ed at Resident #61. Resident #61 causing his/her balance. Resident to the doorframe and down in his/her right side. staff on the MCU, revealed istory of tearfulness, crying, ued interviews revealed baced ambulation, on the on area, and into other he resident had a history of buse and intrusion of other bace. interview revealed Resident to were roommates on the had verbal behaviors such sident #86 exhibited physical mbativeness and would be 04/22/2021, Resident #86 with a television while in their quently, upon assessment rse identified scattered to Resident #85's right btained for an x-ray. The a right 5th metacarpal (bone	F 600				

Facility ID: 100503

If continuation sheet Page 37 of 337

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP COD	E	-	
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 600	<ul> <li>12/15/2020 Resident sitting in the common room when Resident is Resident if an interview reverse resident #11 hit him/l fist causing redness a</li> <li>5. Record review reverse Resident #16 had a vischeduled smoke bre later lead to a physicar review and interview resident #16 kick Resident #16 kick Resident #16 kick Resident #9 were roo Continued review reverse Resident #9 were roo Continued review reverse Resident #9 squeezed resulting in a small br staff the altercation wa and was unwitnessed</li> <li>7. Record review reverse Resident #38 struck her Resident #38 struck her Resident #38 reported #37 to keep Resident #38 reported #37 to keep Resident #38 reported #37 to keep Resident #38 reported #21 who in return slag MCU staff separated in the staff separated</li></ul>	arms, subsequently ruise on his/her right interview revealed on #10 and Resident #11 were area outside of the dining #10 yelled out loud, then her in the face with a closed and swelling. ealed Resident #15 and erbal altercation during a eak on 12/24/2020 which al altercation. Continued revealed CNA #4 witnessed sident #15 in the chest. ealed Resident #8 and mmates on the MCU. ealed on 10/20/2020 d Resident #8's wrist uise. Per interviews with as reported by Resident #8 l. ealed Resident #37 reported him/her in the chest. d he/she struck Resident #37 out of his/her (Resident #37 out of his/her (Resident pped Resident #2. The the residents, assessed for iff provided 1:1 supervision	F	600				

Facility ID: 100503

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	-	ID HUMAN SERVICES				FORM	D: 07/16/2021
STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>9. Record review reverses Resident #2 pushed F</li> <li>Resident #19 to lose Resident 's #20 foot.</li> <li>10. Record review reverses Resident #2 slapped leaving a red mark, w</li> <li>11. Record review reverses Resident #2 struck Resident #12 kiss Re</li> <li>15. On 04/23/2021, R to hit Resident #28 or common area.</li> <li>The facility's failure to take immediate action ensure all residents w caused or is likely to a impairment or death to the take the take the take to the take the take take take take take take take tak</li></ul>	ealed on 11/21/2020 Resident #19 causing his/her balance and step on vealed on 03/10/2021 Resident #3 on the face, thile on 1:1 supervision. vealed on 03/09/2021 esident #19, Resident #25, he facility provided 1:1 incident. vealed on 03/10/2021 esident #3 leaving a red as under 1:1 supervision at nt. vealed on 03/24/2021 esident #21 in the left arm. 1:1 supervision to Resident vealed staff observed isident #13 on the lips. Resident #56 was observed in the leg while in the o have an effective system to no to prevent further abuse to vere free from abuse has cause serious injury, harm, to a resident. Immediate bstance Quality of Care	F 600				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 39 F 600 Freedom from Abuse, Neglect, and Exploitation, F600 on 05/07/2021, and was determined to exist on 04/22//2021. The facility provided an acceptable credible Allegation of Compliance (AoC)/ IJ Removal Plan on 05/20/2021 alleging removal of the Immediate Jeopardy on 05/20/2021. The State Survey Agency determined the Immediate Jeopardy had been removed 05/20/2021, as alleged, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of an "G" while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings included: Review of the facility's policy titled, Abuse Prohibition, revealed the facility would do all within their control to prevent occurrences of abuse. Per policy, Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of good and services that were necessary to attain or maintain physical, mental or psychosocial well-being. Additionally, abuse of all patients (residents), irrespective of any mental or physical condition, cause physical conditions, cause pain or mental anguish. Per policy, the facility's Executive Director (ED) was responsible for operationalizing policy and procedures that prohibited abuse. Continued review revealed training and reporting obligations would be provided to all employees through orientation, at minimum annually. Training included but was not

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 07/16/2021

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		O. 0938-039
ND PLAN O	CORRECTION	DENTIFICATION NUMBER:	. ,		CON	IPLETED
					С	
		185301	B. WING		05/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 600	should report their kn allegations; what com misappropriation; der resident abuse preve behavioral symptoms increase the risk of all respond. Review rev abuse included provid staff with information may report concerns, and intervening in situ more than likely to occ revealed staff who ide would report immedia employee alleged to l abuse would be imme pending investigation was resident to reside threatened or attacker removed from the set investigation would be facility was responsib who had a history of interaction or exhibite more likely to be invo Review of the facility' Supervision: Continue revised 11/01/2019, r utilized to provide saf residents. 1:1 superv behaviors that include violent behaviors or r monitoring to ensure	hibition Policy; how staff owledge related to stituted abuse, neglect and mentia management and ntion; and understanding of residents that may buse and neglect and how to ealed actions to prevent ding residents, families and on how to and to whom they and identifying, correcting uations in which abuse was cur. Further review entified or witnessed abuse ately to their supervisor, who ately to the Center ED. An have committed the act of ediately removed from duty . If the suspected abuse ent, the resident who was ad another would be ting or situation and an e completed. Per policy, the le for identifying residents disruptive or intrusive ad behaviors that made them lved in an altercation. s Enhanced Patient bus one to one (1:1) policy, evealed 1:1 supervision was rety of the resident and other vision was implemented for ed sexual, agitation, and esidents that required close safety such as substance acute delirium. The policy	F 60			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 600	used the Continuous for documentation of 1. Record review rever Resident #21 to the M 01/01/2020 with a prin Alzheimer's Disease. included Senile Dege Depressive Episodes Disorder with Delusion behavioral disturbance Further review reveals medical and financial Review of Resident # Care Plan), initiated of resident exhibited synt to delusions; whisperit throwing items while i was for the resident to stability. Interventions limited to: provide cor and structured daily ro resident in a calm, un as needed; and monit to medications. Review of Resident # (MDS) Quarterly Asse revealed the resident express ideas, wants, understood. Per the <i>J</i> usually had the ability content of others. Th resident to have a Bri Status (BIMS) score of severely impaired cog	sitor safety. Facility staff 1:1 Supervision Flowsheet 1:1 supervision. ealed the facility admitted Memory Care Unit (MCU), on mary diagnosis of Additional diagnoses neration of the Brain, , Anxiety Disorder, Psychotic ns, Dementia without ee, and Adjustment Disorder. ed the resident had a Power of Attorney (POA). 61's CCP (Comprehensive on 02/27/2020, revealed the nptoms of psychosis related ing, screaming, and in his/her room. The goal o demonstrate increased s included but were not nsistent, trusted caregivers outine; approach the hurried manner, reassure tor the resident's response 61's Minimum Data Set essment, dated 07/11/2020, usually had the ability to , and make himself/herself Assessment, the resident ' to understand verbal e facility assessed the ef Interview for Mental of four (4), which indicated	F 600				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	resident under Section symptoms, no signs of potential indicators of behavioral symptoms Additional review of R on 09/16/2020, reveal potential for psychoso multiple medical prob Dementia without beh Adjustment Disorder of Major depressive diso exhibited tearfulness, wandering. The goal no signs or symptoms The interventions incl complete behavior mo behavior was exhibited observe for signs and distress (tearfulness, Social Service visits a Review of Resident # dated October 2020, n 07/21/2020, for Rispe medication) 0.25 millig (2) times a day for Mo review revealed the re 09/25/2020, which stat behavior free? If behaviors." Review of Resident # 10/01/2020 through 1 documented evidence	the facility assessed the in E, to have no depression or symptoms of delirium, no psychosis, and no present. Resident #61's CCP, initiated led the resident had ocial distress related to lems and diagnoses of: havior disturbance, with depressed mood, and order. The resident crying, irritability, and was for the resident to show s of psychosocial distress. uded but were not limited to: onitoring documentation if d; psychological services; symptoms of psychosocial crying, irritability); and Is necessary. 61's Physician's Orders, revealed an order, dated ridone (antipsychotic grams (mg) by mouth two pod Disorder. Further esident had an order, dated	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION			LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 43	F	600				
	MCU revealed they w tearful and crying on 7 5:30 PM. However, th of person centered int the IDT (Interdisciplina resident and reduce th the behaviors; includin Additional review of R Notes, dated 10/02/20 by Licensed Practical the resident had an al and lost his/her balan Per the Note, the Unit and she stayed with th floor until help arrived Review of the Risk Ma Event Summary Repor revealed on 10/02/20 had a resident-to-resid abuse, and he/she wa the Activities Assistan Resident #21 push Re injury. Continued revi had a BIMS' score of had b BIMS' score of had b BIMS' score of had b BIMS' sc	anagement System (RMS) ort, completed by LPN #36, 20 at 6:38 PM, Resident #21 ident altercation with alleged as the victim. Additionally, it, on the MCU, witnessed esident #61 down causing riew revealed Resident #61 four (4), and Resident #21 three (3). Further, the itnessed the residents get ons and then Resident #21 to the ground. Per the e of the altercation was id Resident #21 became						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING _				C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				504 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	from the acute care h that he/she was trans revealed the resident' in the upper arm) was review revealed a frac- eight (8) weeks. Addi for this type of fracture arm adequately immo with an orthopedic do Review of the facility's Facility-Self Report In dated 10/02/2020, sig Executive Director (C of Physical Abuse had between Resident #2 Physician, POA, Depa Based Services (DCE Enforcement were no on 10/02/2020. Addit witnessed to push Re Resident #61 complai The residents were se an investigation was i review of Resident #6 resident was diagnost behavior disturbance, with depressed mood Review of Certified Ne witness statement, da Resident #61 was ups the resident-to residen physical abuse. Per t was snappy towards of 10/02/2020. Addition Resident #21 could be	61's "After Care Instruction" ospital Emergency Room ferred to, dated 10/02/2020, s Humerus (the long bone a fractured. Continued cture healed in six (6) to titionally, the main treatment e was a sling, to keep the bilized. Further, follow up ctor was required. a Long Term Care cident Form/Initial Report, ned by the previous Center ED), revealed an Allegation d occurred on 10/02/2020 1 and Resident #61. The artment of Community 4S), and Local Law tified of the alleged abuse ionally, Resident #21 was sident #61 to the floor. The of right shoulder pain. eparated and assessed and nitiated. Per the report, 1's history, revealed the ed with Dementia without and Adjustment Disorder urse Aide (CNA) #8's ted 10/06/2020, revealed set on 10/02/2020 prior to nt altercation involving he Statement, Resident #61	F	600			

Facility ID: 100503

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED	
		185301	B. WING		C 05/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMP THE APPROPRIATE DA	X5) PLETIO ATE
F 600	Continued From page		F 6	000		
		ctual event that took place he behaviors leading up to				
	on 04/22/2021 at 4:15	8 (nine {9} months on MCU), 5 PM revealed on :00 PM, she was in the				
	activity. CNA #8 state	ing residents in a group ed Resident #61 left the and crying. However, she				
	normal behavior that	he nurse, because it was a the resident had many times ne knew the resident had the				
	behavior all the time. resident left the comm	The CNA stated when the non room, he/she tried to room (room right beside				
	Resident #61's room) revealed she could se	). Continued interview ee Resident #61's room from				
	#8 stated Resident #6	nere she was standing. CNA 61 continued to cry in the #21's doorway. The CNA				
		ne Resident #21 was ambulation up and down the w, Resident #21 became				
	more agitated when F was near his/her roor	Resident #61 was crying and n. Continued interview ard a commotion (yelling				
		staff ran to Resident #21 and er, she did not witness what				
	statement, dated 10/0	activities Assistant's witness 02/2020, revealed at M, he witnessed a physical				
		Resident #21 and Resident				
		es Assistant (seven {7} , on 04/22/2021 at 4:10 PM,				

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		10. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
			A. BOILDING			С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				4604 LOWE ROAD		
REGIS WO	DODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
E 600	Continued From non	- 40	E 00/			
F 600	Continued From page		F 600			
		20 around 5:00 PM, he was				
	-	esident # 61's room working				
		dar, which was close to Resident #21's rooms. Per				
		sident #61 standing by the				
		ay and then ambulate to				
		that time, Resident # 21				
:	walked passed him to					
	-	t #21 and Resident #61				
		another. Per interview, the				
		g, but only the first words in audible because they were				
		off. The residents were				
	-	t; Yes, I can." The residents				
		at one another. However, he				
		ot redirection before Resident				
		ident #61 in the chest,				
	•	t off balance, which caused				
		ckwards towards the door,				
		the hallway and onto the				
	floor. Additionally, th	-				
	-	ed, and Resident #21 was				
	-	staff. Further interview				
	· ·	1 did not have any obvious				
		ortly after the incident,				
	he/she was sent to th	e Emergency Room				
	because he/she verb	alized pain in his/her right				
		he had worked on the				
		was ambulatory and paced				
	-	ways and in the common				
	-	ost days. Additionally, he				
		the resident would become				
		hers residents at times when				
	-	Per interview, he was aware				
		n physically aggressive				
		Continued interview revealed				
		rked on the MCU, Resident				
	#61 had tearful and c	wing onloaded intermittently				1
		rying episodes intermittently nost days. He stated he did				

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	the nurse because the On 04/26/2021 at 2:24 10:30 AM, SSA attern via telephone; she do Summary Report, on On 04/26/2021 at 2:27 contact the previous O via telephone. Interview with the Mer (MCPD), on 04/26/20 had worked at the fac one (1) year and had months. However, st MCU when the abuse #21 and Resident #61 a Social Worker, she Social Services on the responsibility of the pr Interview with the faci 05/05/2021 at 2:10 Pf responsible to ensure physical abuse by foll Policy. Per interview, and aides to identify, observed behaviors. communication amon and consistent docum record related to behave ensure a safe environ	t's behaviors at that time to e nurse was already aware. 5 PM and on 05/11/2021 at pted to contact LPN #36, cumented the RMS Event 10/02/2020 at 5:38 PM. 7 PM, SSA attempted to Center Executive Director, 7 PM, SSA attempted to Center Executive Director 21 at 3:00 PM, revealed she illity as a Social Worker for been the MCPD for six (6) he was not working on the e occurred between Resident 1. She stated in her role as was not responsible for e MCU, that was the revious MCPD. lity's Physician, on M revealed the facility was residents were free from owing the facility's Abuse she expected the nurses document and report The Physician stated gst the direct caregiver staff hentation in the medical aviors was essential to	F	600	0			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				(X3) DATE COMP	SURVEY LETED
		185301	B. WING				C 05/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	facility's Abuse Policy Policy to be maintaine happening. Additional (QA) /Quality Assurar Improvement (QAPI) abuse investigations if expected staff to iden licensed nurses who exhibited behaviors, if the behavior, the inter Continued interview re being identified, repor IDT could not properly expression/distress to safe environment. Interview with the Cer (CED), on 05/11/2021 had worked at the face Per interview, residen abuse. Continued interview abuse. Continued interview prevent abuse, and if facility's policy and ke Additionally, he provide allegations of abuse in staff were provided tra Per interview, he expec- identify and report be monitoring and super document in the medi-	a abuse. Continued off were educated on the and she expected the ed to prevent abuse from ally, the Quality Assurance ace Performance Committee discussed monthly. Further, she tify and report behaviors to should document the in a Progress Note, including vention, and the response. evealed without behaviors ted, and documented, the y support and reduce the residents and provide a here Executive Director at 3:25 PM, revealed he ility for three (3) months. Its should be free from erview revealed his acility was responsible to it did happen, to follow the ep the residents safe. ded oversight to all in the facility and ensured aining on the Abuse Policy. ected direct caregivers to haviors and provide vision to the residents and cal record. The CED stated exhibited he expected direct ent an intervention/action to the behaviors and to onment.	F	600				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		185301	B. WING				C 22/2021		
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-			
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 600	care while in the hallw revealed staff took Re to help calm him/her of revealed Resident #8 television while in the Subsequently, upon a the nurse identified so swelling to Resident # were obtained for an 5th metacarpal (bone Record review reveal Resident #86 were ro Review of Resident # the resident had verb out. Resident #86 ex such as combativenes Review of the RMS E dated 04/22/2021 at 1 Licensed Practical Nu after the altercation bo Resident #86, Reside the area, placed on 1 and was transferred to psychiatric evaluation Review of the Situation Review of the Situation Review of the Situation Review of the RMS E communication Form PM, revealed after the #86, staff were to mon #85 for signs and sym	e combative and resistive to vay of the MCU. Interviews esident #86 to his/her room down. Further review 6 struck Resident #85 with a ir shared room. essessment on 04/25/2021, cattered bruising and 485's right hand, new orders x-ray, results showed a right in the hand) fracture. ed Resident #85 and ommates on the MCU. 85's clinical record revealed al behaviors such as yelling hibited physical behaviors ss and resistive to care. vent Summary Report, 10:30 PM, completed by erse (LPN) #14, revealed etween Resident #85 and nt #86 was removed from c1 increased supervision, o an acute care facility for a on-Background- nendation (SBAR) , dated 04/22/2021 at 11:48 e altercation with Resident nitor and observe Resident	F	600					

Facility ID: 100503

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PRINTED: 07/16/2021

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-	( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued review reveal not verbalize what hat denied pain at that tim Review of the After He Services, dated 04/25 revealed the on-call p bruising and swelling Resident #85's right h revealed an order way x-ray. Review of the Radiolo 04/25/2021 at 1:52 Pl suffered an acute frace distal metacarpal (bro- mild displacement. Record review reveal Resident #86 on 03/1 Quarantine Unit," per COVID-19. Continue resident's diagnoses i Behaviors, Parkinson Weakness, Hallucinat Review of the Admiss dated 03/25/2021, rev assessed for a BIMS revealed mood conce he/she exhibited no b assessment. Continued record revi was placed on a 1:1 i on the 14-Day Quarant falls. Interview with th	<ul> <li>v assessed the resident.</li> <li>ealed Resident #85 could ppened to his/her hand but he.</li> <li>burs On-Call Physicians 5/2021 at 10:52 AM, hysician was notified of new over the medial part of land. Further review s received for a right hand</li> <li>bygy Results, dated M, revealed Resident #85 sture involving the right 5th ken bone in the hand) with</li> <li>ed the facility admitted 9/2021 to the "14-Day the facility's policy due to d review revealed the ncluded Dementia without</li> </ul>	F 600				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 // APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	increased activities to falling. Review of the care pla revealed Resident #8 processes related to D included redirection, p with familiar items, cre environment, and spe Review of the 1:1 doo room change, dated O Resident #86 exhibite kicking, and resistive AM, 2:00 AM, 2:30 AM 5:30 AM. Further rev at 10:00 AM, Residen such as screaming/dis the care plan revealed these behaviors and f and interventions to a Review of Progress N 2:30 AM, revealed Re to get out of bed on ro redirected. Continued Notes, dated 04/22/20 Resident #86 was wa seeking, was unable f agitated, and was not door. Review of the RMS E dated 04/22/2021 at 1 #86 became agitated yelling out and hit him	eam (IDT) made the ident #86 to the MCU due to help divert him/her from an, dated 03/22/2021, 6 had impaired thought Dementia. Interventions bersonalize his/her room eate a calm/smoothing tak in a normal-toned voice. cumentation prior to his/her 03/27/2021, revealed d behaviors such as hitting, to care at 1:00 AM, 1:30 M, 3:00 AM, 3:30 AM, and iew revealed on 04/06/2021 t #86 exhibited behaviors sruptive sounds. Review of d the facility failed to identify ailed to create a care plan ddress these behaviors. Notes, dated 03/25/2021 at esident #86 was attempting bunds and was unable to be d review of the Progress 021 at 3:37 AM, revealed ndering the hall and exit to be redirected and became ed to be banging on the unit	F 60				
	Resident #86 exhibite kicking, and resistive AM, 2:00 AM, 2:30 AM 5:30 AM. Further rev at 10:00 AM, Residen such as screaming/dis the care plan revealed these behaviors and f and interventions to a Review of Progress N 2:30 AM, revealed Re to get out of bed on ro redirected. Continued Notes, dated 04/22/20 Resident #86 was wa seeking, was unable f agitated, and was not door. Review of the RMS E dated 04/22/2021 at 1 #86 became agitated yelling out and hit him	d behaviors such as hitting, to care at 1:00 AM, 1:30 M, 3:00 AM, 3:30 AM, and iew revealed on 04/06/2021 t #86 exhibited behaviors sruptive sounds. Review of d the facility failed to identify failed to create a care plan ddress these behaviors. Notes, dated 03/25/2021 at esident #86 was attempting bunds and was unable to be d review of the Progress 021 at 3:37 AM, revealed ndering the hall and exit to be redirected and became ed to be banging on the unit					

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	S FOR MEDICARE &						<u>10. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		NSTRUCTION		TE SURVEY MPLETED
			A. BOILDII			с	
		185301	B. WING			0	5/22/2021
AME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
EGIS WO	200			4604	LOWE ROAD		
				LOU	ISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 52	F6	500			
		e of the altercation and staff					
		ect Resident #86. Further					
		dent #86 was placed on 1:1					
		to an acute care facility for a					
		n and treatment. Upon Resident #86 was moved off					
	the MCU and placed						
	increased agitation a	-					
		ed Nurse Aide (CNA) #8, on					
		M, revealed she worked the					
		on the MCU. Continued esident #85 was alert and					
		n and yell. She stated she					
	was aware of the res	-					
	-	e resident would hallucinate					
		ited she had previously sat hile he/she was on 1:1					
		eing at risk for falls. She					
		e could become agitated					
	-	t to get out of bed or his/her					
		hard to redirect. Further					
		e has seen the resident are and that would make					
		tive. Continued interview					
		d after the facility moved					
		sident #85's room, Resident					
		into his/her room to have					
		/her due to Resident #85 g. Additionally, she revealed					
		ecome agitated with loud					
	noises.	0					
	Continued interview	with CNA #8, on 05/12/2021					
	at 2:32 PM, revealed	-					
		21, Resident #86 stated					
		e the restroom but refused to					
	LICO bic/bor private re	stroom due to Resident #85					

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	G		
		185301	B. WING			С
		185501				5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	IDE	
REGIS WO	ODS					
				LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	<del>-</del> 53	F 60			
	room. CNA #8 revea		1.00			
		und 7:00 PM) Resident #86				
started to become "squirrely" in his/her wheelchair by trying to enter other residents'						
	rooms, trying to stand up and was very hard to redirect. CNA #8 stated she was the only aide on					
	the MCU. She stated	she had to leave the unit to				
	find assistance with p	outting residents to bed.				
		was not enough staff on the				
	MCU to provide prop	•				
		terview revealed after she				
	obtained assistance f					
	bed.	ls and assisted residents to				
		19, on 05/12/2021 at 3:30				
		s asked by CNA #8 to come				
		ls and placing residents in				
		IA #19 stated she was in a				
		rming care when she heard				
		Ilway. She stated she				
		Ilway and noticed Resident				
		other room and the nurse direct, and guide him/her				
		way toward his/her room.				
		revealed while back in the				
		aming from the hallway and				
		er care and exited the room.				
	•	ealed LPN #14 was yelling				
		esident #86 was hitting				
		e television and Resident				
		out. CNA #19 stated she ran				
		ped up Resident #85 in her				
	arms and carried him room where he/she w	/her into another resident's vould be safe.				
	Interview with Certifie	ed Medication Technician				
		1 at 11:30 AM, revealed prior				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PRC	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WOO	DDS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
# r I A N 1 c c c I F C C F r t # a c c I F C C F r t # a c c I F C C F r t # a c c I F C C F F C C F F C F F F C F F F F F	AM, revealed prior to MCU he/she was a fa 1:1 supervision. She could be aggressive a care. Interview with LPN #1 PM, revealed on the r 04/22/2021, Resident his/her wheelchair, wh resident, he/she beca trying to hit her. She #86 back to his/her ro and that Resident #85 ime. LPN #14 stated were in Resident #86 blocking them from le and kick them. Contin distracted Resident #46 blocking the room, she and she went immedia for the room. LPN #14 eaving the room, she and she went immedia foom. She stated she bover Resident #85, wh n his/her hand and sh Resident #85 on the la revealed she yelled for the television out of R LPN stated CNA #19 Resident #85 from the time Resident #86 wa Resident #85's bed an himself/herself out. L receive report of any la		F	600				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION			SURVEY PLETED
		185301	B. WING			_		22/2021
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	moving to the MCU. Interview with RN #1, revealed when she ar morning for her shift of notified her that she for #85's sheet. Continue entered Resident #85 head to toe assessme source of the blood. If #86 (roommate prior to abrasions on his/her at that was where the bl interview revealed up assessment she note Resident #85's right h these findings she no received a new order Interview with the Dire 05/12/2021 at 4:00 Pl determined to move F through discussions in in clinical meeting. Fu was not aware of any behaviors exhibited b altercation with Resid Interview with the CN PM, revealed she exp and neglect policies a	on 05/12/2021 at 8:15 AM, rived to the facility in the on 04/25/2021, the CNA bund blood on Resident d interview revealed she 's room and completed a ent to attempt to find the She stated that Resident to the altercation) had arms and they determined ood originated. Further on the head to toe d bruising and swelling to and. Additionally, upon tified the physician and for an x-ray. ector of Social Services, on M, revealed the facility Resident #86 to the MCU in the morning meetings and irther interview revealed she physical aggression or y Resident #86 before the ent #85 on the MCU. E, on 05/12/2021 at 7:20 pected the facility's abuse ind procedures to be	F	600		DEFICIENCY)		
	aware that Resident # and she expected sta stated behaviors shou in the record so the fa interventions to help i	e continued she was not #86 was having behaviors, ff to notify her. The CNE uld have been documented ucility could have placed dentify the triggers and g aggressive behaviors.						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		185301	B. WING				C 05/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE,	ZIP CODE			
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
F 600	afraid of Resident #86 stated if the IDT was a had behaviors, the pro- would have been diffe the IDT, it was not dis preferred not to have plan. Interview with CED, of revealed the decision Resident #86 to MCU activities for him/her the him/her distracted from he thought the move Continued interview re- communicate to him of #86's behaviors prior behaviors should hav IDT could have implet decrease the behavior revealed the Memory failed to communicate issues with Resident stated if he had know roommate issues the find the root cause of have moved Resident 3. Closed record revie and Resident #52 we of the Memory Care U at approximately 12:5	ot aware that staff were 6 during the altercation. She aware that Resident #86 ocess for room changes erent. She stated that during acussed that Resident #85 roommates, as per the care In 05/12/2021 at 6:36 PM, was made to move due to there being more o participate in to keep m falling. The CED stated was good and appropriate. evealed staff did not or the CNE about Resident to the move. He revealed e been documented so the mented interventions to help rs. Continued interview Care Program Director e with the IDT of the ongoing #85 and Resident #86. He n of the behaviors and facility would have tried to the problem and would not t #86 rooms. ew revealed Resident #45 re ambulating in the hallway Jnit (MCU), on 03/18/2020 0 PM, when they er. Resident #45 and #52 arms, subsequently ruise on his/her right	F	600					

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		MEDICAID SERVICES				IO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY
			A. BUILDING	G		С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO		
				4604 LOWE ROAD		
REGIS WO	JODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
<b>F</b> 000						
F 600	Continued From page		F 60	00		
	Resident #52 no long	er resided in the facility.				
	Closed record review	revealed the facility				
	admitted Resident #5	· · · · · · · · · · · · · · · · · · ·				
	03/03/2011, with diag					
	-	et, Lack of Coordination,				
	Psychotic Disorder w	ith Delusions, Cognitive				
	Communication Defic					
	Disorder, Anxiety, De					
	Disturbances and Un	specified Psychosis.				
	Review of the Quarte	rly Minimum Data Set				
	(MDS) Assessment, o	dated 02/17/2020, revealed				
		sessed to have adequate				
	•	as able to make his/her				
		uld understand others. he MDS revealed the facility				
		52 to have a Brief Interview				
		MS) score of three (3) of				
		licated the resident had				
		gnition. Further review of the				
	MDS revealed Reside	ent #52 had no behaviors				
		assessed Resident #52 to				
	require setup help on					
	-	per the MDS, Resident #52				
		sychotics for seven (7) out of g the assessment period.				
	Review of the Physic	ian's Orders, dated				
		Resident #52 was admitted				
	- · ·	an for long term placement.				
	Continued review rev					
		#52 exhibited behaviors				
		ng at staff, and paranoia.				
		ed staff were to monitor for otherapeutic medications				
		review revealed Resident				
	-	epakote two-hundred and				
		B) times a day for Dementia				

Facility ID: 100503

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	-	ID HUMAN SERVICES				FORM	: 07/16/2021
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		185301	B. WING			05/2	) 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC) CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	twice a day for Demer Review of Resident # 06/03/2019, revealed of negative behaviors aggression with staff/ and delusional type b revealed interventions vent feelings, approad manage any unmet ne interventions and resp supervision when in the review revealed the factor plan after the ph Resident #45. Review of the Risk Ma Event Summary Report 12:40 AM, revealed a residents walk up to e grabbed each other's revealed the residents separated, and notific provider, the CNE and were completed. Inter 05/11/2021 at 2:15 Ph not provide contact in witnessed the altercal Record review reveals Resident #45 to the M diagnoses that include Behaviors. Review of the Quarter revealed the facility at have adequate hearing	Seroquel twenty-five (25) mg ntia. 52's care plan, dated Resident #52 has a history , including physical peers, depression, anxiety ehaviors. Continued review s included: allow him/her to ch in a calm manner, eeds, document ponses, and increase he common area. Further acility failed to update the ysical altercation with anagement System (RMS) ort, dated 03/18/2020 at CNA witnessed two (2) each other on the unit and arms. Further review s were immediately cations were made to the d CED and assessments erview with the CNE, dated M, revealed the facility could formation for the CNA that tion. ed the facility admitted ICU, on 12/18/2019, with	F 600				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>#45 had a BIMS of eigresident had moderat Further review of the had no behaviors note Resident #45's MDS of for walking in the corr antianxiety medication (7) days.</li> <li>Review of the Physici 06/04/2014, revealed with the discharge pla placement and pain m revealed Resident #4 (5) mg twice a day for Review of Skin Check 10:00 PM, revealed R skin issues prior to the #52. Continued revie 03/18/2020 at 1:40 Pl altercation with Resid reddened/bruised are</li> <li>Review of the RMS E dated 03/18/2020 at 1 separated Resident # after the altercation. notifications were man CED. Resident #45 v supervision, however documentation regard supervision.</li> <li>Interview with RN #15</li> </ul>	ad impaired vision. he MDS revealed Resident ght (8) which indicated the ely impaired cognition. MDS revealed Resident #45 ed. The facility assessed to require limited assistance idor and had received ns for seven (7) out of seven an's Orders, dated Resident #45 was admitted an for long term care nonitoring. Further review 5 was ordered Buspar five r Anxiety. C form, dated 03/16/2020 at Resident #45 had no new e altercation with Resident w of Skin Check form, dated M, revealed after the ent #52, Resident #45 had a to the right forearm. vent Summary Report, 12:40 PM, revealed staff 45 and #52 immediately Continued review revealed de to the provider, CNE and vas placed on 1:1 , the facility failed to provide ding this increased 5, on 05/11/2021 at 2:06 PM, agency nurse, but only	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	<ul> <li>completed the RMS E she was unable to reach Resident #45 and Reach Resident #45 and Reach Resident #45 and Reach Resident #45 and Reach Reach Resident #45 and Reach Resident Resident Resident Resident Resident Resident Resident #11 hit with a closed fist cause Review of the SBAR of 12/15/2020 at 6:45 Pl to the left side of Resident #11 on 01/1 included Schizophrent Disorder.</li> <li>Review of the Quarter 12/02/2020, revealed the facility a show no mood disturt Further review of the Start Review of the Start Review of the Start Review of the Start Resident #11 on 01/1 included Schizophrent Disorder.</li> </ul>	e was the nurse on duty and Event Summary Report, but call the altercation between sident #52. D, on 05/11/2021 at 2:15 lity could not recall the tant (CNA) nor could they ber for her. Per review of nary Report, the CNA hts and provided increased ealed on 12/15/2020 after ent #10 and Resident #11 mmon area outside of the sident #10 yelled out loud, Resident #10 in the face sing redness and swelling. Communication Form, dated M, revealed ice was applied ident #10's face after the lent #11. ed the facility admitted 0/2020 with diagnoses that hia and Major Depressive	F	600			

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_	05/	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO				46	604 LOWE ROAD			
REGIS WC	005			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Schizophrenia.	9 61	F	600				
	(MAR) and Treatment (TAR), dated Novemb	tion Administration Record Administration Record oer and December 2020 and ed no documented evidence hibited behaviors.						
		1 would shake his/her fists could not have certain						
	PM, revealed Resider screaming and yelling #11 would become ag him/her being on a sp able to eat regular tex interview revealed sh altercations with Resi with each other or wit interview revealed CN out of the dining room Resident #11 were sit and she heard Reside continued that the nur #10 and Resident #11	g loud. She stated Resident ggressive with staff due to becialized diet and not being stured food. Continued e had not known any other dents #10 and #11 either h other residents. Further IA #12 was taking residents of while Resident #10 and ting in the common area ent #10 yell. CNA #12 rses ran toward Resident						
	revealed she was sitti charting while Reside were sitting in the cor interview revealed she out and she looked up	5, on 04/22/2021 at 3:05 PM, ing at the nurse's station nt #10 and Resident #11 nmon area. Continued e heard Resident #10 yell o and saw Resident #11 hit ace. She continued that she rd the residents and						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			604 LOWE ROAD			
			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	completed skin assess condition and made th Additionally, she state on 1:1 supervision an Resident #10's face. 5. Record review rever Resident #16 had a vis scheduled smoke bre lead to a physical alte Resident #16 kick Res Interview with Reside 10:55 AM, revealed th were outside during a Resident #16 became CNA. Continued inter confronted Resident # down and to quit talkin manner. Further inter Resident #16 back ins verbal aggression tow stated after the smoke his/her wheelchair by waiting for the nurse th room so he/she could Continued interview re Resident #16 coming told him/her (Residen stated he/she put his/ Resident #16 came for #15 backward in his/he his/her foot and kicke Additionally, Resident	ther interview revealed she sments and a change of ne appropriate notifications. ed Resident #11 was placed d ice was placed to ealed Resident #15 and erbal altercation during a ak on 12/24/2020 which ercation. CNA #4 witnessed sident #15 in the chest. Int #15, on 04/14/2021 at nat he/she and Resident #16 smoke break when e verbally aggressive with a rview revealed Resident #15 #16 and told him/her to calm ing to the CNA in that rview revealed staff wheeled side due to continuing the vard the CNA. Resident #15 e break, he/she was in the nurse's medication cart to come out of a resident's request pain medication. evealed he/she saw toward him/her and he/she t #16) to stop. Resident #15 her arms up to keep ting him but instead orward, wheeling Resident her wheelchair. Resident	F 600				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMPI	SURVEY LETED
		185301	B. WING		_	05/2	; 22/2021
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page the CNE came and as he/she was okay. Co Resident #16 was mo unit and their smoke to Resident #15 stated P other altercations with see him/her anymore. Record review reveale Resident #16 on 06/1 included Cerebral Infa Bipolar Disorder, Maje Anxiety. Review of the Quarter 06/24/2020, revealed Resident #16 to have which indicated the re- intact. Continued rev assessed Resident #7 Review of Resident #7 revealed he/she was wheelchair on the unit Review of the care pla revealed Resident #11 current behavior of ex- all caregivers. Interve behaviors, explain all from the environment becomes resistive pos for expression of feeli Interview with Reside 10:35 AM, revealed he	e 63 sessed him/her to ensure ntinued interview revealed wed to a room on a different imes were changed. he/she had not had any n Resident #16 and did not red the facility admitted 7/2020 with diagnoses that arction, Right Hemiparesis, or Depressive Disorder, and rly MDS Assessment, dated the facility assessed a BIMS' of fifteen (15) esident was cognitively iew revealed the facility 16 to have no behaviors. 16's functional status able to self-propel in his/her t. an, dated 06/18/2020, 6 had a history of and spressing negative views of entions included complete evaluate the triggers of the care, remove the resident if needed, if resident stpone care, and allow time	F 60				
	smoke break and he/s	she was taken back inside. evealed he/she did kick					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 1 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	changed his/her room Interview with CNA #4 revealed he was the C altercation. CNA #4 s sitting at the nurse's m Resident #16 wheeled fight. CNA #4 stated kick Resident #15, but them. Further intervie the CNE and moved f their smoking times w Attempts were made a witness to the inciden and 1:57 PM without s Interview with RN #2, on 04/20/2021 at 10:3 not recall the incident Resident #16. 6. Record review reve Resident #9 were roo Continued review reve Resident #9 squeezed resulting in a small br staff the altercation w and was unwitnessed Review of the SBAR C 10/20/2020 at 1:45 Pf Resident #9 were invo altercation in their roo to Resident #8's right revealed Resident #9	hest in the hallway. staff separated them and h. 4, on 04/20/2021 at 9:55 AM, CNA on duty the day of the stated Resident #15 was medication cart when d up to him/her and tried to he did witness Resident #16 t immediately separated ew revealed the nurse called him/her to another unit and vere changed. to contact CNA #6, a t, on 04/20/2021 at 9:56 AM success. a witness per facility record, B1 AM, revealed she could between Resident #15 and ealed Resident #8 and mmates on the MCU. ealed on 10/20/2020 d Resident #8's wrist uise. Per interviews with as reported by Resident #8	F 600				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 1 <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	him/her that breakfas Resident #9 then graf wrist. Resident #9 re and sat down on the I revealed Resident #8 nurse outside their ro Interview with Reside PM, revealed he/she four (4) months. Con he/she could not reca #9. Record review reveal Resident #9 on 02/07 included Dementia wi Dependence with Alco Alcohol Induced Pers Major Depressive Dis Encephalopathy, Imp Episodes. Review of Resident # Assessment, dated 00 facility assessed him/ four (4), which indicat cognition. Continued #9 had no mood distu during the assessmen Review of the Physici 05/09/2020, revealed for behaviors. Review of the care pla revealed Resident #9 physical behaviors re abuse, impaired cogn	t was not ready yet. bed Resident #8 by his/her leased Resident #8's wrist bed. Continued review reported the incident to the om. nt #8, on 04/14/2021 at 2:15 had been in the facility for tinued interview revealed ill the incident with Resident ed the facility admitted /2020 with diagnoses that th Behaviors, Alcohol ohol Induced Dementia, isting Amnestic Disorder, order, Wernicke's ulsiveness, and Depressive 9's Quarterly MDS 7/31/2020, revealed the her to have a BIMS score of red severely impaired review revealed Resident urbances nor behaviors ht period. an's Orders, dated an order for staff to monitor an, dated 09/19/2017, had the potential to exhibit lated to history of alcohol	F	600			

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PRINTED: 07/16/2021

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		185301	B. WING		_	( 05/:	C 22/2021	
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
REGIS WO	OODS			604 LOWE ROAD .OUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	for non-verbal signs of to the resident and as approach Resident #9 manner, observe new medications for side e Observations of Reside 11:45 AM, 04/15/2021 04/16/2021 at 8:30 AM private room on a diffe appeared to be resting playing. Interview with Residen 11:45 AM, revealed hi admitted to the facility revealed Resident #9 but he/she could not r resident grabbing his/ 7. Record review reve to the nurse on 01/25/ him/her in the chest. revealed Resident #3 #37 to keep him/her of Review of Resident #3 revealed on 01/25/20 LPN #10 that Resider chest on the Memory stated he/she tapped shoulder to keep him/ to prevent his/her belo Facility staff separated injuries were assesse Review of the clinical	<ul> <li>, explain all care, observe f physical aggression, listen sist in trying to deescalate, o in a calm, unhurried /changed/discontinued ffects.</li> <li>lent #9, on 04/14/2021 at at 9:20 AM, and <i>A</i>, revealed he/she was in a erent unit. Resident #9 g in bed with the television</li> <li>her are was good since</li> <li>Continued interview remembered Resident #8, ecall the altercation of the her wrist.</li> <li>aled Resident #37 reported 2020 that Resident #38 hit Further record review 8 stated he/she hit Resident ut of his/her room.</li> <li>37's Progress Notes 20, Resident #37 reported to it #38 hit him/her in the Care Unit. Resident #38 Resident #37 on the her out of his/her room and ongings from being taken. d the residents and no</li> </ul>	F 600					

Facility ID: 100503

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	-	ID HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	MCU, with diagnoses Disease, Secondary F Disorder. Review of the Minimu 01/21/2020, revealed resident to have a Bri (BIMS) score of nine impaired cognitive sta Review of Resident 3 System (RMS) Event 01/25/2020, complete event was a resident an alleged abuse victi revealed the correctiv the residents, assess #38 was placed on 1: #37 was treated with medication for pain). facility substantiated t abuse with the root-ca entered Resident #38 Interview with Reside 1:30 PM, revealed he another resident hittin Review of the facility's Facility-Self Report In dated 01/25/2020, rev informed LPN #10 he Resident #38 punchet the chest. Review of the facility's	that included Alzheimer's Parkinsonism, and Anxiety Im Data Set (MDS), dated the facility assessed the ef Interview of Mental Status (9), which revealed mildly atus. 7's Risk Management Summary Report, dated ed by LPN #10, revealed the to resident altercation with im. Additional review re action was separation of ment for injuries. Resident 1 supervision, and Resident 1 buprofen (anti-inflammatory Further review revealed the the unwitnessed event as ause as Resident #37 had t's room. Int #37, on 05/03/2021 at /she did not remember tog him/her in the chest. s Long Term Care toident Form/Initial Report, vealed Resident #37 /she was looking into to greet him/her and d him/her in the left side of	F 600				

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	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	hit Resident #37. Interevealed Resident #3 him/her and this persereres Resident #38. The Sespoke with Resident #37 resident stated that here resident stated that here resident stated that here resident #37, but here resident resident #38, with diagnoses that in Behavioral Disturbance Disorder, and Psychol Review of the Progress through 02/05/2020, resistive to care, easi facility staff, and frequereview revealed the fat #38 on 01/27/2020 to evaluation. Review of Psychiatry and 01/22/2020, revere behaviors, which inclus process, paranoid, ar physical/verbal aggres control. On 12/31/202 prescription for Olanz staff were instructed of likelihood of aggression his/her room and part activities.	8 told LPN #10 that he/she erview with LPN #10 7 stated a (man/woman) hit on was verified to be ocial Services Director #38, on 01/27/2020, and the e/she did not intend to hurt she was attempting to keep is/her room. The MCU Resident #37 on 01/27/2020 nosocial distress were noted. revealed the facility 8 on 12/29/2019 to the MCU icluded Dementia with be, Antisocial Personality tic Disorder with Delusions. ss Notes, dated 12/29/2019 evealed Resident #38 was by agitated, cursed/yelled at iently refused care. Further acility transferred Resident a psychiatric facility for Notes, dated 12/31/2019 aled Resident #38 displayed uded altered thought iger directed towards staff, ssion, and poor impulse 20, Resident #38 received a apine (an antipsychotic) and on strategies to decrease on that included eating in	F 600				

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	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 600	was assessed to have Status (BIMS) score of revealed the resident Further review revealed displayed behaviors is care, or disorganized Review of Resident # Plan (CCP,) initiated of focus included the po- behaviors with a goal coping skills and acce frustration, impatience Interventions for phys the resident to seek s observe resident for r aggression, monitor re effects to psychotropi a calm environment. Unsuccessful attemp Practical Nurse (LPN) 05/04/2021 at 2:00 PI PM. Resident #38 re #10. Interview with CNA #7 AM, revealed Residen the unit up and down Interview with LPN #1 AM, revealed Residen MCU due to his/her e Resident #38 had ma agitation, argumentat staff, and refusal of po-	020, revealed Resident #38 e a Brief Interview of Mental of fourteen (14), which was cognitively intact. ed the resident had not such as psychosis, refusal of thinking. 38's Comprehensive Care on 12/29/2020, revealed the tential to exhibit physical that included effective eptable ways to express e and/or anger. b ical behaviors included for taff for distressed mood, nonverbal signs of esident's response/side c medications, and provide ts to contact Licensed 0 #10, were made on M and 05/06/2021 at 2:15 ported the incident to LPN 13, on 05/04/2021 at 8:54 nt #37 wandered throughout the MCU halls. 1, on 05/06/2021 at 10:13 nt #38 was placed on the lopement risk. He stated ny behaviors that included ive with staff, cursing at	F 600				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	displayed aggressive staff. He stated Resid assist with his/her car any behavioral disturt of the MCU stated Re to one on one (1:1) ac in large groups due to facility had tools such posting a stop sign or unwanted entry into a Interview with the Cer on 04/29/2021 at 9:17 of physical abuse as a physical touch such a stated verbal abuse in degrading a resident. Interview with the CEI PM, revealed he defin physical or verbal inter and residents. He sta facility to be care for a 8. Record review reve MCU common area, s slap Resident #21, an slapped Resident #22. the residents, assess staff provided 1:1 sup after the incident. Review of the clinical admitted Resident #2 diagnoses that include Dementia without Ber	A, revealed Resident #38 behaviors toward facility dent #38 allowed him to e and he had not witnessed bances. The former Director sident #38 responded well crivities and did not do well agitation. He stated the as closing the door or the door to prevent nother resident's room. AM, revealed the definition any action that resulted from shitting or kicking. She acluded cursing, yelling, or D, on 04/30/2021 at 3:12 red abuse as any unwanted raction involving facility staff thed residents came to the and maintain safety. Attended on 10/28/2020 in the staff observed Resident #2 d then Resident #21 The MCU staff separated ed for injuries, and MCU ervision for Resident #2 record revealed the facility 1 on 01/01/2020 with ed Alzheimer's Disease,	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185301	B. WING					C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE,	ZIP CODE		
REGIS WO	ODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	<del>?</del> 71	F	600	1			
	10/18/2020, revealed	21's Quarterly MDS, dated a BIMS score of three (3) e cognitive impairment.						
	behaviors toward ano prevent harm to self o revealed interventions	the focus included physical ther resident with a goal to or others. The review s for physical behaviors that ion with agitation and offer						
	2:01 PM, revealed he	nt #21, on 04/14/2021 at /she was slapped on the ent. Resident #21 did not esident's name.						
	Review of the clinical admitted Resident #2 diagnoses that include Psychotic Disorder wi Frontotemporal Deme	ed Bipolar Disorder, ith Delusions, and						
	10/28/2020 at 2:46 PM							
	2020, revealed there resident for behaviors care twice daily with c	2's MAR, dated October was an order to monitor the which included refusal of documentation that revealed ave any behaviors present.						
	dated 01/09/2021, rev	2's Comprehensive MDS, vealed a BIMS score was resident had severely						

Facility ID: 100503

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	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PR	OVIDER OR SUPPLIER		S	FREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS			004 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	The facility's assessm exhibited behaviors in (1) to three (3) days a occurred four (4) to si Review of Resident # 08/14/2020, revealed potential for psychoso included the resident psychosocial distress revealed interventions sign of psychosocial of Visits as needed; and Services. Review of Resident # Report, dated 10/28/2 described the event a The report revealed th witnessed the event. cause was determined psychiatric diagnoses Depressive Disorder, The report revealed th placement of Resident (1:35 PM, revealed the clapping his/her hand front of him/her watch Attempted to interview 04/19/2021 at 3:28 PM respond.	Ils for daily decision-making. ent revealed Resident #2's foluded rejection of care one week and wandering that x (6) days of the week. 2's CCP, initiated on the resident had the boad distress with a goal that would exhibit no signs of daily. The care plan a that staff would observe for distress; Social Service evaluation by Psychiatry 2's RMS Event Summary 2020, completed by LPN #7, s "combative behavior." he MCU Activities Assistant The report revealed the root d to be Resident #2's of Bipolar Disorder, Major and Psychotic Disorder. he corrective action was the tt #2 on 1:1 supervision. ent #2, on 04/23/2021 at a resident sitting in a chair s with a drink on the table in ing a television program. v Resident #2, on M, but the resident did not ivities Assistant, on	F 600				

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	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #2 and Resi slapped Resident #21 slapped Resident #21 Assistant stated he ap help separate them. Interview with CNA #7 AM, revealed Resider started talking to Resi Resident #2 stood up the face, and Resider back. CNA #14 state went over to separate Attempted to contact 05/05/2021 at 3:27 PI AM. Interview with the CE PM, revealed their go residents. He stated supervised the MCU of stated the facility staff unpreventable occurr 9. Record review reve Resident #2 pushed F area on the MCU, cat on Resident #2 from the #20 stated Resident # foot and was complai ordered an x-ray on F revealed no fracture. Review of Resident # 11/20/2020, revealed	sident #21 was talking to ident #2 stood up and . He stated Resident #21 in return. The Activities oproached the residents to 14, on 04/20/2021 at 9:36 ht #21 walked over and ident #2. She stated , slapped Resident #21 on ht #21 slapped Resident #2 d she called for help, and e the residents. the former CED, on M and 05/06/2021 at 9:31 D, on 04/30/2021 at 3:12 al was the safety of the the facility's staff adequately residents. The CED further f learned from ences.	F 600				

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/16/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		X3) DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP	CODE	
REGIS W	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 600	combative with the ph Review of Resident # dated 01/09/2021, rev not assessed and the impaired cognitive ski The assessment reve behaviors that include wandering. Review of Resident # 08/31/2020, revealed physical aggression to initiated on 10/28/202 resident was to have residents and accepta and interventions. Th approach resident in a and remove resident in time to calm before ref Review of the Continu documentation, dated 10:30 AM, and 1:30 F revealed Resident #2 included hitting, cursit The facility did not pro Continuous 1:1 Super 11/19/2020 through 1 Review of Resident # Report, completed by 10:39 AM, revealed th resident-to-resident a The report revealed F observation in the MC television and Reside	bally abusive, cursing, and hysical examination. 2's Comprehensive MDS, vealed a BIMS score was resident had severely Ils for daily decision-making. aled Resident #2 exhibited ed rejection of care and 2's CCP, initiated on focuses that included oward another resident, 0. The goal included; the no conflicts with other ance of staff's redirection the interventions included: a calm, supportive manner, from the situation to allow eturning to previous area.	F 600			

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 07/16/2021 FORM APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3)	B NO. 0938-0391 DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COI	DE	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	<ul> <li>#20's left big toe. The redirection of Resider him/her at a safe distaresidents.</li> <li>Observation of Resider 9:00 AM, revealed the hall with a sitter of Resident #2. Resident #2. Resident #2. Resident #19 on 05/0 included Vascular Der Disturbance and Alzh Review of Resident # dated 03/18/2021, revealed three (3), which indicating airment.</li> <li>Observation of Resident #2. Common area with a vappropriately, and paractivity.</li> <li>Interview with Reside 8:15 AM, revealed he pushing him/her. How identify who pushed her sident #20 on 07/1 include Alzheimer's D without Behavioral Disrevealed Resident #20 on 07/1 include Alzheimer's D without Behavioral Disrevealed Resident #20</li> </ul>	en stepped on Resident e corrective action included at #2 and ensured staff kept ance from the other ent #2, on 04/23/2021 at e resident sitting in a chair in n the floor sitting next to nt #2 was not interviewable. ed the facility admitted 1/2018 with diagnoses that mentia with Behavioral eimer's Disease. 19's Comprehensive MDS, vealed a BIMS score of ated severe cognitive ent #19, on 04/15/2021 at e resident was in the walker, dressed rticipated in an exercise nt #19, on 04/15/2021 at /she remembered someone wever, he/she could not nim/her or when it occurred. ed the facility admitted 3/2018 with diagnoses to	F 600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	<del>)</del> 76	F	600				
	11/21/2020, revealed the resident's left foot performed by LPN #6 swelling, or laceration LPN #6 documented f fractures of the left foo Review of Resident # dated 03/01/2021, rev three (3), which indica impairment. Interview with CNA #7 PM, revealed she was #2 on 11/21/2020. Sh from his/her chair in th pushed Resident #19 sway a little bit and he backwards. CNA #16 Resident #19 step on stated Resident #2 co movements without a Interview with CNA # AM, revealed she did Resident #2's behavio Supervision form. Sh Resident #2 reach aro resident on the MCU, when it occurred.	<ul> <li>a revealed no bruising,</li> <li>hs. Further review revealed the x-ray was negative for ot.</li> <li>20's Comprehensive MDS, vealed a BIMS score of ated severe cognitive</li> <li>16, on 04/20/2021 at 3:46</li> <li>a the 1:1 sitter for Resident the stated Resident #2 got up the common area and the stated severe cognitive</li> <li>b stated she did not see Resident #20's foot. She bould be quick in his/her ny warning signs.</li> <li>14, on 04/20/2021 at 9:36 not remember documenting fors on the Continuous 1:1 the stated she witnessed bound her to hit another but could not remember</li> <li>Licensed Practical Nurse 2021 at 2:00 PM and</li> </ul>						
		on 04/15/2021 at 3:10 PM, ed Resident #2 numerous						

Facility ID: 100503

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		-	( 05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	prevented him/her fro residents. She stated displayed loud clappin and other times there his/her agitation/beha Interview with the CN AM, revealed staff we the 1:1 sitters provide Resident #2 and the co Interview with the CEI AM, revealed resident ones to the facility to safe. The CED stated re-education, it was re use when assigned to resident as he had ob phone, and distracted 10. Record review rev Resident #2 slapped I past him/her in the ha was on 1:1 observatio was walking behind R the residents and ass injuries. RN #3 provid for the responsibilities Review of Resident #2 01/22/2021 at 10:56 A documented Residem he/she walked past hi	hers, but she or other staff m making contact with other at times Resident #2 ng, or a look on his/her face, were no warning signs of viors. E, on 04/29/2021 at 9:17 re re-educated to ensure d adequate space between other residents on the MCU. D, on 05/11/2021 at 10:04 ts' families sent their loved receive care and to be kept d with the sitter's eiterated no cellular phone 1:1 supervision of a served a staff on a cellular from the task of 1:1. realed on 01/22/2021, Resident #3 while walking II on the MCU. Resident #2 on at the time and Sitter #1 esident #2. Staff separated essments revealed no ded Sitter #1 re-education for 1:1 supervision. 2's Progress Notes, dated M, revealed the MCU LPN ts #2 slapped Resident #3 as m/her in the hallway. The dent #2 was on 1:1 e related to a history of	F 600				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	that included the reside with other residents a staff redirection and ir review revealed intervi- with staff within close resident in a calm ma- return to room for agit and redirect resident f from other residents. Review of Resident #2 dated 10/22/2020, rev- resistive to care, com Staff would re-approa prescribed Risperdal ir recommendation was treatment of Risperdal injection every two (2) Observation of Residen 1:48 PM, revealed the of bed eating lunch wi bedside. Resident #2 Record review reveale Resident #3 to the M0 diagnoses that include Disturbance and Psyc Delusions. Review of Resident #3 01/22/2021, revealed completed by MCU LF identified.	a focus for physical ther residents with a goal dent would not have conflicts ind to have acceptance of interventions. The CCP ventions for 1:1 supervision personal space, approach inner, encourage resident to ation to allow time to calm, to maintain a safe distance 2's psychiatry evaluation, vealed Resident #2 was bative, and hitting staff. ch to administer the injections. The to continue the same 1 twenty-five (25) mg ) weeks. ent #2, on 04/14/2021 at e resident sitting on the side ith a sitter in a chair at the was not interviewable. ed the facility admitted CU on 01/20/2021 with ed Dementia with Behavioral chotic Disorder with 3's Progress Notes, dated a skin assessment PN with no concerns	F 60	0			

	-	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	impairment. The facil with physical behavior Observation of Reside 1:51 PM, revealed he and walking down the Interview with Reside AM, revealed he/she resident slapping him. Review of the facility's Facility-Self Reported Report, dated 01/26/2 01/22/2021 Resident Resident #3 as they p Resident #2 had a BII assessed) and Reside residents were separa injuries with none not redirect Resident #2 a Review of the facility's Facility-Self Reported dated 01/26/2021, rev incident happened wit review revealed staff Resident #2 was at le residents and the imp Resident #2. The fac incident as abuse. Interview with Sitter # PM, revealed she was #2 on 01/20/2021. St the hall behind Reside up to Resident #2, was	h indicated severe cognitive ity assessed the resident rs directed towards others. ent #3, on 04/14/2021 at /she was groomed, dressed, hall with another resident. int #3, on 04/23/2021 at 9:10 did not remember another /her. s Long Term Care Incident Form/Initial 2021, revealed on #2 reached out and slapped bassed in the hallway. MS score of 99 (not ent #2's was five (5). The ated and assessed for ed. Staff were instructed to away from other residents. s Long Term Care Incident Form/Final Report, vealed Sitter #1 stated the thout warning. Further were re-educated to ensure ast arm's length from other ortance of redirection for ility substantiated the 1, on 04/19/2021 at 4:00 s the 1:1 sitter for Resident he stated she was walking in ent #2. Resident #3 walked	F 600				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #2 had a his residents. She stated protect the residents f Attempted to contact 9:22 AM and 05/03/20 Interview with RN #3, revealed he was in the spoke with Sitter #1 a Residents #2 and #3. have a reason why sh Resident #2. He state re-educated to redirect others to prevent him, #3 stated he commun observation was to pr hitting other residents Interview with the Ass Services (ADNS), on revealed he re-educa keep the resident on residents and redirect resident. Interview with the CN AM, revealed Resider unpredictable behavio and the nurse caring f 01/22/2021 received f walking behind Resid in front of him/her.	stated she was aware story of hitting other I the facility's goal was to from abuse. MCU LPN, on 04/20/2021 at 021 at 11:32 AM. on 04/22/2021 at 11:03 AM, e facility on 01/22/2021 and fter the altercation between He stated Sitter #1 did not he was walking behind ed the sitter was of Resident #2 away from ther form hitting others. RN icated with Sitter #1 that 1:1 event Resident #2 from istant Director of Nursing 04/22/2021 at 10:09 AM, ted staff on 01/26/2021 to 1:1 away from other c others away from the E, on 04/29/2021 at 9:17 ht #2 had impulsive and ors. She stated Sitter #1 for the resident on	F 600				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING		_	C 05/2	, 22/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS W	DODS			604 LOWE ROAD OUISVILLE, KY 40220	l i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	continuous supervision hospital for psychiatric Review of Resident # 03/09/2021 at 5:28 PI by MCU LPN that Resistaff and other resider documented the CED behaviors. The LPN of Condition (CIC) that r aggression, notification order was received to hospital for evaluation transported to the hos 03/09/2021. Review of the Psychia 03/09/2021, revealed observation at the tim had any behaviors, an with "Geodon" treatm Review of Resident # Report, dated 03/09/2 LPN, revealed the evaluation. Resident #2 made co #25, and #26. Immed Resident #2's diagnos combative behaviors. Observation of Resident 11:08 AM, revealed the in the Common Area,	ident #2 was place on 1:1 on until transfer to the c evaluation. 2's Progress Notes, dated M, revealed documentation sident #2 continued to hit nts. The MCU LPN 9 was notified of the documented a Change in revealed physical on of the physician, and an 9 transport the resident to the h. Resident #2 was spital at 7:01 PM on atry Notes, dated Resident #2 was not on 1:1 te of the incident, had not nd showed improvement ent. 2's RMS Event Summary 2021, completed by a MCU ent was described as The summary stated ntact with Residents #19, diate interventions included event was related to ses associated with	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP	P CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD B D THE APPROPRIA		(X5) COMPLETION DATE
F 600	next to the resident. clapping loudly. Addi Resident #2, on 04/26 revealed the resident lying in bed with his/h sitter at bedside. Record review reveale Resident #19 on 05/0 included Vascular Der Disturbance and Alzh Review of the Progres completed by the MC Resident #19 was hit assessed the resident redness of his/her arm Review of Resident # dated 03/18/2021, rev three (3), which indica impairment. Record review reveale Resident #25 to the M 06/27/2018, with diag Alzheimer's Disease, Delusions, Anxiety, an Review of Resident # 03/09/2021 at 7:24 Pf revealed another resis smacked and yelled a were separated and F revealed redness to h was not interviewable	Resident #2 was observed tional observation of 6/2021 at 11:10 AM, was groomed and dressed, her eyes open, with a 1:1 ed the facility admitted 01/2018 with diagnoses that mentia with Behavioral eimer's Disease. ss Notes, dated 03/09/2021, U LPN at 7:22 PM, revealed on the arm. The nurse t for injuries, and slight m was noted. et ly's Comprehensive MDS, vealed a BIMS score of ated severe cognitive ed the facility admitted Memory Care Unit, on proses that included Psychotic Disorder with nd Dementia with Behaviors. et 25's Progress Notes, dated M, completed by MCU LPN, dent walked up to him/her at him/her. The residents Resident #25's assessment his/her arms. Resident #25 e. ed the facility admitted	F	600				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Visual Loss, and Apha Review of the Progres completed by the MC #26 was sitting in a cl him/her. The nurse p that revealed no injuri Review of Resident # 02/18/2021, revealed was three (3), which i impairment. Observation of Reside 2:46 PM, revealed the dressed, lying in bed wheelchair was prese Attempted to interview 04/15/2021 at 2:46 Pl answer questions app Attempted to contact #19, #25, and #26 for at 10:00 AM and on 0 Interview with the CN AM, revealed Resider after medication chan revealed after a sugg MCU, there was a sitt began on 02/24/2021 provided a 1:1 sitter for transfer to the hospital	noses to include esis, Vascular Dementia, asia. ss Notes, dated 03/09/2021, U LPN revealed Resident hair when Resident #2 hit reformed an assessment ies. 26's Quarterly MDS, dated Resident #26's BIMS score ndicated severe cognitive ent #26, on 04/15/2021 at e resident was groomed, with eyes closed, and a ent at the bedside. w Resident #26, on M, revealed he/she did not propriately. the nurse for Residents #2, 03/09/2021, on 05/01/2021 05/03/2021 at 9:01 AM. E, on 04/29/2021 at 9:17 nt #2's behavior improved ges. Further interview estion by the Director of the ter free trial period that . The CNE stated the facility or Resident #2 prior to al on 03/09/2021. D, on 04/30/2021 at 3:12	F	600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS W	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION DTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	management had bee constantly trying new distract the resident a behaviors. He stated keep the residents sa 12. Record review re approximately 1:30 P down the hall on the I #3 on the face that let of Resident #3's chee residents, the nurse r for 1:1 supervision. Review of the Progres revealed Resident #2 they were passing in removed Resident #2 with the resident. A r the psychiatrist for Ge (10) mg intramuscula for three (3) days. Th 03/10/2021 at 2:29 PI Director called other f placement but was ur relocation. The MCU Resident #2 returned at 1:00 AM after an e no medication change Medical Physician, sig PM, revealed staff ha hit staff and other res encounter note revea obtain lab work, a urir infection, and to follow Review of Resident # revealed a new order	en difficult and they were interventions or activities to and, therefore, address the the facility's goal was to fe. evealed on 03/10/2021 at M, Resident #2 walked MCU and slapped Resident ft a red mark on the left side ek. After separation of the emained with Resident #2 ess Notes, dated 03/10/2021, slapped Resident #3 as the hallway. The MCU LPN from the area and stayed new order was received from eodon (an antipsychotic) ten r injection daily as needed to Nurse's Notes, dated M, revealed the MCU facilities to check for nsuccessful in finding Director's note revealed to the facility on 03/10/2021 valuation on 3/09/2021 with es. A follow up visit by the gned on 03/10/2021 at 5:10 d reported the resident had idents on 03/09/2021. The led the plan for staff to nalysis to check for an w up with psychiatry.	F	600				

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	F DEFICIENCIES	MEDICAID SERVICES					OMB NC	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PR	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, Z	IP CODE		
REGIS WO	ODS				604 LOWE ROAD -OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BI TO THE APPROPRIA		(X5) COMPLETION DATE
F 600	Continued From page needed for agitation for Review of Resident #2 revealed administration 03/11/2021 at 9:45 AM AM. The MAR reveal Geodon ten (10) mg I administered daily fro 03/10/2021, when the and Geodon capsule by mouth, started on 0 Review of the Continue documents, dated 03/ #2's 1:1 observation v after the incident with Review of the most re 03/09/2021, revealed any behaviors reported improvement with the Observation of Reside 8:54 AM, revealed reside Attempted to interview 04/14/2021 at 1:48 PM answer any questions	<ul> <li>885</li> <li>br three (3) days.</li> <li>2's MAR, dated March 2021, on of as needed Geodon on M and on 03/12/2021 at 9:15 ed documentation of M daily for Schizophrenia m 03/01/2021 through order was discontinued; twenty (20) mg twice daily 03/11/2021 at 9:00 PM.</li> <li>brous 1:1 Supervision 10/2021, revealed Resident vas restarted on 03/10/2021 Resident #3.</li> <li>cent Psychiatry Note, dated Resident #2 was not having of by nursing, and showed Geodon treatment.</li> <li>ent #2, on 04/29/2021 at sident lying in bed with gown vere open. Observed sitter e.</li> <li>or Resident #2, on M, but resident did not 5.</li> </ul>		600	DEFICI			
	to the MCU, with diag with Behavioral Distur Disorder with Delusion on 03/10/2021, Resid on the face.	Resident #3, on 01/20/2021 noses to include Dementia bance and Psychotic ns. Record review revealed ent #2 slapped Resident #3 3's Progress Notes, dated						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	revealed a CIC note fi color/condition with no changes noted and no review revealed a skin by the MCU LPN, on revealed resident had his/her face. Review of the Compr 01/27/2021, revealed score of five (5), which impairment with physi- towards others. Review of Resident # Report, dated 03/10/2 LPN, revealed Resider cheek as Resident #2 the hall on the MCU, w Resident #3's cheek. the residents, assess remained with Reside The report revealed the was due to Resident # combative behaviors. Observation of Reside 9:10 AM, revealed resident hall with another reside Review of the facility's Facility-Self Report/Fi 03/15/2021, revealed fifteen minute checks psychiatry services re- medications, modified updated the care plan	ed by ADNS at 4:14 PM, or a change in skin o mental or functional status o new orders. Further in assessment documented 03/10/2021 at 4:55 PM, I redness to the left side of rehensive MDS, dated Resident #3 had a BIMS h indicated severe cognitive ical behaviors directed 3's RMS Event Summary 2021, completed by the MCU ent #2 hit Resident #3 on the 2 walked past Resident #3 in which left a red mark on The MCU LPN separated ed Resident #3, and ent #2 on 1:1 supervision. he root cause of the incident #2's diagnoses and ent #3, on 04/23/2021 at sident was walking down the dent. s Long Term Care inal Report, dated Resident #2 was placed on with 1:1 supervision,	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		SURVEY PLETED
		185301	B. WING				22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS W	DODS				604 LOWE ROAD .OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	fluctuations expected Attempted to contact 03/10/2021, on 05/01. 05/03/2021 at 9:01 Al Interview with the MC 10:01 AM, revealed th supervision of Reside safe and the other res She stated she had co facilities for alternative #2, but was unsucces stated the sitters were residents or others av ensure their safety be unpredictable behavio Interview with the faci 04/22/2021 at 2:44 Pl telemedicine visits witvideo conference and came to the facility. If many behaviors and I right medication to ad The Psychiatrist state behaviors/incidents a staff regularly regardin Interview with the CN AM, revealed they co and consulted with the Resident #2's Geodon stated staff had been Resident #2 was at le from others. The CNI various activities such	ipolar Disorder with mood at times. Resident #2's nurse for /2021 at 10:00 AM and on M. CU Director, on 04/20/2021 at he goal of the 1:1 ent #2 was to keep him/her sidents safe on the unit. ommunicated with other e placement for Resident ssful. The MCU Director e aware to either redirect way from Resident #2 to ecause Resident #2 had brs. ility's Psychiatrist, on M, revealed he conducted th Resident #2 regularly via I his Medical Assistant who He stated Resident #2 had he was attempting to find the Idress his/her behaviors. ed the facility reported nd he spoke with facility ng Resident #2's care. E, on 04/29/2021 at 9:17 nducted a medication review e Psychiatrist who increased in medication dose. She	F	600			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	2005			4	604 LOWE ROAD			
				L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Resident #2. Interview with the CE	2 88 D, on 04/30/2021 at 3:12	F	600				
	(IDT) meetings includ Resident #2's behavio	y Interdisciplinary Team ed discussions regarding ors and they brainstormed to to address the behaviors n.						
	approximately 4:00 Pl #21 on the left arm in Facility staff separate nurse assessment rev have any injuries. Re	vealed on 03/24/2021 at M, Resident #2 hit Resident the MCU Common Area. d the residents and the vealed Resident #21 did not sident #2 was on 1:1 altercation took place.						
	March 2021, revealed 03/15/2021 at 3:49 PI was agitated and disp when others got to clo was placed back on 1 ambulance transporta resident to the hospita revealed Resident #2 from 03/15/2021 and 03/22/2021. A CIC no PM, completed by the Resident #2 was havi The MCU LPN contact 03/24/2021 at 4:45 PI to increase Geodon to and place the resident	tion arrived to send the al for evaluation. The review remained in the hospital returned to the facility on ote, on 03/24/2021 at 4:00 a MCU LPN, revealed ng aggressive behaviors. oted the Psychiatrist, on M, and received a new order o forty (40) mg twice daily t on 1:1 observation. 2's Physician Orders, dated						
		an order for Ativan nxiety) one half (0.5) mg needed for anxiety and						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CO	DE	-	
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	)N SHOULD B E APPROPRI/		(X5) COMPLETION DATE
F 600	Continued From page Geodon twenty (20) m Review of Resident # revealed a dose of At was given on 03/25/2 MAR revealed staff do not have any behavio hospital on 03/22/202 Review of Resident # 03/24/2021, revealed earlier in the day, whi aggression toward oth revealed Resident #2 residents stayed out of facility decided to ens prevent other residen Review of Resident # Report, dated 03/24/2 LPN, revealed the ever resident-to-resident a abuse-aggressor. Th #2 grabbed Resident arm multiple times. T Resident #2 had sever behaviors. Observation of Residen 11:08 AM, revealed R clapping loudly in the sitter sitting in a chair	<ul> <li>a 89</li> <li>ng twice daily.</li> <li>2's MAR, dated March 2021, ivan, ordered as needed, 021. However, review of the ocumented the resident did rs since return from the formation of the president had behaviors chincluded agitation and the resident had behaviors chincluded agitation and the residents. The note was behavior free when of his/her space and the foure staff were close to ts from getting too close.</li> <li>2's RMS Event Summary 2021, completed by the MCU ent was described as litercation with alleged e report revealed Resident #21 by the arm, hit his/her the root cause revealed to ent #2, on 04/14/2021 at the sident #2 sitting in a chair Common Area with the 1:1 adjacent to the resident.</li> </ul>		600				
	admitted Resident #2 diagnoses to include a Dementia without Bet	Alzheimer's Disease,						

Facility ID: 100503

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	MENT OF HEALTH AN					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	90	F	600			
	03/24/2021 at 3:30 PM LPN, revealed Reside television room and a #21 multiple times on separated the residen performed by the MCU 3:30 PM, revealed no were noted. Review of Physician O revealed Resident #2 (medication for Deme included monitoring re behaviors with docum behaviors in the nurse Review of Resident # 05/03/2021, revealed which indicated sever Observation of Reside 2:01 PM, revealed the around the unit with a Interview with Reside 2:01 PM, revealed he being hit by another re Review of the facility's Facility-Self Reported Incident/Final Report, Resident #2 hit Resid Area on the MCU. St with removal of Reside	nentation of exhibited e's note. 21's Quarterly MDS, dated a BIMS score of two (2) re cognitive impairment. ent #21, on 04/14/2021 at e resident was walking inother resident. nt #21, on 04/14/2021 at //she did not remember esident.					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
REGIS WO	ODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Attempted to contact f on 04/20/2022 at 11:2 leave a message. Interview with CNA # AM, revealed she prov Resident #2 after the to make sure he/she of Interview with the CNI AM, revealed CNA #1 regularly scheduled si was informed of his/he stated Resident #2 re members so they tried provided the 1:1 supe Interdisciplinary Team brainstorming to come diversional activities for Interview with the CEI PM, revealed the facil supervision for Reside aggressive/combative He stated the facility f powered, life-like cat a #2 would respond to t 14. Review of the faci sexual abuse as non- of any type with a resi Review of the facility's policy, dated 11/28/20 revealed residents wo the nursing assessme of cognitive loss/deme	the nurse assigned to MCU, 25 PM, but was unable to 15 on 04/20/2021 at 11:21 vided 1:1 observation to incident and was instructed did not hit anyone. E, on 04/29/2021 at 9:17 5 on 03/24/2021 was not a itter for Resident #2, but er behaviors. The CNE sponded well to certain staff d to ensure the same staff ervision. She stated the n (IDT) was constantly e up with new techniques or or Resident #2. D, on 04/30/2021 at 3:12 lity would provide 1:1 ent #2 as long as the e behaviors were present. had ordered a battery and dog to see if Resident them. lity's abuse policy defined consensual sexual contact ident. s Dementia: Care of Patient 016 and revised 02/28/2021; buld be evaluated as part of ent process for the presence entia upon on, quarterly, with change of	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/16/2021 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DA1	E SURVEY IPLETED
		185301	B. WING		0	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	<u></u>	STI	REET ADDRESS, CITY, STATE, ZIP COL		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	assessments of the p background were con care and assistance t needs. Residents we of self and others to in Record review reveal Resident #12, on 02/0 assessed the residen Mental Status (BIMS) indicated severely imp Record review reveal Resident #13's on 09/ a Brief Interview of Mit two (2), which indicate cognition. Review of Resident # 09/21/2020, complete Nurse (LPN) #34, rev commented to staff the the opposite sex in his a grown up and shoul someone in his/her ro someone in h	ed interdisciplinary (IDT) erson's abilities and npleted in order to provide ailored to his/her individual are to be monitored for safety nclude intrusive wandering. ed the facility admitted 06/2020. The facility t to have a Brief Interview of score of five (5), which paired cognition. ed the facility admitted /10/2019. The resident had ental Status (BIMS) score of ed severely impaired 12's Progress Notes, dated ealed the resident hat he/she could not have s/her room and he/she was ld be allowed to have bom, if they wanted to have bom. 12's Quarterly Minimum assment, dated 10/07/2020, ssessed the resident to have 5) out of fifteen (15), which that severe cognitive ally, the resident usually had	F 600			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05//	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
REGIS WO	2008		4	604 LOWE ROAD			
			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Living (ADL), with the the resident was asse and have a wander gu Review of Resident # 10/18/2020, complete staff observed Reside Resident's #13's hand redirected. Continued Progress Notes, on 10 LPN #34, on 10/19/20 started Resident #12 concerns of sexually i However, there was n a resident-to-resident incident between Res on 10/19/2020. Further review of Res initiated on 10/19/202 tendency to exhibit se included: resident will coping skills related to behavior kissing anoth resident to alternative review. Interventions a place where they wi of psychosocial distre express feelings; prov encouragement and n Services visits to prov divert resident by givin activities; and to lister him/her. Review of Resident #	th his/her Activities of Daily support of one (1). Further, essed to use a wheelchair uard alarm on for daily use. 12's Progress Note, on d by LPN #34, revealed ent #12 attempt to hold d; the resident was easily d review of Resident #12's 0/19/2020, completed by 020, revealed the facility on 1:1 supervision for nappropriate behaviors. to documented evidence of Alleged Sexual Abuse ident #12's Care Plan, 0, revealed the resident had exual expression. The goals demonstrate effective to sexually inappropriate her resident, redirect activity or location thru next included: put the resident in ill not demonstrate any signs ss; allow time for resident to vide empathy, eassurance; Social ride support as needed; ing alternate objects or n to resident and try to calm 12's Progress Note, dated	F 600		JEFICIENCY)		
	divert resident by givin activities; and to lister him/her. Review of Resident #	ng alternate objects or n to resident and try to calm 12's Progress Note, dated d by LPN #34, revealed					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/16/2021 RM APPROVED
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
		185301	B. WING		0	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			304 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	resident's hand. Furth staff he/she asked Re and he/she had the riv resident. Resident #1 that time. Review of the Progress completed by LPN #3 #12 attempt to enter F Further review reveals staff if Resident #13 v touch him/her it was ri- because the two (2) of Review of Resident # revealed the facility at 09/10/2019, with diag behaviors and Psycho Review of Resident # 10/21/2020, completer resident followed ano and "antagonized" the resident if he/she cou Review of Resident # Assessment, dated 10 facility assessed the ri (2) out of fifteen (15), had severe cognitive Continued review of F Notes, four (4) days at Alleged Sexual Abuse by LPN #34, revealed	ident #13's room to hold the er, Resident #12 informed esident #13 to get married ght to hold hands with the 2 was on 1:1 supervision at as Note, dated 10/28/2020, 4, staff observed Resident Resident #13's room. ed Resident #12 informed vanted Resident #12 to not up to staff to say no, f them were to get married. 13's medical records dmitted the resident on noses of Dementia with otic disorder with delusions. 13's Progress Notes, dated d by LPN #41, revealed the ther resident, on the MCU, e resident, and asked the ld go to his/her room. 13's Annual MDS 0/23/2020, revealed the esident had a BIMS of two which indicated the resident impairment. Resident #13's Progress fter the resident-to-resident e, on 10/23/2020, completed the resident was involved in Resident #12. Additionally, d it was okay the kiss	F 600			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PRO	OVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STA	TE, ZIP CODE	-	
REGIS WOO	DDS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
	Additional review of R 10/19/2020, revealed to exhibit sexually inal to cognitive loss/Demi- noted to have given a the lips." The goal wa demonstrate effective sexually inappropriate resident; redirect self location. Interventions Psych/Behavioral Hea Service visits to provid resident with alternative resident and try to cal resident from environe Review of the facility's Facility-Self Report In dated 11/01/2020, four incident, which was re Agency revealed an A had occurred on 11/07 #12 and Resident #13 Department of Comm (DCBS) were notified on 11/01/2020. Per the was witnessed to kiss on the lips." Further, 1:1 Supervision. Con- revealed Resident #12 (5) and it was noted the BIMS score of ninety- Review of LPN #37's 1 10/19/2020, revealed	ed no signs of distress were esident #13's CCP, on the resident had a tendency ppropriate behavior related entia. The resident was nother resident a "peck on as that the resident would coping skills related to e behavior, kissed another to alternative activity or included: evaluate need for alth Consultation; Social de support as needed; divert ve objects/activities; listen to m resident; and remove ment as needed. s Long Term Care cident Form/Initial Report, rteen (14) days after the eported to the State Survey Illegation of Sexual Abuse 1/2020 between Resident 8. The Physician, POA, and unity Based Services of the alleged sexual abuse he Report, Resident #12 Resident #13 a "peck kiss Resident #12 was placed on tinued review of the Report, 2's had a BIMS score of five hat Resident #13 had a	F	600				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			- C 05/22/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 600	placed on 1:1 Superv redirected to the com on duty, notified the F management team. On 04/26/2021 at 3:0 LPN #34, via telephon On 04/26/2021 at 3:0 LPN #12, via telephon On 04/26/2021 at 2:2 contact the previous 0 via telephone. Observation on 04/26 Resident #12 and #13 #13's room. Residen wheelchair and Resid chair. It appeared the to each other. Staff w and the door was ope Phone interview with 04/21/2020 at 7:20 Pl the facility from March Per interview, she pro Resident #12, after th However, the facility of what to do for 1:1 sup Continued interview r sit with the resident in his/her room. Additio #13 would follow Res "honey," attempt to ho try to get the resident	rated and Resident #12 was ision. Resident #13 was mon area. The other LPN POA, doctor and 0 PM, SSA attempted to ne. 5 PM, SSA attempted to ne. 7 PM, SSA attempted to Center Executive Director, /2021 at 8:45 AM, revealed 8 unsupervised in Resident t #12 was seated in a ent #13 was seated in a e residents talked and read vas present across the hall	F	600				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185301	B. WING		C 05/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	<u></u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
			40	604 LOWE ROAD		
REGIS WO	DODS		L	OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	to keep an eye on Re #13 because they wo room. Per interview, mad at staff when he/ allowed in Resident # Interview with LPN #2 AM, revealed she pre Manager of the MCU. 1:1 supervision for Re Further interview rever who were cognitively to have sexual relation not understand the re that type of relationsh Interview with facility's at 3:00 PM, revealed score of ninety-nine (9 consent of any kind b cognitively impaired. should be involved in determined if resident consent to a sexual re rare for such a relation Interview with Memor Director (MCPD) who October 2020, on 04/2 revealed prior to becc worked as the Social main facility from Jan Per interview, Reside needed consent to ha they both had low BIN they suffered cognitive inability to make such	rked night shift and was told sident #12 and Resident uld try to go in each other's Resident #12 would become (she was redirected and not i13's room. 25, on 04/22/2021 at 11:10 viously was the Unit . Additionally, she provided esident #12 on 10/24/2020. ealed she stated residents impaired could not consent nships because they could sponsibilities that come with ip. s Psychiatrist, on 04/22/2021 a resident with a BIMS 99) would not be able to give ecause they were severely Additionally, he revealed he any assessment that ts in the MCU were able to elationship and it would be nship to be okay. y Care Unit Program had been in that role since 23/2021 at 10:35 AM,	F 600			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/16/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 05/22/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE		
F 600	the conclusion that concerns with the current of two (2) residents where Further, she reported concerns with the current of the concerns of of the con	onsent could be given for the owere cognitively impaired. I she discussed her rrent CNE and the previous the final decision, that esident #13 could have a uded holding hands and a as per established by each interview, the MCPD know what the State SOM) was when asked if she ake a determination who if consent for cognitively have sexual ent #12's POA, on M, revealed he was lity to ask for consent for mily member and he told the ot consent for Resident #12 o with another resident in the he informed the caller he with that, and the resident's e and the resident had view, he revealed he could of the person that called to the facility "absolutely not" if mention of sexual ed.	F 6	00			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/16 FORM APPRO OMB NO. 0938-
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185301	B. WING		C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLE IE APPROPRIATE DAT
F 600	#13's present relation it was strictly a friend was it described as s interview, he describe tongue kissing, touch touching of the genita body. The POA reve okay with him and no revealed he was new member had been in opposite gender and Continued interview r wanted to know why allowed in his family member would be all room. Per interview, raped fifty (50) years provided care for the became very angry if gender touched him/f member knew the per Additional interview v 3:30 PM, revealed re impaired cognition ar supervision. Per inter score of eight (8) or le decisions and require on their behalf. Cont residents with impaire consent to have sexu Additionally, she did companionship of sitt or a kiss as sexually Continued interview r Resident #13 had ag the Alleged Sexual Al towards Resident #12	hship with another resident, if ship; however at no time omething sexual. Per ed sexual contact to include hing over the clothes, alia and kissing over the aled a peck of a kiss was of sexual. Further, he er informed his family bed with a resident of the was not okay with that. revealed he would have another resident would be member's room, or his family owed in another resident's Resident #13 had been ago and when he still family member, he/she fanyone of the opposite her; even if his family rson. with MCPD, on 04/29/2021 at sidents on the MCU had nd required constant rrview, residents with a BIMS ower could not make sound ed a POA to make decisions inued interview revealed ed cognition required ual relationships.	F 60		

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_\_ С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 100 F 600 F 600 residents and staff, "Can I give you a kiss?"; Per interview, she had discussed with staff on the MCU, to attempt to keep Resident #12 and Resident #13 apart. Interview with CNE (for six {6} months), on 05/04/2021 at 10:00 AM, revealed residents with impaired cognition could not consent to sexual relationships with other residents. He stated it would not be safe for vulnerable residents to engage in sexual relationships because they would not understand safe sex practices and could not make decisions for themselves. Additionally, the residents' POAs alone could not give consent for the residents to have sexual relationship; it would be an IDT decision. Continued interview revealed she was aware that Resident #12 had impaired cognition, was confused. However, she was not aware that Resident #13 had aggressive behaviors/sexual expression, directed towards others, until the Allegation of Sexual Abuse, in October 2020. Continued interview revealed it was common knowledge that Resident #12 and Resident #13 had a relationship, which began in October 2020. Per interview, Resident #12 gave Resident #13 a "pop kiss on the lips" and she did not consider that as sexually inappropriate. However, the Care Plans were developed to include sexually inappropriate behavior to ensure the residents were monitored for potential inappropriate sexual expressions. Further interview revealed it was her understanding that the MCPD contacted the residents POAs and talked to them at length about consent for the residents to continue their companionship, with no concerns reported. The CNE stated those conversation should be documented in each resident's medical record.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 100503

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185301	B. WING	_	C 05/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	PM, revealed sexual of unwanted by another could not consent, it w Additionally, it was the residents especially th because they were a interview, there was in residents with impaired any type of relationsh revealed he was unsu- could give consent for sexual relationships b involved in the decision Further, residents have those rights were met decision. However, h Resident #12 and Res- until the SSA informed investigation of the All interview, residents of involved in any type of resident's impaired co 15. Record review rev Resident #26 became #28 on his/her leg. Review of the facility's Facility-Self Report In dated 04/23/2021, rev Resident #28 were wa area when Resident # made contact with Re- review, the residents i immediately. Review of the Five (5) Report, dated 04/28/2	D, on 05/04/2021 at 3:45 contact as anything resident and if a resident was considered the same. e facility's job to protect all nose residents on the MCU vulnerable population. Per increased potential for ed cognition to be involved in ip. Continued interview ure if the POA or guardian r a resident in MCU to have but stated the IDT should be on making process. ve rights and to ensure t, it should be an IDT e was not aware of sident #13's relationship d him during the leged Sexual Abuse. Per in the MCU should not be of relationship due to the ognitive impairments. vealed on 04/23/2021, e agitated and hit resident s Long Term Care incident Form/Initial Report, vealed Resident #56 and atching TV in the common #56 became agitated and esident #28's leg. Per	F 600				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185301	B. WING		_	C 05/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	progressing brain turn contributed to the resi the Urinary Tract Infec revealed Resident #5 facility with hospice and Review of Resident # Data Set (MDS) Asse revealed the facility as a Brief Interview for M of six (6) out of fifteen cognitive impairment. Review of Resident # dated 04/23/2021, rev Review of Resident # revealed the facility and 04/08/2020, with diag Schizo-Effective Diso Anxiety, Dementia with Depressive Disorder. Review of Resident # Assessment, dated 04 facility assessed the r score of thirteen (13) indicated the resident Additional review of the revealed the facility as Section E, to have no behaviors towards oth period. Observation and inter 05/05/2021 at 9:00 All	<ul> <li>bonsiveness to his/her for. Per review, this ident's behavior, as well as, ction (UTI). Further review 6 would come back to the nd was non-ambulatory.</li> <li>28's Quarterly Minimum assment, dated 02/26/2021, seessed the resident to have lental Status (BIMS) score of (15), indicating severe</li> <li>28's Skin Assessment, vealed no injuries noted.</li> <li>56's medical record dmitted Resident #56, on noses which included rder, Bipolar Disorder, thout Behaviors, and Major</li> <li>56's Annual MDS 4/06/2021, revealed the resident to have a BIMS' out of fifteen (15), which was cognitively intact. he MDS Assessment seessed the resident under physical and/or verbal hers within the last review</li> <li>view with Resident #56, on M, revealed he/she was 8 and thought the incident</li> </ul>	F 60	D				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING					C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	·	
REGIS WO	OODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	÷ 103	F	600				
	(BOM), on 05/06/2021 has had education rel that when abuse occures ident-to-resident, it immediately to the nu Administrator. Contin revealed she was una incident, but believed to lunch. She stated temperatures of staff the facility and overhe over a wallet. She stated that Resident #28 too interview revealed a f second incident, Resi someone (unidentified Resident #56 was talk interview, the resident lead to Resident #56 the leg. The BOM state behind the hit, but it we considered abuse. Pow was the only witness immediately separate stated she reported the Administrator. Interview with the CN approximately 10:00 // Administrator was resis the resident-to-reside Resident #28 and Resis the CNE reported the incident, other than the Interview with the CE	t would be reported inse supervisor and/or nued interview with the BOM aware of the date of the first it occurred sometime prior she was checking and/or visitors who entered eard the residents arguing ated Resident #56 reported ok his/her wallet. Continued few days later, on the ident #56 was talking to d) and Resident #28 thought king about him/her. Per its began to argue which "smacking" Resident #28 on ated there was no force would have still been er interview, she stated she in both incidents and ed the residents. She further he incident to the IE, on 05/06/2021, at AM, revealed the sponsible for investigating ent altercation between isident #56. Per interview, are were no witnesses to the he BOM.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185301	B. WING		_	( 05/2	; 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>would be considered a</li> <li>Review of the IJ Rem facility implemented the separated by the Schuthe event on 04/23/20</li> <li>were immediately not Scheduler on 04/23/20</li> <li>were immediately not Scheduler on 04/23/201 by Director. Resident #50 on 04/23/2021 by the The Director of Social of care for Residents to reflect the current r</li> <li>The Social Service Di Residents #56 and #22 determine Psychosoc noted.</li> <li>2. Residents #21 and separated by License upon the discovery of Resident #2 was on o CED and CNE were in event by the Nurse or report was sent in to the Summer set of the sent in to the sent in the sent in</li></ul>	<ul> <li>abuse.</li> <li>abuse.</li> <li>aval Plan revealed the he following:</li> <li>#28 were immediately eduler upon the discovery of 021. The CED and CNE ified of the event by the 021. The initial report was yarding Residents #56 and v the Center Executive 56 and #28 were reassessed Registered Nurse (RN).</li> <li>I Services updated the plan #56 and #28 on 04/23/2021 heeds of the residents.</li> <li>I Services updated the plan #56 and 05/12/2021 to ial Wellbeing, no concerns</li> <li>#2 were immediately d Practical Nurse (LPN)</li> <li>the event on 03/24/2021. The initial the SSA regarding 2 on 03/24/2021 by the</li> </ul>	F 600		DEFICIENCY)		
	Residents #21 and #2 03/24/2021 by the Lic (LPN). No concerns w	ensed Practical Nurse					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C 05/22/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 600	05/11/21 to determine issues. 3. Residents #2 and # separated by the LPN event on 03/10/2021. one observation. The immediately notified of 3/10/2021. The initial SSA regarding Reside 03/10/2021 by the Ce Residents #2 and #3 03/10/2021 by the Ce Residents #2 and #3 03/10/2021 by the RN The ADNS reassesse 05/11/2021 to determ no concerns were not 4. Resident #2, Resid Resident #26 were im LPN upon the discove 03/09/2021. Resident #2 was on of CED and CNE were i event by the Nurse of The initial report was Resident #26 on 03/0 Executive Director. Resident #2 was sent evaluation and return orders.	r of Nursing (ADNS) #21 and Resident #2 on any psychosocial wellbeing #3 were immediately I upon the discovery of the Resident #2 was on one to a CED and CNE were of the event by the Nurse on report was sent in to the ents #2 and #3 on inter Executive Director. were reassessed on I. No concerns were noted. id Residents #2 and #3 on ine psychosocial wellbeing, red. ent #19, Resident #25, and mediately separated by the ery of the event on one to one observation. The mmediately notified of the in 03/09/2021. sent in to the SSA regarding t #19, Resident #25, and	F	600				

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	the LPN. No concerns The Social Service Di #2, Resident #19, Res #26 on 03/10/2021 to wellbeing with no issue 5. Residents #2 and 3 separated by the RN event on 01/22/2021. one observation. The immediately notified of nurses on 01/22/2021 in to the SSA regardin 01/22/2021 by the Ce The Social Service Di Residents #2 and #3, determine Psychosoc were noted. 6. Residents #2 and 3 separated by the licer discovery of the even and CNE were immed by the LPN on 10/28/2 sent in to the SSA reg #21 on 10/28/2020 by Director. Residents #15 and separated upon the d 12/24/2020. The CED	assessed on 03/09/2021 by s were noted. rector reassessed Resident sident #25, and Resident determine Psychosocial les noted. #3 were immediately upon the discovery of the Resident #2 was on one to e CED and CNE were of the event by licensed . The initial report was sent ng Residents #2 and #3 on inter Executive Director. rector reassessed on 01/28/2021, to ial wellbeing. No issues #21 were immediately need nurse upon the t on 10/28/2020. The CED diately notified of the event 2020. The initial report was parding Residents #2 and it he Center Executive I were reassessed on N. No concerns were noted. #16 were immediately iscovery of the event on	F	600				

If continuation sheet Page 107 of 337

ID SERVICES					FORM	07/16/2021 APPROVED 0. 0938-0391
/IDER/SUPPLIER/CLIA	· /				(X3) DATE SURVEY COMPLETED	
185301	B. WING			_	C 05/22/2021	
				ATE, ZIP CODE		
PRECEDED BY FULL	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
cutive Director. reassessed on ncerns were noted. assessed 28/2020 to eing, no issues re immediately discovery of the D and CNE were ent by the nurse on was sent in to the and #10 on cutive Director. eassessed on ent #10 had de of his/her face. assessed 16/2020 to eing, no issues re immediately discovery of the D and CNE were ent by a LPN on was sent in to the and #20 on cutive Director. eassessed on rs for x-rays was	F	600				
	ID SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER: 185301 DF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION) and #16 on ecutive Director. reassessed on ncerns were noted. eassessed /28/2020 to eing, no issues re immediately discovery of the ED and CNE were ent by the nurse on was sent in to the and #10 on ecutive Director. reassessed on dent #10 had ide of his/her face. eassessed /16/2020 to being, no issues re immediately discovery of the ED and CNE were ent by the nurse on was sent in to the and #10 on ecutive Director. reassessed /16/2020 to being, no issues ere immediately discovery of the ED and CNE were ent by a LPN on was sent in to the and #20 on ecutive Director. reassessed on re injuries were	VIDER/SUPPLIER/CLIA       (X2) MULT         TIFICATION NUMBER:       A. BUILDI         185301       B. WING         185301       B. WING         PRECEDED BY FULL       PREFING INFORMATION)         PRECEDED BY FULL       PREFING INFORMATION)         Fring INFORMATION)       TAG         and #16 on       Precedent of the context of the c	VIDER/SUPPLIER/CLIA       (X2) MULTIPLE         TIFICATION NUMBER:       A. BUILDING         185301       B. WING         185301       PRECEDED BY FULL         FYING INFORMATION)       PREFIX         TAG       F 600         and #16 on       PRECEDED BY FULL         FYING INFORMATION)       F 600         and #16 on       PRECEDED BY FULL         reversessed on       PRECEDED BY FULL         reversesses on       PRECED BY FULL <td< td=""><td>VIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         185301       B. WING         185301       B. WING         2000       STREET ADDRESS, CITY, ST         4604 LOWE ROAD       LOUISVILLE, KY 40220         DF DEFICIENCIES       ID         PROVIDER'S       PROVIDER'S         PPRECEDED BY FULL       PREFIX         PTRECEDED BY FULL       PREFIX         FYING INFORMATION)       F 600         and #16 on       ID         ncerns were noted.       PRESSER         P28/2020 to       F         eing, no issues       F         re immediately       discovery of the         ED and CNE were       PRESSER         ent #10 had       Ide of his/her face.         Passessed       (16/2020 to         weing, no issues       Pressessed on         re immediately       discovery of the         ED and CNE were       Pressessed         PREFIX       PREFIX         PRESSES       PRESSES         rre immediately       discovery of the         ED and CNE were       PRESSES         ent by a LPN on       was sent in to the         and #20 on       reassessed on         res for x-ra</td><td>VIDERISUPPLIERICLIA       (X2) MULTIPLE CONSTRUCTION         185301       B. WING         185301       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE         4604 LOWE ROAD         LOUISVILLE, KY 40220         DF DEFICIENCIES       D         PRECEDED BY FULL       PREFIX         PRECEDED BY FULL       PREFIX         TAG       CROSS-REFERENCED TO THE APPROPRIU         and #16 on neerns were noted.       F 600         assessed       CROSS-REFERENCED TO THE APPROPRIU         2/28/2020 to       Eing, no issues         re immediately       discovery of the         D and CNE were       and #10 on was sent in to the and #10 on wassessed         and #10 on wassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         re and #10 on wassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         read #10 on was sent in to the and #20 on cutive Director.       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed on lent #10 had       CROSS-REFERENCE</td><td>VIDERSUPPLIERICLIA THICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATE COMP (COMP</td></td<>	VIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         185301       B. WING         185301       B. WING         2000       STREET ADDRESS, CITY, ST         4604 LOWE ROAD       LOUISVILLE, KY 40220         DF DEFICIENCIES       ID         PROVIDER'S       PROVIDER'S         PPRECEDED BY FULL       PREFIX         PTRECEDED BY FULL       PREFIX         FYING INFORMATION)       F 600         and #16 on       ID         ncerns were noted.       PRESSER         P28/2020 to       F         eing, no issues       F         re immediately       discovery of the         ED and CNE were       PRESSER         ent #10 had       Ide of his/her face.         Passessed       (16/2020 to         weing, no issues       Pressessed on         re immediately       discovery of the         ED and CNE were       Pressessed         PREFIX       PREFIX         PRESSES       PRESSES         rre immediately       discovery of the         ED and CNE were       PRESSES         ent by a LPN on       was sent in to the         and #20 on       reassessed on         res for x-ra	VIDERISUPPLIERICLIA       (X2) MULTIPLE CONSTRUCTION         185301       B. WING         185301       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE         4604 LOWE ROAD         LOUISVILLE, KY 40220         DF DEFICIENCIES       D         PRECEDED BY FULL       PREFIX         PRECEDED BY FULL       PREFIX         TAG       CROSS-REFERENCED TO THE APPROPRIU         and #16 on neerns were noted.       F 600         assessed       CROSS-REFERENCED TO THE APPROPRIU         2/28/2020 to       Eing, no issues         re immediately       discovery of the         D and CNE were       and #10 on was sent in to the and #10 on wassessed         and #10 on wassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         re and #10 on wassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         read #10 on was sent in to the and #20 on cutive Director.       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)       CROSS-REFERENCE OF THE ACTION SHOLD BIERCIENCY)         reassessed on lent #10 had       CROSS-REFERENCE	VIDERSUPPLIERICLIA THICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATE COMP (COMP

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 1 APPROVED 2: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 108	F 600				
	The Social Service Di Residents #19 and #2 determine Psychosoc were noted.						
	separated by LPN up event on 10/02/2020. immediately notified of 10/02/2020. The initia SSA regarding Reside	nd #21 were immediately on the discovery of the The CED and CNE were of the event by the LPN on al report was sent in to the ents #61 and #21 on nter Executive Director.					
	10/02/2020 by the LP noted. The Social Service Di #61 and #21, on 10/0	21 were reassessed, on N. No concerns were rector assessed Residents 8/2020 to determine ad occurred with no issues					
	and CNE were immed by the LPN, on 04/22/ sent in to the SSA reg						
	#86 and #85 on 04/23	rector assessed Residents 3/2021 to determine ad occurred with no issues					
	12. On 05/11/2021, T Director (CED), and C (CNE), notified the Ma	Center Nurse Executive					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE	_	
REGIS WO	ODS			46	604 LOWE ROAD			
				L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 600	(QAPI) meeting was of CNE, and Medical Dir recommendations dev including audits, reed monitors for residents 13. On 05/11/2021, th operations contacted Organization (QIO) for 14. On 05/12/2021, th (Corporate) National S conducted reeducatio Executive Director (CI Managers ADNS, Nur the facility's policy, Be Symptoms and that ea and the facility must p behavioral health care maintain the highest p and psychosocial well the comprehensive as to protect residents ag harm, or death. Addit included De-escalate Behaviors: How to Re Causes Unpredictable the Quality Improvem a posttest requiring a hired SSD, CNE, CEE receive education and verify understanding the Practices Team or CC 15. Starting 05/14/20	An ad Hoc Quality ice Improvement Committee conducted with the CED, rector at this time for veloping the action plan ucation, and compliance at risk for abuse/neglect. The Vice President of Clinical the Quality Improvement r behavior element support. The Senior Director from the Specialty Practices Team n with the SSD, Center ED), CNE, NPE, Unit rsing Supervisor regarding thaviors: Management of ach resident must receive provide the necessary and services to attain or practicable physical, mental, I-being in accordance with ssessment and plan of care gainst serious injury, serious cionally, the reeducation Challenging Situations and spond when Dementia the Behavior obtained from ent Organization (QIO) with 100% grade. Any newly D, NPE, and or UM will d complete a posttest to by the National Specialty	F	600				
	Director (SSD), Socia							

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIE	PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	IPLETED
						С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Program Manager an review the progress r presenting with beha meeting to determine health services daily including weekends a times per week times eight (8) weeks then (8) weeks then month ongoing thereafter as Assurance Performan Committee to ensure residents are met wit discovery. 16. On or before 05/1 Director (SSD), Socia Executive (CNE), Ass Services (ADNS), Un Practice Educator (N and or Licensed Prace conduct an audit of re with behaviors to incl agitation, and anger s behavioral symptoms and/or not directed at need for a behavioral Additionally, behavior determine the need for consultation. 17. On or before 05/1 Executive (CNE), Un	NS), Memory Support ad/or Unit Manager (UM) will notes of residents viors in the clinical morning the need for behavioral times two (2) weeks and holidays then three (3) (2) weeks then weekly for every other week times eight hy times (1) month then the determined by the Quality nee Improvement (QAPI) the behavioral needs of the h any corrective action upon (9/2021, the Social Services al Worker, Center Nurse sistant Director of Nursing it Manager (UM), Nurse PE), Registered Nurse, (RN) ctical Nurses (LPN) will esidents' records presenting ude signs of frustration, such as physical or verbal directed toward others t others to determine the health consultation. r rounds were conducted to or behavioral health	F 60			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ol> <li>18. On or before 05/1</li> <li>NPE, Unit Managers in urses to complete a a behavior occurs to it to develop a person of post- test requiring a grade of 100% was reduring this time frame be provided re-educate the Unit Managers and to work. New hires in provided education are orientation by the CN</li> <li>19. The Center Nurse Assistant Director of Nunit Manager (UM), L Nursing Assistant, Me Nurse Practitioner wor rounds to determine to managed appropriate upon discovery weeked bi-weekly times four (4) months determined by the Qu Performance Improve ensure the behavioral were met with any condiscovery.</li> <li>20. The CED and/or Of the audits and intervise identified were address 21. The SSD, SW and review findings daily to was removed to the OP Performance Improve</li> </ol>	9/2021, the CNE, ADON, will provide reeducation for thorough investigation when dentify the triggers in order entered care plan with a 100% grade. A passing equired. Staff not available to include agency staff will tion including post- test by d or CNE upon day of return cluding agency staff will be nd a posttest during E, NPE or Unit Managers. Executive (CNE) or Nursing Service (ADNS), i.icensed Nurse, Certified ental Health Provider or uld conduct behavior hat behaviors were ly with corrective action y times four (4) weeks, 4) weeks then monthly then ongoing thereafter as iality Assurance ement (QAPI) Committee to I needs of the residents rrective action upon	F	600			

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &						FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	185301	B. WING _					C <b>22/2021</b>
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WOODS				604 LOWE ROAD OUISVILLE, KY 40220			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
Services, Medical Di Director, Dining Serv Information Manager Therapy Program Di Activity Director and any additional follow the issue was resolv thereafter as determ The State Survey Ag implementation of th 1. Interview with the (SSD), on 05/21/202 updated Resident #5 check on the residen revealed the residen and was placed on F the care plan was no on 04/23/2021, but of resident's behavior of items. Continued int revealed she followe 05/12/2021 and the p concerns related to to 2. Interview with the AM and the CED on revealed they were r on 03/24/2021, revealed assessed Resident # notified the CNE and Interview with the AE PM, revealed he visi	sistant Director of Nursing irector, Social Service vice Director, Dietitian, Health r, Business Office Manager, irector, Maintenance Director, Certified Nursing Aides for r up and/or in servicing until red and then ongoing ined by the QAPI committee. gency validated the re facility's AOC as follows: Social Service Director 21 at 5:30 PM, revealed she 56's care plan to have staff nt. Continued interview it was no longer in the facility Hospice. She further stated bu updated for Resident #28 on 04/20/2021, related to the of taking other resident's terview with the SSD ed up with the residents on residents expressed no their Psychosocial Wellbeing. e CNE, on 04/29/2021 at 9:17 04/30/2021 at 3:12 PM, notified by the MCU LPN #43, cord review, dated d the MCU LPN separated, #2 and #21 for injuries, and	F	500				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>03/24/2021. Record revaluated Residents # wellbeing and determ</li> <li>3. Interview with the QAM, and the CED, on revealed they were no 03/10/2021.</li> <li>Record review revealed residents for injuries a CNE of the incident of Interview with the ADI PM, revealed he visite Resident #3 on 05/11, psychosocial distress 03/10/2021.</li> <li>Interview with the CEI PM, revealed he sent on 03/10/2021.</li> <li>4. Interview with the CED on revealed they were no 03/09/2021. Record revealed they were no 03/09/2021. CAM, and the CED on revealed they were no 03/09/2021. CAM, and the CED and 03/09/2021. CAM, and the CED an</li></ul>	review revealed the ADNS #2 and #21 for psychosocial ined no concerns. CNE, on 04/29/2021 at 9:17 04/30/2021 at 3:12 PM, otified by LPN #43, on ed LPN #43 assessed both and notified the CED and n 03/10/2021. NS, on 05/22/2021 at 3:00 ed with Resident #2 and /2021, and determined no from the incident on D, on 04/30/2021 at 3:12 the initial report to the SSA CNE, on 04/29/2021 at 9:17 04/30/2021 at 3:12 PM, otified by LPN #43 on review revealed LPN #43 CNE of the incident on 0/2021, LPN #43 assessed 25 with redness noted to dent #26 was assessed with D, on 04/30/2021 at 3:12 the initial report to the SSA	F	600				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS		-	604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Further record review returned to the facility with no new orders. Interview with the SSI PM, revealed she ass and #26 on 03/10/202 by talking with them v Record review reveal Residents #19, #25, a psychosocial status a 5. Interview with the C AM, and the CED on revealed they were no 01/22/2021. Interview with the CE PM, revealed he sent of the event. 6. Interview with LPN AM, revealed he assis Residents #2 and #27 were assessed with m Record review reveal residents for injuries v Interview with the CN AM, revealed she was incident on 10/28/202 7. Record of the resid revealed Residents # by the CNE, on 12/24 were no concerns ide	<ul> <li>Prevealed Resident #2</li> <li>Provo 03/10/2021 at 1:00 AM</li> <li>D, on 05/22/2021 at 5:09</li> <li>Sessed Residents #19, #25, 21 for psychosocial distress with no concerns noted.</li> <li>ed the SSD assessed and #26 on 03/10/2021 for und no concerns were noted.</li> <li>CNE, on 04/29/2021 at 9:17 04/30/2021 at 3:12 PM, otified by LPN #43, on</li> <li>D on 04/30/2021 at 3:12 can initial report to the SSA</li> <li>J #6, on 04/20/2021 at 11:11 sted in the separation of 1. He stated the residents no injuries noted.</li> <li>ed LPN #6 assessed the with no concerns noted.</li> <li>E, on 04/29/2021 at 9:17 s notified by LPN #6 of the 20.</li> <li>dents' skin assessment 15 and #16 were assessed by 2020, per review, there</li> </ul>	F 600		PEFICIENCY)		

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		ID HUMAN SERVICES				FORM	): 07/16/2021 MAPPROVED
STATEMENT O	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	<ul> <li>PM, revealed she ass Psychosocial needs a identified.</li> <li>8. Review of the resid dated 12/15/2020, rev bruise/swollen face.</li> <li>Interview with the Soc 05/21/2021 at 6:21 Pl assessing Resident # bruise to the resident in noted the resident wa further stated she ass psychosocial wellbein no concerns.</li> <li>9. Review of Resider record revealed the re without injuries noted</li> <li>Interview with the SSI PM, revealed she rea #20 and noted no psy</li> <li>10. Review of Resider assessment, dated 10 concerns noted.</li> <li>Review of Social Serv 10/08/2020, revealed noted.</li> <li>11. Review of the SS 04/23/2021, revealed noted.</li> <li>12. Review of the Ad</li> </ul>	sessed the residents for and no concerns were dents' skin assessments, vealed Resident #10 had a cial Service Director, on M, revealed she recalled #10, but did not recall a 's face. She stated she as not in any pain. She sessed the resident's ng on 12/16/2020 and noted hts #19 and #20's clinical esidents were assessed D, on 05/21/2021 at 6:21 issessed Residents #19 and ychosocial concerns. ent #61 and #21's skin 0/02/2020, revealed no	F 600				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE COM	E SURVEY PLETED
		185301	B. WING			C / <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COL		-
			460	4 LOWE ROAD		
REGIS WC	DODS		LO	UISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG F 600	Continued From page Director (CED), Cente and Medical Director discuss the immediate Interview with the Mer 05/22/2021 at 5:30 PI immediately notified f notations of jeopardie the facility held an immediately not discuss the information staff, and audits for co interview revealed the on the progress of ed changes which were w information. The dire will review all abated for at least six (6) mod 13. Interview with Qu Organization, on 05/2 3:40 PM, revealed sh VPCO with setting up Care Unit. Per intervie and much of the trainin 14. Telephone intervie Clinical Operations (V 5:14 PM, revealed sh two (2) which covered	e 116 er Nurse Executive (CNE), met on 05/11/2021 to e jeopardy. dical Director, on M, revealed the facility nim by phone with both es. The Director revealed mediate Ad-HOC QAPI to on, formulate education to ompliance. Continued e facility updated him daily ucation, audits, and any warranted after review of the ctor stated the committee jeopardies audits monthly nths, longer if warranted. 2/2021 at approximately e had worked with the training for the Memory iew, she lived out of state ing was provided virtually. ew with the Vice President of (PCO), on 05/22/2021 at e was the VPCO for Division d the facilities located in ew, the VPCO stated she ty Specialist (CQS)	F 600			
	education the facility tags. She further stat Quality Improvement worked with QIO to do education/re-education stated she provided e	would need to address the ted she reached out to the Organization (QIO) and				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	further stated she can 05/16/2021, to help de Improvement Plan, we assessments. Interview with the Dire and Education, on 05, 5:30 PM, and the Ser Practice, at approxima provided education, ve team on 05/12/2021. was recorded and cou- trainings. Further inter addressed the resider triggers, deescalating Memory Support and Director of Social Wor management team we Review of the attendar revealed the SSD, CN Managers, ADNS, an reeducated with one-I the posttest by 05/12/ Interview with the Uni 05/21/2021 at 2:50 Pf (NPE), on 05/21/2021 Social Service Director 5:20 PM, Medical Dire Center Executive Director Sizon PM, revealed they we Zoom, to address the	g management staff. She ne to the facility on Sunday, evelop the Quality hich would include the ector of Memory Support /22/2021 at approximately nor Director of Social Work ately 5:45 PM, revealed they irtually to the management Per interview, the education uld be used for future rview revealed the training nt's behaviors and potential behaviors. The Director of Education and the Senior rk Practice stated the ere provided a posttests NE, CED, NPE, Unit d Nursing Supervisors were hundred percent (100%) on 2021. t Manager (UM), on M, Nurse Practice Educator at approximately 4:30 PM, or (SSD), on 05/21/2021 at ector, on 05/22/2021 at 5:30, ector (CED) and Center NE), on 05/22/2021 at 6:30 ire provided education, via concerns related to the and abuse. Per interview, posttest and received	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/2	22/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
REGIS WO	ODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	PM, revealed she real President of Clinical C regards to working with Support and Educatio Director of Social Wore experience working with Continued interview with discussed the resident de-escalating behavior revealed management which she administered 15. Review of the Aut 05/14/2021, revealed Center Nurse Execution Care Support Director completed the audits. Interview with the Ser Manager/Memory Care 05/22/2021 at 12:09 F with the National Tear interim Memory Care interview, she stated she for any recognized be 16. Interview with the 6:30 PM, revealed sho rounds on the resident presented with behav towards others and/or health consultation. F	S, on 05/22/2021 at 3:06 ched out to the Vice Dperations (VPCO) in th the Director of Memory in, as well as, the Senior rk Practice, since they had with residents with behaviors. with the CQS revealed they its, potential triggers, and ors. Continued interview it was provided a posttest, ed and signed off on. dit Tool for F600, beginning Registered Nurse (RN) #14, ve (CNE), and the Memory r signed of as having hior Rapid Response re Support Director, on PM, revealed she worked m and was currently the Support Director. Per she had completed the audit on the Memory Care Unit. e audited Resident #31 daily shaviors. e CNE, on 05/22/2021 at e completed behavioral hts to determine if they ioral symptoms directed r had a need for behavioral Per interview, those	F 60	0			

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	
		185301	B. WING				22/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REGIS W	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	17. Review of the att revealed nursing staff educated on the facili Policy and De-escala Situations and Behav Dementia Causes Un one-hundred percent or before 05/19/2021. this time would receiv day of return to work Managers or the CNE Interview with the CN PM, revealed educati process and was provemployee returned to Interviews with Certifi #14, on 05/21/2021 at 05/21/2021 at 1:45 05/21/2021 at 1:45 PM at approximately 1:59 #1 on 05/21/2021 at 2:00 PI 2:05 PM, CNA#36, or and CNA #35, on 05/2 revealed they were en- behaviors, how to doo de-escalating the resi Additionally, interview staff provided the edu 18. Interviews with Li (LPN) #14, on 05/21/2 005/21/2021 at app Registered Nurse (RM	endance roster and posttest including agency staff were ty's Behavior Management tion of Challenging iors: How to Respond when predictable Behavior with a (100%) on the posttest on Staff not available during the education upon the provided by the Unit  E, on 05/22/2021 at 3:00 ng staff was an ongoing vided the first day the work. ed Nursing Assistant (CNA) t 1:40 PM, CNA #34, on imately 1:43 PM, CNA #23, 5 PM, CNA #13, on M, Licensed Practical Nurse I, LPN #22, on 05/21/2021 PM, Registered Nurse (RN) 2:00 PM, CNA #19, on M, RN #16, on 05/21/2021 at n 05/22/2021 at 6:20 PM, 22/2021 at 7:05 PM, ducated on residents with cument the behaviors, and dents with the behaviors. vs revealed management	F	600			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 120 F 600 F 600 they were educated on how to investigate residents with behaviors. Per interviews, they were provided a posttest and received a passing score. 19. Interview F 656 Develop/Implement Comprehensive Care Plan F 656 SS=J CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-(A) The resident's goals for admission and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING				C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	future discharge. Fac whether the resident's community was asses local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forth section.	eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the h in paragraph (c) of this	F	656			
	by: Based on interview, if facility's policy, and re Medicare and Medica "Resident Assessmer 3.0," it was determine an effective system to care plan with individu care needs related to include specific behar monitoring and interviexpressions/distress,	nt Instrument (RAI) Manual ed the facility failed to have b develop and implement a ualized, person centered b behavior symptoms to viors, supervision,					

Facility ID: 100503

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	-	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	-	
REGIS W	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>#3, Resident #12, Resident #61, and Resident #61, and Resident #61, and Resident revealed incidents on 10/10/2020, and 10/0</li> <li>#21 intruded the pers residents, slapped Retowards another resident, pushing a real face, pacing behavior resident, pushing a real incidents occurred (MCU).</li> <li>Continued review revealed review revealed review revealed discrepancies the MAR and Progress</li> <li>Additionally, there waa a Care Plan (CP) was individualized resident stressors identified or support and reduce e each exhibited behavior</li> <li>2. Review for Resider revealed on 10/02/20, tearful, crying episode another resident, on the resident on the resident for the resident for the resident exhibited interviews and review revealed discrepancies the MAR and Progress.</li> </ul>	sident #13, Resident #21, esident #86. In t #21's medical record 10/28/2020, 10/25/2020, 2/2020 in which Resident onal space of other esident #2, showed anger lent, patted a resident on the s, arguments with another esident down onto the floor. on the Memory Care Unit ealed the Comprehensive lated on 01/14/2020, the or complications related to rugs with an intervention to onitoring documentation if behaviors. However, staff of the medical record es in behavior monitoring on is Notes. s no documented evidence a developed with ts' behaviors and behavior specific interventions to xpression/distress after the ior. In t #61's medical record 20, Resident #61 had a e and a verbal argument with	F 656				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
		185301	B. WING			05/2	; 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	, CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 656	use of psychotropic di complete behavior mo the resident exhibited interviews and review revealed discrepancie the MAR and Progres Continued review reve evidence the Care Pla individualized residen stressors identified or support and reduce effective each exhibited behavio days after the abuse; developed to include to towards others. 3. Review of Residen prior to his/her room of 03/27/2021, revealed behaviors such as hitt care; however review revealed no documen was developed with p individualized interver resident's behaviors. The facility's failure to place to ensure devel of the care plan with in centered care needs of supervision, monitorin reduce expressions/d serious injury, harm, i resident. Immediate	rugs with an intervention to onitoring documentation if behaviors. However, staff of the medical record s in behavior monitoring on s Notes. ealed no documented an (CP) was developed with t behaviors and behavior specific interventions to corression/distress after the or until 10/08/2020, six (6) further, the CCP was not verbal behaviors directed t #86's 1:1 documentation thange, to the MCU, dated Resident #86 exhibited ing, kicking, and resistive to of the resident's care plan ted evidence the care plan ted evidence the care plan erson-centered tions to address the (Refer to F-600 and F-740) have an effective system in opment and implementation ndividualized person related to behavior	F 656				

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						NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
				Ŭ		С
		185301	B. WING		a	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				4604 LOWE ROAD		
REGIS WO	0005			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 124	F 6	56		
	· · · · · · · · · · · · · · · · ·	an acceptable Allegation of	100			
	Compliance (AoC) or					
	removal of the Immed					
	05/20/2021. The Sta					
		diate Jeopardy was been				
		as alleged, prior to exit on				
		aining non-compliance at a				
		of a "G" while the facility mented a Plan of Correction				
	and the facility's Qua					
	-	compliance with systemic				
	changes.					
	The findings include:					
		Person-Centered Care Plan,				
	revised 07/01/2019, r	5				
		mented a comprehensive, an within seven (7) days				
	after completion of th					
		resident that included				
		es and timetables to meet a				
		ursing, nutrition, and mental				
	and psychosocial nee					
		ssment. Additionally, the				
		eviewed and revised by the				
	Interdisciplinary Team	y and comprehensive) and				
		he response to care and				
		goals. Per policy, care plan				
		ssisted residents to attain or				
		practicable physical, mental				
		II-being, and to eliminate or				
		may cause re-traumatization				
	of the resident' and to	een resident, resident				
	representative, and the					
	-	ptimize clinical outcomes.				
		ensive person-centered care	1			1

Facility ID: 100503

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	-	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		185301	B. WING				C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	plan was developed fi described the service services required but resident's right to refu- resident's care plan w individual resident's p communicated to app Review of the Centers Services, "Resident A Manual 3.0," dated O Comprehensive Care interdisciplinary comm- include measurable o and must describe the attain or maintain the practicable physical, r well-being. The RAI I must be reviewed and basis to reflect chang care the resident rece 1. Resident #21 was a MCU on 01/01/2020 v Alzheimer's Disease. included Senile Dege Depressive Episodes Disorder with Delusio behavioral disturbanc Further, the resident # Power of Attorney (PC Review of Resident # Plan (CCP), initiated o resident was at risk for use of psychotropic d resident to have the s	or each resident and s that would be furnished; not provided due to the se. Per policy, the vas customized to each references and needs and ropriate staff. s for Medicare and Medicaid ssessment Instrument (RAI) ctober 2017, revealed the Plan was an nunication tool and must bjectives and time frames e services to be furnished to resident's highest mental, and psychosocial Manual stated the care plan d revised on an ongoing es in the resident and the sived. admitted to the facility's with a primary diagnosis of Additional diagnosis neration of the brain, , Anxiety Disorder, Psychotic ns, Dementia without e, and Adjustment Disorder. nad a medical and financial DA). 21's Comprehensive Care on 01/14/2020, revealed the or complications related to rugs. The goal was for the mallest, most effective dose Interventions included but	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	mental status and fun the Medical Director ( 01/14/2020; and obse medication as related dated 01/14/2020. However the facility fa resident behaviors an identified and specific developed to support expression/distress fo and documented in R record. Further, the fa the residents CCP by monitoring documenta behaviors. Observations of Resid Survey Agency (SSA) 04/26/2021 at 10:40 Å 04/28/2021 at 8:00 AI PM, revealed the resi common rooms, hallw with intermittent, pace the resident was intru personal space for an crossed. Review of tt 01/14/2020, revealed behaviors to complete documentation. How Progress Notes, revea evidence of the behav and times (paced am) personal space).	behavior monitoring 0 01/14/2020. Other 1 to observe for changes in actional level and report to MD) as indicated, dated erve for continued need of to behaviors and mood, ailed to ensure individualized ad behavior stressors were and reduce or the behaviors identified esident #21's medical acility failed to implement not completing behaviors ation with exhibited dent #21, by the State ), on 04/22/2021 at 4:02 PM; AM and 1:55 PM; M; and 04/30/2021 at 2:30 dent on the MCU in vays, and in resident rooms, ed ambulation. Additionally, sive of other resident's by residents' path he/she he CCP, initiated on if the resident exhibited e behavior monitoring ever, review of the MAR and	F	656				

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		O. 0938-03		
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED		
						С		
		185301	B. WING		0	5/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	E		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 656	Continued From page	a 197	F 65	6				
1 000			F 05	0				
		U), on 04/22/2021 at 4:10 e worked on the MCU,						
		bulatory and paced up and						
		nd in the common areas						
		ays. Additionally, he was						
		ould become defensive						
		nts at times when their paths						
		aware Resident #21 had						
		essive towards others too.						
		appropriate care to each						
		e did not know if Resident						
		the resident's behaviors, the						
	resident's responses	to stressors, or listed person						
		s to support the resident and						
	· · · · · · · · · · · · · · · · · · ·	stress of the behaviors.						
	,	amiliar with Resident #21's are Resident #21's had						
	crying behaviors on t							
	Interview with CNA #	2 (seven {7} months on the						
	MCU), on 04/26/2021	at 10:45 AM, revealed						
		king on the MCU, Resident						
	-	own hallway, all over the						
		ontinued interview revealed						
		P as guide to know what eeded. However, she was						
		dent #21's CCP related to						
		lly, she was not aware of the						
		such as intrusion of personal						
		nysical behaviors directed						
		interview, she did not know if						
		specified the resident's						
		nt's responses to stressors,						
		ered interventions to support ice expression/distress of						
		er, she did not report or						
	document Resident #	-						

Facility ID: 100503

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED
		185301	B. WING		04	C 5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	<i>5/22/2</i> 021
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 656	Continued From page did it all the time.	e 128	F 65	56		
	month on the MCU), or revealed she followed CCP when providing interview, she expect behaviors to her immediate document and staff or interventions to support to ensure the residen care. Continued inter familiar with Resident ambulation on the har she was not aware the behaviors such intrus on 04/26/2021 or any was not aware of the listed the resident's s resident's responses centered intervention reduce expression/dis However, direct care ensure the CCP was with changes in the re- developed to address and a behavior was in time should be developed behaviors and interver Interview with RN #1 MCU), on 04/28/2021 CCP was followed by resident's individualiz Per interview, if a CC resident exhibited bel monitoring document report to her if they w	ould intervene with ort the resident's behaviors t received safe, quality of rview revealed she was t #21's behavior of paced Ils continuously; however, at the resident had any ion of others personal space of other time. Further, she CCP for Resident #21 that pecific behaviors, the to stressors, or listed person s to support the resident and stress of the behaviors. nurses were responsible to implemented and accurate esident; if the CCP was not to the resident's behaviors dentified the CCP at that oped to include the entions. (four {4} months on the 1 at 2:30 PM, revealed the the IDT to ensure each ed care needs were met. P intervention stated if the haviors to complete behavior ation, she expected aides to				

Facility ID: 100503

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	-	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		185301	B. WING			05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE	, ZIP CODE		
			46	04 LOWE ROAD			
REGIS WO	DODS		L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 656	about what the behavior it was important to fol ongoing monitoring ar resident behaviors for to ensure intervention resident exhibited a b and to maintain a hea- interview, since she h Resident #21 was an would walk up and do continuously. Further when another resident however, she was not documented any beha 04/28/2021. Continue was not aware if Resi CCP that specified the behavior, the resident a expression/distress of Interview with CNA #5 on 04/28/2021 at 3:11 CCP to know what ca Additionally, Resident behaviors towards oth staff's arms and sque resident was defensiv when they were in his interview revealed the /her voice, intrude oth space, and put his/he the resident walked u rooms and the comm- However, she was no CCP specifying those	free text Progress Note for action was. Additionally, low the CCP and provide and documentation of safety of the residents and as were implemented when a ehavior for their well-being of the resident well-being of the new resident well-being of the new resident was defensive at approached him/her; t aware of and had not aviors for Resident #21 on ed interview revealed she dent #21 had a behavior e resident's specific t's responses to stressors, tered interventions to and reduce f the behaviors.	F 656				

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	-	D HUMAN SERVICES				FORM	): 07/16/2021 1 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING			05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	when he/she was exh interview, she did not on this date (paced an personal space), to the already aware of them Interview with Agency the MCU), on 04/30/2 the Kardex/Care Plan know what care each interview, Resident #2 down the hallways an space since he/she w however, CNA #19 w had a CCP that speci behaviors or approach he/she exhibited a be behaviors or capproach he/she exhibited a be behaviors occurred sh today, she did not rep Resident #21 had wal intruded other resider all staff knew the resider support and reduce e each exhibited behavior support and reduce e each exhibited behav implement the CCP a behaviors as evidence Note with no docume ambulation and intrus Review of the MAR, c 04/01/2021-04/30/202 11/06/2020, is the residence of the market of the market of the market of the market and the market of the market of the market of the output and reduce of the market of the market of the ambulation and intrus	ibiting behaviors. Per report behaviors observed mbulation and in others e nurse because she was n. CNA #19 (two {2} years on 021 at 3:30 PM, revealed was a guide she used to resident needed. Per 21 always walked up and d got into other peoples as admitted to the MCU; as not aware if the resident fied the resident's specific hes to implement when havior. Further, when he reported to the nurse; but ort to the nurse that ked the hallway and dt's space, all day, because dent had this behavior. CCP, revealed no e the facility developed ts' behaviors and identified specific interventions to xpression/distress after the ior. The facility failed to nd ensure complete locumentation with exhibited e by the MAR and Progress intation of behaviors (paced ion of others space).	F 65	56			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4604 LOWE ROAD			
REGIS WO	JODS			LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Observe for refusal of cursing, yelling at othe the unit related to Alzi Additional review reve "YES" was document present. However, re- for those dates reveal evidence of a behavior intervention, or outcor Continued review of F Notes, dated 03/06/20 #30, revealed the resi behaviors directed tow and verbal behaviors, almost daily. Addition directed towards othe wandering almost dai risk and was intruding review of the CCP, re evidence the facility d individualized residen stressors identified or support and reduce e each documented bel Review of Resident # and December,2020, March, 2021 revealed is the resident behaviors p no documented evide the interventions, or of thirteen (13) instances incidents in February,	d outcomes in Nurses Note). care, throwing items, ers, and wandering around heimer's Disease. caled five (5) times in April ed indicating a behavior was view of the Progress Notes led no documented or exhibited, type, mes. Resident #21's Progress 21 at 12:18 PM, by LPN ident displayed physical wards others almost daily, directed towards others hally, other behaviors, not rs almost daily and ly which posed a significant on others. However, vealed no documented eveloped or implemented ts' behaviors and behavior specific interventions to xpression/distress after the havior on the 03/06/2021. 21's MAR, for November and January, February and I an order dated 11/06/2020, or free? Continued review hces in November, 2020, in December, 2020 that resent, however, there was nce of a behavior exhibited, utcomes. Review revealed s in January, 2021, six (6)	F 65	6			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	evidence of a behavior interventions, or outco implement the CCP a behavior monitoring d behaviors. Review of Resident # 11/09/2020, the reside refusal of care, throwi yelling at others, and The goal was for the r others. The intervent resident frequently; ta his/her understanding when attempting to pr invades others person was 1) no documente Notes or the MAR for behaviors on 11/05/20 evidence the individua stressors were identific Review of Resident # 10/01/2020-10/31/202 evidence of behavior Resident #21. Howey Notes in October 202 evidence of exhibited CCP did not reflect th residents' behaviors a	re was no documented or exhibited, the omes. The facility failed to ind ensure complete locumentation with exhibited 21's CCP revealed on ent exhibited physical other resident. On ent exhibited behaviors of ng items, cursing and wandering around the unit. resident to not harm self or ions included to distract the activities; observe the lk to the resident to assess i; and redirect the resident rovide care or he/she hal space. However, there d evidence in the Progress the listed exhibited 020 and 2) no documented alized residents' behavior ied. 21's MAR, dated 20, revealed no documented monitoring ordered for ver, review of the Progress 0 revealed documented behaviors; however, the at the individualized and residents' behavior specific interventions were and reduce	F 656				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STAT	E, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	Notes/Physician's Pro 10/29/2020 revealed in notified on 10/28/2020 resident had aggressi altercations with anoth Physician's Progress behaviors were due to resolved at the time of was no further docum #21's aggressive beha- in the Progress Notes However, review of R (RMS) Events Summa LPN #34, on 10/28/20 Resident #21 had a re altercation with allege Resident #21 walked beside Resident #2 an "what's going on in he slapped Resident #21 then slapped Resident witnessed the altercat separated the resident Mote, dated 10/25/2020 revealed the resident marks on his/her uppe further documented e sustained the scratch However, review of R Report, completed by 10/25/2020 at 4:00 Af a resident-to-resident abuse. Per Report, R	by gress Note, dated the on-call provider was D after hours, that the ve behaviors and an her resident. Per the Note, the aggressive o dementia and were f the assessment. There ented evidence of Resident aviors with another resident aviors with another resident for 10/28/2020. isk Management System ary Report, completed by 020 at 10:40 AM, revealed esident-to-resident d abuse. Per report, into the common room and asked the resident ere?" Resident #2 then in the face. Resident #21 at #2 in the face. Staff tion and immediately its. esident #21's Progress 20 at 12:24 PM, by LPN #1, had three (3) red scratch er chest. There was no vidence of how the resident es in the Progress Notes.	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		-
REGIS WO	OODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	Resident #26 then sch his/her cheek. Continued review of F Notes, dated 10/10/20 revealed the resident his/her roommate and you don't live here, se was immediately redin minutes became upse and required the room the room. However, review of th documented evidence implemented individua and behavior stressor interventions to suppo expression/distress at on 10/10/2020, 10/25 Review of Resident # 10/09/2020 at 10:00 Å the Interdisciplinary To resident's recent ever resident down, causin was made to remove related to the resident no recollection of the others. Additionally, review of revealed on 10/09/2020 identified the resident at he aggressor, was re Additional review rever	esident #26 on the cheek. ratched Resident #21 on Resident #21's Progress 020 at 5:39 PM, by LPN #36, showed anger towards d stated get out of my room, everal times. The resident rected however after several et again with the roommate mate to be removed from the CCP, revealed no e the facility developed or alized residents' behaviors rs identified or specific ort and reduce fter the behaviors exhibited /2020, or 10/28/2020. 21's Progress Note, dated AM, by LPN #36, revealed eam (IDT) discussed the nt of pushing another ng injury. The discussion 1:1 supervision at this time, t having impaired cognition, event, or anger towards f Resident #21's CCP, 20, the focus Care Plan that .was in a ltercation; Resident #21 was	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656		ident #21's CCP, initiated	F 656				
		, revealed the resident naviors towards another nt had a diagnosis of					
	would not harm him/h	d but were not limited to:					
	10/08/2020; and talk t	08/2020; Observe of when agitated, dated to the resident to assess situation, dated 10/08/2020.					
	implemented individua (yelling directed at oth identified or specific in	e the facility developed or alized residents' behaviors ners) and behavior stressors nterventions to support and					
	•	stress after the 10/02/2020 tified specific resident					
	dated 10/02/2020 at 7 revealed an aide note another resident and	ident #21's Progress Notes, 7:09 PM, by LPN #37, ed the resident yelled at pushed another resident New interventions included					
	Event Summary Report revealed on 10/02/2020 had a resident-to-resident abuse. Additionally, t	gement System (RMS) ort, completed by LPN #36, 20 at 6:38 PM, Resident #21 dent altercation with alleged the Activities Assistant, on Resident #21 push Resident					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 136 F 656 #61 down. Further, the resident had a history of verbal and physical abuse and intrusion of personal space of others. Interview with Activities Assistant (seven {7} months on the MCU), on 04/22/2021 at 4:10 PM. revealed he used the CCP to know how to provide appropriate care to each resident; however, he did not know if Resident #21's CCP specified the resident's behaviors, the resident's responses to stressors, or listed personal centered interventions to support the resident and reduce expression/distress of the behaviors. Additionally, he was not familiar with Resident #21's CCP and was not aware he had failed to implement Resident #21's CCP by not reporting or documenting the resident's behaviors. Further, on 10/02/2020 at approximately 5:00 PM, he observed Resident #21 with paced ambulation in the hallway; he also observed Resident #21 yell at Resident #61, invade the resident's personal space, and physically shove the resident to the ground. Interview with CNA #8, on 04/22/2021 at 4:15 PM revealed she used the CCP to know how to provide care to residents. Continued interview revealed she was not aware if Resident #21 had a behavior CP that listed specific behaviors the resident exhibited or interventions to attempt when the resident was exhibiting behaviors. Per interview, on 10/02/2020 around 5:00 PM, she was in the common area on the MCU, watching residents in a group activity. Additionally, she observed Resident #21 with paced ambulation up and down the hallway near his/her room; however, she did not report to the nurse, because it was a normal behavior that the resident had many times each day and everyone knew the

FORM CMS-2567(02-99) Previous Versions Obsolete

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		185301	B. WING				22/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident had the beha However, review of R on 01/14/2020, revea for complications rela (revised on 10/02/202 resident-to-resident a the aggressor. Additi intervention were revi include 1:1 supervisio CCP, revealed no do facility developed or in residents' behaviors a identified or specific in reduce expression/dis documented behaviors until 11/09/2020, thirty resident-to-resident a facility also failed to in ensure complete beha documentation with e 2. Resident #61 was a MCU on 12/17/2019 of unspecified Dementia disturbance. Addition diagnosed with Adjus depressed mood, on secondary diagnosis. medical and financial Review of Resident # 02/27/2020, revealed symptoms of psychos	avior all the time. esident #21's CCP, initiated led the resident was at risk ted to use of psychotropic, 20), to include ltercation; Resident #21 was onal review revealed the sed on 10/02/2020, to on. However, review of the cumented evidence the mplemented individualized and behavior stressors netrventions to support and stress after the each rs of paced ambulation, residents rooms, and verbal directed towards others, y-eight (38) days after the buse, on 10/02/2020. The mplement the CCP and avior monitoring xhibited behaviors. admitted to the facility's with a primary diagnosis of without behavioral tally, the resident was tment Disorder with 06/16/2020, as his/her Further, the resident had a	F	656			
	in the resident room. resident to demonstra	The goal was for the					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	provide consistent, tru structured daily routin a calm, unhurried mail and monitor the reside medications. Additional review of R on 09/16/2020, reveal potential for psychoso multiple medical prob Dementia without beh Adjustment Disorder w Major depressive diso exhibited tearfulness, wandering. The goal no signs or symptoms The interventions incl complete behavior mo behavior was exhibite observe for signs and distress (tearfulness, Social Service visits a Review of Resident # 10/01/2020-10/31/202 evidence of behavior However, review of th October 2020 reveale exhibited behaviors si crying. Review of Resident # 10/02/2021 at 5:38 Pf revealed the resident Resident #21 losing h on the floor.	but were not limited to: isted caregivers and e; approach the resident in nner, reassure as needed; ent's response to esident #61's CCP, initiated ed the resident had ocial distress related to ems and diagnosis of: avior disturbance, with depressed mood, and order. The resident crying, irritability and was for the resident to show a of psychosocial distress. uded but were not limited to: onitoring documentation if d; Psychological services; symptoms of psychosocial crying, irritability); and s necessary. 61's MAR, dated 20, revealed no documented monitoring for Resident #61.	F 65	6			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	revealed on 10/02/202 had a resident-to-resident abuse. Further, the A MCU, witnessed Resident #61 However, there was merited by state altercation, included were identified by state altercation. Interview with CNA #8 revealed she used the provide care to resided revealed she used the provide care to resided revealed she was not a behavior CP that liss resident exhibited or i when the resident was interview, on 10/02/20 observed Resident #6 upset and crying. Fun to cry in the hallway b however, she did not behavior to the nurse, behavior all the time. Interview with Activitied at 4:10 PM, revealed how to provide approp however, he did not k specified the resident responses to stressor centered interventions	ort, completed by LPN #36, 20 at 6:38 PM, Resident #61 dent altercation with alleged cctivities Assistant, on the dent #21 and Resident #61 cation and Resident #21 to the ground. o documented evidence of ed leading up to and during ing yelling or crying, which if who witnessed the 8, on 04/22/2021 at 4:15 PM, e CCP to know how to nts. Continued interview aware if Resident #21 had ted specific behaviors the nterventions to attempt is exhibiting behaviors. Per 020 around 5:00 PM, she at leave the dining room ther, the resident continued y Resident #21's doorway; report the resident's because it was a normal dent had many times each ew the resident had the es Assistant, on 04/22/2021 he used the CCP to know oriate care to each resident; now if Resident #61's CCP 's behavior, the resident's	F 656				

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CENTER			0.00			<u>10. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
			A. BUILDIN	G		С
		185301	B. WING		0	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		5/22/2021
				4604 LOWE ROAD		
REGIS WO	DODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	<u>-</u> 140	F 6	56		
		not familiar with Resident				
		not aware he had failed to				
		#61's CCP by not reporting				
		esidents behaviors. Further,				
		served Resident #61 crying				
	and yell at Resident #					
		TZ 1.				
	Further review of Re	sident #61's CCP, revealed				
		evelop the resident's CP to				
	include the resident-to	-				
		2020, six (6) days after the				
		Continued review revealed				
	the resident was push					
	resident which could					
	psychosocial distress					
	diagnosed with Deme					
	•	or Depressive Disorder. The				
	-	lent to show no signs of				
		. Interventions included but				
		ncourage interaction with				
		her life in the facility; and				
		symptoms of psychosocial				
		crying, irritability). However,				
	•	ented evidence the facility				
	developed or impleme	-				
	· · ·	(velling directed towards				
		stressors identified or				
	,	to support and reduce				
		fter the verbal altercation				
	leading to the abuse					
	Review of Resident #	61's MAR, dated 04/01/2021				
		revealed an order dated				
		e resident behavior free?" If				
		irful, crying, irritability),				
		ventions and outcomes in				
		y day and night shift for				
	-	I review revealed each day				

If continuation sheet Page 141 of 337

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER OUNDER CLAN LIDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BULDING     (X2) MULTIPLE CONSTRUCTION A BULDING A BULDI		-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 // APPROVED ). 0938-0391
185301     B.WING	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,				(X3) DATE COMF	SURVEY LETED
4604 LOWE ROAD LOUISVILLE, KY 40220           (M1)D TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PRETRX NAS         POVIDER'S PLAN OF CORRECTIVE ACTORS HOLD BE (EACH CORRECTIVE ACTORS HOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Country DeFICIENCY           F 656         Continued From page 141         F 656           "YES" was documented indicating the resident was behavior free every day and night shift.         F 656           Observations of Resident #61, by the SSA, on 04/22/2021 at 2:30 PM, revealed the resident on the MCU in common rooms, hallways and in his/her room, tearful and crying. However review of Resident #61's Progress Notes, dated 04/01/2021 through 04/30/2021, at 2:30 PM, revealed no documented evidence of a behavior (tearful, crying, irritability), interventions or outcomes.         The facility failed to implement the CCP, developed on 09/16/2020, and complete behavior monitoring documented evidence of the behavior (tearful, crying).         Interview with Activities Assistant, on 04/22/2021 at 4:10 PM, revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most         Interview with Activities Assistant, on 04/22/2021 at 4:10 PM, revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most			185301	B. WING					
LOUISVILLE, KY 40220       COUISVILLE, KY 40220       COUISVILE, KY 40220       COUIS	NAME OF PF	ROVIDER OR SUPPLIER		•			E, ZIP CODE	-	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET INFERDICENCY         F 656       Continued From page 141 "VES" was documented indicating the resident was behavior free every day and night shift.       F 656         Observations of Resident #81, by the SSA, on 04/22/2021 at 4:02 PM; 04/26/2021 at 10:40 AM and 1:55 PM; 04/28/2021 at 8:00 AM; and 04/30/2021 at 2:30 PM, revealed the resident on the MCU in common rooms, hallways and in his/her room, tearful and crying. However review of Resident #61's Progress Notes, dated 04/01/2021 through 04/30/2021, revealed no documented evidence of a behavior (tearful, crying, irritability), interventions or outcomes.       The facility failed to implement the CCP, developed on 09/16/2020, and complete behavior monitoring documentation if a behavior was exhibited, for the above dates, as evidence by review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (tearful, crying).       Interview with Activities Assistant, on 04/22/2021 at 4:10 PM, revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most	REGIS WO	OODS							
"YES" was documented indicating the resident was behavior free every day and night shift.         Observations of Resident #61, by the SSA, on 04/22/2021 at 4:02 PM; 04/26/2021 at 10:40 AM and 1:55 PM; 04/28/2021 at 8:00 AM; and 04/30/2021 at 2:30 PM, revealed the resident on the MCU in common rooms, hallways and in his/her room, tearful and crying. However review of Resident #61's Progress Notes, dated 04/01/2021 through 04/30/2021, revealed no documented evidence of a behavior (tearful, crying, irritability), interventions or outcomes.         The facility failed to implement the CCP, developed on 09/16/2020, and complete behavior monitoring documentation if a behavior was exhibited, for the above dates, as evidence by review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (tearful, crying).         Interview with Activities Assistant, on 04/22/2021 at 4:10 PM, revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTI CROSS-REFERENCE	VE ACTION SHOULD B		COMPLETION
days. However, he had not observe the resident         with crying/tearful behaviors at this time.         Continued interview revealed he used the CCP to         know how to provide appropriate care to each         resident. Further, he was not familiar with         Resident #61's CCP, and he did not know if         Resident #61's CCP specified the resident's         behavior, the resident's responses to stressors,         or listed personal centered interventions to         support the resident and reduce         expression/distress of the behaviors.         Interview with CNA #2, on 04/26/2021 at 10:45	F 656	"YES" was document was behavior free ever Observations of Resid 04/22/2021 at 4:02 Pl and 1:55 PM; 04/28/2 04/30/2021 at 2:30 Pl the MCU in common his/her room, tearful a of Resident #61's Pro 04/01/2021 through 0 documented evidence crying, irritability), inte The facility failed to in developed on 09/16/2 monitoring documenta exhibited, for the abov review of the MAR an no documented evide (tearful, crying). Interview with Activitie at 4:10 PM, revealed the MCU, Resident #6 episodes intermittent! days. However, he hav with crying/tearful beh Continued interview re know how to provide resident. Further, he Resident #61's CCP, Resident #61's CCP s behavior, the resident or listed personal cen support the resident a expression/distress or	ed indicating the resident ery day and night shift. dent #61, by the SSA, on M; 04/26/2021 at 10:40 AM 021 at 8:00 AM; and M, revealed the resident on rooms, hallways and in and crying. However review gress Notes, dated 4/30/2021, revealed no e of a behavior (tearful, erventions or outcomes. nplement the CCP, 1020, and complete behavior ation if a behavior was ve dates, as evidence by d Progress Notes, revealed nce of the behaviors es Assistant, on 04/22/2021 that since he had worked on 61 had tearful and crying y throughout the day, most ad not observe the resident haviors at this time. evealed he used the CCP to appropriate care to each was not familiar with and he did not know if specified the resident's t's responses to stressors, tered interventions to and reduce f the behaviors.	F	656				

Facility ID: 100503

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						O. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	·		
		185301	B. WING			C
	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP CO		5/22/2021
	CONDER OR SOFFLIER			4604 LOWE ROAD	JE	
REGIS WC	ODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THI DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 142	F 65	6		
		he had worked on the MCU,	1 00			
		ed all the time. Continued				
review to know		looked at the CCP as guide				
	to know what care ea	C C				
	However, she was no	ot familiar with Resident				
	#61's CCP related to	behaviors. Additionally, she				
	was did not know if R	esident #61's CCP specified				
	the resident's behavior	or, the resident's responses				
	to stressors, or listed					
		ort the resident and reduce				
	•	f the behaviors. Further,				
	-	sident #61's behavior of				
	resident cried all the	ecause everyone knew the				
		ume.				
	Interview with Register	ered Nurse (RN) #6, on				
		M, revealed she followed				
		nd the CCP when providing				
	care to residents. Pe	er interview, she expected				
	aides to report reside	nt behaviors immediately to				
	her so she could doc					
	intervene with interve					
		to ensure the resident				
	received safe, quality					
		e was familiar with Resident				
		coming tearful and crying ay. However, she was not				
		had a CCP that specified the				
	resident's specific be					
	responses to stresso					
		s to support the resident and				
		stress of the behaviors.				
	-	evealed, direct care nurses				
	were responsible to e					
		curate with changes in the				
	resident; if the CCP v	•				
		s behaviors and a behavior				
		P at that time should be				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING			05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		-
			46	04 LOWE ROAD			
REGIS WO	DODS		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	resident's behavior ex became tearful becau was not aware the res of the interview. Interview with RN #1, revealed the CCP wa ensure each resident' were met. Per intervi stated if the resident ecomplete behavior mo she would expect aid witnessed/observed a mark "Yes" on the MA free text Progress No action was. Additiona follow the CCP and pi and documentation of safety of the residents interventions were im exhibited a behavior f maintain a healthy en since she had worked cried continuously; ho of and had not docum resident on 04/28/202 revealed she was not having a behavior CC resident's specific beh responses to stressor centered interventions reduce expression/dis	r, she did not document the very time he/she cried or use it was so frequent. She sident was crying at the time on 04/28/2021 at 2:30 PM, s followed by the IDT to 's individualized care needs ew, if a CCP intervention exhibited behaviors, onitoring documentation, es to report to her if they a behaviors and she would AR and make a narrative te about what the behavior ally, it was important to rovide ongoing monitoring f resident behaviors for s and to ensure plemented when a resident for their well-being and to vironment. Per interview, d on the MCU, Resident #61 owever, she was not aware nented any behaviors for the 21. Continued interview aware of Resident #21 CP that specified the navior, the resident's 's, or listed personal s to support the resident and stress of the behaviors. D, on 04/28/2021 at 3:11 PM, e CCP to know what care a ditionally, shortly after mitted to the MCU, he/she	F 656				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPI	SURVEY LETED
		185301	B. WING		_	05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident would cry in f activities and during of resident would attemp when they became te 04/28/2021 staff had (tearful or crying), nor behaviors. Per intervi- behaviors observed of ambulation and in oth nurse because she with Interview with Agency 3:30 PM, revealed the guide she used to kno needed. Per interview behaviors to the nurse always cried and even this behavior. Further resident and distract f however, she was not CCP that specified the behaviors or approach he/she exhibited a be behaviors occurred sh today, she did not rep Resident #61 had crie because all staff knew behavior.	sis. Per interview, the the middle of a meal, during care. Additionally, the ot to go to his/her room arful. However, on not reported behaviors had she observed those iew, she did not report n this date (paced ers personal space), to the as already aware of them. CNA #19, on 04/30/2021 at e Kardex/Care Plan was a ow what care each resident w, she did not always report e because Resident #61 ryone knew the resident had r, she tried to console the nim/her to help stop crying; t aware if the resident had a e resident's specific hes to implement when havior. Further, when ne reported to the nurse; but oort to the nurse that ed on and off, all day, w the resident had this mory Care Program Director 21 at 3:00 PM, revealed she ility as a Social Worker for been the MCPD for six (6) w, she expected the CCP to isidents' behaviors and entified and specific ed to support and reduce	F 65	6			

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	MPLETED	
						С	
		185301	B. WING		0	5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP CODE			
REGIS WO	2005			4604 LOWE ROAD			
KEGIS W	5663			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 656	Continued From page	e 145	F 65	56			
		esponsibility of the direct care					
		CCP was developed to					
		aviors and to also ensure					
		ented related to behavior					
		mentation of exhibited					
	behaviors. Additiona	liness and crying all the time					
	and Resident #21's p						
,		dent's space. However, she					
	was not aware the re	-					
		Itercation or that the CCP's					
		o include the resident's					
		behaviors stressors or					
		ntions. Further, she was al IDT meetings which					
	reviewed behaviors a	0					
		e needs of the residents;					
	however, the CCP's f	or Resident #21 and					
		t been developed to include					
		its' behaviors and behavior					
		nd specific interventions					
	developed to support	The MCPD stated it was					
	important to develop						
		or and interventions to					
		nat information and to ensure					
	resident safety.						
	Interview with the Cli	nical Reimbursement					
		on 04/29/2021 at 3:00 PM,					
		bed the CCP, using the					
		IDS) Assessments, and the					
		veloped the CCP between					
		or changes in a resident's					
		aviors. Continued interview					
		d information from resident terviews and review of the					
		she was developing the					
	CCP. Per interview,					1	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	paced ambulation and space. Additionally sl #21 had been involve altercations as the ag verbal and physical be others. Continued int aware Resident #61 h tearfulness and crying resident-to-resident al behaviors directed tow CRC stated the CCP reflection of individual needs to ensure quali CCP should have bee individualized residen stressors identified an developed to support expression/distress. Interview with the in fa 05/05/2021 at 2:10 Ph have a CCP developed resident behaviors an identified and specific support and reduce et Additionally, residents care and services thro IDT per the CCP. Fun care nurses and aides implement action, and by residents consister Interview with the faci on 05/05/2021 at 4:22 facility nursing staff to CCP to include individ and behavior stressor	poing behaviors such as d intrusion of other residents ne was not aware Resident d in resident-to-resident gressor and victim or had ehaviors directed towards erview revealed she was not ad daily episodes of o r had been involved in a tercation and had verbal wards others. Further, the should be an accurate ized resident-centered care ty care and safety; and, the en developed to include ts' behaviors and behavior id specific interventions and reduce acility Physician, on <i>M</i> , revealed residents should d behavior stressors interventions developed to expression/distress. a should receive behavior ough collaboration of the ther, she expected direct is to identify, document, I report behaviors exhibited	F 656				

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			0.00			10. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDIN	G		С
		185301	B. WING		n	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		5/22/2021
				4604 LOWE ROAD		
REGIS WO	DODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	a 147	F 6	50		
1 000		or residents with behaviors.		00		
	Further interview reve					
		staff to have knowledge of				
		ors and habits and to ensure				
		ervene and implement				
		ort the residents when they				
	were exhibiting behave	VIUI5.				
	Interview with the Cer	nter Nurse Executive (CNE),				
		25 AM, revealed the MDS				
		le to develop and revise the				
		ssessment, and the direct				
	implement the CCP w	ponsible to develop and with any changes in a				
		aviors, between MDS				
	Assessments. Per in	terview, the CCP should be				
		n the same day a change in				
		was noted. The CNE stated				
		nd Resident #61 exhibited Plan should have been				
		o include individualized				
		and behavior stressors				
	identified and specific	c interventions developed to				
		expression/distress. Further				
		E revealed the CCPs should				
	•	ted to include consistent onitoring documentation				
		its exhibited and staff				
	identified behaviors, p					
	Intonviow with the Ca	nter Executive Director				
		1 at 3:25 PM, revealed the				
		onsible for developing and				
	revising the CCP with	the MDS Assessments,				
	and all nurses were re	-				
		care plan with or with				
	changes in the reside behaviors, between N	ent's condition, status, or				
	Dellaviors, Delweell I					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	behavior stressors ide interventions develop expression/distress; t to provide necessary resident. Continued i #21 and Resident #67 developed to include Further, he stated dire implemented the CCF behaviors each reside CED stated if the IDT Resident #21 and Resident #21 of interventions relate risk or prevent behavior 3. The facility admitte	resident behaviors and entified and specific ed to support and reduce his ensured staff knew how care for the individualized nterview revealed Resident 1's CCP should have been all exhibited behaviors. ect care nurses should have P and documented ent exhibited. Further, the had been informed of sident #61's ongoing ave triggered implementation d to behaviors, reduce the fors.	F	656				
	without Behaviors, Pa Weakness, Hallucinat Further review reveal on 1:1 supervision du Review of the Minimu 03/25/2021, revealed assessed for a Brief II (BIMS). Continued re exhibited no behavior Continued review of t administered to Resid seven of seven (7/7) of period. Further review active diagnoses of N and Parkinson's disea Review of progress no	m Data Set (MDS), dated Resident #86 was not nterview for Mental status eview revealed he/she s at the time of assessment. he MDS revealed the facility lent #86 antipsychotics for days during the assessment w revealed he/she had on-Alzheimer's Dementia						

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-		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF PROVIDER (	OR SUPPLIER		-		TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WOODS					604 LOWE ROAD OUISVILLE, KY 40220			
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
to get o Continu 04/22/2 was wa unable was no Review 03/27/2 behavia resistiv 2:30 Al Further AM, Re scream Review reveale behavia review though interve Reside calm/si normal Review dated 0 Carbido (25-100 Parkins Demen bedtim (15) mg	ued review of t 2021 at 3:37 Al andering the ha to be redirected of the to be bang of the 1:1 doo 2021, revealed ors such as hit re to care at 1:0 M, 3:00 AM, 3: r review reveal esident #86 exh hing/disruptive of the care plan ors of aggressi revealed the re t processes rel ntions to inclue the for come with the for mod core on a f Resident # 03/25/2021, rev opa-Levodopa 0) milligrams (r son's, Aricept the tata, Seroquel t e for mod core g for prevention ew with the Clir nator (CRC), o ed nursing staff	was unable to be redirected. he progress notes, dated M, revealed Resident #86 all and exit seeking, was ed and became agitated, and jing on the unit door. cumentation, dated Resident #86 exhibited ting, kicking, and was 00 AM, 1:30 AM, 2:00 AM, 30 AM, and 5:30 AM. ed on 04/06/2021 at 10:00 hibited behaviors such as	F	656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	to develop care plans the staff can properly Further interview rever developing a care pla Resident #86. She re aware of any behavio with Resident #85. S care plan should have unsure why it was not for doing that. Interview with the Cer on 05/11/2021 at 11:2 was responsible for d care plan using the M staff nurses were resp updating the care plan resident conditions be Continued interview re should be updated on changes were identifier revealed when Reside and resistance to care have developed a care behaviors. Interview with the CEI PM, revealed the CR0 developing the care plan for developing the care plan should have bee	e revealed it was important on identified concerns so care for the residents. ealed the IDT did not discuss n for behaviors related to evealed the IDT was not rs prior to his/her altercation he revealed Resident #86's e been developed but was t and she was responsible ther Nurse Executive (CNE), 25 PM, revealed the CRC eveloping and updating the DS Assessment, and the consible for developing and ns with any changes in etween MDS assessments. evealed the care plan the same day that the ed. Further interview ent #86 exhibited aggression a, the staff nurses should re plan addressing those D, on 05/11/2021 at 3:25 C was responsible for lan with the MDS taff nurses were responsible re plan with changes to the even MDS assessments. ealed Resident #86's care n developed to address behaviors of aggression	F 656				

Event ID: ODNZ11

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>4. Record review reverse approximately at 10:5 the hall on the Memory Resident slapped Resident slapped Resident #2 was on of at the time of the incide walking behind Resident #2' assistance.</li> <li>Review of the clinical admitted Resident #2' Memory Care Unit (Minclude Bipolar Disord Dementia, and Psych Delusions.</li> <li>Review of Physician Of through 11/21/2020, repsychiatrist prescriber twenty-five (25) milligginjection every two (2) staff to monitor reside and side effects related psychotropic medicatific Review of Resident #2' Minimum Data Set (Minimum Data Set (Minimum Data Set) assessed Resident #2' Review of Care one of and wandering that or days a week.</li> </ul>	ealed on 01/22/2021 at 6 AM, while walking down ry Care Unit (MCU), sident #3 on the face. one to one (1:1) supervision dent and Sitter #1 was ent #2. Sitter #2 stated she s hand and called for staff record revealed the facility on 08/31/2020 to the CU) with diagnoses to der, Frontotemporal otic Disorder with Drders, dated 08/31/2021 evealed the facility d Resident #2 Risperdal rams (mg) intramuscular ) weeks for Schizophrenia, ent and document behaviors ed to the administration of ions. 2's Comprehensive IDS), dated 01/09/2021, paired cognitive skills for ; a Brief Interview of Mental ot assessed. The facility 2 for behaviors to include (1) to three (3) days a week courred four (4) to six (6)	F 656				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS			604 LOWE ROAD			
			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page intervention was initia redirect resident away provide a safe distance others residents on the Observation of Reside 11:08 AM, revealed re- the common area, cla observed of both arms Interview with Sitter # PM, revealed she was history of hitting other stated before the incid not have any warning slap Resident #3. Sitt Nurse #3 educated he the Resident #2 but in him/her. She stated t directions for care pro- as safety interventions interventions could re- Interview with Register 04/23/2021 at 1:35 PN included interventions and when the care pla interfered with resider Interview with the MD 04/26/2021 at 2:05 PN CNA's utilized the car resident care. The ca-	e 152 ted on 11/21/2020 to y from residents, and staff to ce between the resident and ie unit. ent #2, on 04/14/2021 at esident sitting in a chair in pping at times, and tremors s. 1, on 04/19/2021 at 4:00 s aware Resident #2 had a residents and staff. She dent on 01/22/2021 she did Resident #2's was going to ter #1 stated Registered er to avoid walking behind histead beside or in front of he care plan provided ovided to the residents such s and failure to follow sult in an injury. ered Nurse (RN) #1, on M, revealed the care plan is to keep the resident safe an was not followed, it it safety. S Coordinator, on M, revealed the nurses and	F 656				
	the care plan. Interview with the Nur (NPE), on 04/26/2021	se Practice Educator at 2:34 PM, revealed					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05//	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	highest level of function provided individualize concern or problem id Interview with the Cerr on 04/29/2021 at 9:17 the care plan could re- the proper care. The not keep Resident #2 walking behind Reside monitoring his/her bef #1 was re-educated oo Resident #2 or redirect from Resident #2 and resident #2 or redirect from Resident #2 and resident. Interview with the Cerr (CED), on 04/30/2021 care plan identified th the clinical team could stated resident care without implementation. 5. Record review revea Resident #2 was in th hit Residents #19, #29 Resident #2 from the assessed Residents # injuries noted. The fa 1:1 supervision. Review of the clinical	n was important ensure the on for the residents and d interventions for the lentified. AM, revealed not following sult in a resident not getting CNE stated the sitter did away from others and ent #2 was not effective in naviors. She stated Sitter in 01/22/2021 to redirect of the other residents away walk beside or in front of her Executive Director at 3:12 PM, revealed the e focus or problem and how d provide the best care. He yould suffer and not receive ut proper care plan ealed on 03/09/2021, e MCU common area and 5, and #26. Staff removed area and the nurse #19, #25, and #26 with no icility placed Resident #2 on record revealed the facility on 08/31/2020 to the MCU ude Frontotemporal corder, and Psychotic	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		185301	B. WING			05	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 656	Continued From page	9 154	F	656	\$		
	through 03/09/2021, r ordered Geodon ten ( injection daily for Sch and Aricept five (5) m ordered on 02/17/202 Review of Resident # 08/31/2020, revealed 11/21/2020 that includ resident away from re- safe distance betwee residents. Review of the Progres revealed the 1:1 supe due to the absence of Review of Resident # dated 01/09/2021, rev assessed and the res severely impaired cog decision making. The #2 for behaviors to in- occurred four (4) to si rejection of care one of Review of the clinical admitted Resident #1 diagnoses to include J	2's Care Plan, initiated on an intervention initiated on ded for staff to redirect esidents, and to provide a n the resident and the other ess Notes, dated 02/24/2021, ervision was discontinued f Resident #2's behaviors. 2's Comprehensive MDS, vealed a BIMS was not ident was assessed as gnitive skills for daily e facility assessed Resident clude wandering that ix (6) days of the week and (1) to three (3) days a week.					
		•					
	Review of the Progre	ss Notes, dated 03/09/2021,					

PRINTED: 07/16/2021

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 656	revealed Resident #1 nurse assessed for in his/her arm was noted Record review reveal Resident #25 to the M diagnoses to include Alzheimer's Disease, Delusions. Review of the Progres revealed Resident #2 and smacked his/her Resident #25 on 03/0 injuries and some red arm. Review of the clinical admitted Resident #2 on 03/11/2013, with d Hemiplegia, Hemipar Visual Loss, and Aph Review of the Quarte revealed Resident #2 (3), which indicated s and no behaviors wer Observation of Reside 2:44 PM, revealed resident #2 in his/her room. Obset Interview with Certifie on 04/19/2021 at 3:02 observed Resident #2 Resident #2 did not h before the incident. C	9 was hit on the arm, the juries, and slight redness of d. ed the facility admitted MCU, on 06/27/2018, with Dementia with Behaviors, and Psychotic Disorder with ss Notes, dated 03/09/2021, walked up to Resident #25 arm. The nurse assessed 19/2021 with no serious Iness was noted to his/her record revealed the facility 6 to the Memory Care Unit, liagnoses to include esis, Vascular Dementia, asia. rly MDS, dated 02/18/2021, 6's BIMS score was three evere cognitive impairment re present. ent #2, on 04/15/2021 at sident sitting on side of bed erved 1:1 sitter at bedside. ed Nurse Assistant (CAN) #9, 2 PM, revealed she 2 walk past and hit	F 656				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
			4	604 LOWE ROAD			
REGIS WO	1003		L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page assisted staff in provid		F 656				
	Attempted to contact 05/01/2021 at 10:00 A 9:01 AM, who worked	AM and on 05/03/2021 at					
	AM, revealed the MCI residents on 03/09/20 tried to socially distan other residents as per Resident #2 was quic he/she walked past at #25, and #26. She st revised to include 1:1 Interview with the CEI PM, revealed the staff ensured the proper tre	<ul> <li>21. She stated the staff</li> <li>ce Resident #2 from the</li> <li>r his/her care plan, but</li> <li>k in his/her actions as</li> <li>nd slapped Residents #19,</li> <li>ated the care plan was</li> <li>supervision for safety.</li> <li>D, on 04/30/2021 at 3:12</li> <li>f following the care plan</li> <li>eatment of the residents.</li> </ul>					
	unpredictable. The CI discussed incidents a interventions for Resid						
	approximately 12:56 F Resident #3 on the fa hallway. Resident #2 area. The MCU nurse	was removed from the e assessed Resident #3 with cident. Resident #2 was					
		order, and Psychotic					
	Review of Resident #	2's Physician Orders, dated					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	03/10/2021, revealed Geodon ten (10) mg of needed for agitation a for Dementia. Review of Resident # 08/31/2020, revealed 03/10/2021 for 1:1 su redirect resident away redirect other resident Review of Resident # dated 01/09/2021, rev severely impaired cog decision-making. The #2 for behaviors that it to six (6) days of the v one (1) to three (3) da Record review reveale Resident #3, on 01/20 diagnoses to include 1 Disturbance and Psyc Delusions. Review of the Compre 01/27/2021, revealed score of five (5), whic impairment and physi towards others. Observed Resident #2 AM, sitting in the com on and the 1:1 sitter in Attempted to contact	orders that included daily for three (3) days as and Aricept five (5) mg daily 2's Care Plan, initiated on new interventions dated pervision and staff to y from other residents or ts away from him/her. 2's Comprehensive MDS, realed an assessment of gnitive skills in daily e facility assessed Resident ncluded wandering four (4) week and rejection of care hys of the week. ed the facility admitted 0/2021 to the MCU, with Dementia with Behavioral chotic Disorder with ehensive MDS, dated Resident #3 had a BIMS h indicated severe cognitive cal behaviors directed 2, on 04/20/2021 at 9:35 mon area with the television in the next chair.	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<b>·</b>	
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Interview with the CN AM, revealed the facili include 1:1 supervision the psychiatrist. She redirected from other he/she was not on 1:1 the incident therefore residents was not imp Interview with the CEI PM, revealed by not fir resident care suffered proper care. 7. Record review reveau approximately 4:00 PI Resident #21 on his/h were separated, the n #21, and no injuries w Review of Resident # the facility admitted re diagnoses to include I Psychotic Disorder wi Disorder. Review of Resident # revealed orders dated (10) mg daily for Dem (20) mg twice daily fo (medication to treat an mg every six (6) hours Review of Resident # 08/31/2020, revealed intervention for medic psychiatrist, encourage	E, on 04/29/2021 at 9:17 lity updated the care plan to on and the facility consulted stated Resident #1 was not residents on 03/10/2021, as 1 supervision at the time of a safe distance from other olemented. D, on 04/30/2021 at 3:12 following the care plan, d and not provided the ealed on 03/24/2021 at M, Resident #2 slapped her left arm. The residents hurse assessed Resident vere noted. 2's clinical record revealed esident on 08/31/2020 with Frontotemporal Dementia, ith Delusions and Bipolar 2's Physician Orders, d 03/10/2021 for Aricept ten hentia and Geodon twenty r anxiety, and Ativan nxiety) zero point five (0.5) s as needed for Anxiety. 2's Care Plan, initiated on on 03/12/2021 an eation review by the ge resident to return to room e or behaviors, offer resident	F	656			

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 // APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	CODE	-	
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
F 656	redirection of resident maintain a safe distar Review of Resident # Minimum Data Set, da Resident had severel daily decision-making Resident #2 for behave wandering four (4) to rejection of care one of week. Review of the clinical admitted Resident #2 diagnoses to include / Dementia without Bet Psychotic Disorder wit Disorder. Review of Resident # 10/18/2020, revealed which indicated sever able to communicate behaviors. Observation of Resident 11:08 AM, revealed re clapping, sitting, and sitter next to him/her. Interview with CNA # AM, revealed she pro Resident #2 after the to make sure he/she of Attempted to contact	t from other residents to nce. 2's Comprehensive ated 01/09/2021, revealed y impaired cognitive skills in g. The facility assessed viors that included six (6) days of the week and (1) to three (3) days of the record revealed the facility (1 on 01/01/2020 with Alzheimer's Disease, havioral Disturbance, ith Delusions, and Anxiety 2'1's Quarterly MDS, dated a BIMS score of three (3), re cognitive impairment, was with others, and revealed no ent #2, on 04/14/2021 at esident in the common area, walking around with the 15 on 04/20/2021 at 11:21 ovided 1:1 observation to incident and was instructed	F	656				
	week. Review of the clinical admitted Resident #2 diagnoses to include a Dementia without Bet Psychotic Disorder with Disorder. Review of Resident # 10/18/2020, revealed which indicated sever able to communicate behaviors. Observation of Reside 11:08 AM, revealed re clapping, sitting, and sitter next to him/her. Interview with CNA # AM, revealed she pro Resident #2 after the to make sure he/she of Attempted to contact on 04/20/2022 at 11:2	record revealed the facility 1 on 01/01/2020 with Alzheimer's Disease, havioral Disturbance, ith Delusions, and Anxiety 21's Quarterly MDS, dated a BIMS score of three (3), re cognitive impairment, was with others, and revealed no ent #2, on 04/14/2021 at esident in the common area, walking around with the 15 on 04/20/2021 at 11:21 ovided 1:1 observation to incident and was instructed did not hit anyone. the nurse assigned to MCU,						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STAT	E, ZIP CODE		-
REGIS WO	DODS				4 LOWE ROAD UISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	Interview with CNA # AM, revealed she pro Resident #2 after the to make sure Resider Interview with the CN AM, revealed the assi witness to the inciden 03/24/2021 was not a for Resident #2, but w behaviors. The sitter barrier with her body other residents. Interview with the CEI PM, revealed the care act as a barrier betwee to prevent the resident with others. 8. Observation of Res 1:48 PM, revealed res with tremors/repetitive that interfered with his There was no docume functional status char were aware of the cha was no documentatio facility Physician or th regarding the tremors Review of the clinical admitted Resident #2 diagnoses to include	15 on 04/20/2021 at 11:21 vided 1:1 observation for incident and was instructed at #2 did not hit anyone. E, on 04/29/2021 at 9:17 igned MCU nurse was not t and CNA #15 on regularly scheduled sitter vas informed of his/her was expected to provide a between Resident #2 and D, on 04/30/2021 at 3:12 e plan directed facility staff to the Resident #2 and others at from coming in contact sident #2, on 04/14/2021 at sident sitting on side of bed e movement of both arms s/her ability to feed self. entation of the tremors or nge, even though MCU staff anges. In addition, there in for notification to the the facility Psychiatrist t. record revealed the facility on 08/31/2020 with Bipolar Disorder, Psychotic ins, and Frontotemporal an Orders, dated	F 6	56				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Geodon from ten (10) the morning and forty 04/01/2021. Further for staff to monitor res behaviors and side eff medications with doct effects in the medical Review of the Medica (MAR), dated 04/14/2 documented no side of month of April. Review of the Progres revealed no document change in Resident # ability to feed self. Observation of Resident 1:48 PM, revealed rest bed with constant trent both arms. An additio 04/19/2021 at 3:28 PI with tremors of both at Interview with CNA #2 revealed Resident#2 his/her arms that inter feed self. She stated had gradually gotten of doctor were aware of Interview with RN #1, revealed she notified approximately one (1) Resident #2's arm treat tremors gradually gotten of	riodic dose increase of mg daily to sixty (60) mg in (40) mg at night ordered on order review revealed orders sident twice daily for fects related to psychotropic umentation of behaviors/side record. tion Administration Record 2021, revealed facility effects or behaviors for the ss Notes, dated April 2021, tation of arm tremors or a 2's functional status or ent #2, on 04/14/2021 at sident sitting on the side of mors/arm movements of onal observation, on M, revealed Resident #2 arms. 2, on 04/15/2021 at 8:30 AM, had developed shaking in rfered with his/her ability to the shaking of his/her arms worse and the nurse and the her concerns. on 04/23/2021 at 8:45 AM, the Medical Doctor ) week ago regarding	F	656			

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PRINTED: 07/16/2021

		D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		185301	B. WING			05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	TE, ZIP CODE		-
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>(2) weeks ago. She s resident's tremors and would notify the Psych</li> <li>Interview with CNA #2 PM, revealed she was room when RN#1 bro- into the room to have tremors.</li> <li>Interview with License on 04/20/2021 at 1:56 observed the arm trencaused by the Geodo notified the physician continue monitoring for additional symptoms. the Geodon was cause</li> <li>Interview with the com 04/22/2021 at 1:49 PI the residents side effer medications to ensure least amount of side of the progression of the effects for staff to mon- included movement d The Pharmacist state contacted her Reside tremors.</li> <li>Interview with the fact 04/21/2021 at 10:03 A aware of Resident #2 ADNS and the CNE m She stated she was m arm tremors and diffic</li> </ul>	the Psychiatrist about two stated the MA observed the d the MA informed her she hiatrist. 21, on 04/23/2021 at 1:45 s present in Resident #2's ught the psychiatrist's MA her observe the arm 22 Practical Nurse (LPN) #7, 3 PM, revealed she mors and thought it might be n. LPN #7 stated she and received instructions to or the development of LPN #7 stated she thought sing the tremors. 23 Sulting Pharmacist, on M, revealed staff monitored ects related to psychotropic the lowest effective dose, 24 ffects, and assisted with a treatment. She stated side hitor for related to Geodon isorders and over sedation. d facility staff had not nt #2's Geodon and arm	F 656				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
REGIS WO	DODS				604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	arm tremors. She sta was a symptom of EP such as tremors, slurr restless/inability to ke spasm/abnormal post dosing or unusual rea medications); she put informed the nurse to Psychiatrist. Interview with the faci 04/22/2021 at 2:44 Pf to monitor for Geodor and tremors. He state notified him of Reside his/her change in abil 04/21/2021. The Psy assessed Resident #2 dose adjustments. Interview with the CN AM, revealed MCU no Resident #2's care pla his/her arm tremors a medical provider notif symptoms. Interview with the CEI PM, revealed failing to could result in the om 9. Review of the facili Use Policy, revised 17 psychotropic medicati medication that affect and behaviors. The p utilized psychotropic ref	<ul> <li>//2021 revealed pronounced ated she thought the tremors PS (abnormal side effects red speech, muscle the ep still, and muscle there related to improper actions to antipsychotic at the medication on hold and a contact the facility</li> <li>ility Psychiatrist, on M, revealed the side effects in included symptoms of EPS ed the nursing staff had not ent #2's arm tremors or ity to feed self until trehiatrist stated he had not 2's response to the recent</li> <li>E, on 04/29/2021 at 9:17 urses had not followed an by failing to document and documentation for fications regarding</li> <li>D, on 04/29/2021 at 3:12 o implement the care planission of proper care.</li> <li>ty's Psychotropic Medication 1/28/2016, revealed</li> </ul>	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	The policy revealed m behaviors included m effectiveness, and ha Review of the clinical admitted Resident #3 with diagnoses to incl Delusions and Demen Disturbance. Review of the Medica (MAR), dated 02/01/2 revealed behavior mo documentation in the behaviors observed b Resident #3 had been Review of Resident # 02/01/2021 through 0 resident was prescrib (medication to treat D mg at bedtime (medic Disorders), and Traza daily (for treatment of review revealed an or behaviors in the nurse Review of Resident # dated 01/27/2021, rev (5), which indicated s and physical behavior The assessment reve received seven (7) da seven (7) days of anti Review of the Care P	failed to address behaviors. nedications used to treat onitoring for risks, benefit, rm or adverse effects. record revealed the facility to the MCU on 01/20/2021 ude Psychotic Disorder with ntia with Behavioral tion Administration Record 021 through 04/15/2021, unitoring every shift and nurse's notes with the y staff. The MAR revealed n free from behaviors. 3's Physician Orders, dated 4/15/2021, revealed the ed Aricept ten (10) mg daily ementia), Risperdal one (1) cation to treat Psychotic idone fifty (50) mg twice Psychosis). Further order der to monitor resident for with documentation of e's note. 3's Comprehensive MDS, vealed a BIMS score of five evere cognitive impairment rs directed towards others.	F	656				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	functional level. Observations of Resid 1:58 PM and on 04/19 resident appropriately and walking down the Attempted to interview 04/14/2021 at 1:58 Pf alert to person with co- place. Interview with RN #1, revealed the care plan individualized residen safety, interventions r as monitoring for side issues. She stated st ensure resident safety Interview with RN #6, revealed staff monitor and symptoms of EPS medication administra with RN #6, on 05/20/ it was the nurse's resp orders to monitor the side effects with a new medications. Interview with License #24, on 04/24/2021 for care plan ensured resp	ing for side effects, jes in mental status or dent #3, on 04/14/2021 at 5/2021 at 2:45 PM, revealed v dressed, well groomed, e hall with another resident. w Resident #3, on M, revealed resident was onfusion about time and on 04/23/2021 at 1:35 PM, n provided direction for it care to ensure physical related to medications such e effects, and behavior taff followed the care plan to y. on 04/22/2021 at 10:48 AM, red residents over- sedation S with antipsychotic ation. Additional interview /2021 at 10:39 AM, revealed ponsibility to initiate the resident for behaviors and w order for psychotropic	F	656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	04/22/2021 at 1:49 PM for psychotropic medi for the lowest possible response to the medic Interview with the NPI PM, revealed nurse o specific education for medications/side effec employees received to preceptor. Interview with the MD 04/26/2021 at 2:05 PM psychotropic side effec assisted the provider of the treatment. She behavior and side effec orders initiated by the Interview with the CNI AM, revealed the care was properly cared fo the care plan resulted care. She stated the entered the standing of effect monitoring to er was included on the care had access to the care during their daily mee	Assulting Pharmacist, on M, revealed staff monitored ication side effects to assess e dose and evaluate cation. E, on 05/20/2021at 10:45 wientation did not include psychotropic cts. She stated the new hat information from his/her PS Coordinator, on M, revealed monitoring for ects was in the care plan and regarding the effectiveness e stated the orders for ect monitoring were standing e staff nurses. E, on 04/29/2021 at 9:17 e plan ensured the resident or and areas not included on d in omission of resident nurses or staff on the IDT orders for behavior and side nsure staff assessed and it	F	656		IEFICIENCY)		
		ensed Practical Nurse (LPN) t 11:10 AM, revealed she						

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	-	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	witnessed Resident # She reported she rem took resident to the m reported she was info were allowed to be in family approved it. Lf happened some time revealed, Memory Ca required constant sup be allowed in the opp Observation on 04/26 Resident #12 in Resid seated faced toward f the privacy curtain. R wheelchair and Resid chair. Interview with (CNA) #13, at the tim was okay for them to Interview with Certifie 04/21/2021 at 7:20 Pl was the aggressor. F follow Resident #12, I his/her room. She als required constant sup why he/she was not of Record review reveal Resident #13 on 09/1 Dementia with behavid delusions, Transient I Hypothyroidism, Hype Review of Resident # 10/23/2020, revealed (2) out of fifteen (15) impairment. The resi	12 and #13 in bed together. noved Resident #13 and urse on duty. LPN #25 rmed that the residents bed together because the PN #25 believed this in February 2021. She also re Unit (MCU) residents vervision and should never osite sex's room. /2021 at 8:45 AM, revealed dent #13's room. They were the window partially behind esident #12 was in his/her ent #13 was seated in a Certified Nurse Assistant e of observation, revealed it be in the room. d Nurse Assistant (CNA), on M, revealed Resident #13 Resident would constantly polow kisses, tried to enter so revealed Resident #13 pervision and did not know tare planned for it. ed the facility admitted 0/2019 with diagnosis of ors, Psychotic disorder with schemic Attack (TIA), ertension, and Osteoporosis.	F	656	3		

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	E SURVEY PLETED
		185301	B. WING			C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
			4	604 LOWE ROAD		
REGIS WO	DODS		L	OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	personal hygiene. Resupervision with the p (1) staff to walk in the locomotion on/off unit resident was mobile w behaviors noted. Review of Resident # facility created a focus on 10/29/2020 where for psychosocial distra- where a male resident the lips. The resident Dementia, Major Dep Psychotic Disorder. The resident will show no distress daily thru new listed as resolved on encourage activities of room and interaction whealth/Psychiatric ser observe for signs or s distress (tearfulness, Continued review of F revealed the facility of 10/19/2020 the reside exhibit sexual express will demonstrate effect sexually inappropriate male resident, redireco The interventions creat as, will not demonstrat distress (tearfulness, evaluate need for Psy Consult, Social Service	fers, dressing, toileting, and esident #13 required obysical assistance of one room, walk in the corridor, and for eating, and the with a walker only. No 13's Care Plan revealed the s on 10/19/2020 and revised resident had the potential ess related to an incident t gave a resident a kiss on thad a diagnosis of ressive Disorder and The goal for this focus was signs of psychosocial ct review. Interventions were 10/26/2020 and included of choice, meals in dining with peers, mental vices as needed and ymptoms of psychosocial crying, etc.). Resident #13's Care Plan reated a focus area on ent had the tendency to sion. The goal was resident tive coping skills related to a behavior, giving a kiss to a at self to alternative activity. ated 10/19/2020 were listed ate any signs of psychosocial crying, irritability, etc.), vch/Behavioral Health ces visits as needed, divert ernative objects or activities,	F 656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
			4	604 LOWE ROAD			
REGIS WO	DODS		L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	as needed. Review of the resident admitted resident #12 diagnosis of Non-trau Hemorrhage, Dement Arterial Fibrillation, Hy Heart Failure, and Ad Review of Resident # (MDS), dated 10/07/2 assessed the residen (5) out of fifteen (15), impairment. The facil to need supervision a staff for bed mobility i on/off unit, and to eat staff. Additionally, the Resident for limited at assistance of one (1) room, to dress, to toile Review of Resident # resident had a focus a tendency to exhibit se cognitive loss/dement another resident a pe 10/19/2020 and revise listed for this focus wa demonstrate effective sexually inappropriate resident to alternate a review, created 10/19 10/27/2020. The inter resident will not demo psychosocial distress of feelings, provide effective	the record revealed the facility on 02/06/2020 with matic Intracerebral tia without behaviors, ypertension, Congestive justment disorder. 12's Minimum Data Set 2020, revealed the facility t with a BIMS score of five indicating severe cognitive lity assessed the Resident nd physical assist of one (1) ndependent for locomotion with set up only needed by e facility assessed the ssistance with physical staff for transfer, to walk in et, and for personal hygiene. 12's Care Plan revealed area the resident had the exual expression, related to tia, resident noted to kiss ck kiss on the lips, created ed 11/05/2020. The goal as the resident will e coping skills related to e behavior kissing another activity or location thru next //2020 and revised ventions listed were the	F 656				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		185301	B. WING			( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE	, ZIP CODE		
REGIS WO	DODS			4 LOWE ROAD UISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 656	objects or activities, licalm, and resident on 10/19/2020 and revised Interview with Reside (POA), on 04/26/2021 facility contacted him family member to hav resident. The POA refacility it was not okay still married and becar Dementia. Interview with CNA #' AM, revealed she with Resident #13 in bed to blankets and fully clot residents were not su room. Resident #12 to supervision after this revealed both resident continuous supervisio ended to ensure they Interview with Activitie 04/23/2021 at 1:50 PI keep all residents in the could be supervised. and Resident #13 tho couple. He also reveas should not be in the recomposite sex. Interview with Memor (MCPD), on 04/20/200 concerns of residents relationship was new	vert resident with alternative sten to resident and try to 1:1 supervision, created ed 11/16/2020. Int #12's Power Of Attorney at 7:20 PM, revealed the to ask if it was okay for his e a relationship with another vealed he informed the because Resident #12 was use the resident had 14, on 04/24/2021 at 9:25 hessed Resident #12 and ogether, on top of the hed. CNA #14 stated the pposed to be in each other's was placed on 1:1 incident. CNA #14 also ts should have been on n once Resident #12's 1:1 both remained safe.	F 656				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE SURVEY COMPLETED C	
		185301	B. WING	_		<i>_</i> 22/2021	
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	#13 since she had wo When MCPD was info Resident #13's room of revealed the residents resident's room and it appropriate for them t constant supervision of However, MCPD reve staff to get Resident # he/she required two (2 two (2) aides and one also revealed all of the required constant sup Interview with CNA #S revealed Resident #12 Resident #12 and tha #12 was taken off of 1 #13 continued to try to room, still tried to get revealed once 1:1 sup Resident #12, staff sh supervision of these to have kept residents in as possible. CNA #9 anything on the care p Interview with Social S 04/20/2021 at 10:10 A provide services for th residents who are cop consent for themselve who tried to have a re should be kept apart. important to keep the activities and different	orked in Memory Care. ormed Resident #12 was in on 04/26/2021, she is should not have been in a would have been more to be in the common area so could be provided. aled there were not enough #13 out of the room because 2) staff and there were only (1) nurse on the unit. She is Memory Care residents envision. 2, on 04/22/2021 at 4:00 PM, 3 always wanted to be with t did not stop after Resident 1:1 supervision. Resident 1:1 supervision. Resident 1:1 supervision. Resident 1:1 supervision. Resident 1:1 supervision. Resident 1:1 supervision. Staff should in Resident #12's bed. She pervision was stopped for nould have continued closer wo residents. Staff should in the common area as much revealed she did not recall plan about supervision. Service Director (SSD), on AM, revealed she did not he MCU. She did state gnitively impaired could not es and any resident in MCU elationship with another She revealed it would be m on different sides at t ends of the hall for rooms. e care plan should have	F 656				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	05/04/2021 at 3:45 PI and Resident #13 were could not decide anyt also revealed she exp common area as muce required lots of directi CNE also reported ch Care Plan to remover behaviors because she to be monitored. How additional intervention continued supervision Interview with Center on 05/04/2021 at 3:45 Care residents shared concerns because on have related it to a fair revealed the facility is residents. The CED r comfortable with any "having a relationship part of prevention. Review of the IJ Rem facility implemented th 1. On 05/17/2021, the (CED), and Center No notified the Medical D An ad Hoc Quality As: Improvement Commit conducted with the CI Director at this time for developing the action reeducation, and com-	Nurse Executive (CNE), on M, revealed Resident #12 re cognitively impaired and hing for themselves. She bected residents to be in the chas possible because they ion and supervision. The anges were not made to the sexually inappropriate he still wanted the residents wever, there were no his developed to account for h of these two residents. Executive Director (CED), 5 PM, revealed if Memory d a kiss there would be e of the residents could mily relationship. He responsible to protect revealed he did not feel resident in the MCU, " and supervision was a big oval Plan revealed the he following: e Center Executive Director urse Executive (CNE), birector of the alleged event. surance Performance ttee (QAPI) meeting was ED, CNE, and Medical or recommendations plan including audits, apliance monitors for	F 656				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 1 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
REGIS WO	ODS			4604 LOWE ROAD			
				LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>(RN) to include the spintrusion of other residents rooms updated to support the expression/distress of including physical berresident's personal spyelling at another resident's personal spyelling at another resident, and wanderir rooms.</li> <li>3. On or before 05/19, plan was updated by a safe distance from oth supervision, removing situation, and for staff from other residents.</li> <li>4. On or before 05/19, reassessed by a RN f documentation was up behaviors that was explanation and councentation was up behaviors that were explained by a safe distance from other residents.</li> <li>5. On or before 05/19, reassessed for behav physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a documentation was up behaviors that were explained by a safe discussed the resident physical aggression a</li></ul>	ed by a Registered Nurse pecific physical behavior, dent's personal space, elling at another resident, ent, and wandering into a and the interventions were e residents to reduce f the behaviors identified, havior, intrusion of other bace, pacing the hallway, dent, shoving another ng into other resident's /2021, Resident #2's care an RN to include providing a her residents, one on one g the resident from the to provide a safe distance /2021, Resident #61 was for behaviors and pdated to reflect any chibited, including crying. /2021, Resident #86 was iors by a RN including ind resistance to care and pdated to reflect any xhibited. The IDT tt's behaviors including ind resistance to care and a	F 656		DEFICIENCY)		
	<ul><li>including physical age care.</li><li>6. On or before 05/19.</li></ul>	ented for his/her behaviors gression and resistance to /2021, the Social Services I Worker, Center Nurse					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			46	604 LOWE ROAD			
REGIS WC	JODS		L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page Executive (CNE), Ass Services (ADNS), Uni Practice Educator (NF (LN) would conduct a plans presenting with of frustration, agitation physical or verbal ber toward others to deter developed with specifi implemented address corrective action upor 7. The Clinical Quality education to the CNE facility must develop a centered plan of care residents with behavior the care plan must into to prevent/minimize the supervision needs of reeducation included monitoring of the care interventions to meet resident. A post-test re-educated by CNE, Supervisors, and/or C facility must developm person centered plan include residents with others, the care plan include the super The reeducation included monitoring of the care	e 174 istant Director of Nursing it Manager (UM), Nurse PE), and or Licensed Nurses n audit of resident's care behaviors to include signs n, and anger such as havioral symptoms directed rmine care plans were ic interventions and ing the behavior with n discovery. / Specialist (CQS) provided regarding the policy that the and implement a person for all residents to include ors directed toward others, clude specific interventions he behavior, and include the the resident. The the need for ongoing e plans and updating the specific needs of the will be given at the time of te understanding. Licensed Staff will be ADON, UMs, Nurse charge Nurses regarding the nent and implement a of care for all residents to behaviors directed toward must include specific nt/minimize the behavior, vision needs of the resident. ded the need for ongoing e plans and updating	F 656				
	interventions to preve and include the super The reeducation inclu monitoring of the care interventions to meet	nt/minimize the behavior, vision needs of the resident. ded the need for ongoing					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE : COMPI	ETED
		185301	B. WING		-	05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		-
			46	04 LOWE ROAD			
REGIS WO	DODS		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	passing score of 100% available during this ti staff will be provided in test by the Nurse Sup CNE upon day of retur including agency staff and a posttest during NPE, Supervisors, or 9. The Center Nurse I Director of Nursing, U Supervisors, Social W Nurse) would conduct newly identified behavior plan was developed a the specific behavior of including weekends, t times (2) weeks, then weeks, then biweekly monthly times (1) mor by the QAPI committee concern corrected upor ADON, UM, Nurse Su Nurses. 10. The Social Worke Nursing Services and (CNE) would report the immediate jeopardy w Assurance Performant which consisted of the Center Nurse Executi Nursing Services, Me Service Director, Diniti Dietitian, Health Inforn Office Manager, Ther Maintenance Director	te understanding with a %. Licensed Staff not ime frame to include agency re-education including post- vervisors, NPE, UMs, and/or rn to work. New hires will be provided education orientation by the CNE, UMs. Executive, Assistant nit Managers, Nurse /orker and/or LN (Licensed t audits of residents with viors to determine a care and implemented to address daily times two (2) weeks hen three (3) times a week weekly times eight (8) times (2) months, then th and then as determined ew with areas identified as a on discovery by CNE, upervisors, or Charge r, Assistant Director of /or Center Nurse Executive ue findings daily until the vas removed to the Quality ice Improvement Committee e Center Executive Director, ve, Assistant Director of dical Director, Social	F 656				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	and then ongoing their QAPI committee. The State Survey Age implementation of the 1. Review of the 05/1 Performance Improver revealed it was signed Medical Director, who review, a plan related deficiencies was discu- linterview with the Mer 5:30 PM, revealed the him by phone with bo The director revealed immediate AD-HOC O information, formulate audits for compliance facility updated him /o education, audits, and warranted after review director revealed the o abated jeopardies aud (6) months, longer if v 2. Review of Resider 05/14/2021, 05/17/20 Social Services (SS) a revealed the resident safe distance between Additionally, his/her c noise or close proxim aggression. 3. Review of Resider	until the issue is resolved reafter as determined by the ency validated the facility's IJ Plan as follows: 7/2021, Quality Assurance ement (QAPI) sign-in sheet d by the CED, CNE, and o met over the phone. Per to the additional ussed. dical Director, 05/22/2021 at e facility immediately notified th notations of jeopardies. the facility held an QAPI to discuss the e education to staff, and . The director revealed the faily on the progress of d any changes which were v of the information. The committee will review all dits monthly for at least six varranted. ht #12's care plan, revised 21, and 05/18/2021 by #1, SS #2, and UM/RN #8, was care planned to have a	F 656				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	<ol> <li>Review of Resider on 05/17/2021 by UM SS#1, revealed the re- was updated to includ being tearful with inte- the resident by giving activities and provide</li> <li>Review of Residem revised 05/15/2021 by resident's care plan w physical behaviors and interventions to includ periods, playing cour- one-to-one activities.</li> <li>Per review of the B dated 05/18/2021 and the residents were re- plan updates. Furthe plans were completed and Registered Nurse Interview with RN #8, revealed she updated plans. Per interview, completed by reviewin progress notes and sp</li> <li>Review of the CNE 05/15/2021, revealed care plan process, the assessment, physicia process, and the resident</li> </ol>	th increased supervision. In #61's care plan, revised I/RN #8 and 05/18/2021 by esident's behavior care plan de residents behavior of rventions to include diverting alternative objects or a calm well-lit environment. It #86's Behavior Care Plan, y the CNE, revealed the vas revised to include the daggression with de to have increased rest try music, and to provide Behavior Care Plan sheet, d 05/19/2021, revealed all of viewed for behavior care r review revealed the care d by the CNE, ADNS, NPE, e (RN) #8. on 05/21/2021 at 3:30 PM, d many of the residents' care she revealed this was ng the audits, residents peak with staff. E's posttest, dated education consisted of the e interact tools, nursing n notification, care delivery dent's care path review. ed the CNE passed with	F	656			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185301	B. WING _				C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	provided the education she informed the CNE admitted with behavior resident has a care pl stated she went over with effective intervent CQS stated this would interventions that were residents behavior be stated she gave the CC CNE passed. Interview with the CNI PM, revealed she was related to the resident interview, she stated se resident's care plans a 8. Interviews with Lice #14 at 1:55 PM, LPN approximately 1:59 PH (RN) #1, on 05/21/202 05/21/2021 at 2:05 PH 05/22/2021 at 5:57 PF educated on how to d residents care plans r behaviors. Continued were provided a postt Interview with the CNI PM, revealed education process and was prov- employee returned to revealed staff sign-in	ical Quality Specialist at 3:06 PM revealed she in to the CNE. She stated if that if a resident was rs, staff should ensure the an in place. She further the process of coming up tions for the resident. The d come by asking staff what e used that made the tter or worse. She further NE a post-test, which the E, on 05/22/2021 at 6:30 is educated by the CQS is behavior care plans. Per she took a test related and passed the test. ensed Practical Nurse (LPN) #22, on 05/21/2021 at M, and Registered Nurse 21 at 2:00 PM, RN #16, on M, and LPN #29, on M, revealed they were evelop and implement the elated to the residents 1 interview revealed they est and passed. E, on 05/22/2021 at 3:00 ng staff was an ongoing rided the first day the work. Record review	F	56			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 07/16/2021 ORM APPROVED 3 NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, Z	IP CODE	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE	(X5) COMPLETION DATE
F 656	<ul> <li>9. Review of the F656 column for the resider "review of the progress presenting with behaviors in the clinic determine the need for services", a column wheeded, has referral to which stated conduct plans to determine the and was up to date in column which stated, plans for new behavior column which stated, Including specific behaviors and/or preservicewing the resident interview, she stated to daily.</li> <li>10. Interview with the PM, revealed she has progress notes to enswere captured for any updates.</li> <li>Interview with the CN PM, revealed she rep audits with the CED of revealed that identifier to the QAPI meeting view of progress related to a stated no other concerns</li> </ul>	6 Audit Tool revealed a nts' name, a column for ss notes of residents viors, including abusive cal morning meeting to or behavioral health vhich stated, "If service is been made?" a column audits of behavioral care e plan of care was followed	F 656			

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STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	O. 0938-039	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		185301	B. WING		0	C 5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	•		
REGIS W	DODS			LOWE ROAD JISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 656	1.5	e 180	F 656				
	jeopardy. Care Plan Timing and CFR(s): 483.21(b)(2)		F 657				
	<ul> <li>be-</li> <li>(i) Developed within T</li> <li>the comprehensive a</li> <li>(ii) Prepared by an inincludes but is not liminal of the attending physical of the standard physical of the stand</li></ul>	orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the					

Facility ID: 100503

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				4	604 LOWE ROAD			
REGIS WC	1005			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	181	F	657				
	<ul> <li>by:</li> <li>Based on observation review of the facility's Centers for Medicare (CMS), "Resident Ass Manual 3.0," it was de to have an effective sy residents' care plans by the interdisciplinant assessment for four (4 sampled residents (R #52 and #85).</li> <li>1. Observation on 04 4:10 PM, revealed Re medications that were to include blood press antihistamine, anticon and pain medications revealed the resident unlabeled in a cup that resident. These medi- medications for urinant prostate and hair loss nerve pain medications revealed the resident unlabeled in a cup that resident. These medi- medications, fluid reter antibiotic. Interviews resident had an histor rummaging through o However, per review of Comprehensive Care</li> </ul>	were reviewed and revised / team after each 4) of eight-seven (87) esidents #31, #45, /30/2021 at approximately sident #31 had a cup of e labeled with his/her name sure medications, vulsive antidepressants, a. Further observation had medications that were th were not prescribed to the cations included y retention, enlarged , an antidepressant and us, antihypertensive ention medications, and an with staff revealed the y of hoarding and ther residents' property.						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	9 182	F 657				
	related to Resident #8 with a television moni #85's Comprehensive facility failed to update altercation with Resid 3. Closed record revie and Resident #52 we of the Memory Care U at approximately 12:5 #52 grabbed each oth Resident #45 had a b forearm. Continued re failed to update Resid after their resident-to- Immediate Jeopardy v and was determined to Immediate Jeopardy v 42 CFR 483.21 Comp Centered Care Plans, and Revision at a sco "J". The facility's failu system in place to en- reviewed and revised cause serious injury, to a resident. The faci Immediate Jeopardy v The facility provided a Allegation of Complia alleging removal of th 05/20/2021. The Stat determined the Imme removed 05/20/2021,	ew revealed Resident #45 re ambulating in the hallway Unit (MCU), on 03/18/2020 0 PM. Resident #45 and her's arms, subsequently ruise on his/her right eview revealed the facility lent #45 and #52's care plan resident altercation. was identified on 05/14/2021 to exist on 04/22/2021. was identified in the area at orehensive Resident , F-657 Care Plan Timing pe and severity (S/S) of a ure to have an effective sure care plans were has caused or is likely to harm, impairment or death ility was notified of the (IJ) on 05/14/2021. an acceptable credible nce (AoC) on 05/20/2021 e Immediate Jeopardy on te Survey Agency diate Jeopardy had been as alleged, prior to exit on					
	"J". The facility's failu system in place to en- reviewed and revised cause serious injury, to a resident. The faci Immediate Jeopardy of The facility provided a Allegation of Complia alleging removal of th 05/20/2021. The Stat determined the Imme removed 05/20/2021, 05/22/2021, with rema	The to have an effective sure care plans were has caused or is likely to harm, impairment or death ility was notified of the (IJ) on 05/14/2021. An acceptable credible nce (AoC) on 05/20/2021 e Immediate Jeopardy on te Survey Agency diate Jeopardy had been					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			(X3) DATE : COMPI	SURVEY _ETED
	185301	B. WING			05/2	; 22/2021
NAME OF PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WOODS			4 LOWE ROAD UISVILLE, KY 40220			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
and the facility's Qual to ensure compliance The findings include: Review of the facility's Care Plan" Policy, dat that care plans will be the interdisciplinary te including both the com review assessments, response to care and Review of the Centers Services, "Resident A Manual 3.0", dated O care plan must be rev periodically, and the s arranged should be co resident's written plan of the manual, reveale not only by identified of conditions, but also by characteristics, streng Furthermore, a care p assessment and effec making, was compatit clinical practice that p optimal approaches to of life needs of individ stated a well developed assessment and care resident's status at pr annually, or if a signifi	ents a Plan of Correction ity Assurance (QA) monitors with systemic changes.	F 657				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	IG	COMPLETED
		185301	B. WING		C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET HE APPROPRIATE DATE
F 657	05/10/2013 with diagr Dementia without be Alzheimer's, Adjustma mood, Psychotic diso Insomnia. Observation on 04/30 4:10 PM, revealed Re have his/her medication of the medication cup resident's name writte others were observed the cups, without a re cups. Resident #31 a Agency (SSA Survey which medications to the Center Nurse Exe Observation on 04/30 the Center Nurse Exe Survey Agency (SSA) #31's room. The CNE to show the pills the r surveyor. Further obs twenty-two (22) medic an unlocked drawer of room. Some of these Resident #31's name contained a total of the assorted medications (37.5) pills were comp	t #31's clinical record dmitted Resident #31 on noses that included havioral disturbance, ent disorder with Depressed order with delusions, and 0/2021, at approximately esident #31 was observed to ions in several cups. Many as were observed to have the en on them. However, d to have medications within esident's name noted on the asked the State Survey or) to "help" him/her decide take. The Surveyor notified ecutive (CNE). 0/2021 at 4:15 PM, revealed ecutive (CNE) and State ) Surveyor entered Resident E then asked Resident #31 esident had shown the servation revealed cation cups were found in of a cabinet in the resident's e cups were labeled with . Four (4) of the cups hirty-seven and a half (37.5) a. The thirty-seven and a half pared to Resident 31's by Registered Nurse #13 and	F 6	57	
	were found included:	evealed the medications that three (3) Eliquis 5 mg Effexor 37.5 mg- (which			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	was an anti-depressa mg- (which was an ar Metoprolol ER 25 mg- Hypertension), two (2 pain), one (1) Lamotri anti-convulsant), and Resident 31's pills. Th later identified to be: t anti-depressant), two sedative and hyperter (an antacid), one (1) G anticholinergic), one (1) anticholinergic), one (1) F retention medication of prostate and hair loss Amitriptyline 5 mg- (a for nerve pain), one E medication ) Hydroch antihypertensive and one (1) Ciprofloxacin Review of Resident # Plan, revealed that or initiated that stated th inappropriate behavior rummaging related to silverware/medication included: to learn the hoarding and observer return items/belonging However, further revie and the interventions 11/02/2020. Continue plan was not reviewer focus statements or in	<ul> <li>nt), nine (9) Hydroxyzine 25</li> <li>ntihistamine)-, four (4)</li> <li>-( a beta blocker for</li> <li>b) Tylenol ES-( used for</li> <li>igine 25 mg- (an</li> <li>eleven (11) that were not</li> <li>ne eleven (11) pills were</li> <li>two (2) Mirtazapine- (an</li> <li>(2) Clonidine 0.1 mg- (a</li> <li>nsive), one (1) Famotidine-</li> <li>Glycopyrrolate 1 mg-(an</li> <li>(1) Griseofulvin- (an</li> <li>inasteride 5 mg-(an urinary</li> <li>used to treat enlarged</li> <li>a in men), one (1)</li> <li>n antidepressant and used</li> <li>(an unidentified</li> <li>lorothiazide 20 mg - (an</li> <li>used for fluid retention), and</li> <li>125 mg- (an antibiotic).</li> <li>31's Comprehensive Care</li> <li>n 07/07/2014, a focus was</li> <li>e resident exhibited</li> <li>ors of hoarding and</li> <li>the resident's hoarding</li> <li>ms/washcloths. Interventions</li> <li>resident's room daily and</li> <li>gs to other residents.</li> <li>ew revealed both, the focus</li> <li>were resolved on</li> <li>ed review revealed the care</li> <li>d and revised to add new</li> <li>nerventions related to</li> <li>tions, until the care plan</li> </ul>	F	657				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	(CMT), on 05/04/2021 worked at the facility f was familiar with Reside Per interview, she had because they would g soon as she turned he always made sure hele pills on top. The CMT her residents take the swallowed them. She refused the medicatio cart. The CMT stated medications at bedsid Interview with LPN #1 PM, revealed that Resident things). LPN #14 stat Resident #31 rummag station looking for thin resident's ex-roomma because the resident roommate's drawers a belongings. LPN #14 resident's behaviors to said she always watch his/her pills and she h medications at the be Interview with the Clin (CRC), on 05/12/2021 was responsible for re residents' care plans. familiar with Resident resident had a care pl and "hoarding" silvery	d Medication Technician at 8:39 AM, revealed she for over three (3) years and dent #31 as she had ent for the last few years. d residents she had to watch the in medication carts as er back. She stated she r cart was locked with no stated she always watched ir pills and made sure they stated if the resident n, she would return it to the she would not leave any for any reason. 4, on 05/06/2021 at 3:35 sident #31 had behaviors of (irresistible urge to take ed she has witnessed ge through the nursing togs like Kerlix. She said the te cursed at Resident #31 was going through the and other personal stated she would expect to be on the care plan. She hed Resident #31 take tad never left the resident's dside. incal Record Coordinator 1 at 10:26 AM, revealed she evising and updating the Per interview, she was #31 and revealed the an related to "rummaging"	F 65	;7			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 07/16/2021 RM APPROVED IO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185301	B. WING		o	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 657	care plan was "care p "resolved", as it was r resident. Continued i revealed the care plan to reflect the continue and an intervention to (his/her)" pills due to f 'cheeking" (placing m mouth without swallow Interview with the Cer on 05/12/2021 at 06:0 should have been an about watching Resid his/her hoarding pills his/her cheeks and sp Further interview reve taken the medications sick. She said she wa having a history of run nursing station drawe 2. Review of the clinic facility admitted Resid diagnoses to include 3 Weakness, Bed Conff Mobility. Review of the MDS, of Resident #85 was ass three (3) which indica cognitively impaired. O Resident #85 had no assessed that Reside and as needed pain in the assessment the re	rventions of the resident's lanned", but had been to longer a concern for the interview with the CRC in should have been updated d concern of the resident observe the resident "take the resident's history of edication to the side of wing) his/her medications. Ther Nurse Executive (CNE), 00 PM, revealed that there intervention in the care plan ent #31 take pills related to and putting medications in bitting them back out. ealed if Resident #31 had s, he/she could have gotten is not aware of resident mmaging through the rs either. cal record revealed the lent #85 on 01/24/2020 with Schizophrenia, Muscle inement, and Reduced lated 04/22/2021, revealed sessed to have a BIMS of ted the resident was Continued review revealed mood concerns and was not	F 657			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		-	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	have any skin issues Additionally, Resident antipsychotic for seve Review of the resident Resident #85 exhibite demonstrate verbal b diagnosis of Schizoph used to being in a roc over stimulated easily included approach in behavior monitoring, of trigger of the behavior Review of the Risk M Event Summary Repo 10:30 PM, revealed R agitated related to Re hit him/her with a sma Continued review reve at the time of the alter Review of Resident # 01/25/2020, revealed his/her care plan after Resident #86 on 04/2 3. Review of Resident with 03/03/2011, with diag Alzheimer's Late Ons Psychotic Disorder wit Communication Defic Disorder, Anxiety, De Disturbances and Uns Review of the Minimu 02/17/2020, revealed	at the time of assessment. t #85 was administered an en (7) of seven (7) days. At's care plan revealed ed or had the potential to ehaviors related to his/her menia. Resident #85 was om alone; would become ty; and yell out. Interventions a calm manner, complete observe the nature and rs, and explain all care. anagement System (RMS) ort, dated 04/22/2021 at Resident #86 became esident #85 yelling out and all television monitor. ealed no injuries were noted rcation 85's care plan, dated the facility failed to revise r the altercation with 2/2021. t #52's Face Sheet revealed im/her to the MCU, on noses that included et, Lack of Coordination, ith Delusions, Cognitive it, Major Depressive mentia with Behavior specified Psychosis. Im Data Set (MDS), dated	F 657				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	<ul> <li>which indicated the recognitively impaired. If revealed Resident #5 identified.</li> <li>Review of Resident # 06/03/2019, revealed of negative behaviors aggression with staff/ and delusional type b revealed interventions in the revealed interventions and resp supervision when in the review revealed the factare plan after the ph Resident #45.</li> <li>4. Review of Resident # 12/18/2019, with diag Dementia with Behav</li> <li>Review of the MDS, or Resident #45 had a B of fifteen (15) which in moderately cognitively the MDs revealed Resident # 12/18/2019, reveal</li></ul>	e (3) out of fifteen (15) esident was severely Further review of the MDS 2 had no behaviors 52's care plan, dated Resident #52 has a history , including physical peers, depression, anxiety ehaviors. Continued review s for staff included : allow gs, approach in a calm unmet needs, document conses, and increase he common area. Further acility failed to update the ysical altercation with t #45's Face Sheet revealed im/her to the MCU, on noses that included iors. dated 12/24/2019, revealed BIMS' score of eight (8) out ndicated the resident was, y impaired. Further review of sident #45 had no behaviors	F	657			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	physical altercation, rewith Resident #52. Interview with the Clir Coordinator (CRC), o revealed nursing staff through the computer any nurse can update She stated it was imp plans when the reside ensure staff were pro- them. Continued inter plans for Resident #4 Resident #85 should I their altercations with interview revealed she plans were not update her responsibility. Interview with the Cer on 05/11/2021 at 11:2 CRC's responsibility t with the staff nurses. revealed the care plan new changes to the re review revealed Resid Resident #85's care p revised after their alte were providing the co stated if the care plan residents potentially v care. Interview with the Cer (CED), on 05/11/2021 CRC was responsible along with the staff nurse	e the care plan after the esulting in a small bruise, nical Reimbursement n 05/12/2021 at 4:21 PM, thad access to the care plan system at all times, and the care plan as needed. ortant to update the care ent's condition changed to viding the best care for view revealed the care 5, Resident #52, and have been updated after other residents. Further e was not sure why the care ed but it would have been ther Nurse Executive (CNE), t5 PM, revealed it was the o revise the care plan along	F 657				

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	Resident #45, Reside care plans to be upda altercations to ensure appropriate care. Review of the IJ Rem facility implemented th 1. On 04/30/2021, Re by a license nurse wit physician was notified Resident #31's room. to crush the resident' able to be crushed an medications administe and verify that medicat Additionally, the medi #31's room were dest discovery by the CNE 2. On or before 05/19, plan was updated by a behaviors of hoarding cups, washcloths and resident rooms and be were added to the car injury, serious harm, a death. 3. On or before 05/19 Director (SSD), Socia Executive (CNE), Ass Services (ADNS), Uni Practice Educator (NF (LN) will conduct an a care plans with identifi and rummaging to de	<ul> <li>ant #52, and Resident #85's ited after their physical estaff were providing</li> <li>oval Plan revealed the he following:</li> <li>esident #31 was assessed the no issues noted. The d of the medications found in New orders were received is medications that were ind non-crushable ered whole in apple sauce ations were swallowed.</li> <li>cations found in Resident royed immediately upon it.</li> <li>/2021, Resident #31's care a RN to reflect inappropriate it silverware, medication for unmaging through other elongings. Interventions re plan to prevent serious and serious impairment or</li> <li>D/2021, the Social Services if Worker, Center Nurse isstant Director of Nursing it Manager(UM), Nurse PE) and or Licensed Nurses indit of all other residents' fied behaviors of hoarding etermine interventions were sist the behavior. Corrective</li> </ul>	F 657				

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	G		
		185301	B. WING			С
	ROVIDER OR SUPPLIER	103301		STREET ADDRESS, CITY, STATE, ZIP COD		5/22/2021
INAIVIE OF P	ROVIDER OR SUPPLIER			4604 LOWE ROAD	=	
REGIS WO	DODS			LOUISVILLE, KY 40220		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO
F 657	Continued From page	192	F 6	57		
	4. The Clinical Qualit					
		regarding the revision of				
	residents care plans to include residents with					
		ppropriate interventions to				
	address the behavior					
	hoarding. A post test	was given at the time of				
	re-education.					
	5 On or before 05/19	/2021, all licensed nursing				
		d by the Center Nurse				
		Director of Nursing, Unit				
	Managers, LN, and o					
	regarding the revisior	n of residents care plans to				
	include residents with	C C				
	appropriate interventi					
		ing and hoarding. A post-				
		time of re-education with a % required to validate				
		nsed Staff not available				
		e including agency staff will				
		ucation/education including				
	post-test upon returni	ing to work or during the				
		Center Nurse Executive,				
		Nursing, Unit Managers,				
	Charge Nurses and c	or nurse supervisors.				
	6. The Center Nurse	Executive, Assistant				
	Director of Nursing, L					
		orker, and or charge nurses				
		ten (10) behavioral care				
		plans for hoarding and				
		nine the plan of care is				
		date including revisions with viors, daily time two (2)				
	-	kends, then three (3) times a				
		eeks, then weekly times				
		biweekly times two (2)				
		times one (1) month and				
		y the QAPI committee with				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
			40	604 LOWE ROAD			
REGIS WC	DODS		L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 657	discovery by CNE, AE supervisors, or charge 7. The SW, ADNS ar review findings daily u was removed to the G Performance Improve consists of the Center Nurse Executive, Ass Services, Medical Dim Director, Dining Servi Information Manager, Therapy Program Dire Activity Director and G any additional follow u the issue was resolve thereafter as determin The State Survey Age implementation of the The facility provided a Allegation of Complia that alleged removal of (IJ) on 05/20/2021. R the facility implementation 1. On 04/30/2021, Re a license nurse with n physician was notified Resident #31's room. to crush the resident's to be crushed; non-cr administered whole in that medications were the medications found	addor concern corrected upon DON, UM, nurse e nurses. addor CNE will report the until the immediate jeopardy quality Assurance ment Committee which Executive Director, Center istant Director of Nursing ector, Social Service ce Director, Dietitian, Health Business Office Manager, ector, Maintenance Director, Certified Nursing Aides for up and/or in servicing until d and then ongoing hed by the QAPI committee. ancy validated the facility's AOC as follows: an acceptable credible nee (AoC) on 05/20/2021 of the Immediate Jeopardy leview of the AoC revealed ed the following. sident #31 was assessed by o issues noted. The of the medications found in New orders were received a medications that were able ushable medications applesauce; and, verify a swallowed. Additionally, I in Resident #31's room	F 657	DEFICIEN	JCY)		
	that medications were the medications found	swallowed. Additionally,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185301	B. WING				C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	2 194	F	657			
	plan was updated by behaviors of hoarding cups, washcloths and residents' rooms and were added to the car injury, serious harm, a death. 3. On or before 05/19 Director (SSD), Socia Executive (CNE), Ass	9/2021, Resident #31's care a RN to reflect inappropriate silverware, medication rummaging through other belongings. Interventions re plan to prevent serious and serious impairment or 9/2021, the Social Services I Worker, Center Nurse sistant Director of Nursing it Manager (UM), Nurse					
	(LN) will conduct an a care plans with identiand rummaging to de	PE) and or Licensed Nurses audit of all other residents' fied behaviors of hoarding termine if interventions were s the behavior. Corrective red upon discovery.					
	residents' care plans behaviors including a address the behaviors	regarding the revision of to include residents with ppropriate interventions to s of rummaging and was given at the time of assing score of 100%					
	staff were re-educate Executive, Assistant I Managers, LN, and or regarding the revision include residents with appropriate interventi behaviors of rummag	of resident's care plans to behaviors including ons to address the					

Facility ID: 100503

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PRINTED: 07/16/2021

						IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY	
			7			С	
		185301	B. WING		0	5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD			
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 657	Continued From page	e 195	F 65	7			
		of 100% required to validate	1 00				
		nsed Staff not available					
		e, including agency staff will					
	-	ucation/education including					
posttest upon returning to work or during the orientation period by the Center Nurse Executive,							
	Assistant Director of Nursing, Unit Managers,						
	Charge Nurses and c						
	6. The Center Nurse	Executive, Assistant					
	Director of Nursing, L	-					
	-	orker, and or charge nurses					
		ten (10) behavioral care plans for hoarding and					
		nine, if the plan of care was					
		ate including revisions with					
		viors, daily time two (2)					
		kends, then three (3) times a					
		eeks, then weekly times biweekly times two (2)					
		/ times one (1) month and					
	-	y the QAPI committee with					
		concern corrected upon					
	discovery by CNE, A supervisors, or charg						
	7. The SW, ADNS a	nd/or CNE will report the					
		until the immediate jeopardy					
	was removed to the (						
		ement Committee which r Executive Director, Center					
		sistant Director of Nursing					
	Services, Medical Dir	•					
	-	ice Director, Dietitian, Health					
	-	, Business Office Manager,					
		ector, Maintenance Director, Certified Nursing Aides for					
	-	up and/or in servicing until					
	the issue was resolve						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	The State Survey Age	ned by the QAPI committee.	F	657				
	05/22/2021 at 12:15 F medication in the sha soon as she complete Interview with Registe 05/21/2021 at 5:00 Pl	ered Nurse #13 on, M, revealed she assessed -toe including vitals and						
	came to the facility ar on 04/30/2021 at 6:32 Hospice Physician on revealed that she was with Resident #31. R there was a physician Chief Medical Officer	evealed that a Hospice nurse ad assessed Resident #31, 2 PM. Interview with the b, 05/10/2021 at 10:45 AM, a made aware of the incident ecord review revealed that 's order from the Hospice to crush the resident's a able to be crushed and medications whole in						
	Resident #31's care p Registered Nurse (RN behaviors of hoarding cups, washcloths and residents' rooms and were added to the car	ealed that on 05/15/2021, blan was updated by N) #8 to reflect inappropriate g silverware, medication rummaging through other belongings. Interventions re plan to prevent serious and serious impairment or						
		ealed that starting on ere done of all the residents' fied behaviors of hoarding						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4604 LOWE ROAD			
REGIS WO	DODS			LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	<ul> <li>were appropriate to a was conducted by the (SSD), Social Worker (CNE), Assistant Dire (ADNS), Unit Manage Educator (NPE) and c Corrective action was</li> <li>4. Interview with the C (CQS), on 05/22/2021 provided education to regarding the revision to include residents w appropriate intervention behaviors of rummaging Review of the posttess provided education to policy for the develop a person centered calinclude residents with others, specific intervention the resident with a pounderstanding. Reco posttest for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the CNE w passing score.</li> <li>5. Review of the post for the post for the the post for the the post for the the post for the post for the the post for th</li></ul>	termine if the interventions ddress the behavior. This e Social Services Director , Center Nurse Executive ctor of Nursing Services er (UM), Nurse Practice or Licensed Nurses (LN). completed upon discovery. Clinical Quality Specialist 1 at 11:25 PM, revealed she the Center Nurse Executive of the residents' care plans ith behaviors including ons to address the ing and hoarding. t revealed the CQS the CNE regarding the ment and implementation of re plan for all residents to behaviors directed towards entions to prevent/minimize ude the supervision needs of sttest to validate rd review revealed a was one-hundred (100%)	F 65	7			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185301	B. WING					C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZI	IP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI		(X5) COMPLETION DATE
F 657	<ul> <li>#14 at 1:55 PM, LPN approximately 1:59 PI (RN) #1 on 05/21/202</li> <li>05/21/2021 at 2:05 PI 05/22/2021 at 5:57 PI education that included implementation of the and included those will included those will included those will revealed education with the CN PM, revealed education process and was provemployee returned to revealed staff sign in education with postter percent (100%) passi seventy-four (74) staff</li> <li>Record review rev Executive, Assistant I Managers, nurse supor charge nurses combehavioral care plans hoarding and rummago of care was followed a revisions with newly in since 05/20/2021.</li> <li>Interview with the CN PM, revealed she aucobehavioral care plans revisions when neces</li> </ul>	st with a one-hundred sed Practical Nurse (LPN) #22, on 05/21/2021 at M, and Registered Nurse Plat 2:00 PM, RN #16, on M, and LPN #29, on M revealed they received ed development and e care plan for all residents ith behaviors. E, on 05/22/2021 at 3:00 ng staff was an ongoing vided the first day the work. Record review roster for care plan sts with a one-hundred ng score. Per review, f members were educated. ealed that the Center Nurse Director of Nursing, Unit ervisors, social worker, and ducted audits of ten (10) a, including care plans for ging to determine if the plan and up to date, including dentified behaviors, daily E, on 05/22/2021 at 6:30 dited the residents' a and made the needed sary. Per interview, ied and brought to the QAPI	F	657				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/16/2021 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		185301	B. WING		0!	C 5/22/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C	ODE	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From page	9 199	F 657			
F 658 SS=J	PM, revealed she wor and address concerns concerns were resolv Services Provided Me	ed. eet Professional Standards	F 658			
	-	d or arranged by the facility, mprehensive care plan,				
	by: Based on observatio and review of the faci determined the facility system to ensure pro- met related to medica the needs of the resid	is not met as evidenced n, interview, record review, lity's policy, it was y failed to have an effective fessional standards were ation administration to meet dents. This failure effected en (87) residents, Resident				
	Alzheimer's, Adjustme mood, Psychotic diso Insomnia. The facility #31, initiated on 08/10					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WC	ODS		4	604 LOWE ROAD			
			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page times and was a hoar revealed they were aw hoarding behaviors ar medication cups. Obs 4:15 PM, revealed two cups in an unlocked d resident's room. Som labeled with Resident cups contained a tota (37.5) assorted medic facility's Pharmacist re medications, if consur lead to increased drow blood pressure. The facility's failure to professional standard administration has can serious injury, harm, i resident. Immediate a on 05/07/2021, and w 04/30/2021. The facili Immediate Jeopardy of The facility submitted 05/20/2021, alleging r Jeopardy on 05/20/20 Agency (SSA) validate was removed as alleg exit on 05/22/2021, w non-compliance at a S while the facility devel of Correction (POC) a	e 200 der. Interviews with staff ware Resident #31 exhibited nd was infatuated with servation, on 04/30/2021 at enty-two (22) medication lrawer of a cabinet in the ne of these cups were #31's name and four (4) I of thirty-seven and a half cations. Interview with the evealed some of the med by Resident #31 could wsiness, and decreased provide services that met s related to medication used or is likely to cause mpairment or death to a Jeopardy (IJ) was identified ras determined to exist on ty was notified of the on 05/07/2021. an IJ Removal Plan on removal of the Immediate 121. The State Survey ed the Immediate Jeopardy jed on 05/20/2021, prior to	F 658	( 			
	with systemic change The findings include:	s. s "NSG305 Medication:					
	i te iacility s						

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	-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Administration: Gener 11/01/2019, revealed administered staff wo needed and remain wa administration was co medications should n bedside. If the reside medication should be attempt to administer time. Review of Resident # the facility admitted R with diagnoses that in without behavioral dis Adjustment disorder wi Psychotic disorder wi Review of Resident # Plan, revealed that or was care planned witt inappropriate behavio and hoarding silverwa washcloths. Continue interventions included hiding places for hoar room daily, and to ret other residents. How interventions were no 11/02/2020. Observation on 04/30 4:10 PM, revealed Re room with several cup the medication cups w resident's name writte were observed to hav cups, without a reside	ral" policy, dated that when medication was uld assist the resident as with the resident until ompleted. It also stated ot be left at the resident's ent refused medications, the discarded and staff should the medication at a later 31's clinical record revealed tesident #31 on 05/10/2013 included Dementia with sturbance, Alzheimer's, with Depressed mood, th delusions, and Insomnia. 31's Comprehensive Care n 07/07/2014 the resident h a focus related to ors to include rummaging are/medications/ ed review revealed d to learn the resident's rding, to observe resident's urn items/belongings to ever, both the focus and the	F	658	3		

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PRINTED: 07/16/2021

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/16/202 <sup>2</sup> MAPPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DAT	e survey IPleted	
		185301	B. WING			C 05/22/2021		
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	• •	-	
REGIS WO	DODS				04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 658	him/her decide which On 04/30/2021 at 4:1 Executive (CNE) and #31's room. The CN medication/pills the re- surveyor. The reside twenty-two (22) medi drawer of a cabinet in of these cups were la name and four (4) cu and a half (37.5) asso thirty-seven and a ha to Resident 31's curre Registered Nurse (RI Executive. The medic (3) Eliquis 5 mg (milli 37.5 mg, nine (9) Hyd half (4.5) Metoprolol ES, one (1) Lamotrig not Resident 31's pills later identified to be: Clonidine 0.1 mg, one Glycopyrrolate 1 mg, Finasteride 5 mg, one (1) Hydrochlorothiazi Ciprofloxacin 125 mg Interview with RN #13 revealed that Resider pills. She said many looked like the reside medications. She sa the basics of watchin it was bad practice, a the facility's policy. Fa administered medicat	<ul> <li>medications to take.</li> <li>5 PM, the Center Nurse surveyor entered Resident IE asked to see the esident had shown to the int was found to have cation cups in an unlocked in the resident's room. Some ibeled with Resident #31's ps contained thirty-seven orted medications. The If (37.5) pills were compared ent medications with N) #13 and Center Nurse cations identified were: three gram), seven (7) Effexor droxyzine 25 mg, four and a ER 25 mg, two (2) Tylenol ine 25 mg, and 11 that were s. The eleven (11) pills were two (2) Mirtazapine, two (2) e (1) Famotidine, one (1) one (1) Griseofulvin, one (1) e (1) Amitriptyline 5 mg, one de 20 mg, and one (1) .</li> <li>3, on 04/31/2021 at 4:50 PM, nt #31 was known to cheek of the unidentified pills</li> </ul>	F	658	DEFICIENCY)			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE	E, ZIP CODE	•	
				4	604 LOWE ROAD			
REGIS WO	DODS			L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	203	F	658				
	Assistant General Ma 8:42 PM, revealed the Manager reported Re possession no Level 1 however, there were s Level 4 interactions th concern to the resider some of the medication drowsiness if taken to blood pressure to an problem, and others w if taken together for a would likely build up in interacting upon react Interview with the Hos 05/10/2021 at 10:45 A aware of the incident pills and medication of locked carts, did not ha at the residents' beds resident take them, the problem with RN #15 revealed she only wo Unit for a few weeks, Per interview, RN #15 the residents' medica names labeled on the stations. Additionally into some of the resid of the residents' medica names tabeled on the stations. Additionally into some of the resid of the residents' medica names to the unlabeled cups with m	esident #31 had in his/her 1 interactions medications; some Level 2, Level 3, and hat might be of some nt. Further review revealed ons would increase ogether, some might lower extent that could be a would generally only interact n extended period, as each n the system and start hing therapeutic levels. spice Physician, on AM, revealed she was made with Resident #31 hoarding cups. She also stated if staff eave medications on cart, or ide without watching the hen there would be no						

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					C
		185301	B. WING		05/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 658	Continued From page	e 204	F 6	58	
	unit without administe	ering the medications to the			
	residents, and would				
		d (MAR) as "administered."			
		icult to determine which			
		to which resident and the			
		sident received the wrong receive their medications			
		ent had an adverse effect.			
		ealed to her knowledge this			
		the potential was there.			
	She further revealed	the nursing staff would prep			
		dvance because of not			
		on the unit to administer the			
		<ul> <li>RN #15 stated she told time of her observations.</li> </ul>			
		ed Medication Technician			
	(CMT) #1 on 05/04/2 Licensed Practical Nu				
		M, and with RN #2 on			
		M, revealed that they have			
		s at the bedside. They			
		ne medications into the room			
	-	ained to the resident what			
		e, and watched the resident			
		ver, staff could not explain quired all of this medication.			
		nter Nurse Executive (CNE),			
		00 PM, revealed that the ering medications was to			
	-	ke the medications before			
		he said the facility's policy			
	•	ed because Resident #31			
		hat many pills. She further			
		ave been an intervention on			
	-	plan to watch the resident			
		e resident's putting the			
	medication in cheeks	and spitting them back out.			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE COMP	SURVEY LETED	
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	the pills the resident of there was potential fo incident she did get th and evaluate Residen not know how Reside medications. It was a they were. She further of Resident #31 havin through the nursing st Interview with the Cer 05/12/2021 at 07:33 F medications should no and staff should make getting their medication He stated the facility of #31 had and the phan resident could have ta no untoward effects. about Medication Adn and that staff was edu the incident. Review of the IJ Rem facility implemented th 1. The medications for were destroyed after to 04/30/2021 by the Ce (CNE). 2. Resident #31 was nurse on 04/30/2021, 3. The physician was found in Resident #31 New orders were rece	sident #31 had taken all of nay have gotten sick and r harm. The night of the ne Hospice Nurse to come in it #31. She said she does nt #31 got all those ilso not identified who's pills er stated she was not aware og a history of rummaging tation drawers either. Ther Executive Director, on PM, revealed that ever be left at the bedside e sure the residents were ons and in a timely manner. did identify the pills Resident macist consultant stated the aken all the medications with He said the facility's policy ninistration was not followed ucated immediately following oval Plan revealed the ne following: bund in Resident #31's room they were identified on nter Nurse Executive assessed by a license	F 658				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE S COMPL	URVEY ETED
		185301	B. WING			C <b>05/2</b>	2/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z			
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD BE		(X5) COMPLETION DATE
F 658	<ul> <li>place non-crushable r and verify that medica</li> <li>4. An Ad Hoc Emerge completed on 05/03/2 director to discuss the medications found at review and recomment</li> <li>5. An audit was conditioned to determine if there with rooms on 04/30/2021</li> <li>Center Nurse Execution of Nursing (ADNS), at corrective action upor were identified.</li> <li>6. The Clinical Qualition reeducation to the Cert on 05/03/2021 regard Medication Administration is medications at the part post-test to validate ut</li> <li>7. The CNE provided Practice Educator (NF the policy NSG305 M include to assist the re- remain with the reside complete and to not be resident's bedside, with understanding.</li> <li>8. Reeducation was post-test (CM)</li> </ul>	meds whole in apple sauce ations were swallowed. ency QAPI meeting was 2021 with the medical e action plan as a result of the bedside for further ndations. ucted of all resident rooms were medications in resident by Nurse Supervisor, ve (CNE), Assistant Director nd charge nurses with any n discovery. No other issues y Specialist provided enter Nurse Executive (CNE) ing the policy NSG305 ation to include to assist the nd remain with the resident complete and to not leave tient's bedside, with a enderstanding. I reeducation to the Nurse PE) on 05/03/2021 regarding edication Administration to esident as needed and to ent until administration is eave medications at the th a posttest to validate	F 658				

		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY
						С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 658	Continued From page 207 Supervisors, and Nurse Practice Educator (NPE) regarding the policy, NSG305 Medication Administration to include to assist the resident as needed, to remain with the resident until administration is complete, and to not leave medications at the patient's bedside, with a posttest to validate understanding. 9. Medication competencies completed on all CMTs and licensed nurses beginning on 05/03/2021 by CNE, ADNS, Unit Manager, Nurse Supervisors and NPE. 10. The CED, CNE, UMs, Nurse Supervisors and/or Charge Nurse will conduct visual observation rounds checking the bedside tables of ten (10) residents across the nursing twelve (12) hours shifts including weekends, then three times a week times two (2) weeks, then weekly times eight (8) weeks, then biweekly times two (2) months, then monthly times one (1) month, and then as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure that medications are not in the resident rooms including bedside table drawers with any corrective action upon discovery.		F 65	8		
	submitted by the CEE the immediate jeopart for six (6) months to t consisting of the CED Nursing, Activity Direct Admissions Director, Food Service Director Maintenance Director Health Information's (	and/or the CNE daily until dy is removed and continue				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		185301	B. WING			05	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		-
REGIS W	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE         DEFICIENCY)       DEFICIENCY)			D BE	(X5) COMPLETION DATE		
F 658	Continued From page needs until the issue thereafter as determin The SSA validated the following actions to re Jeopardy: 1. Interview with the 05/22/2021 at 12:15 F the medication in the as soon as she was c 2. Interview with Reg 05/21/2021 at 5:00 Pl assessed Resident #3 vitals and neuro chec found. Record review Hospice nurse came Resident #31 on 04/3 3. Interview with the 05/10/2021 at 10:45 A made aware of the inter Record review reveal physician's order from Officer to crush reside able to be crushed ar meds whole in apples 4. Interview with the	e 208 is resolved and ongoing hed by the QAPI committee. e facility implemented the emove the Immediate Center Nurse Executive on, PM, revealed that she put sharps bin to destroy them lone identifying the pills. istered Nurse #13, on M, revealed that she 31 head-to-toe including ks, after the pills were v also revealed that a to the facility and assessed 0/2021 at 6:32 PM. Hospice Physician, on AM, revealed that she was cident with Resident #31. ed that there was a n the Hospice Chief Medical ent's medications that were ed place non-crushable sauce.		658	DEFICIENCY)		
	an Ad Hoc meeting of Resident #31 that he 5. Record review rev used to check each re	n 05/03/2021 to talk about did attend. ealed the check off sheet esident's room and who did Clinical Reimbursement 2/2021 at 11:33 PM,					

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PRINTED: 07/16/2021

	-	D HUMAN SERVICES				FORM	07/16/2021 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	FREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			004 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	resident drawers and including resident bat tables, and locked dra then given to the Cen Center Executive Dire Nurse Practice Educa PM, revealed that she audits done on all the Center Executive Dire PM, revealed that he involved looking at all and bedside tables. 6. Interview with the 0 05/22/2021 at 11:25 F provide education bef Center Nurse Executi Medication Administra also used to validate of 7. Interview with the 0 05/22/2021 at 12:15 F provide reeducation to Educator regarding th Administration policy posttest on the materi 8. Interview with Nurs 05/21/2021 at 5:14 PI education regarding ti Administration Policy Technicians and the li provided them with a check off about Medic 9. Interview on 05/21	said they went through rooms with permission hroom, closets, bedside awers. The information was ter Nurse Executive and the ector. Interview with the tor, on 05/21/2021 at 5:14 e was also a part of the residents. Interview with the ector on, 05/22/2021 at 2:55 was a part of the audit that residents rooms, drawers, Clinical Consultant, on PM, revealed that she did fore anyone else to the ve on the NSG305 ation policy. A posttest was understanding. Center Nurse Executive, on PM, revealed that she did to the Nurse Practice e NSG305 Medication and also provided her with a tal. se Practice Educator, on M, revealed she did provide he NSG305 Medication to the Certified Medication censed nurses. She also posttest and a competency cation Administration.	F 658				

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STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0 (X3) DATE SU	RVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLET	TED
		185301	B. WING		C 05/22	/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00,22	2021
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) COMPLETIO DATE
F 725	<ul> <li>#16 at 2:05 PM, reveleducation on Medical completed a posttest 05/22/2021 at 5:58 P educated on Medical completed a post test showed the posttest completed.</li> <li>10. Interview with the on 05/21/2021 at 5:10 of Nursing, on 05/21/2021 at 5:10 of Nursing, on 05/21/Center Nurse Execute PM, revealed they par Rounds every day. F the Observation Rourd daily.</li> <li>11. Interview with the 05/22/2021 at 12:15 Executive Director, or revealed that the rest Round Audits were d Sufficient Nursing Sta CFR(s): 483.35(a)(1)</li> <li>§483.35(a) Sufficient The facility must have the appropriate completed completed at the rest and considering the rest and const and c</li></ul>	N) #1 at 2:00 PM, and RN aled all had received tion Administration and . Interview with LPN #29, on M, revealed that she was ion Administration and t. Record review also and competencies that were e Nurse Practice Educator, 4 PM, the Assistant Director 2021 at 5:20 PM, and the ive, on 05/22/2021 at 12:15 articipated in the Observation Record review revealed that nd Audits were conducted e Center Nurse Executive, on PM and the Center n 05/22/2021 at 2:55 PM, ults of the Observation iscussed daily in QAPI. aff (2) Staff. e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care	F 65			

Event ID: ODNZ11

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page at §483.70(e).	211	F 725				
	by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not					
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio and review of the faci determined the facility system in place to en nursing staff were ava nursing and related so residents' care needs each resident's rights psychosocial well-bei (MCU). Additionally, was limited staff to as	section, the facility must nurse to serve as a charge duty. is not met as evidenced n, interview, record review, lity's policies, it was / failed to have an effective sure sufficient qualified ailable at all times to provide ervices to meet the in a manner that promoted , physical, mental and ng on the Memory Care Unit interviews revealed there sist with answering the which resulted in long wait					
	staffed with three (3) (CNAs) and a Register increased behaviors of						

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	; 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	short to intervene whe behaviors. (Refer to F Review of the facility's long wait times. Obse call lights revealed res (20) to thirty (30) minu (Refer to F-558) The facility's failure to provide the residents and service needs in each resident's rights cause serious injury, I to a resident. Immedii identified on 05/14/20 exist on 04/22/2021. the Immediate Jeopar The facility submitted 05/20/2021, alleging r Jeopardy on 05/20/20 Agency (SSA) validat was removed as alleg exit on 05/22/2021, w non-compliance at a S while the facility deve of Correction (POC) a Assurance (QA) moni with systemic change The findings include: Review of the facility's Plan," reviewed 07/16 provided qualified, an to meet the needs of	views revealed they were too en residents had increased F-600, F-658, and F-740). Is call light audits revealed ervations of the residents' sidents had to wait twenty utes for staff to respond. In their assessed care a manner that promotes has caused or is likely to harm, impairment or death iate Jeopardy (IJ) was 121, and was determined to The facility was notified of rdy on 05/14/2021. In IJ Removal Plan on removal of the Immediate 021. The State Survey ed the Immediate Jeopardy ged on 05/20/2021, prior to ith remaining Scope and Severity of a "G" lops and implements a Plan and the facility's Quality itors to ensure compliance	F 725				

Facility ID: 100503

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · ·	E SURVEY	
		185301	B. WING		0	C 5/22/2021	
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 04 LOWE ROAD			
REGIS WO	DODS		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 725	were scheduled, and	opropriate staffing levels maintained.	F 725				
	Review of the facility's policy titled, "Facility Assessment" (FA), revised on 05/02/2018, revealed the facility would complete and document a Facility Assessment annually to include the facility's resident population and facility resources. Additionally, the Center Executive Director (CED), the Center Nurse Executive (CNE), the Governing Body (GB), and the Medical Director (MD), would determine resources necessary to competently care for residents during day-to-day operations. Further, the CED would lead the Facility Assessment Team to use the findings to determine staffing levels to ensure sufficient number of qualified staff were available to meet each residents needs.						
	revealed the Average one hundred seventy- twenty-nine (29) on the NF1 Unit, fifty-one (57 thirty-two (32) on Tran Additionally, the Avera Discharge was thirty ( the resident population and physical and cog psychiatric mood disc and infectious disease revealed the resident treatments such as re	ne MCU; fifty-seven (57) on 1) on NF2 Unit; and nsitional Care Unit (TCU). age Monthly Admission and (30). Per the Assessment, on had disease/conditions nitive disabilities such as orders, neurological disease,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 1 APPROVED	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED	
		185301	B. WING		-	05/2	C 22/2021	
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE			
			4604 LOWE ROAD					
REGIS WC	1005		L	OUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page needs such as Activiti Health and Behaviors Management, Infectio Management of Media Nutrition, and Psychol staffing plan needed t support and care for t day included; one (1) Director of Nursing Se Registered Nurse (RN Nurse (LPN) Charge I Care Unit Staff include CNAs, one (1) RN or One (1) RN or LPN; TO RN or LPN; MCU two LPN. Other required s limited to; one (1) Reg Nurse Practice Educa Director, one (1) Socia (1) Activity Director, or two (2) Minimum Data one (1) Rehabilitation seven (7) therapist.	e 214 es of Daily Living, Mental , Medications, Pain on Prevention and Control, cal Conditions, Therapy, social support. The facility's o provide competent he resident population every CNE; one (1) Assistant ervices (ADNS); one (1) V) or Licensed Practical Nurse for each shift. Direct ed: NF1 Unit three (3) LPN; NF2 three (3) CNAs, CU three (3) CNAs, one (1) (2) CNAs, one (1) RN or staff included but was not gistered Dietician, one (1) tor, one (1) Social Services al Services Assistance, one ne (1) Captivity Assistant, a Set (MDS) Coordinators, Program Manager and interview revealed, on #86 became combative and in the hallway of the MCU. taff took Resident #86 to alm him/her down. Further dent #86 struck Resident while in their shared room. essed, on 04/25/2021, and cattered bruising and #85's right hand, new orders x-ray. The x-ray results	F 725					
	revealed the resident (bone in the hand) fra	had a right 5th metacarpal cture.						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		185301	B. WING		_	( 05/:	C 22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
			4	4604 LOWE ROAD				
REGIS WO	0005		1	OUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Interview with Certifie 05/12/2021 at 2:32 PI majority of her shifts of CNA #8 stated, on the 04/22/2021, Resident to use the restroom buy private restroom due therefore, care was pr CNA #8 revealed after pass (around 7:00 PM to enter other residen and was very hard to was the only aide on the had to leave the unit the putting residents to be not enough staff on the supervision to the ress #8 stated she asked of Interview with CNA #7 PM, revealed she was and assist with rounds bed on the MCU. CN resident's room perfor some noises in the has stepped out in the hal #86 trying to enter and the nurse was attemp him/her further down room. Continued inter the room she heard s and hurried to complet room. Further intervie yelling for help and st hitting Resident #85 was sor stated she ran in the random Resident #85 in her a	d Nurse Aide (CNA) #8, on M, revealed she worked the on the MCU. Per interview, e night of the altercation, #86 stated he/she needed ut refused to use his/her to Resident #85 screaming, rovided in the shower room. r dinner and medication 1) Resident #86 was trying ts' rooms, trying to stand up redirect. CNA #8 stated she the MCU. She stated she o find assistance with ed. CNA #8 stated there was the MCU to provide proper idents. Per interview, CNA CNA #19 to assist. 19, on 05/12/2021 at 3:30 is asked by CNA #8 to come is and placing residents in A #19 stated she was in a rming care when she heard allway. She stated she lway and noticed Resident other resident's room and ting to redirect, and guide the hallway toward his/her rview revealed while back in creaming from the hallway ete her care and exited the ew revealed LPN #14 was ated Resident #86 was vith the television and eaming out. CNA #19	F 725					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD OUISVILLE, KY 40220			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page safe.	216	F 725				
	revealed when she ar morning for her shift of notified her that she for #85's sheet. Continue entered Resident #85 head to toe assessme source of the blood. If #86 (roommate prior to abrasions on his/her at that was where the bl interview revealed up assessment she note Resident #85's right h 2. Observation, on 0 4:10 PM, revealed Re room with several cup the medication cups w resident's name writte were observed to hav cups, without a reside cups. Resident #31 at Agency (Surveyor) to medications to take. Pharmacist revealed for #31's possession cou drowsiness, and decr Interview with RN #18 revealed she only wo Unit (MCU) for a few 2020. Per interview, leave the residents' m their names labeled of nurse's stations. Add	arms and they determined ood originated. Further on the head to toe d bruising and swelling to hand. 4/30/2021, at approximately esident #31 was in his/her os of medications. Many of were observed to have the en on them; however, others re medications within the ent's name noted on the asked the State Survey "help" him/her decide which Interview with the the medications in Resident Id lead to increased eased blood pressure. 5, on 05/19/2021 at 6:19 PM, rked on the Memory Care weeks, around February of RN #15 revealed staff would hedications in cups, with					

Facility ID: 100503

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ATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		185301	B. WING			C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		5/22/2021
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 725	find some of the resid bedside table. Lastly times open the drawe find unlabeled cups w RN #15 stated staff w the unit without admir the residents, and wo Administration Record She stated it was diffi medication belonged only way to tell if a re- medication or did not would be if the reside She further revealed their medications in a	e 217 lents' mediations on their , she revealed she would at er to the medication cart and vith medications in them. yould sign off and/or leave histering the medications to build sign the Medication d (MAR) as "administered". foult to determine which to which resident and the sident received the wrong receive their medications ent had an adverse effect. the nursing staff would prep dvance because of not on the unit to administer the	F 72	5		
	Memory Care Unit (M complete her daily ch shift. RN #1 stated sl supervising and intera redirect them. She st distractions to preven could result in alterca normally the staffing of nurse and three (3) C staffing included only difficult to provide car residents adequately	ered Nurse #1, on M, revealed she worked the ICU) and was not able to arting until the end of the he was constantly acting with the residents to tated she would provide it or intercept behaviors that tions. RN #1 stated on MCU included one (1) NAs, but on days when two (2) CNAs, it was very re and supervise the				
	revealed on the NF2	4/23/2021 at 9:55 AM, Unit, the call light monitor ited for staff to respond to				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
		185301	B. WING		04	C 5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		)/22/2021
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 725	Resident #22, on 09/ the diagnoses of Mor	17/2020, to room 215 with bid Obesity, Viral Hepatitis,	F 725	5		
	and Bipolar. Review of the Quarterly Minimum Data Set (MDS), dated 03/25/2021, revealed the facility assessed the resident to have a BIMS' score of fifteen (15), which was indicative of being cognitively intact.					
	1:00 PM, revealed he the bathroom. The re regularly responded i	nt #22, on 04/23/2021 at /she called for assistance to esident stated facility staff n thirty (30) to sixty (60) 22 stated he/she was a				
	complained monthly a the call lights by staff facility staff complaine and other residents w care. Resident #22 re					
	<ul> <li>care. Resident #22 revealed the two (2) staff members would be unavailable for long periods when other residents needed help.</li> <li>4. Observation, on 04/26/2021 at 10:07 AM, revealed the call light monitor for the Transitional Care Unit (TCU) alarmed for room 323 for nine (9) minutes and nine (9) seconds and room 324 for approximately eleven (11) minutes with staff not visualized on the TCU hallway. In addition, staff were not observed on the 300 Hall or the 400 Hall. Continued observation revealed no staff were observed on the unit from 10:07 AM until 10:20 AM. Further observation revealed two</li> </ul>	4/26/2021 at 10:07 AM, monitor for the Transitional ned for room 323 for nine (9) seconds and room 324				
	(2) staff exited room 3 entering room 323 at	321 with one (1) staff 10:21 AM, to deactivate the observed without staff on				

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		MEDICAID SERVICES			OMB NO. 0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SU COMPLET	
					с	
		185301	B. WING		05/22	/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE	(X5) COMPLETIO DATE
F 725	Continued From page	e 219	F 72	25		
	323 total wait time wa	as twenty-two (22) minutes wait time was twenty-eight				
Review of Resident #15's chart revealed the facility re-admitted the resident, on 12/07/2020, to room 323 with the diagnoses of Paraplegia, Septicemia, and Hypertension. Review the Quarterly MDS, dated 03/04/2021, revealed the resident was assessed to have a BIMS score of fifteen (15), indicating the resident was cognitively intact.						
	Interview with Resident #15, on 04/26/2021 at 10:41 AM, revealed he/she waited over two (2) hours for pain medication on a day shift and over three (3) hours for response to the call light on the third shift on Easter weekend (4/24 to 4/25). The resident stated staff expressed to him/her that the facility was short of staff. Resident #15 stated that staff stated told him/her that other residents' care required two (2) staff at the bedside and and that pulled both staff off the floor. Further interview revealed that at times, one (1) nurse and one (1) aide staffed the unit.					
	AM, revealed the faci call-outs over Easter and other administrat help. The CED state clinical care, but coul	D, on 05/05/2021 at 10:00 lity had numerous staff weekend which required him ive staff to come in and d he could not complete d support staff in other ways e clinical staff worked with				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING			C 05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STAT	E, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 725	Quarterly Minimum D 05/12/2021, revealed cognitive patterns with Mental Status (BIMS) and determined the re- linterview with Reside 12:04 PM, revealed th light, on 04/26/2021, it bath. The resident sta (3) hours to respond t #87 stated it took two and staff would have assist, which extended Interview with CNA #37 PM, revealed the facil call lights immediately used their call lights for revealed residents be fall when staff do not CNA #37 stated anyo light and they should than 5 minutes. The answer quickly, howe residents which require staff off the floor, and CNA revealed the sch takes to care for the re number of residents of Interview with LPN #37 AM, revealed resident basic needs, and req The LPN stated the far respond as soon as p activated the call light included numerous re	ata Set (MDS), dated the facility assessed for in the Brief Interview for with a score of fifteen (15) esident interviewable. Int #87, on 05/14/2021 at he resident activated the call in the AM to start his/her ated it took staff over three o his/her call light. Resident (2) aides to care for him/her to go find another aide to d the staff's time response. B7, on 05/20/2021 at 2:40 lity expected staff to answer V. CNA #37 stated residents or safety. The CNA come impatient, get up and answer the light timely. ne could answer the call be answered at least less CNA revealed staff try to ver, the facility had red two (2) staff, which took may require the nurse. The neduler did not look at what it esidents on the unit just the	F 725				

Facility ID: 100503

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	· /	PLE CONSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED	
		185301	B. WING		0	C 5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
REGIS W	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 725	and they were unable The LPN revealed wh resident's might get h urine, and have skin Further interview with facility had staff short Further interview with 4:22 PM, revealed Re extensive assistance (2) staff in the room for revealed if the facility residents' call lights w response. The LPN f in NF2 required more administrator realized staff was pulled from residents, which increases response. Interview with LPN #4 revealed the Transition where Long Term Ca residents with comple LPN revealed one nut assigned to the unit, a two (2) staff, and they to cover the floor. LF often took up to thirty staff were not able to lights when they wen acceptable response up to seven (7) minut twenty (20) to thirty (3 the residents to wait,	e to respond to the lights. nen this happened the nurt, fall, have pain, lay in breakdown from pressure. In the LPN revealed the tages "here and there." In LPN #3, on 05/05/2021 at esident #84 required for care and required two or his/her care. LPN #3 Thad enough staff, the would have a "timely" further stated the residents e attention than the d. LPN #3 revealed agency providing care to the eased the residents' call light 4, on 04/26/2021 at 1:18 PM, onal Care Unit (TCU) was re (LTC) and new admission ex care needs resided. The trse and one aide were and many residents required y did not have enough staff PN #4 stated residents' care (30) minutes, therefore; hear the residents' call t off. The LPN revealed an time for call lights included tes. The LPN revealed 30) minutes was too long for and could cause a resident became impatient. LPN #4	F 72				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	because the facility di aides on the halls. Fu often could not get he end of shift. The LPN concerns to the scheo However, the facility of and treatments were in LPN #4 stated staff co expectations when the staff with high acuity in Interview with Register 05/21/2021 at 2:45 PM at the facility numerou facility worked short s the residents' call ligh (30) to forty-five (45) in nurse were in a reside care or a transfer with stated the units had in required two (2) staff care. The RN reveale schedule for those residents' accidents' interview with the faci 05/05/2021 at 2:10 PM facility was not consis always find answers to residents. She stated were not familiar with know the resident, that resident was normal; ensure accurate inform related to care.	d not want to have two (2) arther interview revealed she or duties completed by the I stated she voiced her duler and to the director. did not make any changes not always done. However, build not meet the facility's e schedule had minimal residents. ered Nurse (RN) #2, on M, revealed the RN worked us years. The RN stated the taffed and the responses to ts were delayed up to thirty minutes when the aide and ent's room providing wound a mechanical lift. RN #2 umerous residents which and long periods of time for ed the facility did not sidents and the staff got g call lights and responding s/incidents. lity Physician, on M, revealed staffing in the tent and she could not o her questions about I staff would tell her they the resident, they did not at they were new or the	F 725				

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 07/16/202 DRM APPROVE NO. 0938-039
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ISTRUCTION	(X3) D	ATE SURVEY OMPLETED
		185301	B. WING				C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CO		
REGIS WO	DODS				.OWE ROAD SVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 725	revealed she had wo (7) months. Per inter determined by the re the residents. Additi- the CED and the Sta responsible to ensure facility. Further, she staffing levels in the was adequate to prov Interview with the Ce on 04/29/2021 at 9:1 was staffed adequate instructed the MCU r the nurse's station by common area to obs charting. Interview with the CE PM, revealed followin Recertification Surve corporate level overs the staffing was later complained about the CED stated the norm included one (1) mar and a sitter for one o stated the MCU Direct observe the resident nurse, CNAs, the sitt and the MCU Direct (5) staff to resident ra Interview with the Me 05/12/2021 at 10:25 problem in the facility rate of nursing staff a	arked at the facility for seven rview, staffing was sidents' census and needs of onally, she stated that she, ffing Coordinator were e sufficient staffing in the had no concerns with facility and stated staffing vide care to the residents. Enter Nurse Executive (CNE), 7 AM, revealed the MCU ely. She stated she had hurses to avoid charting at ut to take a laptop out in the erve the residents while ED, on 04/30/2021 at 3:12 ng the previous ey, administration at the staffed the facility. He stated reduced and staff e reduction in staffing. The hal staff present on the MCU haging nurse, two (2) CNAs, n one (1:1) observation. He ctor and the Activities ent for a portion of the day to s. The CED stated the ter, the Activities Assistant, or resulted in a one (1) to five atio, which was acceptable	F	725			

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING		_	C 05/2	, 22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS W	DODS			1604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	felt with the low staffir difficult for staff to pro- high acuity residents. he was not involved in selection of new resid concern related to sta the facility's population Review of the IJ Rem facility implemented the 1. The Staffing Coord Executive (CNE) obta according to resident discovery. 2. On or before 05/1 President of Operation Nursing Home Admin and CFR 483.35 which have sufficient nursing competencies and ski related services to as attain or maintain the mental, and psychoso resident, as determined and individual plans of number, acuity and di resident population in assessment required Executive Director (C information to verify th responsibility includin with a posttest by the facility's systems were	ng levels in the facility it was vide necessary care to the Further interview revealed in the screening/admission lents, but he had voiced his offing and quality of care for in to the CED. oval Plan revealed the he following: dinator and Center Nurse ined staff to cover all units acuity and care needs upon 9/2021, the Regional Vice ns (RVPO) reviewed the istrator's Job Description sch stated the facility would g staff with the appropriate ill set to provide nursing and sure resident safety and highest practicable physical, ocial well-being of each ed by resident assessment of care and considering the agnoses of the facility's accordance with facility at 483.35 with the Center ED). He reviewed the ne CED's understanding of g the intent of the tags cited RVPO to ensure the e in place to adequately lent needs and care issues.	F 725				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	225	F	725				
		o verify understanding by the						
	Director, Center Nurs Director of Nursing Se Managers will review labor management to hours per patient per days, assignments for were available to prov per the care plan for a twenty-four (24) week holidays, to include of rearranging staff to m residents, ensure call timely, and supervision were met to prevent in thereafter as determin Assurance Performan 4. The CED will monifie each unit daily to ensi- nursing staff with the and skill set to provide services to assure res- maintain the highest p and psychosocial well determined by residen individual plans of can number, acuity and di resident population in Facility's Assessment prevent serious injury the facility. 5. The CED will report	staffing needs, using the ol which consists of the day (HPPD) for three (3) r all shifts to ensure staff vide care and services as all residents daily for is including weekends and obtaining additional or neet the needs of the lights were answered on needs of the residents njury/accidents then ongoing ned by the Quality nee Improvement. tor personnel assigned to ure the facility has sufficient appropriate competencies e nursing and related sident safety and attain or oracticable physical, mental, I-being of each resident, as nt assessment and re. They will consider the agnoses of the facility's accordance with the required at 483.35 to , serious harm, or death in						
	immediate jeopardy h	ort findings daily, until the as been removed, to the rformance Improvement						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Assistant Director of M Director, Social Servic Director, Dietitian, He Business Office Mana Director, Maintenance and Certified Nursing follow up and/or inser resolved and then ong determined by the QA The State Survey Age implementation of the 1. Interview with the 05/22/2021 at 6:30 PI reviewed daily to ensu- meet the residents' ac Further interview reve- reviewing the resident level of care. Continu- facility's assessment of by Regulations. 2. Interview with the I 3:35 PM, revealed he description with the C 05/17/2021. Per inter staffing requirements assessment. He furth provided a posttest ar (100%) percent to sho information administe Review of the posttess revealed the test was which included the CE	sists of the Center enter Nurse Executive, Nursing Services, Medical ce Director, Food Service alth Information Manager, ager, Therapy Program e Director, Activity Director Aides for any additional vicing until the issue was going thereafter as API committee. ency validated the facility's AOC as follows: CED and CNE, on M, revealed staffing was ure all units were covered to cuity and care needs. ealed this was completed by ts' diagnoses and required ued interview revealed the would be utilized as required the would be utilized as required exert the job ED since taking over on view, he discussed the as per the facility's her stated the CED was not scored one-hundred ow understanding of the red.	F 725				

Facility ID: 100503

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING			
		185301	B. WING			C
	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP CC		5/22/2021
				4604 LOWE ROAD		
REGIS WO	DODS			LOUISVILLE, KY 40220		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	χ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF			(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETIO
F 725	Continued From page	e 227	F 72	5		
		ther review revealed the				
		red percent (100%) and it				
Wa	was signed off by the	RVPO on 05/19/2021.				
		D, on 05/22/2021 at 6:30				
		provided education related y (PPD) (Calculating the				
		s of care per resident/day) to				
	determine the staffing					
		d the education included how				
		dents acuity and the census				
		ber of staff needed to care				
	for the residents. He					
		ed by the FRVPO who gave o staffing and received a				
	-	ionally, he stated his job				
		issed and his responsibilities				
	related to providing o	versight of the facility.				
		Business Office Manager				
	l ( ).	1 at 4:06 PM, revealed she				
		nter Executive Director				
		r Nurse Executive (CNE), "Labor Meeting," to discuss				
		evious day, the current day,				
	• ·	ffing for the next day. Per				
		they met everyday. The				
		ooked at the Hour Per				
	• · · ·	to determine the staffing				
	-	The BOM stated this was				
		he number of staffing hours the census to come up with				
		for the day. Continued				
		e findings would be reported				
	to QAPI until the issu					
	4. Interview with the	CED, on 05/22/2021 at 6:30				
	FIVI, LEVEAIEU HE WUU	Id monitor the HPPD related				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIF	CODE	-	
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 725 F 730 SS=F	attain or maintain the practicable physical, r well-being. 5. Interview with the of PM, revealed the find be reported daily to Q jeopardy was remove concerns were identif Interview with the BO PM, revealed she atter meetings. She stated every meeting. Nurse Aide Peform Re CFR(s): 483.35(d)(7) §483.35(d)(7) Regula The facility must comp of every nurse aide at months, and must pro- education based on th reviews. In-service tr requirements of §483 This REQUIREMENT by:	ng needs were met and to residents' highest mental, and psychosocial CED, on 05/22/2021 at 6:30 ings related to staffing would API until the immediate d. He further stated no ied. M, on 05/22/2021 at 4:06 ended all of the QAPI d staffing was discussed in eview-12 hr/yr In-Service r in-service education. plete a performance review t least once every 12 ovide regular in-service he outcome of these aining must comply with the		725	DEFICIE	NCY)		
	the facility's policy it w failed to complete yea three (3) of three (3) s Assistants (CNAs #20	vas determined the facility arly performance review for sampled Certified Nursing 0, #34 and #39) employed er than twelve (12) months.						
	The findings include: Review of the facility's Appraisal, revised 03/							

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, Z	IP CODE	-	
REGIS W	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED <sup>-</sup> DEFICI	ACTION SHOULD B		(X5) COMPLETION DATE
F 730	and regular casual en performance appraisa based conversation. measured results, est opportunities, and set This applied to all em in-service education t provided to staff base reviews. Review of employees and #39 revealed the performance reviews In addition, the facility performance reviews records). Interview with CNA #2 PM, revealed she had facility since 1989. The should complete a reviews been a long time, yea CNA #20 stated if the with feedback she wo improvement was need Interview with CNA #3 PM, revealed she had five (5) years. The Cl remember the last tim completed. CNA #34 completed yearly. She provided opportunities negative performance to improve resident ca growth with her profest	egular full time, part-time, nployees to complete a al or have a performance The performance review ablished development goals for the coming year. ployees. In addition, o employees would be d on the outcome of staff ' records for CNA's #20, #34 facility did not complete for 2018, 2019 and 2020. could not produce from other sources (online 20, on 05/22/2021 at 2:20 d been employed at the he CNA stated the facility view yearly; however, it had rs, since her last review. facility did not provide her uld not know where eded. 34, on 05/22/2021 at 5:15 d been employed for over NA revealed she could not he an annual review was stated reviews should be re stated the reviews is to learn their positive and e skills which allowed them are, services and personal	F	730				

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>'</i>	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	C 05/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 730 F 740 SS=J	PM, revealed the facil annual review every tr #39 stated she had be for many years; howe overdue by around eig stated if the staff did r their review, it would r addition, she stated th goals for staff to grow Interview with the Cer on 05/22/2021 at 5:1 should complete a ye all staff. The CNE sta staff member's perfort weaknesses, and set She further stated trad due was the responsi resource office. How responsibility to ensur completed and to require port. Behavioral Health Set CFR(s): 483.40 §483.40 Behavioral he Each resident must re provide the necessary services to attain or m practicable physical, r well-being, in accorda assessment and plan encompasses a resid mental well-being, wh limited to, the prevent and substance use di	ity should complete an welve (12) months. CNA een employed at the facility ver, her annual review was ght (8) months. The CNA not ask the facility about not be completed. In he facility needed to set and learn. Ther Nurse Executive (CNE), 5 PM, revealed the facility arly review for all CNA's and ated the review evaluated a mance, strengths, goals for the employee. cking when reviews were bility of the facility's human ever, it was also her re the reviews were uest a performance review rvices ealth services. eceive and the facility must y behavioral health care and haintain the highest mental, and psychosocial unce with the comprehensive of care. Behavioral health ent's whole emotional and ich includes, but is not ion and treatment of mental	F 73				

Event ID: ODNZ11

Facility ID: 100503

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
		185301	B. WING		_	05/2	<i>,</i> 22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	the facility's policy, it y failed to ensure indivisi- behaviors and behavi and specific intervent support and reduce e (3) of eighty-seven (8 (Resident #21, Resident revealed the resident behaviors directed to 10/02/2020, Resident up and down the hally argument with another resident's personal sp resident down onto the occurred on the MCU #21 showed anger to several times. On 10 intruded another resident patted him/her on the resident intruded Ress slapped another reside at the resident, on the However, the facility f care for Resident #21 causes for the resider reduce the expression behaviors that were id Observations on the N 04/26/2021, 04/28/20 revealed Resident #2	ecord review and review of was determined the facility dualized residents' or stressors were identified ons were developed to xpression/distress, for three 7) sampled residents ent #61 and Resident #86). #21's medical record had several incidents of wards others. On #21 had paced ambulation vay, initiated a verbal r resident, intruded another bace and shoved another e floor, all the incidents . On 10/10/2020, Resident wards his/her roommate /25/2020, Resident #21 lent's personal space and face. On 10/28/2020, the ident #2's personal space, ent in the face and cussed MCU (Memory Care Unit) . ailed to develop a plan of that identified underlying nt's specific behaviors, the to stressors, and person s to support the resident to h/distress of the specific lentified by the facility. MCU, on 04/22/2021,	F 74				

Facility ID: 100503

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					ONSTRUCTION		0. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		<b>I</b> ` '	E SURVEY PLETED	
			A. BUILDIN	NG		с	
		185301	B. WING				
	ROVIDER OR SUPPLIER	100001			REET ADDRESS, CITY, STATE, ZIP CODE	05/22/2021	
	ROVIDER OR SUFFLIER				4 LOWE ROAD		
REGIS WO	DODS				UISVILLE, KY 40220		
							(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 740	Continued From page	a 232	<b>E</b> 7	740			
1 7 40	· · · · · · · · · · · · · · · · ·			40			
	Resident #21 was ob	served with paced bown the hallways. The					
		er residents' personal space.					
		ne Medication Administration					
		Progress Notes for Resident					
		umented evidence of that the					
	exhibited behaviors (	paced ambulation, intrusion					
		bace,) were identified or					
	documented by staff.	There was no documented					
	evidence of person c	entered interventions to					
	support all the resident's behaviors, or to reduce						
	the expression/distre	ss of the known behaviors.					
	Interviews with staff c	on the MCU, revealed					
	Resident #21 exhibite	ed paced ambulation, on the					
		non area, and into other					
	residents' rooms) dai	ly, prior to the 10/02/2020					
		Itercation and since then,					
		ngoing. Per interviews, the					
	· ·	until he/she was exhausted					
		tinued interviews revealed					
		story of physical and verbal					
		ds others and intrusion of onal space. However, they					
		e underlying causes of the					
		unaware of the resident's					
	responses to stresso						
	-	rson centered interventions					
		erdisciplinary Team (IDT), to					
	support the resident a						
	expression/distress o						
	interview, direct care	staff were not involved in					
		ing that discussed resident					
		unlicensed staff revealed					
		e resident's behaviors each					
	time they occurred be						
		al. Per interviews with					
		ehavior should be charted					
	on the MAR, and in the	ne Progress Notes; however,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, Z	IP CODE	-	
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD B		(X5) COMPLETION DATE
F 740	not all behaviors were did not have time to d Resident #21 had cor intrusive behaviors. 2. Review of Residen revealed the resident directed towards othe On 10/02/2020, Resid crying and had a verb resident, on the MCU Additionally, interview revealed Resident #6 tearfulness and crying interviews, the reside cry for unknown rease the day. However, st underlying causes for and were unaware of stressors, and were m centered interventions support the resident a expression/distress o interview, direct care Clinical IDT meeting t behaviors. Further, u they did not report the time they occurred be behaviors were normal licensed staff, each b on the MAR, and in the not all behaviors were did not have time to d Resident #61 had interventions.	e documented because they locument that often, as ntinuous pacing and t #61's medical record had verbal behaviors ers. dent #61 was tearful and bal altercation with another vs with staff on the MCU, 1 exhibited episodes of g on a daily basis. Per nt would become tearful and ons intermittently throughout aff were not aware of the the resident's behaviors, the resident's behaviors, the resident's responses to not knowledgeable of person s developed by the IDT, to and reduce f the behaviors. Per staff were not involved in the hat discussed resident inlicensed staff revealed e resident's behaviors each ecause the resident's al. Per interviews with ehavior should be charted he Progress Notes; however, e documented because they	F	740				

Facility ID: 100503

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	22/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	behaviors (yelling dire resident's responses centered interventions reduce the expression behaviors that were id Observations on the M 04/26/2021, 04/28/20 revealed Resident #6 common rooms, and i continued tearful, cryi review of the MAR an no documented evide exhibited behaviors a Comprehensive Care Interview with the Mer (MCPD) revealed the Behavior Rounds per MCU. Additionally, re behaviors documente were discussed daily, However, residents w not discussed in the C staff notified the MCP IDT meeting. Per inter care nurses failed to c in the medical record. implemented action to she was not aware dire documented behavior Sheet. 3. Resident #86, was	and addressed the Resident #61's specific ected at others), the to stressors, and person is to support the resident to n/distress of the specific dentified by the facility. MCU, on 04/22/2021, 21, and 05/05/2021 1 on the MCU in the in his/her room with ng episodes. However, d Progress Notes revealed nce staff identified the nd documented per the Plan or Physician's Orders. mory Care Program Director facility failed to maintain the facility's policy, on the esidents on the MCU with d in the medical record in the Clinical IDT meeting. ith known behaviors were Clinical IDT meeting, unless D of concerns prior to the erview, she was aware direct document known behaviors However, she had not o correct the issue. Further, rect care staff no longer is on a Behavior Flow	F 74	0			
	Quarantine Unit", on (	3 admitted to the "14-Day 03/19/2021. The resident e-to-one (1:1) sitter at that					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 07/16/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		X3) DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE	
REGIS W	DODS			604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATI EFICIENCY)	(X5) COMPLETION DATE
F 740	Quarantine Unit. Rev documentation log re exhibited behaviors to resistance to care, an Clinical record review identify these behavio #86 to the MCU, on 0 in the room with Resi Risk Management Sy Summary Report, dat Resident #86 was ext resistance to care in to redirected Resident # he/she picked up a te his/her roommate, su suffered from a right st The facility's failure to place to ensure indivi- behaviors and behavior and specific intervent support and reduce th caused or is likely to impairment or death to Jeopardy (IJ) was ide was determined to ext The facility provided a Allegation of Complia alleging removal of th 05/20/2021. The Sta determined the Imme removed 05/20/2021, 05/22/2021, with rem Scope and Severity of develops and implem	creased falls while on the riew of the 1:1 sitter vealed Resident #86 o include hitting, kicking, d screaming/yelling. revealed the facility failed to ors and transferred Resident 4/06/2021, placing him/her dent #85. Review of the stem (RMS) Event ed 04/22/2021, revealed hibiting aggression and he hallway of the MCU, staff 86 to his/her room where levision monitor and struck bsequently Resident #85 5th metacarpal fracture. thave an effective system in dualized resident's or stressors were identified ions were developed to he expression/distress has cause serious injury, harm, o a resident. Immediate ntified on 05/07/2021, and ist on 04/06/2021. an acceptable credible nce (AoC) on 05/20/2021 e Immediate Jeopardy on	F 740			

Facility ID: 100503

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			0.00	E CONCERNICE CONCERNING		IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		185301	B. WING		C 05/22/202	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO			
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 740			F 74	0		
	to ensure compliance	e with systemic changes.				
	The findings include:					
	11/01/2019, revealed behavioral symptoms evaluated to determin the interdisciplinary te underlying medical, p psychosocial, emotio environmental cause in the resident's beha who displayed or wer disorders or psychos received appropriate correct the problem of practicable mental ar Continued review rev non-pharmacological approach to managin addressed in the Car and Interventions Flo residents exhibiting b verbal or physical ab inappropriate/disrupti etc.); implement non- interventions as initia rounds are recomme identify and manage to Behavior Rounds I	a would be individually the the behavior. Per policy, eam (IDT) would identify obysical, functional, nal, psychiatric, or s that contribute to changes avior. Additionally, residents re diagnosed with mental ocial adjustment difficulty treatment and services to or to attain the highest nd psychosocial well-being. realed staff would use interventions as first line og behaviors; which would be e Plan. Behavior Monitoring w Record would be used for behavioral symptoms (e.g., usive, socially ive, resist care, wandering, opharmacological l intervention; Behavior nded as a best practice to behavioral symptoms (refer Best Practice). Further, the ify, prevent, and manage				
	non-pharmacological interventions and ong and safe environmen monitor outcomes of	approaches as initial going; promote a therapeutic t for residents and staff; Care Plan interventions, to psychotropic medications for				

Facility ID: 100503

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			(VO) 1			10. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		С
		185301	B. WING			
		165501		STREET ADDRESS, CITY, STATE, ZIP COD		5/22/2021
NAME OF P	ROVIDER OR SUPPLIER				'E	
REGIS WO	DODS					
				LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 740	Continued From page	237	F 74	0		
. , 10			F / 4			
	dementia.	oral symptoms and/or				
	Poviow of the facility'	s protocol, titled "Behavior				
		e", revised November 2013,				
		bunds were conducted twice				
	monthly and at minim					
	purpose was to prom	-				
r c		interventions for behavioral				
		ally, Behavior Rounds was				
		am members to discuss the				
	care of residents in th	ne facility. Per protocol, the				
		esentatives involved with the				
		vere not limited to the				
	-	Iurse Unit Managers, Social				
		, Program Director, Certified				
	•	lurse Practitioner, and ending Physician, Nurse				
		Mental Health Provider. The				
	process protocol was					
		e developed and maintained				
		tified the IDT of residents for				
		or Rounds. Residents for				
	•	vere not limited to: residents				
		nange in behavior; residents				
		ents which occurred in the				
	P	who received as needed				
		ue to behavior change;				
		ents receiving psychoactive				
		lents with current psychiatric t psychiatric t psychiatric hospitalization.				
		vior Rounds, the IDT would				
	· · ·	behavior was new; the length				
		had been exhibited; time of				
	day and frequency of					
		it happen/and who was				
		interventions/outcomes.				
	Per protocol, the Beh					
		avior wonitoring and				

Facility ID: 100503

If continuation sheet Page 238 of 337

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		185301	B. WING			C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 740	needs) or behavioral effectiveness of non-printerventions. Per pro Consider in IDT Beha included: ruling out ur physical causes and t root cause of the beha- resident representativ patterns; were non pricentered interventions documented; were spi identified, were caregi behaviors and were d documented? 1. Record review rev Resident #21 to the M primary diagnosis of A Additional diagnoses Degeneration of the b Anxiety Disorder, Psy Delusions, Dementia disturbance, and Adju review revealed the re- financial Power of Atter Review of Resident # Plan (CCP), initiated or resident to have the si without side effects. were not limited to: If behaviors, complete to documentation, dated changes in mental star report to the Medical	g., potential triggers, unmet disturbances and pharmacological ptocol, Questions to wior Rounds for review nderlying medical and treatment to determine the aviors; was the resident and ve consulted about prior life narmacological, person s tried, and results becific target behaviors ivers aware of target lesired outcomes ealed the facility admitted MCU, on 01/01/2020 with a Alzheimer's Disease. included Senile brain, Depressive Episodes, vchotic Disorder with without behavioral ustment Disorder. Further esident had a medical and orney (POA). 21's Comprehensive Care on 01/14/2020, revealed the br complications related to rugs. The goal was for the smallest most effective dose Interventions included but the resident exhibits	F 740			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				(X3) DATE COMP	SURVEY PLETED
		185301	B. WING _			_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	ODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	mood, dated 01/14/20 Further review of the 04/08/2020, revealed distressed/fluctuating Psychiatric Disorder a was for the resident to mood state as eviden appearance, and hap interventions included Encourage the reside distressed mood, date resident with somethin 04/08/2020; and enco participate in activity p 04/08/2020. However the facility fa resident behaviors an identified and specific developed to support expression/distress for and documented in R record. Review of Resident # revealed an order dat resident behavior free behavior is present, d and outcomes in Nurs refusal of care, throwi others, and wandering Alzheimer's disease. order dated 03/18/202 (antipsychotic medica by mouth, two (2) time	s related to behaviors and 220. CCP, initiated on the resident was at risk for mood symptoms related to and Dementia. The goal o demonstrate an improved iced by a calmer pier demeanor. The d but were not limited to: ent to seek staff support for ed 04/08/2020; Refocus the ng positive, dated ourage the resident to preference, dated alled to ensure individualized ad behavior stressors were and reduce or the behaviors identified tesident #21's medical 21's Physician's Orders, ted 11/06/2020, for "Is the e?" YES or NO (if NO and locument type, intervention, ses Note). Observe for ing items, cursing, yelling at g around the unit related to Further review revealed an 21, for Risperdal ation) 0.25 milligrams (mg), es a day for Anxiety.	F7	740				
	(antipsychotic medica by mouth, two (2) time	ation) 0.25 milligrams (mg),						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	OODS			1604 LOWE ROAD			
				,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	revealed the resident express ideas, wants, understood. Per the <i>i</i> usually had the ability content of others. The resident to have a Bri Status (BIMS) score of severely impaired coord decision-making. Add assessed to have no signs or symptoms of indicators of psychosis symptoms present. Of the resident was amb physical assistance a assistance of two (2) surfaces. Further, the had one (1) non-injury assessment. Further review of the discrepancies in docu Resident #21's behav Progress Notes and O Review of Resident # 05/01/2021-05/03/202 evidence of behaviors review revealed the re a Urinary Tract Infecti Further, observations	essment, dated 07/18/2020 usually had the ability to and make himself/herself Assessment, the resident to understand verbal e facility assessed the ef Interview for Mental of three (3) indicating ynitive skills for daily ditionally, the resident was depression symptoms, no delirium, no potential s, and no behavioral Continued review revealed ulatory with one (1) person nd required limited staff for transfers between e resident had no pain and y fall since the previous	F 740		)EFICIENCY)		
	resting in bed at times Observations of Resid 4:02 PM; 04/26/2021	pacing on the MCU and a throughout the day. dent #21, on 04/22/2021 at at 10:40 AM and 1:55 PM; M; and on 04/30/2021 at					

Facility ID: 100503

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIF	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED
						С
		185301	B. WING		0	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				4604 LOWE ROAD		
REGIS WO	JODS			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 740	Continued From page	- 244		10		
F /40			F 74	40		
	2:30 PM, revealed the common rooms, hall	e resident on the MCU in				
		served with intermittent				
		and down the hallways and				
		urther observation revealed				
	the resident was intru	sive of other residents'				
		ny resident's path that he/she				
		eview of the MAR and				
	Progress Notes, reve					
		viors (paced ambulation,				
	specific dates and tim	rsonal space) on those nes.				
		es Assistant (had worked				
		the MCU), on 04/22/2021 at ice he had worked on the				
		vas ambulatory and paced				
		ways, and in the common				
	areas continuously, n	nost days. Additionally, he				
	was aware the reside	ent would become defensive				
		ents at times when their				
		nterview, he was aware the				
		ysically aggressive towards				
		d interview revealed he ongoing and reported				
		o the nurse. However, he				
		underlying cause of these				
		nt's responses to stressors,				
		geable of person centered				
	-	ed by the IDT to support the				
		the expression/distress of				
		nued interview revealed he				
	-	ident's behaviors at "this cause the nurse was already				
		r. Per interview, he was not				
	involved with the Clin					
	discussed residents'	-				
	Interview with Certifie	ed Nursing Assistant (CNA)				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		-	(X3) DATE COMP	SURVEY LETED
		185301	B. WING			05/2	) 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4604 LOWE ROAD			
REGIS WO	JODS			LOUISVILLE, KY 40220	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	at 4:15 PM revealed a observed behaviors in Record (EHR); however report all behaviors to the licensed nurse wood behavior. Additionally the MCU, Resident #2 ambulation and contine the hallways, in rooms However, she did not behavior because it to behavior and everyone time. Continued inter aware the resident wood with other residents, we required redirection. If #21's behaviors include the evenings he/she we were and would say he were at home. Further included agitation in the resident would be an push wheel chairs out defensive if other residents Interview with CNA #2 MCU), on 04/26/2021 since she had worked walked up and down the MCU, all the time. Acc aware of the resident' intrusion of others' pe physical behaviors dir Further, she did not re- behavior of pacing on	n the MCU), on 04/22/2021 aides could document of the Electronic Health ver, it was facility practice to the nurse on the MCU, and build document the resident's of, since she had worked on 21 was independent with buously paced up and down as and in the common areas. report or document the was the resident's common e knew he/she paced all the view revealed she was build also attempt to interact which was unwelcome and Per interview, Resident ded "sundowning", where in would ask where the kids te/she was afraid the kids er, the resident's behaviors the evenings, and the aggressor and attempt to c of his/her way and become dents were in his/her path. 22 (seven {7} months on the at 10:45 AM, revealed on the MCU, Resident #21 the hallway, all over the Iditionally, she was not s behaviors such as rsonal space, or verbal or tected towards others.	F 74	0			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 185301 B. WING 05/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD **REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 740 Continued From page 243 F 740 Interview with Registered Nurse (RN) #6 (one {1} month on the MCU), on 04/26/2021 at 2:30 PM, revealed exhibited behavior symptoms were documented on the MAR or in a Nursing Note by the nurse. Additionally, she expected aides to report behaviors immediately to her. Per interview, it was important to identify behaviors so staff could intervene with interventions to support the resident's behaviors to ensure the resident received safe, quality care. Continued interview revealed it was important to have documented behaviors so the Interdisciplinary Team (IDT) would know the progress and changes with each resident. Further interview revealed Resident #21's behavior was he/she paced/walked the halls continuously; however, she was not aware that the resident had any behaviors such as paced ambulation or intrusion of others' personal space on 04/26/2021. Interview with RN #1 (four {4} months on the MCU). on 04/28/2021 at 2:30 PM revealed behavior monitoring was completed on the MAR each shift for all residents. Per interview, if a resident had a behavior, then nurses would mark "Yes" on the MAR and make a narrative free text Progress Note about the behavior and actions. Additionally, it was important to have ongoing monitoring and documentation of residents' behaviors to ensure interventions were implemented when a resident exhibited a behavior for their well-being and to maintain a healthy environment. Per interview, since she had worked on the MCU, Resident #21 was anxious and confused, and would walk up and down the hallways continuously. Further, the resident was defensive when another resident approached him/her; however, she was not aware of and had not documented any behaviors

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		-	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WC	OODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 740	on 04/28/2021 at 3:11 Resident #21 was add had aggressive behavi interview, the resident and squeeze them tig defensive towards oth were in his/her path. his/her voice, intrude space, and put his/he Additionally, the resid hallway, in rooms and all the time. However behaviors that had be (paced ambulation an space), to the nurse be aware of them. Interview with Agency the MCU), on 04/30/2 when behaviors occur nurse. However, "tod nurse that Resident # and intruded other resis because all staff knew behavior. CNA #19 s always walked up and into other peoples' sp admitted to the MCU. reported the behavior However, interview w MCU revealed they w	A4/28/2021. 9, (two {2} years on MCU), 1 PM revealed shortly after mitted to the MCU, he/she viors towards others. Per t would grab staff's arms th and the resident was her residents when they The resident would raise other residents' personal r hands on others. ent walked up and down the d the common area rooms r, she did not report the teen observed "today" ad in others' personal because she was already A CNA #19 (two {2} years on 021 at 3:30 PM revealed rred she reported to the lay", she did not report to the 21 had walked the hallway sidents' space, all day, v the resident had this tated Resident #21 had d down the hallways and got ace since he/she was Further, she should have to the nurse. ith direct care staff on the	F 740		EFICIENCY)		
	knowledgeable of per	to stressors, and were not son centered interventions rdisciplinary Team (IDT), to					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	IDT meeting that disc and they were not aw Review of the MAR, d 04/01/2021-04/30/202 11/06/2020, which sta behavior free? YES of present, document typ outcomes in Nurses N of care, throwing item and wandering around Alzheimer's Disease. five (5) times in April ' indicating a behavior of the behaviors were pr at 5:30 AM: 04/05/202 04/23/2021; 04/27/200 Nurses Notes for thos documented evidence type, intervention, or of Interview with LPN #2 PM, revealed she doo with no Nursing Note 04/13/2021, 04/14/200 AM. Per interview, sh Nurse Progress Note the MAR, to include th the intervention staff i resident's response/o Further, Resident #21 ambulation on the MO "Yes" on the MAR.	Ind reduce the f the behaviors. Per not involved in the Clinical ussed resident behaviors are of Behavior Rounds. lated 21, revealed an order dated ted, "Is the resident or NO (if NO and behavior is be, intervention, and lote). Observe for refusal s, cursing, yelling at others, d the unit related to Additional review revealed 'YES" was documented was present." Per the MAR, resent on the following dates 21; 04/13/2021; 04/14/202; 21. However, review of the se dates revealed no e of a behavior exhibited, butcomes. 24, on 04/27/2021 at 2:10 cumented "YES" behavior documentation, on 21, and 04/27/2021 at 5:30 he should have made a with all "Yes" responses on he behavior action exhibited, mplemented and the utcome to the intervention. was exhibiting paced 20 when she documented	F 740				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	and behavior stresson interventions to suppo- expression/distress a behavior on the MAR Continued review of F Notes, dated 03/06/20 #30, revealed the res directed towards othe behaviors, directed to Other behaviors, not of also almost daily. Wa and posed a significa others. However, review of the documented evidence implemented individu and behavior stresson interventions to suppo- expression/distress a the 03/06/2021 at 2:1 LPN #30, via telephon behaviors for Resider on 03/06/2021 at 12:7 Review of Resident # 03/01/2021-03/31/202 11/06/2020 which sta free? YES or NO (if M document type, interv Nurses Note). Obser throwing items, cursir wandering around the Disease." Additional	alized resident's behaviors rs identified or specific ort and reduce the fter each documented Resident #21's Nurses 021 at 12:18 PM, by LPN ident had physical behaviors ers almost daily. Verbal owards others almost daily. directed towards others was andering daily or almost daily nt risk and was intrusive of the CCP, revealed no e the facility developed or alized resident's behaviors rs identified or specific ort and reduce the fter identified behaviors in ess Note. 5 PM, attempted to contact ne. LPN #30 documented nt #21 in a Progress Note, 18 PM. 21's MAR, dated 21, revealed an order dated ted, "Is the resident behavior NO and behavior is present, vention, and outcomes in	F	740			

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		185301	B. WING			( 05/:	C 22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740	following dates at 5:30 03/10/2021; 03/11/202 and on 03/31/2021. F "YES" at 5:30 PM on 03/09/2021 and 03/16 However, review of R Notes, for those dates evidence of a behavior intervention, or outcor On 04/26/2021 at 2:12 LPN #14, via telephor "YES" for behavior w documentation, on 03 03/17/2021 at 5:30 AF Further review of the documented evidence implemented individua and behavior stressor interventions to suppor expression/distress at "YES" behavior on the Review of Resident # 02/01/2021-02/28/202 11/06/2020. The Ord behavior free? YES of present, document typ outcomes in Nurses N care, throwing items, and wandering around Alzheimer's Disease.' six (6) times in Februa indicating a behavior opportunities to document	nt. Per the MAR, on the 0 AM: 03/09/2021; 21; 03/14/2021-03/17/2021; Further review revealed the following dates: 5/2021. esident #21's Nurses' s revealed no documented or exhibited, type, mes. 2 PM, attempted to contact the. LPN #14 documented ith no Nursing Note /14/2021 through M. CCP, revealed no e the facility developed or alized resident's behaviors s identified or specific ort and reduce fter the each documented e MA 21's MAR, dated 21, revealed an order dated er stated, "Is the resident or NO (if NO and behavior is ope, intervention, and Note). Observe for refusal of cursing, yelling at others,	F 74	40				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		185301	B. WING _					C 22/2021
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	=		
				46	04 LOWE ROAD			
REGIS WO	DODS			LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 740	02/01/2021; 02/02/20. Further, the following 02/08/2021 at 5:30 Pf 02/12/2021 5:30 AM a nurse failed to docum present or not presen review of the Nurses' revealed no document exhibited, type, interve On 04/26/2021 at 2:11 LPN #2, via telephone "YES" for behaviors w documentation, on 02 5:30 PM. However, review of the documented evidence implemented individua and behavior stressor interventions to suppor expression/distress at behavior on the MAR. Review of Resident # 01/01/2021-01/31/202 11/06/2020, "Is the re- or NO (if NO and behavior type, intervention, and Observe for refusal of cursing, yelling at othe the unit related to Alzi Additional review reve January "YES" was di- behavior was present	<ul> <li>16/2021;</li> <li>21. Continued review</li> <li>0 PM on the following dates:</li> <li>21; and, 02/15/2021.</li> <li>dates were blank:</li> <li>M; 02/11/2021 at 5:30 AM;</li> <li>and 5:30 PM, indicating the ent if behaviors were</li> <li>t during this shift. However, Notes for those dates</li> <li>ted evidence of a behavior ention, or outcomes.</li> <li>7 PM, attempted to contact</li> <li>e. LPN #2 documented</li> <li>vith no Nursing Note</li> <li>v/01/2021 and 02/15/2021 at</li> <li>we CCP, revealed no</li> <li>e the facility developed or alized residents' behaviors 's identified or specific ort and reduce</li> <li>fter each documented</li> <li>21's MAR, dated</li> <li>21, revealed an order dated sident behavior free? YES avior is present, document d outcomes in Nurses Note).</li> <li>f care, throwing items, ers, and wandering around</li> </ul>	F 7	40				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 740	on the following dates 01/19/2021. Continue 5:30 PM on the follow 01/04/2021-01/05/202 01/16/2021-01/18/202 01/29/2021-01/31/202 the following date(s) v 5:30 AM, indicating the if behaviors were present this shift. However, re- for those dates revea evidence of a behavior intervention, or outcoor On 04/26/2021 at 2:1 LPN #2, via telephone behavior with no Nurse 01/04/2021, 01/05/20 and 02/15/2021 at 5:3 However, review of the documented evidence implemented individu and behavior stresson interventions to suppor expression/distress a behavior on the MAR, of 12/01/2020-12/31/202 11/06/2020, which stat behavior free? YES of present, document typ outcomes in Nurses N of care, throwing item and wandering aroun Alzheimer's Disease. <sup>4</sup> eleven (11) times in E	a at 5:30 AM: 01/12/2021; ed review revealed "YES" at ving dates: 21; 01/11/2021-01/12/2021; 21; 01/26/2021; 21. Further review revealed were blank: 01/26/2021 at he nurse failed to document sent or not present during eview of the Nurses Notes led no documented or exhibited, type, mes. 7 PM, attempted to contact e; she documentation, on 21, 01/16/2021, 01/18/2021 30 AM. He CCP, revealed no e the facility developed or alized residents' behaviors rs identified or specific ort and reduce the fter each documented dated 20, revealed an order dated ated, "Is the resident or NO (if NO and behavior is pe, intervention, and Note). Observe for refusal is, cursing, yelling at others, d the unit related to ' Additional review revealed	F	740			

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD			
				LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	and two (2) opportuni were blank. Per the at 5:30 AM: 12/02/202 review revealed "YES following dates: 12/02 12/04/202; 12/06/202 12/11/2020; 12/19/202 12/31/2020. Further, blank: 12/20/2020-12, indicating the nurse fa behaviors were prese shift. However, review those dates revealed a behavior exhibited, outcomes. On 04/26/2021 at 2:17 LPN #2, via telephone for behaviors with no documentation, on 12 12/31/2020 at 5:30 Pf However, review of th documented evidence implemented individua and behavior stressor interventions to suppor expression/distress at behavior on the MAR. Review of the MAR, of 11/01/2020-11/30/202 November "YES" was behavior was present documented a behavio MAR on 11/13/2020 a review revealed "YES following dates: 11/09	ties to document a behavior MAR, on the following dates 20; 12/06/2020. Continued " at 5:30 PM on the 2/2020; 12/03/2020; 0; 12/07/202; 12/10/2020; 20; 12/20/2020; and the following dates were /21/2020 at 5:30 AM, ailed to document if ent or not present during this w of the Nurse's Notes for no documented evidence of type, intervention, or 7 PM, attempted to contact e; she documented "YES" Nursing Note 2/19/2020, 12/20/2020, and M. e CCP, revealed no e the facility developed or alized resident's behaviors rs identified or specific ort and reduce fter each documented dated 20, revealed six (6) times in a documented indicating a and four (4) opportunities to ior were blank. Per the at 5:30 AM. Continued	F 74				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		185301	B. WING		_	( 05/:	; 22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740	AM, indicating the nur behaviors were prese shift. However, review those dates revealed a behavior exhibited, outcomes. On 04/26/2021 at 2:20 LPN #2, via telephone behavior with no Nurs 11/13/2020 at 5:30 AM However, review of R on 11/09/2020, reveal behaviors of (refusal of cursing and yelling at around the unit) on 11 there was no docume Progress Notes or the behaviors on 11/05/20 evidence the individual stressors were identified on 11/09/2020; and no specific interventions and reduce expression Review of Resident # 10/01/2020-10/31/202 evidence of behavior However, review of th October 2020 revealed exhibited behaviors. reflect the resident's in resident's behavior stu- interventions were de reduce expression/dis	20 and 11/24/2020 at 5:30 rse failed to document if int or not present during this w of the Nurses Notes for no documented evidence of type, intervention, or 0 PM, attempted to contact e; she documented "YES" sing Note documentation, on M. esident #21's CCP, revised led the resident exhibited of care, throwing items, others, and wandering 1/05/2020. However, 1.) inted evidence in the e MAR for exhibited 020 and 2.) no documented alized resident's behavior ied until four (4) days later, o documented evidence were developed to support in/distress. 21's MAR, dated 20, revealed no documented monitoring for Resident #21. ie Progress Notes in ed documented evidence of Review of the CCP did not individualized behaviors and ressors or evidence specific veloped to support and	F 740					

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
						С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 740	System (RMS) Event completed by LPN #3	s Summary Report, 34, on 10/28/2020 at 10:40	F 74	40		
	AM, revealed Resident #21 had a resident- to- resident altercation with alleged abuse, and he/she was the victim. Per the report, Resident #21 walked into the common room beside Resident #2 and asked the resident, "What's					
going on in here?", F Resident #21 in the f		esident #2 then slapped ace. Resident #21 then in the face. Staff witnessed				
	residents. Resident # cussing and crying. F other documentation					
	stressors were identif interventions were de reduce expression/dis	e the facility ensured hts' behaviors and behavior				
	others.					
	Report, completed by 10/25/2020 at 4:00 A	21's RMS Events Summary / LPN #38, revealed on M, Resident #21 had a Iltercation with alleged				
	review revealed Resi Resident #26 scratch LPN #38 witnessed F	as the victim. Continued dent #21 reported that ed him/her. Additionally, Resident #21 walk down the				
	patted him/her on the	-				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	
		185301	B. WING			-		22/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 740	based on Resident #2 did not like Resident #2 cheek and took offens report, corrective active redirected. Review of Resident # revision to intervention exhibited physical bell resident. The revision to include redirect the attempted to provide others residents' pers Continued review of F Notes, dated 10/10/20 revealed the resident his/her roommate and you don't live here, se was immediately redin minutes became upse and required the room the room. However, review of the documented evidence individualized resident stressors were identifi interventions were de reduce the expression 10/10/2020 Progress directed towards other Review of Resident # 10/09/2020 at 10:00 A the Interdisciplinary Tr resident's recent ever resident down, causir	26's statement that he/she #21 touching him/her on the se by the contact. Per the on was the residents were 21's CCP, revealed a ns in the focus: the resident haviors towards another n was made on 10/25/2020, e resident when he/she care to others, or invaded ional space. Resident #21's Progress 020 at 5:39 PM, by LPN #36, showed anger towards d stated get out of my room, everal times. The resident rected however after several et again with the roommate nmate to be removed from the CCP, revealed no e the facility ensured its' behaviors and behavior fied and specific eveloped to support and n/distress after the Note to identify anger ers. 21's Progress Note, dated AM, by LPN #36, revealed ieam (IDT) discussed the	F	740				

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	S FOR MEDICARE &					IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · /	E SURVEY IPLETED	
			7.1 20122.111			С	
		185301	B. WING		05/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	1		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 740	Continued From page	e 254	F 74	40			
		t having impaired cognition, event, or angry towards					
	Additionally, review of Resident #21's CCP, revealed on 10/09/2020, the focus Care Plan that identified the resident was in a resident-to-resident altercation; Resident #21 was the aggressor, was resolved (removed). Additional review revealed the intervention of 1:1 supervision; was also resolved (removed) on 10/09/2020. However, there was no documented evidence the individualized resident's behaviors and behavior stressors were identified and specific interventions were developed to support and reduce the expression/distress after the 10/09/2020 resolutions were made to remove the resident when he/she had physical behaviors						
	on 10/08/2020, revea physical behaviors to resident had diagnos Anxiety Disorder, and goal was the resident himself/herself or oth but were not limited t activity based on pre- Observe frequently a dated 10/08/2020; an	Resident #21's CCP, initiated aled the resident exhibited wards another resident. The les of Alzheimer's Disease, d Psychotic Disorder. The					
	However, review of the documented evidence implemented individue	he CCP, revealed no e the facility developed or alized residents' behaviors hers) and behavior stressors					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
REGIS W	DODS				604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD B		(X5) COMPLETION DATE
F 740	Review of Resident # Administration Note, of PM, by the previous A revealed he spoke wit to a pending room cha concern about the resi- behaviors towards po Assistant Administrator selected roommate we and the residents wer Further, the Assistant complications arose, it room assignments wor On 04/26/2021 at 2:27 the facility's previous a telephone; he docume 10/06/2020 at 12:26 F However, review of the documented evidence individualized residen stressors were identifi- interventions were de reduce expression/dis Progress Note identify Further review of Resi Management System Report, completed by 10/02/2020 at 6:38 Pt resident-to- resident a abuse, and he/she wa Additionally, the Activ- witnessed Resident #	n/distress after the o-resident altercation. 21's Progress Note/ dated 10/06/2020 at 12:26 Assistant Administrator, th the resident's POA related ange and the POA voiced sident's sun-downing itential roommates. The or assured the POA the ras a previous roommate re known to get along. Administrator noted if necessary adjustments to ould be made. 7 PM, attempted to contact Assistant Administrator, via ented the Note on PM. The CCP, revealed no e the facility ensured its' behaviors and behavior ied and specific eveloped to support and stress after the 10/06/2020 ying sun-downing behaviors. Sident #21's Risk (RMS) Event Summary LPN #36, revealed on M, Resident #21 had a altercation with alleged	F	740				

Facility ID: 100503

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 740	resident had a history abuse and intrusion of Further, the root caus Resident #21 was cog difficult to redirect. Pa attempted to go into a intervened/pushed Re Corrective Action was 1:1 until directed by II However, review of the no documented evide resident's behaviors a identified or other spe developed to support expression/distress of wandering into other spe developed to support expression/distress of wandering into other for or physical behaviors 2. Record review rever Resident #61 to the M primary diagnosis of tw without behavioral dis resident was diagnos with depressed mood secondary diagnosis. medical and financial Review of Resident # 02/27/2020, revealed symptoms of psychos whispering, screamin in his/her room. The demonstrate increase included but were not consistent, trusted ca routine; Approach the unhurried manner, rea	<ul> <li>of verbal and physical</li> <li>of personal space of others.</li> <li>are of the altercation was that</li> <li>gnitively impaired and</li> <li>er the Report, Resident #21</li> <li>another resident's room and</li> <li>asident #61 down.</li> <li>a to place Resident #21 on</li> <li>DT.</li> <li>be CCP revealed there was</li> <li>and behavior stressors were</li> <li>and reduce the</li> <li>f paced ambulation,</li> <li>residents' rooms, and verbal</li> <li>directed towards others.</li> </ul> ealed the facility admitted ACU, on 12/17/2019 with a unspecified Dementia sturbance. Additionally, the ed with Adjustment Disorder <ul> <li>on 06/16/2020, as his/her</li> <li>Further, the resident had a</li> <li>POA.</li> </ul> 61's CCP, initiated on the resident exhibited sis related to delusions; g, and throwing items while goal was for the resident to ed stability. Interventions <ul> <li>ilmited to: Provide</li> <li>regivers and structured daily</li> </ul>	F	740			

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PRINTED: 07/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185301	B. WING			-		C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	2000			46	604 LOWE ROAD			
				L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page	257	F	740				
	on 09/16/2020, revea potential for psychoso multiple medical prob Dementia without beh Adjustment Disorder y Major depressive diso exhibited tearfulness, wandering. The goal no signs or symptoms The interventions incl Complete behavior m behavior was exhibite Observe for signs and distress (tearfulness, Social Service visits a However, the CCP was specific interventions expression/distress of Review of Resident # (MDS) Quarterly Asse revealed the resident express ideas, wants, understood. Per the <i>J</i> usually had the ability content of others. Th resident to have a Bri Status (BIMS) score of severely impaired cog decision-making. Fur	becial distress related to lems and diagnoses of: navior disturbance, with depressed mood, and order. The resident crying, irritability and was for the resident to show s of psychosocial distress. uded but were not limited to: onitoring documentation if ed; Psychological services; d symptoms of psychosocial crying, irritability); and as necessary. as not developed to include to support and reduce r tearfulness and crying. 61's Minimum Data Set essment, dated 07/11/2020, usually had the ability to , and make himself/herself Assessment, the resident r to understand verbal e facility assessed the ef Interview for Mental of four (4) which indicated gnitive skills for daily ther, the resident was depression symptoms, no delirium, no potential						
	Review of Resident #	61's Physician's Orders,						

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING			C 05/2	; 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
REGIS WO	ODS						
			L L'	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE		(X5) COMPLETION DATE
F 740	(2) times a day for Moresident had an order the resident behavior (tearful, crying irritabil interventions and outor Every day and night s Review of Resident # 10/01/2020-10/31/202 evidence of behavior However, review of th October 2020 reveale exhibited behaviors su crying. However, the individualized residen behavior stressors or interventions were de reduce the expression Additional review of R Notes, dated 10/02/20 by LPN #37, revealed altercation with Resid balance and landing of the Unit Supervisor w with the resident sittin arrived.	ealed an order, dated ridone (antipsychotic grams (mg) by mouth, two bod Disorder. Further, the , dated 09/25/2020, for "Is free?" If behavior present ity), document type, comes in Nursing Notes; hift for behaviors. 61's MAR, dated 20, revealed no documented monitoring for Resident #61. e Progress Notes in d documented evidence of uch as tearfulness and CCP did not reflect the t's behaviors and resident's evidence that specific veloped to support and h/distress. esident #61's Progress 020 at 5:38 PM, completed t the resident had an	F 740				
	Event Summary Report revealed on 10/02/202 had a resident-to- rest abuse, and he/she was the Activities Assistant Resident #21 and Rest	anagement System (RMS) ort, completed by LPN #36, 20 at 6:38 PM, Resident #61 ident altercation with alleged as the victim. Additionally, t, on the MCU, witnessed sident #61 get into a verbal ent #21 pushed Resident					

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-03 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · · ·	MPLETED	
						С	
		185301	B. WING		0	5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
REGIS WO	2006			4604 LOWE ROAD			
	5663			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 740	Continued From page	> 259	F 74	10			
1 740	10	ontinued review revealed	F / 4	10			
		alteration was that Resident					
		o enter Resident #21's room					
		ame angry and pushed the					
		ng injury. Per the Report,					
		was to place Resident #21 by IDT, and send Resident					
	#61 to the emergency	-					
		8, on 04/22/2021 at 4:15 PM					
		20 around 5:00 PM, she was on the MCU, watching					
		activity. Per interview,					
	- · ·	dining room upset and					
		did not report to the nurse,					
	because it was a norr						
		mes each day and everyone					
		d the behavior all the time. e resident left the common					
	-	ied to enter Resident #21's					
	room (room right besi	ide Resident #61's room).					
		evealed she could see					
		from the common room					
		ing. Resident continued to Resident #21's doorway.					
		time Resident #21 was					
		ambulation up and down the					
		w, Resident #21 became					
	-	Resident #61 was crying and					
		n. Continued interview ard a commotion (yelling					
		all staff ran to Resident #21					
	and Resident #61; ho	wever, she did not witness					
	what happened.						
	Review of Resident #	#61's CCP, revealed the					
		op the resident's Care Plan					
	to include the residen	-					
		2020, six (6) days after the					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· /			IPLETED	
			A. DOILDING			С	
		185301	B. WING		0	5/22/2021	
NAME OF PF	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD		00/22/2021	
			4604 LOWE ROAD				
REGIS WC	ODS			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 740	Continued From near	- 200	<b>F 7 4</b>				
F /40	Continued From page		F 740				
		view revealed the resident					
		another resident which se psychosocial distress.					
		gnosed with Dementia					
	without behavior dist	-					
		The goal was for the					
	resident to show no s	•					
		is included but were not					
	limited to: Encourage	interaction with peers;					
	Engage in his/her life	in the facility; and observe					
	• •	ms of psychosocial distress					
		rritability). However, there					
	was no documented	•					
	developed or implemented						
		yelling directed towards stressors identified or					
		to support and reduce the					
	•	fter the verbal altercation					
	leading to the abuse.						
	Interview with the Act	ivities Assistant on					
		M revealed on 10/02/2020					
		was in the hallway near					
	•	working on an Activities					
		close to Resident #61's and					
		s. Per interview, he saw					
	Resident #61 standin	g by the calendar in the					
		bulated to his/her her room.					
		t # 21 walked passed him to					
		mediately they started yelling					
		nterview, the residents were					
		st words in the sentences					
		e they were cutting one					
		d the residents stated, "No					
	you can't." Yes I can.	" Continued interview s were verbally telling one					
	Tevesien the resident		1				
	another they could no	ot come in Resident #61's ne room. However, he was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
			46	04 LOWE ROAD			
REGIS WO	DODS		LC	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	resident off balance, w fall backwards toward wall in the hallway and Additionally, the resid separated, and Resid placed on 1:1 with a s at first obviously injure incident sent to the Er he/she verbalized pain Further interview rever on the MCU, Residen paced up and down th common areas contin Additionally, he was a become defensive tow times when their path he was aware the res aggressive towards of interview revealed that the MCU, Resident #6 episodes intermittenth days. Further, he did behaviors at that time nurse was already aw Additional review of R Data Set (MDS) Quar 03/25/2021 revealed to ability to express idea himself/herself unders the resident usually have verbal content of othe the resident to have a Status (BIMS) score of severely impaired cog decision-making. Fur	in the chest, knocking the which caused the resident to ls the door, then along the d to the ground. ents were immediately ent #21 was immediately staff. Resident #61 was not ed but was shortly after the mergency Room because n in his/her right arm. ealed since he had worked t #21 was ambulatory and he hallways, and in the uously, most days. ware the resident would wards other residents at s crossed. Per interview, ident had been physically thers too. Continued at since he had worked on 61 had tearful and crying y throughout the day, most not report the resident's to the nurse because the vare. Resident #61's Minimum terly Assessment, dated the resident usually had the as, wants, and make stood. Per the Assessment, ad the ability to understand ers. The facility assessed a Brief Interview for Mental of three (3) indicating gnitive skills for daily ther, the resident was depression symptoms, no	F 740				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		-	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STA	ATE, ZIP CODE		-
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 740	4:02 PM; 04/26/2021 04/28/2021 at 8:00 Al 2:30 PM, revealed the common rooms, hallw tearful and crying. H and Progress Notes, f evidence of the behave those specific dates at Additional review of R 04/01/2021 through 0 order dated 09/25/202 behavior free?" If beh crying, irritability), doc and outcomes in Nurs night shift for behavio revealed each day 6:0 PM -6:00 AM , "YES" the resident was behave night shift, except 04/ PM, which was blank. Additional review of R Notes, dated 04/01/20 revealed no document (tearful, crying, irritabil outcomes. However, interview w MCU revealed they w tearful and crying but knowledgeable of per developed by the Inter support the resident at	s, and no behavioral dent #61 on 04/22/2021 at at 10:40 AM and 1:55 PM; M; and on 04/30/2021 at e resident on the MCU in the vays and in his/her room owever, review of the MAR revealed no documented viors (tearful, crying) on ind times. Resident #61's MAR, dated 4/30/20201, revealed an 20, for " Is the resident avior present (tearful, cument type, interventions sing Notes; Every day and rs. Additional review 20 AM - 2:00 PM and 10:00 was documented indicating avior free every day and 10/2021 at 6:00 AM-2:00 Resident #61's Progress 221 through 04/30/2021, ted evidence of a behavior ility), interventions or whether aware the resident was they were not son centered interventions rdisciplinary Team (IDT), to	F 740				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page behavior monitoring.		F 740				
	at 4:10 PM revealed t the MCU, Resident #6 episodes intermittent	es Assistant, on 04/22/2021 hat since he had worked on 61 had tearful and crying y throughout the day, most observe the resident with					
	#8, on 04/22/2021 at 4 had worked on the M0 resident to exhibit cryit daily basis; therefore document the behavior	or because it was the havior and everyone knew					
	AM, revealed since sh Resident #61 cried all not report Resident #6	2, on 04/26/2021 at 10:45 he had worked on the MCU, the time. Further, she did 61's behavior of crying to the one knew the resident cried					
	revealed Resident #6 was tearful and would However, she did not behavior every time h tearful because it was	on 04/26/2021 at 2:30 PM, 1's behavior was he/she cry intermittently every day. document the resident's e/she cried or became so frequent. Further, she sident was crying at the time					
	revealed she was awa	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WC	ODS						
				LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page	264	F 740				
	revealed shortly after to the MCU, he/she be episodes on a regular interview, the resident meal, during activities Additionally, the resid his/her room when he However, on 04/28/20 observed behaviors ( she had not observed Interview with Agency 3:30 PM revealed she behaviors to the nurse always cried and ever this behavior. Further resident and distract h crying. Interview with the Mer (MCPD), on 04/26/20 had worked at the fac one (1) year and had months. Per interview behaviors to be docur by the licensed nurse the intervention and th nurses did not always would make the Progr of the behavior. Additi three (3) day follow up behavior observed to effective and the reside interview, there were	ent would attempt to go to advectory of the second tearful. 221 staff had not reported (tearful or crying), to her and 1 those behaviors either. 2 CNA #19, on 04/30/2021 at a did not always report a because Resident #61 ryone knew the resident had r, she tried to console the him/her to help stop the mory Care Program Director 21 at 3:00 PM, revealed she illity as a Social Worker for been the MCPD for six (6) w, she expected all mented in a Progress Note to include the behaviors, he response. However, a make that happen and she ress Note if she was aware ionally, she expected a o Progress Note, with any ensure interventions were dent's response. Per					
	residents with known	g station, in a binder for behaviors that all direct care to document behaviors.					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTU	PLE CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · · ·	LETED
						2
		185301	B. WING		05/2	22/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
REGIS WO	0006			4604 LOWE ROAD		
REGIS WC	0003			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 740	Continued From page	e 265	F 7	40		
	1.0	ot aware the binder was		+0		
	,	e no Behavior Flow Sheet				
		er 2020. Continued interview				
	revealed she rounde	-				
		and spoke with nursing staff,				
		ice when she entered the				
	-	lso review any Progress ormed her of any behaviors				
		she was at home; however,				
		old her about a resident with				
		t review Progress Notes.				
		g Monday through Friday,				
		d review any documented				
		interventions were in place				
	Resident #61 cried a	changes. Per interview,				
		te his/her needs. Continued				
		esident #21 had paced				
		tantly walked up and down				
		e common areas and would				
		residents' space. However,				
	-	urses to document every time				
		r Resident #21 paced or got 's space because they would				
		0) plus times a day and				
		ng else done. Per the				
		as responsible to ensure all				
	residents with known					
	-	eir specific behaviors and				
	behavior stressors id					
	their expression/distr	bed to support and reduce ess.				
	Interview with the fac					
		M revealed residents should				
	collaboration of the II	e and services through				
		Si. Additionally, She				
	expected direct care	nurses and aides to identify,				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	; 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	000		4	4604 LOWE ROAD			
REGIS WC	005		1	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	individualized interver for effectiveness. Cou- she was not aware of IDT in the facility. She communication with the the medical record to residents exhibited. He facility was not consist always find answers to residents. She stated were not familiar with know the resident, the was normal. Continue that happened she wa on with the resident. she stated Resident # stable. Interview with the faci on 05/05/2021 at 4:22 facility nursing staff to some form or fashion. documentation would things that were going Additionally, he stated were good about callin changes with resident surprised that the doc observations of behav he stated he felt if stat known behaviors, this	build develop and implement nations and re-assess them intinued interview revealed behaviors rounds per the e stated she relied on verbal ne staff or documentation in know what behaviors dowever, staffing in the tent and she could not o her questions about I staff would tell her they the resident, they did not ey were new or the resident ed interview revealed when build talk to the CNE and try s aware of anything going Further, interview revealed t21 and Resident #61 were lity's contracted Physiatrist, 2 PM revealed he expected document all behaviors in . Per interview, nursing be helpful to know those g on with the resident. d he felt the nursing staff ng him with behaviors	F 740		)EFICIENCY)		
	would not be docume wouldn't know to treat not documented. Cor on 04/29/2021, nursin	ntation to support it or he t a problem because it was ntinued interview revealed ng staff had reported to him s stable and review of the					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · · ·	MPLETED	
						С	
		185301	B. WING		0	5/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
REGIS WO	DODS			4604 LOWE ROAD			
				LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 740	Continued From page	e 267	F 74	10			
	_	tes revealed no documented					
	evidence the resident						
	Additionally, on 05/05	5/2021, he had seen					
		23/2021, and the resident					
		d he noted there was no					
		e of nursing notes related to eviewed the medical record.					
		d nursing staff told him the					
	-	Continued interview revealed					
	he had seen Residen	t #61, on 05/05/2021;					
		reviewed the resident's					
	record "yet" or spoke	with nursing staff.					
	Interview with the Ce	nter Nurse Executive (CNE),					
	on 05/11/2021 at 11:2	25 PM, revealed she had					
		for seven (7) months. Per					
		hould receive and the facility					
		ecessary behavioral health dditionally, the facility's					
		should be followed to ensure					
		ecessary care and services.					
		deviated from the Behavior					
	Management of Sym	ptoms policy. The Behavior					
	Rounds Best Practice	-					
		utline and the Behavior					
	•	rentions Flow Record was no facility. The CNE stated the					
	-	cord had not been utilized					
		after implementation of the					
		Continued interview revealed					
		cumented behaviors in the					
	Monday through Frid						
		MCPD brought information					
		nted behaviors to the daily behaviors would not be					
	-	Further, all behaviors					
		ed by direct care staff, if a					
		haviors, in a Progress Note,					
		r, the intervention, and the					

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		MEDICAID SERVICES		E CONSTRUCTION		10. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,			MPLETED	
						С	
		185301	B. WING	G		5/22/2021	
NAME OF PF	OVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	0.00			4604 LOWE ROAD			
REGIS WO	005			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 740	Continued From page	268	F 74				
1 / 10		ortant for all staff to know	F / 4				
		ors a resident had to assist					
		or maintain the highest					
	practicable physical,	mental, and psychosocial					
		ndividualized necessary care.					
		Should review behavior					
		evelop approaches for each					
	resident to address u	nderlying causes of ate the effectiveness and the					
	resident's responses						
	-	haviors being documented,					
		perly support and reduce the					
	-	the residents. Review of					
		viors documentation in the					
	medical record, and i						
		NE revealed the resident's					
	behaviors should hav	dent #21's behaviors would					
		ed in the medical record,					
		hat the behavior effect could					
	have been less for the						
	residents on the MCL	J. Review of Resident #61's					
		vith the CNE revealed those					
	, 0	ors exhibited should have					
		ect care staff, reported and					
		edical record. Continued e felt the facility's failures					
		between direct care staff,					
	MCPD and the IDT; t	-					
		U were not brought to the					
	IDT's attention and w	alking rounds on the MCU					
	only gave the CNE a	snap shot of the residents.					
	Interview with the Ce	nter Executive Director					
	(CED), on 05/11/2022	1 at 3:25 PM, revealed he					
		cility for three (3) months.					
	-	ected the IDT to work					
	together to manage b	abovier icovec for all		1		1	

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						10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		185301	B. WING			
	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP CODE	0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER					
REGIS WO	DODS					
				LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 740	Continued From page	e 269	F 740			
1 / 10		s Policy and Protocols related	F 740			
		llowed and revised as				
		o be inaccurate. Continued				
		e expected direct caregivers				
		behaviors and provide				
		rvision to the residents and				
		lical record. Per interview,				
	the IDT would discus	s all documented stressors				
	and interventions and	d recommend actions to				
		he behaviors. Further, the				
		oughout the facility Monday				
		mornings before Clinical				
		resident concerns; however,				
		ware of behaviors the				
		on cleanliness and any nt might have. Continued				
	interview revealed th	•				
	(QA)/Quality Assurar					
		Committee discussed				
		owever, the QA/QAPI				
	committee had not re	eviewed Resident #21 and				
	#61's behaviors.					
	3. Record review rev	ealed the facility admitted				
		19/2021 with diagnoses that				
	included Dementia w					
	Parkinson's disease,					
		epeated Falls. Continued				
	review revealed Resi					
		nission to the facility due to her review revealed staff				
		sive behaviors prior to being				
		mory Care Unit (MCU)				
		e aggressor in a physical				
	altercation involving a					
		um Data Set (MDS), dated				
		Resident #86 was not				
	assessed for a Brief	Interview for Mental Status.				
	·	vealed mood concerns were				

Facility ID: 100503

If continuation sheet Page 270 of 337

CENTER STATEMENT (	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			LETED
		185301	B. WING				C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD .OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	behaviors at the time Continued review of the #86 was administered diuretics seven (7) of Further review revealed diagnoses of Non-Alz Parkinson's disease. Review of the care plan revealed Resident #88 processes related to It to include redirection, room with familiar iter environment, and spe Further review revealed develop a care plan at behaviors exhibited p MCU involving combat care. Review of the 1:1 doc 03/27/2021, revealed behaviors such as hitt care at 1:00 AM, 1:30 3:00 AM, 3:30 AM, an revealed on 04/06/202 #86 exhibited behavior screaming/disruptive Review of Progress N 2:30 AM revealed Rest to get out of bed and Continued review of the 04/22/2021 at 3:37 Aff was wandering the has	e resident exhibited no of the assessment. he MDS revealed Resident d antipsychotics and the last seven (7) days. ed the resident had active theimer's Dementia and an, dated 03/22/2021, 6 had impaired thought Dementia with interventions personalize Resident #86's ms, create a calm/smoothing eak in a normal-tone voice. ed the facility failed to addressing Resident #86's rior to transferring to the ativeness and resistive to 0 AM, 2:00 AM, 2:30 AM, nd 5:30 AM. Further review 21 at 10:00 AM, Resident ors such as sounds. Notes, dated 03/25/2021 at sident #86 was attempting was unable to be redirected. he Progress Notes, dated M, revealed Resident #86 all and exit seeking, was d became agitated, and was	F	740			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				1604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 740	Record review reveal identify increased agg related to Resident #8 documentation log be the MCU. Interview with CNA #8 revealed prior to Resi MCU, he/she could be the potential to be con Interview with the CM AM, revealed Resider described as combati to his/heraltercation w Interview with LPN #8 AM, revealed prior to Resident #86 could be resistive to care. Interview with RN #1, revealed she notified Director of her concer moving to the MCU d and continuous attem his/her wheelchair. Interviews with the CN 7:20 PM, revealed she Resident #86's behav the MCU and would e She continued that his been documented in f IDT could identify the triggers so interventio	ed the facility failed to gression and agitation 86's 1:1 supervision efore he/she was moved to 8, on 05/12/2021 at 2:32 PM, ident #86's move to the e resistive to care and had mbative with staff. 1T, on 05/12/2021 at 11:30 nt #86 exhibited behaviors ive and resistive to care prior with Resident #85. 5, on 05/12/2021 at 11:45 his/her move to the MCU, e aggressive at times and on 05/12/2021 at 8:15 AM, the Memory Care Program rns with Resident #86 ue to his/her high falls risk npts to get out of bed and NE, dated 05/12/2021 at e was not made aware of viors prior to his/her move to expect staff to notify her. s/her behaviors should have the medical record so the behaviors and known ons could have been in place essive/combative/resistive to	F	740			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/16/2021 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 740	PM, revealed he was behaviors prior to his/ continued Resident # been documented so interventions in place behaviors. Further in Memory Care Program bring these identified meetings to be discus "did not know what th the SSA identified Re- through interviews. Review of the IJ Rem facility implemented th 1. On 05/11/2021 at Executive Director (C Executive Director (C Executive CNE), notid discuss the Immediate Hoc Quality Assurance Improvement Commit conducted with the CD Director for recomment action plan including a compliance monitors behavioral health server 2. On 05/11/2021 Vice Operations contacted Organization (QIO) for 3. On 05/12/2021, a con PPL Therapeutic Server behavioral health server treatment plans and in interpersonal interaction assessments of each	D, on 05/12/2021 at 6:36 not aware of Resident #86's /her move the to MCU. He 86's behaviors should have the IDT could have to help decrease his/her terview revealed it was the m Director's responsibility to behaviors to the IDT sed. He revealed that staff ey were talking about" when sident #86's behaviors toval Plan revealed the he following: 1:00 PM, The Center ED), and Center Nurse ified the Medical Director to e Jeopardy citations. An ad ee Performance ttee (QAPI) meeting was ED, CNE, and Medical ndations developing the audits, reeducation, and for residents at risk for	F	740			

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP	, CODE		
REGIS WO	DODS							
				L	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BI		(X5) COMPLETION DATE
F 740	(Corporate) National	erventions. e Senior Director from the Specialty Practices Team	F	740				
	Executive Director (C Managers ADNS, and regarding the facility's Management of Symp resident must receive provide the necessary services to attain or m practicable physical, m well-being in accordar assessment and plan reeducation included Situations and Behav Dementia Causes un obtained from the Qua Organization (QIO) w one-hundred percent hired staff would rece a posttest to verify un Specialty Practices Te	d Nursing Supervisor s policy, Behaviors: btoms, and that each and the facility must y behavioral health care and naintain the highest mental, and psychosocial nce with the comprehensive of care. Additionally, the De-escalate Challenging iors: How to respond when predictable Behavior ality Improvement ith a posttest requiring a (100%) grade. Any newly vive education and complete iderstanding by the National eam or CQS.						
	Nurse Executive( CNI Nursing Service (ADN Program Manager an would review the Prog presenting with behav meeting to determine health services. This times two (2) weeks in holidays then three (3) (2) weeks then week!	d or Unit Manager (UM) gress Notes of residents viors in the clinical morning the need for behavioral would be completed daily ncluding weekends and b) times per week times two y for eight (8) weeks then es eight (8) weeks then nth then ongoing thereafter						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION			SURVEY LETED
		185301	B. WING			_		22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	<ul> <li>Performance Improve ensure the behavioral were met with any con discovery.</li> <li>6. On or before 05/19 would evaluate Resid behavior stressors wo specific interventions added to the resident behaviors including be other residents. Addi Team (IDT) provided monitoring documenta the Medication Admin were updated.</li> <li>7. On or before 05/19 behaviors and behavi identified and specific developed and added behaviors including be other residents.</li> <li>8. By 05/19/2021, the (SSD), Social Worker (CNE), Assistant Dire (ADNS), Unit Manage Educator (NPE) and c conduct an audit of al presenting with behavior frustration, agitation, a or verbal behavioral s others and/or not dire the need for a behavior affected residents. Av instituted to ensure th</li> </ul>	ement (QAPI) Committee to I needs of the residents rrective action upon 9/2021, the PLLC services ent #21's behaviors, and buld be identified with developed that would be 's care plan to reduce ehaviors directed toward tionally, the Interdisciplinary Behavior Management ation for Resident #21 and distration Records (MAR) 9/2021, Resident #86's or stressors would be to the care plan to reduce ehaviors directed toward to the care plan to reduce ehaviors directed toward e Social Services Director c, Center Nurse. Executive ctor of Nursing Services er (UM), Nurse Practice or Licensed Nurses (LN) will	F	740				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WC	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page revised.	275	F 740				
	Executive (CNE) Unit nurses would provide nursing staff, including facility's policy, Behav Symptoms and that e and the facility must p behavioral health care maintain the highest p and psychosocial well the comprehensive as Reeducation also incl Challenging Situation Respond when Deme Behavior obtained fro Organization (QIO). Additionally, the SSD ADONS, Unit Manage (NPE) and/or Charge re-education for nurse investigation when a b triggers in order to de care plan. A passing grade of or was required. Staff no frame to include agen re-education including Managers and or CNE	ach resident must receive provide the necessary e and services to attain or practicable physical, mental, l-being in accordance with ssessment and plan of care. uded Tips to De-escalate s and Behaviors: How to entia Causes Unpredictable m the Quality Improvement , Social Worker, CNE, er, Nurse Practice Educator Nurse would provide es to complete a thorough behavior occurs to identify velop a person centered me-hundred percent (100%) of available during this time icy staff will be provided g posttest by the Unit E upon day of return to uding agency staff will be					
	10. The Center Nurse	Nursing Service (ADNS),					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/16/2021 RM APPROVED IO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DAT	E SURVEY IPLETED
		185301	B. WING		0	C 5/22/2021
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COI		
REGIS WO	DODS			4 LOWE ROAD JISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 740	Assistant, Mental Hea Practitioner would cor determine that behavi appropriately with cor discovery weekly time times four (4) weeks to months then ongoing the Quality Assurance (QAPI) Committee to needs of the residents corrective action upor 11. The CED and/or da audits and interviews identified were address 12. The SSD, SW an review findings month the Quality Assurance Committee which con Executive Director, Co Assistant Director of N Director, Social Service Director, Dietitian, He Business Office. The State Survey Age implementation of the 1. Interview with the I 05/22/2021 at 4:33 PI Executive Director an Executive (CNE) notifi to the notification of Ir 05/11/2021. He revea Ad-HOC QAPI meetir committee and plan th	sed Nurse, Certified Nursing alth Provider or Nurse nduct behavior rounds to iors were managed rective action upon es four (4) weeks, bi-weekly then monthly times (4) thereafter as determined by e Performance Improvement ensure the behavioral s were met with any n discovery. CNE would review results of daily to ensure concerns ssed upon discovery. cNE would review results of daily to ensure concerns ssed upon discovery. color CNE would report the hly times six (6) months to e Performance Improvement usists of the Center enter Nurse Executive, Nursing Services, Medical ce Director, Dining Service alth Information Manager, ency validated the e facility's AOC as follows: Medical Director, on M, revealed the Center d the Center Nurse fied him by phone in regards mmediate Jeopardy on aled the facility held an	F 740			

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	telephone message w review revealed she r someone representing stated the QIO would 05/17/2021, but anoth gather training materia reference to her reque surrounding behaviora education. Further re sent to the CED, CQS Interview with the Qua Organization (QIO), o revealed the VPCO of request support for be 3. Review of the signe Agreement, signed by the company, dated 0 would provide medical services to the facility revealed the provider cooperate to ensure t be served in an effect	udits, and monitoring e President of Clinical statement, undated, ontacted the QIO on imately 11:00 AM and left a with the QIO. Continued received a call back from g the Kentucky QIO and be out of the office until her advisor would begin to als and audit tools in est for assistance al interventions, training and eview revealed an email was S, and present VPOC.	F	740		DEFICIENCY)		
	the Memory Care Uni signing a contract for	ne residents' behaviors on t, the "Group" suggested therapeutic services. Director of Memory Support						

Facility ID: 100503

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	S FOR MEDICARE &					10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BOILDING			С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				4604 LOWE ROAD		
REGIS WO	5005			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 740	Continued From page	e 278	F 74			
		Education, on 05/22/2021 at		с 		
		ne provided education to the				
	management team, b	-				
	05/12/2021. Per inte					
		ion related to residents'				
		ne behaviors occur. She I de-escalating the residents				
		ons. Further interview				
	•••	was recorded and could be				
	used for future use.	The Director of Memory				
		port and Education stated				
	•	n the facility in reviewing the				
		she had access to the				
	facility's records.					
	Interview with the Se	nior Director of Social Work				
	Practice and Education	on, on 05/22/2021 at				
		PM, revealed she was				
		S to work with the staff's				
		mentia Care. She stated the				
		ided by way of Zoom, on				
		ted the policy and procedure nent was reviewed. Further				
		nior Director of Social Work				
		e explained to staff that "all"				
	behavior had meanin	ig and staff should look for				
	the causes, history, a					
		er revealed the education				
		more of an individualized				
		nning. She stated the facility t with a local provider to				
		nts' behaviors "in house".				
		ed she had partnered with				
	the Director of Memo	ry Clinical Support and				
		be reviewing the residents'				
	charts remotely.					
	5. Record review rev	ealed the facility's audit tools,				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	<ul> <li>the facility's clinical m daily progress notes f the need for services clinical team attendeed</li> <li>Interview with the UM revealed the clinical te documented by staff t services, care plan int assessments. The te behaviors on all high behavior progress not profile behaviors to re</li> <li>Interview with the CN PM, revealed she pull notes daily. She state determine if there were behaviors. Per intervio 05/14/2021.</li> <li>Resident #21 was Services and his/her of 05/17/2021, by Social #2. Resident was pro- monitoring.</li> <li>Review of Resident the residents were se Service Group.</li> <li>Review of Resident #4</li> </ul>	anagement team reviewed or behaviors to determine with signatures of the es. , on 05/20/2021 at 4:00 PM, eam reviewed behaviors o address with clinical tervention or further am printed daily reports for profile residents with tes, medication records, and es on residents with low eview. E, on 05/22/2021 at 6:30 led the residents' clinical ed she reviewed the notes to re any new or existing	F 740				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	on 05/21/2021 at 5:30 completed many of th behaviors; however th Services reviewed the updated as needed. 8. Review of the audi conduct visual observ staff were meeting the five (5) residents with revealed a column for column which stated, rounds to determine if behavioral care needs behavioral care needs behaviors, Yes or No. there was a column, w visual observation rou were meeting the beh residents with dement Interview with the Dire Compliance (DRC), o revealed on 05/19/202 for behaviors for fiftee with known behaviors Interview with the, Se Manager, on 05/22/202 she was the acting "P Memory Care Unit (M behavior observations the residents. Further audited the residents' stated if she found an would write a supplen up with the nurse.	cial Service Director (SSD), PM, revealed she e care plan updates for he Corporate Social e residents' care plans and it tool revealed staff would ration rounds to determine if e behavioral care needs of behaviors. Further review the resident's name, a "Conduct visual observation f staff were meeting the s of residents with Further review revealed which stated, "Conduct unds to determine if staff ravioral care needs of tia. Yes or No." ector of Regulatory n 05/22/2021 at 6:30 PM, 21 the facility initiated audits en (15) identified residents	F 740				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	at approximately 1:59 (RN) #1 on 05/21/202 05/21/2021 at 2:05 PN educated on how to in to residents with behave revealed they were educated the residents' behavior were provided a postfunction of the residents' behavior were provided a postfunction of the the they were educated the DRC administrative team for Continued interview reclinical and non-clinical 10. Interview with the on 05/22/2021 at 12:00 conducted the behavin Per interview, she staresidents at random at day. 11. Interview with the 05/22/2021 at 6:30 PM the audits from the become the educated the behaving the they are the educated the the the educated the the educated the the educated the the the educated the educated the educated the educated the the educated the the educated the	<ul> <li>LPN #22, on 05/21/2021</li> <li>PM, and Registered Nurse</li> <li>1 at 2:00 PM, RN #16, on</li> <li>M, revealed they were</li> <li>Additional interviews</li> <li>Additinterviews</li></ul>	F 740				

Facility ID: 100503

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		185301	B. WING		05	C 5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 758	Continued From page	e 282	F 75	8		
F 758 SS=G	Free from Unnec Psy CFR(s): 483.45(c)(3)	chotropic Meds/PRN Use (e)(1)-(5)	F 75	8		
	affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	hotropic drug is any drug that associated with mental vior. These drugs include, drugs in the following				
	Based on a comprehe resident, the facility n	ensive assessment of a nust ensure that				
	psychotropic drugs an unless the medication	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented				
	drugs receive gradua behavioral interventic	ents who use psychotropic I dose reductions, and ons, unless clinically n effort to discontinue these				
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented				
	are limited to 14 days	rders for psychotropic drugs 5. Except as provided in attending physician or				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMPI	SURVEY LETED
		185301	B. WING			05/2	, 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	ODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 758	beyond 14 days, he o rationale in the reside indicate the duration f §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the at prescribing practitione the appropriateness o This REQUIREMENT by: Based observation, in policy review, it was d to ensure residents re medications with adec actions taken for adve needed (PRN) orders day stop date for two sampled residents, (R #3). Resident #2 had an o five (0.5) milligrams (r (4) hours as needed for stop date. Observatio 04/14/2021 at 1:48 PM tremors of both upper Resident #3 was press (medication for Psych daily. Review of Resi revealed staff were dil effects and document	er believes that it is RN order to be extended r she should document their nt's medical record and for the PRN order. Teders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for of that medication. T is not met as evidenced neterview, record review, and letermined the facility failed eceived psychotropic quate side effect monitoring, erse reactions, and as included a fourteen (14) (2) of eighty-seven (87) Resident #2 and Resident rder for Ativan zero point mg) to be given, every four for anxiety/agitation with no on of Resident #2, on M, revealed resident had rextremities. Scribed Trazadone toosis) one-hundred (100) mg dent #3's the plan of care, rected to monitor for side to n the behavior monitoring record review and interview	F 758				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 758	Use Policy, revised 11 psychotropic medicati medication that affect and behaviors. The p medications were use diagnoses and only a medication therapies behaviors. The policy psychotropic medicati (14) days and not ren from the prescribing p were to monitor the re triggers, symptoms, a on a document titled, Chart/Record." 1. The facility admitter Memory Care Unit, or diagnoses to include 1 Disorder with Delusion Dementia. Review of Resident # 04/06/2021, revealed point five (0.5) mg tab needed for anxiety/ag did not have a stop da included Geodon twe daily for Schizophreni (40) mg twice daily or to sixty (60) mg in the at night on 04/01/202 revealed an order, da	s Psychotropic Medication 1/28/2016, revealed ions included any ed the mental processes policy revealed psychotropic ed with appropriate fter non-medication and failed to address the y revealed as needed (PRN) ions were limited to fourteen ewed without re-evaluation practitioner. Facility staff esident's behaviors with nd episodes documented "Behavior Monitoring d Resident #2 to the n 08/31/2020, with Bipolar Disorder, Psychotic ns, and Frontotemporal 2's Physician Orders, dated an order for Ativan zero olet every four (4) hours as jitation, however, the order	F 758				

Facility ID: 100503

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/16/2021 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			( 05/:	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS W	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 758	Review of the Medica (MAR), dated 03/01/2 revealed the nurses h and side effects relate medications. The doo for side effects reveal effects related to psyc Review of Resident # 03/01/2021 through 0 documentation of side psychotropic medicati Review of Resident # Plan (CCP), initiated o psychotropic medicati included monitoring fo and functional level ai monitor for continued related to behavior an notify the physician fo Review of Resident # Notes, dated 03/02/20 03/24/2021, revealed effects or extrapyrami side effects such as tr muscle restlessness, to improper dosing or antipsychotic medicati telehealth visits or rep Attempted to interview 04/14/2021 at 1:48 Pf respond to questions. Observation of Residen	tion Administration Record 021 through 04/20/2021, ad monitored for behaviors ed to psychotropic cumentation for monitoring ed Resident #2 had no side chotropic medications. 2's Progress Notes, dated 4/20/2021, revealed no e effects related to ions. 2's Comprehensive Care on 08/31/2020, revealed for interventions that or changes in mental status nd report to physician; need of medication as id mood, and monitor and ir side effects. 2's Psychiatry Progress 021, 03/09/2021, and documentation of no side dal side effects (abnormal remors, slurred speech, and muscle spasms related unusual reactions to ions) were observed during ported by nursing staff.	F 758				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	) 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page extremities.	286	F 758				
	04/15/2021 at 8:30 Al was able to independ two (2) weeks ago du	d Nurse Aide (CNA) #2, on M, revealed Resident #2 ently feed self until about e to shaking of the arms. ctor and the nurses were of the arms.					
	PM, revealed she was brought the psychiatri	20, on 04/23/2021 at 1:35 s in the room when RN #1 st's Medical Assistant in the erve Resident #2's tremors.					
	04/23/2021 at 8:45 Al the Medical Assistant Psychiatrist using a ta stated she took the M approximately three w the day she comes to the tremors. RN #1 w each week the tremor worse and the sitters She stated she had in	ered Nurse (RN) #1, on M, revealed she had notified (MA) who rounds for the ablet for video visits. She A into Resident #2's room veeks ago on a Thursday, the facility, and showed her vas concerned because rs had gradually gotten were feeding the resident. formed the facility Medical Id to monitor the resident.					
	on 04/20/2021 at 1:56 #2's upper extremity to for the past couple of notified the medical do concerned since the r abnormal mouth move directions from the do for worsening of treme	esident did not have ements. LPN #7 received octor to monitor and notify ors or additional symptoms. ot document the notification					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		SURVEY LETED
		185301	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	04/22/2021 at 10:48 A from antipsychotic me loss of appetite, treme (involuntary movemer makes it appear one i finger and thumb). Sl arms had been shakir #6 stated a PRN psyc an end date could ress in a medication order Interview with the com 04/22/201 at 1:49 PM not provide any educa psychotropic medicati She stated a quarterly Involuntary Movemen completed on 03/22/2 abnormalities. The P repetitive movement of been from the increase the past month. Interview with the Nur (NPE), on 04/26/2021 did not provide specific employee orientation medications and side Interview with the Asse Services (ADNS), on revealed during the m reviewed new orders facility policy, such as prn medication and st	red Nurse (RN) #6, on M, revealed side effects dications included sedation, ors, and pill rolling at of fingers/hands that is rolling a pill between the ne stated Resident #2's of for about a month. RN hotropic medication without ult in over sedation or result that was no longer needed. tracted Pharmacist, on , revealed the pharmacy did ation to the facility about ons and the side effects. AIMS (Abnormal t Scale) assessment, 021, revealed no narmacist stated the of arms/tremors could have e in the Geodon dose over se Practice Educator at 2:34 PM, revealed she c education with new on the topic of psychotropic effects. istant Director of Nursing 04/22/2021 at 10:09 AM, orning IDT meeting they to ensure they followed the reason or diagnosis for a op dates for prn ons. However, had not	F 7	58			

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						10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
				<u> </u>	с	
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From page		F 7	58		
	04/21/2021 at 3:56 P informed her yesterda tremors. The Medica	M, revealed the ADNS ay regarding Resident #2's I Physician stated she				
	pronounced tremors of she considered EPS.	2 on 04/20/2021, and noted of upper extremities, which She stated she was not				
	floor staff to hold Geo	arm tremors. She directed odon and contact the				
		r directions. The Medical as concerning the nurses did y the physician of the				
	-	ychiatrist, on 04/22/2021 at had recently increased n dose due to				
	stated EPS could incl and akathisia (feeling					
	the facility notified hir #2's arm tremors and	bility to sit still). He stated n on 04/21/2021 of Resident it was most likely from the vhich he discontinued. The				
	him before yesterday tremors. He stated the	cility staff had not notified of the gradually worsening ne nurses should have ocumented the side effects.				
		nter Nurse Executive (CNE),				
	monitored for side eff medications twice da					
	and pill rolling. The C notified her last week	CNE stated the ADNS of Resident #2's arm ing staff should have been				

Facility ID: 100503

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		D HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		185301	B. WING			05/2	) 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 758	entered a prn psychol computer system, sta stop date. The CNE s not specifically entered indefinite. She stated when she entered the 04/06/2021; it was ow Interview with the Cerr (CED), on 4/30/2021 a concern the nurses not document the side notification to the psyc doctor regarding the t independently. 2. The facility admitte Memory Care Unit on to include Dementia v and Psychotic Disord Observation of Reside 1:51 PM, revealed he appropriately dressed with another resident. Review of the Compres Set, dated 01/27/2027 a Brief Interview for M (5), which indicated set with physical behavio Attempt to interview F at 1:51 PM, revealed appropriately to quest Review of Resident # Plan, initiated on 01/2	tropic medication into the ff had to manually enter the stated when a stop date was ed, the field auto refilled to 1 that was what happened e Ativan order on erlooked. Ther Executive Director at 3:12 PM, revealed it was caring for Resident #2 did e effects or document the chiatrist or the medical remors and inability to eat ed Resident #3 to the 01/20/2021, with diagnoses with Behavioral Disturbance er with Delusions. ent #3, on 04/14/2021 at /she was well groomed, I, and walking down the hall ehensive Minimum Data 1, revealed Resident #3 had lental Status score of five evere cognitive impairment rs directed towards others. Resident #3, on 04/14/2021 he/she did not respond	F 758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/16/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		X3) DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP	CODE	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION E DATE
F 758	with a goal for resider without side effects. interventions for a gra documentation on bel monitor for functional/ notification of the phy effects, provide divers psychiatry as needed Review of Resident # dated 01/20/2021 thro orders that included A Dementia) five (5) mg (medication for Psych daily, and monitor resiss hift with documentation present. Review of Resident # through 04/14/2021, r administered Trazado Review of Resident # 01/20/2021 through 0 evidence staff had as behaviors. Record review reveal- titled, Behavior Monitor staff were to use in or such as triggers, sym medication Trazadone Interview with RN #6, revealed it was the nu- the orders for behavior for side effects from p	ht to have the smallest dose The CCP review revealed adual dose reduction, havior monitoring flowsheet, /mental status changes with sician, monitor for side sional activities, and refer to 3's Physician's Orders, bugh 04/14/2021, revealed Aricept (medication for g daily, Trazadone hosis) one-hundred (100) mg sident for behaviors every ion in the nurse's notes if 3's MAR, dated 01/20/2021 revealed nursing had one as ordered. 3's Progress Notes, dated 14/14/2021, revealed no sessed the resident for ed no evidence of a form oring Chart/Record, in which refer to document behaviors ptoms, side effects of the e. on 04/22/2021 at 10:48 AM, urse's responsibility to enter or monitoring and monitoring osychotropic medications in owever, this had not been	F 758			

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	-					FORM	07/16/2021 APPROVED
STATEMENT C	S FOR MEDICARE & I of Deficiencies CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	291	F 758				
	#24, on 04/24/2021 at important to monitor to psychotropic medication allowed the prescribe effectiveness of the modifications.	ion side effects because it					
	Coordinator, on 04/26 licensed staff entered monitoring to assist w psychotropic medicati omission of monitoring medication side effect	6/2021 at 2:05 PM, revealed orders for side effect <i>v</i> ith adequate dosing of ions. She stated the g for psychotropic ts could be life threatening. f side effect documentation					
	PM, revealed monitor medication side effect and staff documented effects were present.	ts appeared on the MAR I in a nurse's note if side The progress note would ciplinary Team (IDT) for any					
	on 04/29/2021 at 9:17 monitor for side media standing order that re information into the cl during the morning (II new orders and she o behavior and side effe psychotropic medication	inical record. She stated DT) meetings, they reviewed often entered the orders for ect monitoring related to					
	PM, revealed the failu	ure to monitor the residents					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		405204				С
		185301	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE		5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			REETADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From page for side effects relate		F 758			
F 835	medications could rea	sult in a lapse in care.	F 835			
SS=K	CFR(s): 483.70					
	§483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.					
	by: Based on interview, the facility's policy, it failed to be administe enables it to use its re efficiently to attain or	esources effectively and maintain the highest mental, and psychosocial				
	compliance, since the survey, in the areas of from Abuse, Neglect CFR 483.21 Comprei Care Plan (F656 and Nursing Services (F7 Behavioral Health (F7	740); 42 CFR 483.70 ); and, 42 CFR 483.75 id Performance				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	its resources to provide to meet the needs of the F600, F656, F657, F7 In addition, the facility levels of care and service to F550, F558, F585, F842). The facility's failure to administration to ensu- related to state and fer for the care and service caused or is likely to de impairment or death the Immediate Jeopardy ( 483.12 Freedom from Exploitation, F600, at "K"; 42 CFR 483.21 C Centered Care Plan, I and severity of a "J"; 4 Services, F725, at a se 42 CFR 483.40 Behar scope and severity of Administration, F835, "K"; and, 42 CFR 483 Performance Improve severity of a "K". The determine to exist on was notified of the Im 05/07/2021. Substandard Quality of in the area of 42 CFR Abuse, Neglect, and B	administration failed to use de quality care and services the residents (Refer to 725, F740, F835 and F867). If failed to maintain standard vices to the residents (Refer F658, F730, F758, and b provide an effective ure care and services ederal regulations guideline ces to the residents has cause serious injury, harm, o residents. (IJ) was identified at 42 CFR Abuse, Neglect and a scope and severity of a Comprehensive Resident F656 and F657, at a scope 42 CFR 483.35 Nursing scope and severity of a "J"; vioral Health, F740, at a 'a "J"; 42 CFR 483.70 at a scope and severity of a .75 Quality Assurance and enent, F867, at a scope and e Immediate Jeopardy was 03/27/2021 and the facility mediate Jeopardy on	F 835				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Agency determined the removed on 05/20/202 on 05/22/2021, with re- a Scope and Severity develops and implement and the facility's Qual- to ensure compliance An additional repeat of 10/09/2020 Recertifics in the area of 42 CFR F585 at a scope and s The findings include: Review of the Job De Executive Director (Cl revealed the CED's of included to ensure po the facility were follow facility would create a members were highly providing the highest compassion to patient The CED would admin activities of the facility degree of quality of ca provided to residents, regulations promulgat to ensure residents re- Review of the 10/09/2 and the 05/22/2021 R revealed the facility far manner to provide quarter	21. The State Survey he Immediate Jeopardy was 21, as alleged, prior to exit emaining non-compliance at of a "G" while the facility ents a Plan of Correction ity Assurance (QA) monitors with systemic changes. deficiency, from the ation survey, was identified 483.10 Resident Rights, severity of a "D". scription for the Center ED), effective 01/01/2016, perational responsibilities licies and procedures for ved to prevent abuse. The n environment where staff engaged and focused on level of clinical care and ts, residents, and families. nister and coordinate all v to assure the highest are was consistently subject to the rules and ted by government agencies eveived the proper services.	F 835				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Interview with the Cer on 05/11/2021 at 11:2 apart of the administra- was to ensure the fac- manner that enables effectively and efficier Clinical Quality Speci- building weekly and p and education to her. the CQS explained to administration involve deficient practices that Interview with the Clir (CQS) on 05/22/2021 went over the CNE's went over the deficier Continued interview re and federal regulation with the CNE. Interview with the Cer (CED), on 05/11/2021 was responsible for e administered in a mar its resources effective maintain the highest p and psychosocial wel further revealed his jo by the former Regiona Operations upon hire. responsible for the ca and supervision of the Continued interview v revealed he was awai during the 10/09/2020 facility addressed the	nter Nurse Executive (CNE), 25 AM, revealed she was ation. She stated her job sility was administered in a it to use its resources ntly. She further stated the alist (CQS) was in the provided additional resources Per interview, she stated o her how the lack of ement contributed to the at were identified. hical Quality Specialist at 3:06 PM, revealed she responsibilities with her and nt practice identified. evealed going over the state as was part of the review net Executive Director 1 at 3:25 PM, revealed he ensuring the facility was nner that enabled it to use ely and efficiently to attain or practicable physical, mental, II-being of each resident. He ob description was reviewed al Vice President of . The CED stated he was are needs of the residents	F	835				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 835	(QA). Per interview, t no documented evide the audits related to a residents' behaviors. staffing was addresse working on hiring mor shift differentials with compete with agency Interview with the forr of Operations (RVP), revealed her current r to the CED. Continue revealed she was una identified within the far Interview with the Reg Operations (RVPO), or revealed he became f Per interview, the RV oversight to the CED watching over the dai He stated the reason deficient practice cited change in CED and C was working with the his role as the Admini Review of the IJ Rem facility implemented th 1. The Regional Vice Operations(RVPO) we description and 483.7 administration/resider were met. He stated administered in a man its resources effective	the CED revealed there was ence the facility continued abuse, care plans, and Further interview revealed ed in QAPI and they were re nurses by increasing the modified compensation to staff. mer Regional Vice President on 05/12/2021 at 8:21 AM, role was to provide support ed interview with the RVP aware of the concerns acility. gional Vice President of on 05/22/2021 at 3:35 PM, the RVPO on 05/17/2021. PO stated he would provide and CNE and would be ly operations of the facility. why the facility had repeat d was because of the CNE. He further stated he CED to help him understand astrator. oval Plan revealed the he following: President of ould review the CED job to to ensure effective int well-being requirements	F	835				

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		ID HUMAN SERVICES				FORM	: 07/16/2021 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE : COMPI	ETED
		185301	B. WING			05/2	) 22/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP (	CODE		
			46	04 LOWE ROAD			
REGIS WO	DODS		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE		(X5) COMPLETION DATE
F 835	<ul> <li>before 05/19/2021, to his responsibilities inc cited at F600, F656, F and F867 and to ens were in place.</li> <li>2. A posttest would b understanding. The 0 ensure the facility was and efficiently to attain practicable physical, r well-being of the resid the facility's governing Center Nurse Executi efficiently oversee and plans of action were in deficiencies.</li> <li>3. The RVPO and/or of would review the qual improvement (QAPI) times six (6) months a additional audits to be recommendations fro- additional follow up and 4. The CED or CNE w Quality Assurance Pe committee consisting Director of Nursing, A Housekeeping Directo Business Office Mana Therapy Program Directo Social Services Direct Coordinator and Centia additional follow up and</li> </ul>	e verify his understanding of cluding the intent of the tags 7657, F725, F740, F835, ure the facility's systems e completed to validate CED would continue to s administered effectively n and maintain the highest mental, psychosocial dents. He stated as part of g body, along with the ve (CNE), they would d ensure that appropriate n place to correct quality Clinical Quality Specialist lity assurance performance committee minutes monthly and ongoing thereafter with e conducted based on m the QAPI committee for nd/or in-servicing. vould submit audits to the erformance Improvement of the CED, CNE, Assistant activity Director, pr, Admission Director, ager, Food Service Director, tor, Health Information's cal Reimbursement ified Nurse Aid for any nd/or in-servicing needs until ed and ongoing thereafter as	F 835				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185301	B. WING				C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	298	F	335			
	The SSA validated the following actions to re Jeopardy:	e facility implemented the move the Immediate					
	Clinical Operations (F 3:35 PM, revealed the the CED's job descrip accepting the position he had reinforced the	Regional Vice President of RVPO), on 05/22/2021 at e former RVPO went over tion with him, prior to him a as the RVPO. However, education by going over the to understand his role as					
	signed by the CED or CED was educated or	ttest, administered and n 05/15/2021, revealed the n administration. The he test on 05/19/2021.					
	PM, revealed she had committee meetings, until the Immediate Je	CQS, on 05/22/2021 at 3:06 d attended all the QAPI which were meeting daily, eopardy has been removed. minutes would be reviewed for six (6) months.					
F 837 SS=K	the audits to the QAP concern was resolved Governing Body	M, revealed they submitted I committee until the I.	F	337			
	body, or designated p governing body, that i	g body. Sility must have a governing Dersons functioning as a Is legally responsible for Dementing policies regarding					

Facility ID: 100503

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 07/16/2021 DRM APPROVED NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		185301	B. WING				C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
REGIS WO	DODS				4604 LOWE ROAD		
					LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 837	Continued From page	e 299	F	83	7		
	the management and	l operation of the facility; and					
	administrator who is-	overning body appoints the tate, where licensing is					
	(ii) Responsible for m and	nanagement of the facility;					
	(iii) Reports to and is governing body.						
	This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective governing body that was responsible for establishing and implementing policies regarding the management						
	by the facility's failure compliance, since the survey, in the areas of from Abuse, Neglect CFR 483.21 Compre- Care Plan (F656 and	facility. This was evidenced e to maintain substantial e 10/09/2020 recertification of 42 CFR 483.12 Freedom and Exploitation (F600); 42 hensive Resident Centered F657); 42 CFR 483.35					
	Nursing Services (F7 Behavioral Health (F Administration (F835 Quality Assurance an Improvement (F867).	740); 42 CFR 483.70 ); and, 42 CFR 483.75 id Performance					
	revealed the facility's ensure residents wer ensure resident beha to ensure sufficient n	ew and record review governing body failed to e free from abuse and viors were addressed; failed ursing staff to ensure of residents and provide					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION			<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		· · ·	PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	ITY, STATE, ZIP CODE	03	
REGIS WO	DODS			4604 LOWE ROAD	40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTI ORRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 837	ensure residents' care implemented; and, fai was effectively manage assurance program to compliance. (Refer to F740, F835 and F867) The facility's failure to governing body respo- implementing policies and operation of the f to cause serious injur death to residents. Immediate Jeopardy 4 483.12 Freedom from Exploitation, F600, at "K"; 42 CFR 483.21 C Centered Care Plan, and severity of a "J"; 5 Services, F725, at a s 42 CFR 483.40 Beha scope and severity of Administration, F835, "K"; and, 42 CFR 483 Performance Improve severity of a "K". The determine to exist on was notified of the Im 05/07/2021. Substandard Quality of in the area of 42 CFR Abuse, Neglect, and I The facility provided a	residents' needs; failed to e plans were revised and iled to ensure the facility ged with an effective quality o maintain substantial o F600, F656, F657, F725, 7). o provide an effective onsible for establishing and a regarding the management facility has caused or is likely ry, harm, impairment, or (IJ) was identified at 42 CFR n Abuse, Neglect and a scope and severity of a Comprehensive Resident F656 and F657, at a scope 42 CFR 483.35 Nursing scope and severity of a "J"; vioral Health, F740, at a f a "J"; 42 CFR 483.70 , at a scope and severity of a 3.75 Quality Assurance and ement, F867, at a scope and e Immediate Jeopardy was 03/27/2021 and the facility imediate Jeopardy on	F 8	37			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING			C 05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
REGIS WO			46	04 LOWE ROAD			
REGIS W	0003		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 837	removed on 05/20/20 on 05/22/2021, with re a Scope and Severity develops and implement and the facility's Qual to ensure compliance An additional repeat of 10/09/2020 recertificat the area of 42 CFR 44 at a scope and severi The findings include: Review of the facility's Body: Centers," revise it was the facility's pol body that consists of f Director, Center Nurs Regional Executive D administrative service body was legally resp implementing policies and operation of the C licensed administrator Center and maintenan Improvement Perform program. Interview with the Cer on 05/11/2021 at 11:2 Governing Body woul reported to him. She went over her job duti her responsibilities. S at the facility since 10	he Immediate Jeopardy was 21, as alleged, prior to exit emaining non-compliance at of an "G" while the facility ents a Plan of Correction ity Assurance (QA) monitors with systemic changes. Afficiency, from the tion survey, was identified in 83.10 Resident Rights, F585 ty of a "D". As policy titled, "Governing ed on 11/20/2019, revealed icy to have a governing the Center Executive e Executive, and the ent of Operations or irector of the Center's e provider. The governing onsible for establishing and regarding the management Center and appointing a r for the management of the nee of the Quality hance Improvement (QAPI)	F 837				

Facility ID: 100503

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ATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY MPLETED
	UNRECHUN	IDENTIFICATION NUMBER:	A. BUILDING		CO	C
		185301	B. WING		O	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 837	Continued From page	e 302	F 83	7		
		Recertification Survey on				
	10/09/2020. However, she was not aware of the residents' behaviors, but should have been.					
		nter Executive Director				
		1 at 3:25 PM, revealed he cility for three (3) months.				
	Per interview, the gov	verning body was				
		sh and implement policy(s) ement and operation of the				
		of the CED, CNE, and the				
	-	ent of Operations (RVPO).				
	to ensure all processe	s responsibility, as the CED, es established by the				
		maintained, to include the				
	QAA/QAPI program. revealed the CED wa	is aware of the previous Plan				
	of Correction for the r	ecertification in October				
	· · ·	cility reported incidents, to his arrival at the facility;				
	-	fully aware of the extent of				
	of Operations (RVP),	mer Regional Vice President on 05/12/2021 at 8:21 AM,				
		rked with the facility since view, the RVP revealed she				
	was part of the gover	ning body, as per the				
	provide support to the	stated her current role was to e CED: however, she				
	revealed the policy up	odates, procedures,				
		leted at a higher level than view with the RVP revealed				
	she was unaware of t	the concerns identified within				
	the facility, but could education if needed.	offer coping, guidance, and				
		gional Vice President of				
	Operations (RVPO), o	giorial vice i resident di				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		185301	B. WING			C 05/2	; 22/2021
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP	CODE		
			46	04 LOWE ROAD			
REGIS WO	DODS		LC	DUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 837	Per interview, the RVI of the governing body the RVPO, he had rev and the training given he would provide ove and would be watchin of the facility. Per inte only way to "fix" this w of staff. He conveyed had repeat deficient p of the change in CED asking for a ten (10) y management team. O he had attended the O suggestions to the CE QAPI. He further stat CED to help him unde Administrator. Review of the IJ Rem facility implemented the 1. As required by reg will continue to have a CNE, and Regional V responsible for establ policies regarding the of the facility. Howev designated additional including the Vice Pre and the Director of Ref will audit and verify th compliance with regul through on site monitor These designated me and CNE accountable implementation of the	the RVPO on 05/17/2021. PO stated he was the head A. He stated since becoming viewed the facility's audits to staff. The RVPO stated rsight to the CED and CNE ag over the daily operations erview, the RVPO stated the vould be to have continuity d the reason why the facility oractice cited was because and CNE adding, "I'm vear contract," to build the Continued interview revealed QAPI meetings and offered ED on how to lead through ted he was working with the erstand his role as the oval Plan revealed the he following: ullation, the facility has and a governing body The CED, ice President are ishing and implementing management and operation er, the governing body has oversight members esident of Clinical Operations egulatory Compliance who he plan of correction, lation and facility policies oring and random audits. embers will hold the CED	F 837				

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CENTER STATEMENT (	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	OODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 837	respect to the cited de requirement of particip 2. Additional support continue to be provid corporate team consis of Clinical Operations Infection Control Cert Development Manage Compliance, Clinical O President of Clinical O Regional Executive D reeducation, chart rev behavior monitoring re- interviews related to b process and Abuse po 3. The Director of Re the Vice President of provide weekly oversi abatement plan and F continue to be mainta CED and CNE. Additi Labor meetings and A conducted daily. The SSA validated the following actions to re- Jeopardy: 1. Interview with the Y Operations, on 05/22/ the governing body ha CED, CNE, Medical E Vice President. She f additional oversight a	eficiencies as well as all pation. t has been provided and will led from the regional sting of the Senior Director a, International with a iffication , Practice er, Director of Regulatory Quality Specialists, Vice Operations and the Director providing views, care plan revisions, ounding, resident and staff behaviors, grievance olicy education. egulatory Compliance and Clinical Operations will ight to determine the POC are implemented and ained and sustained by the ionally, QAPI meetings, AOC review are being	F	837			

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 07/16/2021 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		185301	B. WING				C 5/22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS W	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 837	revealed on 05/14/20 and assisted with the abatement. The DRC the facility to complete will update her weekly compliance and she we either in person or by 2. Interview with the on 05/22/2021 at 5:37 been a part of the dai over the facility's polic practice with the Man provided education. Interview with the Prat Manager, on 05/22/20 she assisted the VPC She further stated she to document and mor behaviors. The Pract stated she educated as scenarios to train staf behaviors. Interview with the Dire Compliance, on 05/22 she would continue to compliance and would Interview with the Clirr (CQS), on 05/22/2027 provided reeducation Interview with the Ser Manager, 05/22/2021	ector of Regulatory on 05/22/2021 at 6:31 PM, 21 she initiated chart audits development of the facility's D revealed she will work with e the POC and the facility y with continued audits for will attend the monthly QAPI teleconference. Regional Executive Director, 7 PM, revealed she has ly QAPI meetings and went cies and the deficient agement team, as well as, actice Development 021 at 5:43 PM, revealed co with the abatement plan. e had IPADs set up for staff nitor the resident's tice Development Manager staff and went over certain if on identifying resident's ector of Regulatory 2/2021 at 6:31 PM, revealed o review the audits for d provide oversight. hical Quality Specialist 1 at 3:06 PM, revealed she and post-test to staff.	F	837			

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/:	22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
REGIS WO	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 837	audits. She further st would be held with the patterns and to review accountability. She fu rounding and complet 3. Interview with VPC PM, and the DRO on revealed they would the POC and abateme Resident Records - Id CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a con agrees not to use or c except to the extent th to do so. §483.70(i) Medical ree §483.70(i)(1) In accord professional standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The faci all information contain	and she would validate the ated a weekly meeting a RVP to discuss the staffing withe reports and urther stated she was ing chart reviews. 20, on 05/22/2021 at 5:14 05/22/2021 at 6:31 PM, provide oversight to ensure ent plan were implemented. Rentifiable Information 483.70(i)(1)-(5) at-identifiable information. elease information that is to the public. lease information that is to an agent only in antract under which the agent disclose the information the facility itself is permitted cords. dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the	F 837				
	(iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faci all information contain regardless of the form	e; and ganized lity must keep confidential ned in the resident's records, n or storage method of the					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_		C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO	ODS			1604 LOWE ROAD LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	<ul> <li>(i) To the individual, or representative where</li> <li>(ii) Required by Law;</li> <li>(iii) For treatment, pay operations, as permitt with 45 CFR 164.506;</li> <li>(iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research pur medical examiners, fu a serious threat to heat by and in compliance</li> <li>§483.70(i)(3) The faci record information aga unauthorized use.</li> <li>§483.70(i)(4) Medical for-</li> <li>(i) The period of time if</li> <li>(ii) Five years from the there is no requirement (iii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State</li> <li>§483.70(i)(5) The med (ii) A record of the resi (iii) The comprehensive provided;</li> <li>(iv) The results of any and resident review endeterminations condured (v) Physician's, nursel professional's progresi</li> </ul>	r their resident permitted by applicable law; yment, or health care ted by and in compliance stativities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed	F 842				

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	S FOR MEDICARE &		()(0)			O. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	· · ·	E SURVEY IPLETED		
		185301	B. WING			C 5/22/2021		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	03	<i>0/22/202</i> I		
REGIS W	OODS			4604 LOWE ROAD LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 842		e 308 equired under §483.50.	F 842					
	by: Based on observatio and the facility's polic facility failed to maint were complete and a standards for three (3 sampled residents (R Observations on the on 04/22/2021, 04/26 04/30/2021 revealed common rooms, hally rooms. Resident #21 ambulation up and do resident intruded othe However, review of th Record (MAR), and F #21 revealed no docu exhibited behaviors h documented by staff.							
	MCU (hallway, comm resident rooms) daily resident to resident a were ongoing. Per in pace until he/she was Continued interviews history of physical an	on the MCU, revealed ed paced ambulation, on the ion area, and into other , prior to the 10/02/2020 Itercation and the behaviors terviews, the resident would s exhausted and had to rest. revealed the resident had a d verbal abuse directed intrusion of other resident's						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/16/2021 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	MAR, and in the Prog behaviors were docur have time to documen had continuous pacin Observations of Resid 4:02 PM; 04/26/2021 04/28/2021 at 8:00 AI PM, revealed the resi common rooms, hallw tearful and crying. H and Progress Notes, f evidence of the behave those specific dates a Review of Resident # through 04/30/20201, 09/25/2020, for "Is the behavior present (tea document type, interv Nursing Notes; Every behaviors. Additional 6:00 AM - 2:00 PM ar "YES" was document was behavior free eve except 04/10/2021 6:0 blank. Additional review of R Notes, dated 04/01/20 revealed no document (tearful, crying, irritabi outcomes. Observation of Reside 04/19/2021 at 3:28 Pl and 04/20/2021 at 9:3	hould be charted on the press Notes; however, not all mented because they did not in that often; Resident #21 g and intrusive behaviors. dent #61 on 04/22/2021 at at 10:40 AM and 1:55 PM; M; and 04/30/2021 at 2:30 dent on the MCU in the vays and in his/her room owever, review of the MAR revealed no documented viors (tearful, crying) on and times. 61's MAR, dated 04/01/2021 revealed an order dated e resident behavior free?" If rful, crying, irritability), rentions and outcomes in day and night shift for I review revealed each day and 10:00 PM -6:00 AM ed indicating the resident ery day and night shift, 00 AM-2:00 PM, which was	F 842				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 07/16/2021 ORM APPROVED NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3)	DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE .	
REGIS WO	OODS					
				UISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From page #9 were aware of the RN #1 and LPN #1 re Resident #2's tremors medical provider, but documentation noted The facility's failure to place to ensure staff of behaviors; and the cli and complete to ensure necessary care and s serious injury, harm, i resident. Immediate of on 05/07/2021, and w 04/01/2021. The facility provided a Plan (Allegation of Co 05/20/2021 alleging re Jeopardy on 05/20/2021 Agency determined th been removed 05/20/2021, w non-compliance at a S while the facility deve Plan of Correction and Assurance (QA) moni with systemic change The findings included 1. Review of Resider	e 310 tremors. Interviews with evealed assessment of a and notification to the there was no in the clinical record. The clinical record. The have an effective system in documented residents' nical records were accurate the residents received the ervices is likely to cause impairment or death to a Jeopardy (IJ) was identified vas determined to exist on an acceptable IJ removal ompliance (AoC)) on emoval of the Immediate D21. The State Survey he Immediate Jeopardy had 2021, as alleged, prior to with remaining Scope and Severity of a "G" loped and implemented a d the facility's Quality itored to ensure compliance ets.	F 842			
	resident behavior free behavior is present, d and outcomes in Nurs refusal of care, throwi others, and wandering	ed 11/06/2020, for "Is the e?" YES or NO (if NO and locument type, intervention, ses Note). Observe for ing items, cursing, yelling at g around the unit related to Further review revealed an				

Facility ID: 100503

If continuation sheet Page 311 of 337

						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · · ·	E SURVEY IPLETED
				~ <u></u>		С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	•	
REGIS WO				4604 LOWE ROAD		
	000			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From page	e 311	F 8	42		
	order dated 03/18/20					
	(antipsychotic medica	ation) 0.25 milligrams (mg),				
	by mouth, two (2) tim	es a day for Anxiety.				
	Record review reveal	led the facility admitted				
		MCU, on 01/01/2020 with a				
	primary diagnosis of					
	Additional diagnoses					
	Anxiety Disorder, Psy	orain, Depressive Episodes, /chotic Disorder with				
	Delusions, Dementia					
	•	ustment Disorder. Further				
	review revealed the refinancial Power of Att	esident had a medical and				
		oney (i OA).				
		dent #21, on 04/22/2021 at				
		at 10:40 AM and 1:55 PM;				
		M; and on 04/30/2021 at e resident on the MCU in				
	•	vays and in rooms. Resident				
	#21 was observed wi	-				
		own the hallways and in				
	common areas. Furth	her, the resident was dent's personal space for				
	any residents' path th	• •				
	However, review of th	ne MAR and Progress Notes,				
	revealed no documer					
		bulation, intrusion of others nose specific dates and				
	times.					
	Poviow of the MAD	datad				
	Review of the MAR, of 04/01/2021-04/30/202	21, revealed an order dated				
	11/06/2020, which sta					
	behavior free? YES	or NO (if NO and behavior is				
	present, document ty	•				
		Note). Observe for refusal of cursing, yelling at others,				

Facility ID: 100503

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD B		(X5) COMPLETION DATE
F 842	Alzheimer's Disease. five (5) times in April ' indicating a behavior on the following dates 04/13/2021; 04/14/20 However, review of th dates revealed no dou behavior exhibited, ty outcomes. Interview with CNA #2 MCU), on 04/26/2021 since she had worked walked up and down MCU, all the time. Ac Resident #21's behav the nurse; because "e resident does it all the were responsible to c Interview with Register month on the MCU), or revealed exhibited be documented on the M the nurse. Additionally report behaviors an record was accurate. important to have doo behaviors so staff cou resident's behaviors to received safe, quality revealed it was impor behaviors so the Inter would know the progr	Additional review revealed 'YES" was documented was present." Per the MAR, a at 5:30 AM: 04/05/2021; 2; 04/23/2021; 04/27/2021. The Nurses Notes for those cumented evidence of a pe, intervention, or 2 (seven {7} months on the at 10:45 AM, revealed 4 on the MCU, Resident #21 the hallway, all over the diditionally, she did not report for of pacing on the MCU to everyone knows", the e time. Further, the nurses hart behaviors. The Nurse (RN) #6 (one {1} on 04/26/2021 at 2:30 PM, havior symptoms were IAR or in a Nursing Note by y, she expected aides to ediately to her, so she could nd ensure the medical Per interview, it was cumentation of identified ald intervene to support the o ensure the resident care. Continued interview tant to have documented rdisciplinary Team (IDT) ess and changes with each	F	342				

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	S FOR MEDICARE &					10. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. DOILDING			С
		185301	B. WING		0	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	2006		4604 LOWE ROAD			
REGIS WC	0003			LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 313	F 842			
-	-	was completed on the MAR	1 0 12	-		
		lents. Per interview, if a				
	resident had a behav	ior, then nurses would				
resident had a behavior, then nurses would document "Yes" on the MAR and make a narrative free text Progress Note about what the						
		y, it was important to have				
	safety of the resident	on of resident behaviors for				
		plemented when a resident				
		for their well-being and to				
		vironment. Further, RN #1				
		as defensive when another				
		him/her; however, she was				
		l not documented any nt #21 on 04/28/2021.				
		11 #21 011 04/20/2021.				
	Interview with CNA #	9, (two {2} years on MCU),				
		1 PM revealed shortly after				
		mitted to the MCU, he/she				
		viors towards others. Per				
		nt would grab staff's arms				
		ght and the resident was her residents when they				
		The resident would raise				
		other residents' personal				
	space, and put his/he	-				
	Additionally, the resid	lent walked up and down the				
		d the common area rooms				
	all the time. Howeve					
		een observed "today" nd in others' personal				
		because she was already				
		her nurses were responsible				
	to document behavio					
	2. Record review review	vealed the facility admitted				
		ACU, on 12/17/2019 with a				
	primary diagnosis of					

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	2: 07/16/2021 APPROVED 0: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		INSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING				( 05/2	_ 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP	CODE		
REGIS WO	DODS				LOWE ROAD ISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI		(X5) COMPLETION DATE
F 842	with depressed mood secondary diagnosis. medical and financial Review of Resident # dated April 2021, reve 07/21/2020, for Rispe medication) 0.25 millig (2) times a day for Mo resident had an order the resident behavior (tearful, crying irritabil interventions and outo Every day and night s Observations of Resid 4:02 PM; 04/26/2021 04/28/2021 at 8:00 AI PM, revealed the resi common rooms, hallw tearful and crying. Ho and Progress Notes, n evidence of the behave those specific dates a Additional review of R 04/01/2021 through 0 order dated 09/25/202 behavior free?" If beh crying, irritability), doc and outcomes in Nurs night shift for behavio revealed each day 6:0 PM -6:00 AM "YES" of the resident was behavior	ed with Adjustment Disorder , on 06/16/2020, as his/her Further, the resident had a POA. 61's Physician Orders, ealed an order, dated ridone (antipsychotic grams (mg) by mouth, two hod Disorder. Further, the , dated 09/25/2020, for "is free?" If behavior present ity), document type, comes in Nursing Notes; hift for behaviors. dent #61 on 04/22/2021 at at 10:40 AM and 1:55 PM; A; and 04/30/2021 at 2:30 dent on the MCU in the rays and in his/her room owever, review of the MAR revealed no documented viors (tearful, crying) on nd times. esident #61's MAR, dated 4/30/20201, revealed an 20, for "Is the resident avior present (tearful, ument type, interventions sing Notes; Every day and	F 84	12				

Facility ID: 100503

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05//	C 22/2021
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
REGIS WO			4	604 LOWE ROAD			
KEGIS WC	003		I	OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page Additional review of R Notes, dated 04/01/20 revealed no documen (tearful, crying, irritabi outcomes. Interview with Activitie at 4:10 PM revealed t the MCU, Resident #6 episodes intermittenth days. Further, he did behaviors at this time. Interview with Certifie #8, on 04/22/2021 at had worked on the MC common for the reside episodes on a daily ba report or document th the resident's common knew he/she cried all nurses responsibility t Interview with CNA #2 AM, revealed since sh Resident #61 cried all did not report Resider the nurse, because ev cried all the time. Fur documented all behav Interview with RN #6, revealed Resident #6	e 315 esident #61's Progress 021 through 04/30/2021, ted evidence of a behavior lity), interventions or es Assistant, on 04/22/2021 hat since he had worked on 01 had tearful and crying y throughout the day, most observe the resident with d Nursing Assistant (CNA) 4:15 PM revealed since she CU Resident #61 it was ent to exhibit crying tearful asis; therefore she did not e behavior because it was n behavior and everyone the time. Further, it was the o document behaviors. 2, on 04/26/2021 at 10:45 he had worked on the MCU, the time. Additionally, she at #61's behavior of crying to veryone knew the resident	F 842				
	However, she did not behavior every time h tearful because it was	document the resident's e/she cried or became s of frequent. Further, she sident was crying at the time					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	316	F	842				
	revealed she was awa continuously; howeve had not documented resident on 04/28/202	21. Further, it was her ment all behaviors in the						
	at, 04/19/2021 at 3:28 PM, and 04/20/2021 a both arms. RN #1, R CNA#9 were aware o with RN #1 and LPN a of Resident #2's trem sent to the medical pr no documentation not Record Review revea	esident #2, on 04/14/2021 B PM, 04/15/2021 at 3:10 at 9:35 AM with tremors of N #6, LPN #7, CNA #2, and f the tremors. Interviews #1 revealed an assessment ors and notifications were rovider; however, there was ted in the clinical record.						
	Resident #2 to the M0 diagnoses to include	CU, on 08/31/2020, with Bipolar Disorder, Psychotic ns, and Frontotemporal						
	dated 01/09/2021, rev severely impaired cog decision-making. The Resident #2 received	2's Comprehensive MDS, vealed the resident had gnitive skills for daily e assessment revealed medications that included nxiety, and antipsychotic						
	dated 03/01/2021 thro orders that included A	2's Physician's Orders, ough 04/14/2021, revealed vricept ten (10) milligram twenty-five (25) mg daily.						

Facility ID: 100503

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	· · ·	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 842	Further order review i Geodon ten (10) mg i with an order change daily for three (3) day On 03/11/2021 reside changed to twenty (2/ 03/24/2021 the Geod ) mg twice daily; and Geodon dose was mo morning and forty (40 orders included Ativai as needed for anxiety was changed to 0.5 m needed on 04/06/202 revealed orders that i effects related to psyc daily and consult the needed and to monito mental or functional s physician. Review of Resident # 03/01/2021 through 0	revealed an order for intramuscular injection daily on 03/10/2021 to 10 mg s as needed for agitation. ent's order for Geodon 0) mg capsule twice daily; on on was changed to forty (40 on 04/01/2021. The odified to sixty (60) mg in the 0) mg at bedtime. Additional n 0.5 mg every six (6) hours or ordered on 03/22/2021 and ng every four (4) hours as 1. The order review ncluded to monitor for side chotropic medications twice physician or pharmacist as or resident for changes in status and report to the etc. 2's Progress Notes, dated 14/14/2021, revealed no	F 842			
	04/14/2021, revealed documentation that re observed by staff. Review of Resident # Involuntary Movemen	2's Medication d, dated 03/01/2021 through side effect monitoring evealed no side effects were 2's Quarterly Abnormal at Scale (AIMS) assessment, mpleted by Registered				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	revealed the absence extrapyramidal side e effects such as tremo of muscle restlessness related to improper do antipsychotic medicat or reported by nursing Observation of Reside 1:48 PM, 04/15/2021 at 9:35 AM, revealed extremities. Interview with Certifie 04/15/2021 at 8:30 Af a change in level of fu inability to feed self do stated the CNA docur documentation for the required for Activities the CNAs would not h arm tremors. Interview with CNA #2 PM, revealed she was the day RN #1 brough Assistant to the room Interview with RN #1, revealed she had noti (MA) who rounds for t tablet for video visits. Medical Physician and approximately three (c presence of worsenin she did not document	of side effects or ffects (EPS-abnormal side rs, slurred speech, feeling is, and muscle spasms osing or unusual reactions to ions) during telehealth visits g staff. ent #2 on 04/14/2021 at at 8:15 AM, and 04/20/2021 notable tremors to the upper d Nurse Aide (CNA) #2, on M, revealed Resident #2 had unction that included the ue to arm tremors. She nentation included e level of assistance of Daily Living (ADLs) and have charted Resident #2's 20, on 04/23/2021 at 1:35 is sitting with Resident #2 on at the psychiatrists Medical to assess the tremors. on 04/23/2021 at 8:45 AM, fied the Medical Assistant the Psychiatrist using a She stated she notified the d the Psychiatrist's MA 3) weeks ago regarding the g arm tremors. She stated the assessment or the cal record. RN #1 stated an rd assisted with	F 842				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
REGIS WO	ODS				604 LOWE ROAD .OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 842	Continued From page	319	F	842				
	on 04/20/2021 at 1:56 #2's upper extremity t for the past couple of the Medical Physician document the notifica Interview with RN #6, revealed she had obs tremors for about a m not document the pre: MAR or in the clinical inaccurate record. RN included documentative effects twice daily. Interview with the ADN Nursing Services), on revealed during the m team) meeting they re ensure they followed to reason or diagnosis for medication and stop of medications. Interview with the Med 04/21/2021 at 3:56 PN not notify her regardin feeding himself/herse The Medical Physician the nurses did not doo had developed either nurse's notes. Interview with the Psy 2:44 PM, revealed he Resident #2's Geodor	on for monitoring for side NS (Assistant Director of 04/22/2021 at 10:09 AM, iorning IDT (interdisciplinary eviewed new orders to the facility's policy such as or a "PRN" (as needed) lates for PRN psychotropic dical Physician, on M, revealed facility staff did ing Resident #2's difficulty If or about the arm tremors. In stated it was concerning cument the side effects that on the MAR or in the rchiatrist, on 04/22/2021 at had recently increased						

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185301	B. WING				C 22/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	stated he communicatelephone and review He stated Resident # not properly monitore the failure of nursing # #2's arm tremors. Interview with the Cer on 04/29/2021 at 9:17 monitored Resident # psychotropic medicat accurate documentatie effectiveness of the m effects. The CNE state record was important Interdisciplinary Team utilized it to determine progress. Interview with the Cer (CED), on 4/30/2021 concerning the nurses not document the side notification to the psy doctor regarding the to independently. Review of the IJ Rem facility implemented to 1. On or before 05/19 or Social Services up psychotherapeutic do #2, #3, #21, #31, #42 #17, #30, and #73 no 2. On or before 05/19 conducted on all reside	ted with the facility staff via ed nursing documentation. 2's treatment progress was d or communicated due to staff to document Resident her Nurse Executive (CNE), 7 AM, revealed staff 2' for side effects of ions twice daily. She stated ion revealed the hedications and/or side ted an accurate clinical because the staff, the n (IDT), and the physicians e the plan of care and/or her Executive Director at 3:12 PM, revealed it was s caring for Resident #2 did e effects or document the chiatrist or the medical remors and inability to eat oval Plan revealed the he following:: 9/2021, the Licensed Nurse dated the behavior and cumentation for Residents , #61, and #86. Residents longer resided in the facility.	F	842	2		

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PRINTED: 07/16/2021

		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		·	· · · ·	MPLETED
						С
		185301	B. WING		0	5/22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 842	persistent crying, hitti throwing objects, phy combative behavior w clinical record with co discovery. Additional review of all residents drugs to determine si	ng, pushing, scratching, sical aggression and vere documented in the	F 84	2		
	discovery. 3. On or before 05/19 or Regional Educator with Licensed Nurses complete clinical reco consisted of complet regarding behaviors i hitting, pushing, scrat physical aggression a to be documented in record when a behav residents receiving per would have side effect documented accurate post-test would be giv re-education to validat passing score of 100° Licensed Staff not av frame to include ager re-education including Supervisors, Nurse P Managers and or CNI work. New hires inclu-	9/2021, the CNE, NPE and would conduct reeducation a regarding accurate and ords. The reeducation ing documentation ncluding persistent crying, tching, throwing objects, and combative behavior are the clinical record clinical ior occurs. Additionally, all sychotherapeutic drugs cts monitored and ely in the clinical record. A ven at the time of ate understanding with a % to validate understanding. ailable during this time ncy staff would be provided g posttest by the Nurse tractice Educator, Unit E upon day of return to uding agency staff will be				
	4. The Center Nurse Director of Nursing, L					

Facility ID: 100503

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	ripi f	CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			1 Y /	PLETED
							С
		185301	B. WING			05/	22/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 842 Continued From page 322 of ten (10) residents with behaviors to determine		F	842				
	complete. Additional receiving psychothera monitored for side eff accurately in the clini weeks including week three (3) times per we then weekly for eight week times (8) weeks month then ongoing to the Quality Assurance	apeutic drugs were fects and documented cal record daily for two (2) kends and holidays then eek times two (2) weeks (8) weeks then every other s then monthly times (1) thereafter as determined by e Performance Improvement ensure the behavioral is were met with any					
	review findings daily was remove to the Q Performance Improve which consists of the Center Nurse Execut Nursing Services, Me Service Director, Dini Dietitian, Health Infor Office Manager, The Maintenance Director Certified Nursing Aide up and/or in servicing	ement (QAPI) Committee Center Executive Director, ive, Assistant Director of edical Director, Social					
	The State Survey Age implementation of the (AOC) as follows:	ency validated the e facility's IJ removal Plan					
		r Residents #2, #3, #21, #31, vealed they were monitored y side effects from					

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 07/16/2021 M APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	D. 0938-0391 SURVEY PLETED
		185301	B. WING			C / <b>22/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	-
REGIS WO	DODS			604 LOWE ROAD .OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	Medication Administra Residents #17, #30, a discharged from the fa 2. On or before 05/19 conducted on all reside and/or SSD to determ persistent crying, hitti throwing objects, phys combative behavior w clinical record with co discovery. Additional review of all residents drugs to determine if f monitored and docum upon discovery. Interview with the Cer on 05/22/2021 at 6:30 residents with behavior psychotherapeutic dru Per interview, the infor residents' behaviors w Administration Record assigned nurse would behaviors identified. assess for any interve- identified, it would be meeting. 3. Interviews with Lic (LPN) #14 at 1:55 PM at approximately 1:59 (RN) #1 on 05/21/202 05/21/2021 at 5:57 PI education on accurate	edications listed on the ation Records (MAR). and #73 had been acility . 9/2021, an audit was dents by a Licensed Nurse hine behaviors including ng, pushing, scratching, sical aggression and vere documented in the rrective action upon ly, the audit included a s on psychotherapeutic the side effects were hented with corrective action hter Nurse Executive (CNE), 0 PM, revealed ten (10) ors and on ugs would be monitored. ormation related to the would be on the Medication d (MAR) and the resident's d assess the resident for any Additionally, the staff would entions used and if discussed in a clinical eensed Practical Nurse 1, LPN #22, on 05/21/2021 0 PM, and Registered Nurse 21 at 2:00 PM, RN #16, on	F 842			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/16/2021 1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING		_	( 05/2	; 22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS			1604 LOWE ROAD LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 F 867 SS=K	they were to monitor if their psychotherapeut they received a poster one-hundred percent 4. Review of the F84 facility would conduct behaviors to determin documentation was a revealed a column for stated, "audits of ten behaviors to determin documentation was a column that stated, "T psychotherapeutic dru and documented acco Continued review rev stated, "Were there a resident's documenta review revealed a col with medications side Additionally there was auditor's name. Interview with the CN PM, revealed she cor days and noted the be Continued interview re the behaviors identifie 5. Interview with the 05/22/2021 at 6:30 PI the audits related to F QAPI until the concer	the residents' reactions to ic medications. Staff stated est and passed with (100 %). 2 audit tool revealed the ten (10) residents with e the behavior ccurate. Further review the date, a column which (10) residents with e the behavior ccurate and complete. A fen (10) residents receiving ugs side effects monitored urately in the clinical record. ealed a column which ny concerns noted the tionYes or No." Continued umn for areas of concern effects notedYes or No." a column that had the E, on 05/22/2021 at 6:30 npleted audits for a few ehaviors of the residents. evealed the residents' updated upon discovery of ed. CNE and CED, on M, revealed the findings of i842 would be reported to n has been resolved. ent Activities	F 842				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		PLETED
		185301	B. WING				C / <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 867	§483.75(g)(2) The qua assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on interview, r the facility's policy and determined the facility	ssessment and assurance. ality assessment and must: ment appropriate plans of tified quality deficiencies; is not met as evidenced record review, and review of d procedures, it was y failed to have an effective	F	867			
	facility failed to identif deficiencies, and faile performance improve improvements were re- is evidenced by repea F-600, F-656, F-657,	Quality Assurance ement (QAPI) meetings. The fy quality of care ed to take actions aimed at					
	(F600), at 42 CFR 48 Person-Centered Car CFR 483.70 Administ Quality of Care was ic Freedom from Abuse, (F600). The facility su	ed at 42 CFR 483.12 , Neglect, and Exploitation 3.21 Comprehensive re Plans (F656), and at 42 tration (F835). Substandard dentified at 42 CFR 483.12 , Neglect, and Exploitation ubmitted an acceptable Plan alleging compliance as of r, the facility failed to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/16/2021 FORM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		MB NO. 0938-0391 (3) DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C	ODE	
REGIS WO	DODS			04 LOWE ROAD DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
F 867	related to resident be- identified and/or care residents on the Mem not supervised and/or residents from abuse. On 10/02/2020, Resid Resident #61 at his/hd doorway. This results Resident #61 causing his/her balance. Resident #61 causing his/her balance. Resident #61 causing his/her balance. Resident #61 causing his/her right side. On 04/22/2021, Resident #85 with a television of Subsequently, upon at the nurse identified so swelling to Resident # results showed a righ the hand) fracture. To Additionally, on 05/14 Agency (SSA) identified Immediate Jeopardy. identified in the areas Comprehensive Reside F656 Develop/Implem Plan, at a S/S of a "J" Administration, F835 "K", F837 Governing F842 Resident Recor at a S/S of a "J", and	23/2021, continuous o-resident abuse occurred haviors that were not planned. Additionally, the iory Care Unit (MCU) were monitored to prevent the monitored to prevent the dent #21 approached er (Resident #21's) ed in Resident #21 shoving resident #61 to lose ident #61 fell backwards into wn to the floor, landing on dent #86 struck Resident while in their shared room. assessment on 04/25/2021 cattered bruising and 485's right hand. The x-ray t 5th metacarpal (bone in tal census 132. //2021, the State Survey ed additional areas of Immediate Jeopardy was of 42 CFR 483.21 dent Centered Care Plans, nent Comprehensive Care and F657, Care Plan at a S/S of a "J", 42 CFR ces, F725 Sufficient Nursing ', 42 CFR 483.70 Administration, at a S/S of a Body at a S/S of a "K", ds-Identifiable Information	F 867			

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/16/2021 / APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING					C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	-	
REGIS WO	ODS				604 LOWE ROAD OUISVILLE, KY 40220			
					·			0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	327	E F	867				
		the Immediate Jeopardies						
	CFR 483.10 Resident Rights/Exercise of Rig Reasonable Accomm Needs/Preferences at Grievances, at a S/S Aide Perform Review The facility's failure to	t a S/S of "E", F 585 of a "D", and F730 Nurse						
	committee that identif maintained substantia							
	of Care (SQC) were in was determined to ex areas of 42 CFR 483.	(IJ) and Substandard Quality dentified on 05/07/2021 and ist on 04/22/2021, in the 12 Freedom from Abuse, tion (F600 at S/S of "K").						
	Allegation of Complia alleging removal of th 05/20/2021. The Stat determined the Immer removed on 05/20/20. on 05/22/2021, with re a Scope and Severity develops and implement and the facility's Qual	an acceptable Credible nce (AoC) on 05/20/2021, e Immediate Jeopardy on te Survey Agency diate Jeopardy had been 21, as alleged, prior to exit emaining non-compliance at of a "G" while the facility ents a Plan of Correction ity Assurance (QA) monitors with systemic changes.						
	Review of the facility's	s policy titled, "Quality						

Facility ID: 100503

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION		IO. 0938-039
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	<u> </u>	CON	<b>MPLETED</b>
						С
		185301	B. WING		0	5/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
REGIS WO	DODS			4604 LOWE ROAD LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 867	Continued From page	328	F 86	.7		
1 007			FOU			
		nce Improvement (QAPI) 02/13/2017, revealed the				
		d to incorporating the				
		Assurance and Performance				
	Improvement (QAPI)	into all aspects of the				
		ses, service lines, and				
		f and stakeholders were				
		nprove the quality of life and				
	quality of care for the	review of the policy, revealed				
	-	as ongoing, integrated, data				
		ensive to address all aspects				
		life. The CED (Center				
	Executive Director)le					
	processes and involv	ed departments, staff and				
		ng a culture of safety, quality,				
		ness. The QAPI processes				
		ere based on evidence				
	drawing from multiple	inities, and bench marking				
		oped targets. Improvement				
		nance Improvement Projects				
		d means through which				
		eas were addressed. The				
	learning, through app					
	continuous, systemat	ic, and organized.				
	Review of the Job De	escription for the Center				
		ED), effective 01/01/2016,				
		sponsibilities included the				
	operational responsit	bility to ensure policies and				
	procedures for the fac	-				
		facility would create an				
		taff members were highly				
		d on providing the highest				
	residents, and familie	and compassion to patients,				
	administer and coord	inate all activities of the				

Facility ID: 100503

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				(X3) DATE COMP	SURVEY PLETED
		185301	B. WING			_		C <b>22/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	subject to the rules ar by government agence received the proper set Review of the Accepta (POC) for the 10/09/2 facility provided educa residents were protect review revealed staff development/impleme and care plan timing/r (F-600, F-656, F-657) Further review of the 10/09/2020, revealed Center Executive Dire Executive (CNE), Ass Services (ADNS), and review the staffing ner review revealed the fa call' schedule to assist rearranging staff to co Additional review of the SW, Center Nurse Ex Memory Support Prog manager would review Notes of residents pre during the clinical met resolved. Continued review reve continue to ensure the effectively and efficier the highest practicabli psychosocial well-bein the facility's governing	<ul> <li>provided to residents, and regulations promulgated cies to ensure residents ervices.</li> <li>able Plan of Correction 2020 survey revealed the ation to staff to ensure the cted from abuse. Continued were educated on entation of the care plan, revisions to the care plans.</li> <li>POC, survey dated the Staffing Coordinator, ector (CED), Center Nurse sistant Director of Nursing d/or Unit Managers would eds for all shifts. Continued acility would adopt an "on st with obtaining and or over shifts.</li> <li>he POC, revealed the SSD, secutive (CNE), ADNS, gram Manager and/or Unit w the residents' Progress esenting with behaviors etings until the issue was</li> <li>ealed, the CED would e facility was administered ntly to attain and maintain e physical, mental and ng of the residents as part of</li> </ul>	F	867				

Facility ID: 100503

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/16/2021 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			05/2	C 22/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4604 LOWE ROAD			
REGIS WO	0005			LOUISVILLE, KY 40220	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	plans of action were in deficiencies, to includ Further review revealed his findings of the faci concern was resolved Lastly, the POC reveal President of Operation reeducated the Center by 11/11/2020, who we Interdisciplinary Team Performance Improve before 11/11/2020, rea maintain a quality ass committee. Further re- and/or CNE would rep QAPI until the issues During the 10/09/2020 facility was cited defice "Sufficient Nursing Sta Services" for failure to provide services to re- behaviors; "Administra substantial complianc Program/Plan" for failure deficient practice. Interview with the Cer- on 05/11/2021 at 11:2 worked at the facility so interview, she stated so repeated deficiencies F740. The CNE state audits from the previous she did not discuss the	ns (RVPO), would d ensure that appropriate n place to correct quality e F-600, F-656, and F657. ed the CED would present lity's audits to QAPI until the l. aled the Regional Vice ns (RVPO)/designee or Executive Director (CED) ould reeducate members of o on the Quality Assurance ment (QAPI) process on or garding a facility must ressment and assurance eview revealed the CED bort the facility's audits to were resolved. D Recertification Survey, the cient practice related to aff"; "Behavioral Health o assess, document, and sidents with known ation" for failure to maintain e; and "QAPI ure to identify and correct ther Nurse Executive (CNE), t5 PM, revealed she had since 10/13/2020. Per	F 86	7			

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-03 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED	
			A. BOILDING			С	
		185301	B. WING		0	5/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				4604 LOWE ROAD			
REGIS WO	DODS			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 867	Continued From near	- 221	<b>_</b>	_			
F 007			F 86	<i>′</i>			
		e visual rounds/observations e Memory Care Unit, but					
		e the rounds "frequently";					
		shot" of the residents'					
		lly, the CNE stated staffing					
		; however, there were no					
	concerns identified.						
	Interview with the Co	nter Executive Director					
		1 at 3:25 PM, revealed he					
		rator 02/15/2021. Per					
		he purpose of the QAPI					
		ectively manage and change					
		r the residents. He further					
	stated the QAPI com	mittee met monthly and "as					
		e facility had two (2) Ad Hoc					
		veek." He further stated he					
		ent identified jeopardy					
		discuss the concerns with					
		cations. The CED stated the ) attended the QA meetings					
	and was very involve						
		ttended, including the Center					
		E), all managers, Social					
		iness Office Manager					
		tary Services, and now					
		ntly involved, attending in					
	person or via telecon						
		ncerns identified in QAPI					
		s' falls. He further stated the difference of the states and the states and the states and the states are states as the states are states are states are states as the states are stat are states are					
		s' care plans if needed. The					
		on obtained for resident care					
		om partnering with direct					
		unds, and talking to the staff					
		were observing with the					
	-	other resources used were					
		developed from the Plan of					
	Corrections (POC) ar	nd addressing concerns that				1	

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION			SURVEY LETED
		185301	B. WING			-		22/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
REGIS WO	DODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 867	correct issues, and st progress. Finally, the of the prior concerns a previous POCs, but h (100) percent aware of in the facility. Telephone interview w (MD), on 05/12/2021 attended the QAPI Pr has been involved wit meetings last week. Of MD revealed the QA of and ongoing concerns behaviors. Interview with the form (FRVP), on 05/12/202 worked with the facilit interview, the FRVP ro oversight to the CED. supportive assistance the procedures, polici communication with th The FRVP revealed th "formally" report issue what they were workin times, they discussed to QAPI. Further inte aware of and had not the facility was workin An additional telephon Director, on 05/22/202 facility immediately not to the identified jeopa	He stated the QAPI ood attempt to identify and ated it was a work in CED stated he was aware addressed in the facility's e was not one-hundred of all the concerns identified with the Medical Director at 10:25 AM, revealed he occess once a month and th a couple of the ad hoc Continued interview with the discussed the POC audits is with the residents' mer Regional Vice President 21 at 8:21 AM, revealed she by since 12/28/2020. Per evealed she provided She stated she provided She stated she provided es and education through he facility's administration. he CED and CNE did not es from the facility to her or ing on in QAPI. Indirectly, at I potential concerns to take rview revealed she was not been made aware of what	F	867				

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	-	ID HUMAN SERVICES			F	NTED: 07/16/2021 ORM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3)	3 NO. 0938-0391 DATE SURVEY COMPLETED
		185301	B. WING			C 05/22/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COE	)E	
REGIS WO	DODS			604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 867	discuss the informatic staff, and audits for co revealed the facility u progress of education which were warranted information.	on, formulate education to ompliance. The MD pdated him daily on the n, audits, and any changes d after review of the	F 867			
	Compliance revealed following: 1. On 05/16/2021, a O Performance Improve held to discuss the ac education, and compl deficiencies F600, F6 F835, and F867 prior date with any correcti 2. On 05/16/2021, th Operations (RVPO) or designee r Executive Director (C 3. By 05/19/2021, a p and implemented by f Performance Improve correct identified repe concerns cited at F60 F835 and F867. 4. On or before 05/19 reeducate members of on the Quality Assura Improvement (QAPI) must maintain a Qual Performance Commit	ement (QAPI) meeting was betton plans including audits, liance monitors for repeat 556, F657, F725, F740, to the alleged compliance ve action upon discovery. e Regional Vice President of reeducated the Center ED). blan of action was developed the Quality Assurance ement (QAPI) Committee to eat quality issues and 00, F656, F657, F725, F740, D/2021, the CED would of the Interdisciplinary Team ince Performance process regarding a facility				

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DEPARTMENT OF HEALTH				FOI	ED: 07/16/2021 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	185301	B. WING		0	C 5/22/2021
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE	E, ZIP CODE	
REGIS WOODS			604 LOWE ROAD OUISVILLE, KY 40220		
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
<ul> <li>other members of t and implement app correct identified qu were completed to by the CED. Memb Team not available provided reeducation graded by the CED New members of th be provided educat graded by the CED</li> <li>5. The Regional Vio and/or Clinical Qua review QAPI minute months then ongoin the QAPI committe were assigned base additional follow up</li> <li>6. The CED or CN audits for F600, F6 and F867 monthly the QAPI committee will Executive Director, Assistant Director of Director, Social Sen Director, Dietitian, H Business Office Ma Director, Maintenar and Certified Nursit follow up and/or in resolved and then of determined by the of The State Survey A</li> </ul>	acility and at least three (3) he facility's staff to develop ropriate plans of action to ality deficiencies. Posttests validate understanding graded ers of the Interdisciplinary during this timeframe will be on and complete posttests upon day of return to work. ie Interdisciplinary Team will ion and complete posttest during orientation. The President of Operations lity Specialist (CQS) would es monthly times six (6) ng thereafter as determined by e to ensure additional audits ed upon recommendations for and/or in-servicing needs. E would report results of the 56, F657, F725, F740, F 835 imes six (6) months to the nich consisted of the Center Center Nurse Executive, if Nursing Services, Medical vice Director, Food Service Health Information Manager, nager, Therapy Program the Director, Activity Director ong Aides for any additional servicing until the issue was ongoing thereafter as	F 867			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/16/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185301	B. WING			-		C <b>22/2021</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	335	F	867				
	dated 05/15/2021, rev F600, F656, F657, F7	IOC QAPI sign-in sheet, vealed the deficiencies for 25, F740, F835, and F867 I members of the QAPI the Medical Director						
	revealed the CED was passed the test with o (100%). Continued re	eview revealed the Regional erations (RVPO) signed off						
	PM, revealed he has through observing and meetings. Per intervie CED suggestions on a still needs to make su together." Continued helping the CED under	interview revealed he was erstand his role as an ther stated he signed off on						
	05/22/2021 at 5:30 Pl 05/22/2021 at 6:30 Pl meeting held on 05/15	Medical Director (MD) on M, and CNE and CED; on M, revealed the QAPI 5/2021 discussed the audits d all of the cited jeopardy						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 07/16/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING		_	C 05/22/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
REGIS WO	OODS		4604 LOWE ROAD LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 867	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 867				

Facility ID: 100503

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