STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Survey Agency (SSA) conducted an Abbreviated Survey on 04/14/2021 and concluded on 05/22/2021. Sixty (60) complaints were investigated. Out of the sixty (60) investigations, thirty-two (32) of the complaints were unsubstantiated without deficiencies cited. The complaints were KY30554, KY30637, KY30690, KY30779, KY 30800, KY30877, KY30912, KY31028, KY31037, KY31103, KY31158, KY31166, KY31172, KY31179, KY31181, KY31208, KY31324, KY31378, KY31393, KY31479, KY31480, KY31486, KY31624, KY 32510, KY32710, KY32779, KY32856, KY33006, KY33105, KY33159, KY33224, and KY33264.

Additionally, twenty-five (25) of the complaints were substantiated with deficiencies cited. However, fifteen (15) out to the twenty-five (25) complaints occurred prior to the facility's 11/12/2020 compliance date for the last Re-Certification survey, thus will be substantiated without deficiencies cited. The substantiated complaints without deficiencies cited were KY30689, KY31016, KY31310, KY31311, KY31376, KY31516, KY31528, KY 31588, KY31606, KY31634, KY31722, KY32178, KY32888, KY32997 and KY33015.

Lastly, thirteen (13) complaints were substantiated with deficiencies cited. Due to continued non-compliance, complaints that occurred prior to the 11/12/2020 compliance date for the last Re-Certification survey were also included. The complaints were KY31095, KY31420, KY32671, KY32708, KY33007, KY33014, KY33016, KY33178, KY33491,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1	F 000		

KY33636, KY33774, KY33789, and KY33888.

The facility admitted Resident #21 on 01/01/2020 with the primary diagnosis of Alzheimer's Disease and additional diagnoses included Depressive Episodes, Anxiety Disorder, Psychotic Disorder with Delusions, Dementia without Behavioral Disturbance, and Adjustment Disorder.

Record review revealed Resident #21 had a history of resident-to-resident altercations. Continued review revealed on 03/24/2021 and 10/28/2020 slapped other residents; on 10/25/2020 Resident #21 patted a resident's face and that resident scratched Resident #21 in the face; and on 10/02/2020 Resident #21 pushed a resident down resulting with the other resident suffering a fracture. Further review revealed no documented evidence the facility developed or utilized person centered interventions to support the resident or reduce the expressions/distress including pacing, intrusion of others' personal space and verbal or physical behaviors directed at others.

Interviews with staff revealed they were unaware of the underlying causes of the resident's behaviors, unaware of the resident's responses to stressors, and were not aware of person-centered interventions to support the resident and reduce expression or distress in the resident. Interview with the Memory Care Program Director revealed the facility failed to maintain Behavior Rounds per policy.

Record review and interview revealed Resident #56 hit Resident #28; Resident #2 was involved in five (5) resident-to-resident altercations involving hitting other residents; Resident #16 kicked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3	F 000		

Additionally, on 05/14/2021, the State Survey Agency (SSA) identified additional areas where immediate jeopardy was identified. The immediate jeopardy was identified on 05/14/2021 and was determined to exist on 03/27/2021 Immediate Jeopardy was identified in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, (F656) Develop/Implement Comprehensive Care Plan and (F657), Care Plan Timing and Revision, at a S/S of a "J", 42 CFR 483.35 Nursing Services, (F725) Sufficient Nursing Staff, at a S/S of a "J", 42 CFR 483.70 Administration, (F835), at a S/S of a "K", (F837) Governing Body at a S/S of a "K", (F842) Resident Records-Identifiable Information at a S/S of a "J", and F867, QAPI/QAA Improvement Activities, at a S/S of a "K". The facility was notified of the immediate jeopardy on 05/14/2021.

Actual harm was also identified at 42 CFR 483.45 Pharmacy Services (F758), Free from Unnecessary Psychotropic Medications at a S/S of a "G".

Additional deficiencies were cited in the areas of 42 CFR 483.10 Resident Rights, (F550) Resident Rights/Exercise of Rights at a S/S of "D", (F558), Reasonable Accommodations of Needs/Preferences at a S/S of "E", and (F585) Grievances, at a S/S of a "D", 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation,42 CFR 483.35 and Nursing Services, (F730) Nurse Aide Performance Review, at a S/S of a "F".

The facility provided an acceptable Credible Allegation of Compliance (AoC) on 05/20/2021, alleging removal of the Immediate Jeopardy on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 05/20/2021. The State Survey Agency determined the Immediate Jeopardy had been removed on 05/20/2021, as alleged, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure residents were treated in a dignified manner for one (1) of eighty-seven (87) sampled residents (Resident #1).

Resident #1 was informed by the facility he/she could not leave the facility to visit with his/her family; however, the facility allowed other residents to visit with his/her family.

The findings include:

Review of the facility's policy, OPS206 Resident Rights Under Federal Law revised 03/01/2018, revealed the facility should treat each patient (resident) with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 550	Continued From page 6	F 550		

his/her self-esteem and self-worth. They should incorporate the patient's goals, preferences, and choices into care. They should recognize each patient's individuality as well as honor and value his/her input. The facility should protect and promote the rights of the resident.

Review of the facility's policy titled, "Guidance Changes Based on Lower (but Not Zero) Community Risk," revised on 03/29/2021, revealed a resident "leave of absence" was strongly discouraged during the pandemic. If a resident decided to leave, the Center Executive Director (CED) or a designated leader reviewed the Resident Outing Agreement with the resident and family member escorting the resident. The resident would be provided with a supply of disposable standard face masks and upon returning to the facility the resident would be placed on "Observation Status."

Review of the facility's policy titled, "Review of the Leaves of Absence (LOA) during the Pandemic," dated 11/08/2020, revealed the facility expected the residents and family members would inquire about the possibility of leaving the facility to go home with family members for part of the day. Further review revealed residents were strongly discouraged from leaving the facility despite the potential risks during the day or for overnight leave for any reason other than medically necessary the following would apply: the resident and family member would be provided an explanation of the risk of leaving the facility and potential consequences. Additionally, the resident would be provided the "Resident Outing Agreement" and would be reviewed and signed by both the resident and family member who was escorting the resident and it would be placed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 550	Continued From page 7	F 550		

the resident's medical record. Continued review revealed the facility would provide the resident with a single, disposable standard facemask for each day that the resident would be away from the facility.

Record review revealed the facility admitted Resident #1, on 11/23/2018, with the diagnoses of Quadriplegia, Hypertension, Bipolar Two (2) disorder, Adjustment disorder, Post-traumatic stress disorder, Chronic Respiratory Failure, Anxiety disorder, Chronic pain syndrome, Stage Four (4) pressure ulcer, and Nicotine Dependence.

Review of the Annual Minimum Data Set (MDS), dated 01/27/2021, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) and determined he/she was interviewable.

Review of Resident #1's Grievance Form, dated 03/16/2021, revealed the concern was reported to Social Services. Per review, the "resident stated that the Center Executive Director informed (him/her) that (he/she) could not leave on weekends anymore when (he/she) was informed by the Center Nurse Executive (CNE) (he/she) could leave the facility. The resident reported a resident across the hall went home for three (3) days, but (he/she) can't anymore." Further review revealed the designated department to take action on the resident's concern was the CED. Review revealed the CED signed off having received the grievance on 03/16/2021 with an undated "resolved" date. Continued review revealed the box was checked "no" without an explanation related to the question, "was grievance/concern confirmed." Additionally, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8	F 550		

resolution of the grievance/concern was that the policy related to the "Leave of Absence" policy was discussed with the resident. Further review revealed the CED met with the resident face to face and was signed off as resolved on 03/19/2021.

Review of the "Resident Outing Agreement," dated 08/24/2020, revealed that when a resident planned to leave the facility accompanied and transported by family or friend for a medical appointment or other outing, the resident and any companions were required to: notify the facility in advance about the day, time, and duration of outing, follow proper infection prevention practices, meet at the front entrance to the facility, wear a mask at all times for the duration of the outing, adhere to social distancing practices, avoid large gatherings, and follow good hand hygiene procedures. The resident had to sign and their family member/friend saying they agreed to these conditions.

Review of Resident #1's Outing Agreement revealed the resident and family signed the agreement on 11/24/2020.

Observations, on 04/22/2021 at 2:45 PM, revealed Resident #1 in his/her room listening to music. The resident was groomed in gray sweats, without odor, sitting in an electric wheelchair. Further observation revealed the resident was able to use his/her right arm.

Interview with Resident #1, on 04/22/2021 at 2:45 PM, revealed he/she did not like the facility and if he/she had a choice he/she would leave. He/she further revealed he/she filed a grievance with the facility, but the facility told him/her that he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

was not allowed to leave the facility without an explanation. The resident stated that he/she felt like he/she was being held against his/her will. The resident said that they had been able to leave the facility, under the previous administration, but now, they could not leave. He/she further revealed other residents were allowed to leave the facility as he/she saw another resident leave to visit his/her loved ones over the weekend. The resident said that the Centers for Disease Control and Prevention (CDC) guidelines did not say that the residents could not leave the facility.

Interview with Resident # 47, on 05/20/2021 at approximately 3:00 PM, revealed he/she was given permission by the CNE to visit his/her family. He further revealed he/she was not aware residents could not leave the building to visit with their family.

Interview with the Social Service Director (SSD), on 05/07/2021 at 6:19 PM, revealed she was "just told" by Resident #1 that Resident #47 was allowed to go out on outings. She stated that to her knowledge, no one was allowed to leave the facility. Further interview revealed she talked to the CNE who told her Resident #47 had an unapproved leave and was now on a fourteen (14) day quarantine. The SSD stated she was not aware of any policy that prevented the residents from leaving the facility and only relied on information that was given to her by the CED. Per interview, the residents leaving the facility was not an "issue" until the current CED came on board. The SSD stated Resident #1 had rights and his/her grievance concerns related to leaving the facility should have been resolved. She further stated in this particular situation, the CED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10	F 550		

handled the resident's grievance.

Interview with the CNE, on 05/11/2021 at 5:05 PM, revealed that Resident #1 was very non-compliant and manipulative and had transferred from center to center because of choices he/she made. She stated the resident refused to stay in his/her room and would not wear his/her mask when moving about in the facility. The CNE stated Social Services spent a lot of time with the resident trying to keep him/her happy and address his/her concerns. She stated that Resident #1 would not stay in his/her room, and would not quarantine, but acknowledged the resident was currently in a private room and was "quarantined." The CNE stated Resident #1 would put other residents at jeopardy, should he/she leave the facility. Continued interview with the CNE revealed she allowed Resident #47 to visit with his/her family as the resident "followed" the rules and quarantined when he/she returned. She further revealed the facility's policy related to the resident's "leave of absence" strongly discouraged the residents from leaving the facility, but the policy/guidance did not state the residents could not leave to visit family or go out on outings. She said she has never told the resident that he/she could not go out, that it would depend on CDC guidelines.

Interview with the CED, on 05/11/2021 at 5:20 PM, revealed that he strongly discouraging residents from going out for anything other then medical necessities. He said with Resident #1's noncompliance and numbers being high at the time was his reasoning for strongly discouraging residents from going home, adding, "I have to protect my residents." The CED stated he had a conversation with Resident #1 and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 11 residents about leaving. He said per all the guidance, residents should not go out unless it was a medical necessity. However, per interview, the CED stated he could not locate such recommendations/guidance. He said the facility was not letting anyone out until the County's COVID positivity rate went down. The CED stated he was afraid Resident #1 would go out, had possible COVID exposure, and not quarantine when he/she got back.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to accommodate residents' needs in a timely manner for five (5) of eighty-seven (87) sampled residents (Residents #15, #22, #53, #84 and #87). Observations revealed five (5) of eighty-seven (87) residents' call lights were not answered timely. Observations revealed call lights were activated up to thirty (30) minutes for two (2) of three (3) units with no staff available for long periods on the hall. Interviews with staff revealed there was not enough staff to meet the needs of the residents on the units. Resident interviews revealed they have to wait a long time for staff to answer their call lights. In addition, long wait times to answer call lights had been discussed in	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12	F 558		

the Resident Council meetings and was noted in the grievance log.

The findings include:

Review of the facility's policy titled, "Activities of Daily Living (ADL's)," revised 11/01/2019, revealed the purpose was to maintain the resident's highest physical, mental, and psychosocial well-being. To achieve purpose, the facility must provide the necessary care and services to ensure a resident's abilities do not diminish. Necessary care included hygiene, which encompasses bathing, dressing, grooming, oral care, mobility, elimination, dining, and communication.

Review of the Skin Delivery Care Process, dated 06/01/2016, revealed basic prevention of injury included to maintain an intact skin surface. Treatment included to provide adequate peri-care (perineal), barrier lotions, and to provide pressure relief with rotation of position.

Review of the facility's policy, "Call Lights," revised 11/01/2019, revealed residents will have call lights within their reach at all times and staff were to respond to all lights and communications devices promptly.

Review of the facility's policy, "Accommodation of Needs," revised 11/28/2016, revealed the facility must provide a safe environment.

Review of the Certified Nursing Assistant (CNA) job description, revised 11/23/2020, revealed all aides answered call lights in a timely manner.

Review of the Resident Council minutes, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 13	F 558		

11/11/2020, revealed the residents notified the facility about the concern of staff's slow response to the call light. The facility did not document a response to the reported concern. Continued review revealed on 12/04/2020, the facility received notification of the Resident Council's continued concern about staff not answering call lights in a timely manner.

Review of the facility's Call Light Audit, dated 12/10/2020, revealed staff audited the 400 Hall in the late AM and noon. On 12/14/2020, staff audited day shift, the 300, and 400 Halls, with a call documented as twelve (12) minutes and twenty-three (23) seconds to respond. On 12/16/2020, the auditor observed from 7:00 AM to 7:45 AM for the 200 Hall Nursing Floor (NF) two (2) (NF2). The auditor noted four (4) residents' call lights were activated. At the conclusion of the audit, the Auditor noted response times of ten (10), fifteen (15), twenty (20), and twenty-five (25) minutes of observed call lights. The Auditor noted in the comment section of the audit that the nurse manager and staff remained at the desk without attempts to respond from the start to the finish of the audit observation. Further review revealed the Auditor noted no one on the unit acknowledged or responded to the call lights. Continued audit review revealed on 01/26/2021, two (2) observations on the day shift with staff's response of thirteen (13) and seventeen (17) minutes; and on 01/27/2021, observations revealed thirty-two (32) minutes to respond to a call light on the day shift. Documentation was not provided by the facility of audits on the second or third shift.

Review of a facility In-service titled, "Call Light Policy and Expectations of Staff," dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 558	Continued From page 14	F 558		

02/02/2021 through 02/17/2021, revealed seventy-eight (78) clinical staff members completed the in-service.

Review of the facility's audit "Call Light Answer Time," dated 04/02/2021, revealed clinical staff audited call light response times by administrative clinical staff. Further review revealed the staff monitored for "various times" for fifteen (15) different residents. The audit revealed the longest wait time of eleven (11) minutes. Review of the 04/06/2021 audits revealed the facility audited "various times" for eight (8) residents with the longest wait time of ten (10) minutes. Continued review of the 04/13/2021 audits, revealed the facility audited eight (8) residents' call lights at "various times" with the longest wait time of twelve (12) minutes. However, the facility's audits did not provide specific times, shift, time of activation and response, staff for unit, activity on unit, interview with resident or staff, and resident census for the unit the day of the audit and residents' needs on the unit.

Further review of the facility's Resident Council Notes, dated 04/19/2021, revealed the resident council's concerns included staff's lack of timely response to call lights. The facility's response included to complete call light audits for unit hallways to ensure staff's timely response.

Observation, on 04/20/2021 at 11:11 AM, revealed the facility's call light alarms could be heard while standing at the administrator's door and they became louder as the State Survey Agency Surveyor approached the NF2 nurse's station. Continued observation revealed two (2) staff sat in the NF2 nurse's station and various staff walked about the unit. One staff identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 15	F 558		

herself as a Hospice Nurse and the other staff identified herself as Licensed Practical Nurse (LPN) #3. Review of the centralized call light 'monitor' unit (an electronic box which identified the room call bell activated and length of time activated and located at the nurse's station) revealed room 204 activated the call light five (5) minutes prior to arrival. Further observation at the NF2 nurse's station revealed observations of Licensed Practical Nurse (LPN) #3 sitting at the desk, and various facility staff walking past the call light handset which continued to alarm without staff response to room 204. Continued observations revealed at 11:25 AM, LPN #3 responded to room 204. Resident #84 resided in room 204. The facility's response time was thirty-nine (39) minutes. According to the facility's policy, staff response should be immediate.

1. Record review revealed the facility readmitted Resident #84 to room 204, on 03/07/2021, with the diagnoses of Parkinson's Disease, Heart failure, and Major Depression Disorder. Review of the Quarterly Minimum Data Set (MDS), dated 03/14/2021, revealed the facility assessed the resident's cognitive patterns with the Brief Interview for Mental Status (BIMS). The resident scored fifteen (15) which indicated he/she was interviewable. The facility assessed the resident as a two (2) person extensive assist for bed mobility, toileting, hygiene, and at risk for skin breakdown.

Interview with LPN #3, on 04/20/2021 at 11:25 AM, revealed the resident used the call light for help and the resident had requested help to reposition. The LPN revealed the facility expected staff to respond as soon as possible when the resident activated the call light. LPN #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 16	F 558		

revealed when staff did not respond in a timely manner the residents might get hurt, fall, have pain, lay in urine, and have skin breakdown from pressure. Further interview revealed the LPN had looked at the monitor before the State Survey Agency Surveyor arrived. She stated the resident 'hit' the call light often, and she figured another staff would answer the light. However, time passed and the LPN decided the call light needed to be addressed. LPN #3 revealed the facility completed in-services for call light response, customer services, and she had attended all required sessions.

Record review revealed LPN #3 signed as an attendee to the facility's in services for call light response. Further review revealed she received and reviewed the facility's call light policy, on 02/13/2021. However, observations revealed the LPN did not follow the facility's policy after completing the education and policy review as observed on 04/20/2021 at 11:25 AM.

Resident #84 was not available for interview at the time, on 04/20/2021 at 11:40 AM.

2. Interview with Resident #53, on 04/20/2021 at 11:50 AM, revealed he/she activated the call light for himself/herself and roommate. The resident revealed he/she had poor vision and staff often moved the call light off the bed or out of his/her reach, and he/she could not locate the call light to activate it for help. The resident stated he/she waited a long time for staff to answer the call light or they did not answer. Resident #53 stated the time could be thirty (30) minutes to an hour for staff to respond. The resident stated he/she activated the call light for his/her roommate who could not activate for his/her needs. Continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 17	F 558		

interview revealed he/she believed staff moved the call light on purpose so he/she would not request help because they knew he/she requested help often and it inconvenienced the staff. Resident #53 further revealed, he/she felt it was wrong not to help people when they asked for help.

Record review revealed the facility re-admitted Resident #53, on 01/29/2019 with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Glaucoma, and history of falls. Review of the Quarterly MDS, dated 03/07/2021, revealed the facility did not assess for the resident's cognitive pattern. However, interview with the resident revealed the resident answered questions factually, and was oriented to self, care needs and surroundings. The facility assessed the resident as an extensive one person assist for hygiene and a limited one person assist for bed mobility, assist for toileting, transfer, and ambulation. Continued review record revealed the facility care planned the resident for the risk of falls with the intervention to have the call bell within reach and within close proximity at all times to the resident.

3. Observation, on 04/23/2021 at 9:55 AM, revealed the NF2 call light monitor showed room 215's call light was activated for 12 minutes. Record review revealed Resident #22 resided in room 215. Further observation revealed initially no staff was observed at the nurse's station and no staff observed in the hallway. At 9:58 AM, LPN #3 exited a resident's room, walked into the nurses' station, reviewed the monitor, and walked into the Center Nurse Executive's (CNE) office. At 10:06 AM, an unknown staff deactivated room 215's call light. Observation revealed the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 18	F 558		

waited twenty-one (21) minutes, which was not per the facility's policy.

Record review revealed the facility re-admitted Resident #22, on 09/17/2020, to room 215 with the diagnoses of Morbid Obesity, Viral Hepatitis, and Bipolar. Review of the Quarterly MDS, dated 03/25/2021, revealed the facility assessed the resident's cognitive patterns with a Brief Interview of Mental Status score of fifteen (15) and determined the resident was interviewable. The facility assessed the resident as a two (2) person extensive assist for bed mobility, and one person limited assist for toileting, transfer, and ambulation.

Interview with Resident #22, on 04/21/2021 at 1:00 PM, revealed he/she called for assistance to the bathroom. The resident revealed staff regularly responded as late as thirty 30 to sixty (60) minutes.

4. Observation, on 04/26/2021 at 10:07 AM, revealed the call light monitor for the Transitional Care Unit (TCU) was activated for room 323 for nine (9) minutes and 9 seconds; and room 324 at ten (10) minutes and fifty-seven (57) seconds with no visible staff on the unit hallway. In addition, no staff was observed on the 300 Hall or 400 Hall. Continued observation revealed two (2) staff exited room 321 and one staff deactivated the call light for room 323 at 10:21 AM. This observation revealed for a total of thirteen (13) minutes there was no staff observed on the unit. Staff from other units entered the unit to care for residents. However, there was no response to the call lights. Observation at 10:28 AM revealed room 324's light was deactivated. Observation revealed the response time for room 323 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 19	F 558		

twenty-two (22) minutes and room 324 was twenty-eight (28) minutes. According to the facility's policy, staff was to respond to call lights immediately.

Record review revealed the facility re-admitted Resident #15, on 12/07/2020, to room 323 with the diagnoses of Paraplegia, Septicemia, and Hypertension. Review of the Quarterly MDS, dated 03/04/2021, revealed the facility assessed for cognitive patterns with the BIMS' score of fifteen (15). Resident #15 was determined to be interviewable. The facility assessed the resident as a two (2) person extensive assist for bed mobility, transfer, hygiene, toileting. Further review revealed the resident received pain medication on an "as needed" (PRN) basis.

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, within the last weekend he/she waited over three (3) hours for response to the call light on the third shift, since admission on Easter weekend. The resident stated that staff, both nurses, and aides, would say that they could not respond due to the needs of other residents which required two (2) staff at the bedside. Further interview revealed when he/she called for medication, his/her pain was at a scale of six (6) out of (10) and by the time he/she received pain relief the pain had reached eight and a half (8 ½). The resident stated that long wait times for staff's response to the call light was common.

5. Record review revealed Resident #87 occupied room 321. The resident was unable to be interviewed at the time on 04/26/2021 at 10:55 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 20	F 558		

Review of the Resident Grievance Log, dated 03/18/2021, revealed the facility documented Resident #87's concern with staff's call light response times. Record review revealed the facility admitted Resident #87, on 03/03/2021, with the diagnoses of Paraplegia, Autonomic Dysreflexia, and Neuralgia.

Review of the Quarterly Minimum Data Set (MDS), dated 05/12/2021, revealed the facility assessed for cognitive patterns with the Brief Interview for Mental Status (BIMS) with a score of fifteen (15) and determined the resident was interviewable. The facility's mobility assessment included the use of a wheelchair; and, transfers and bed mobility required two (2) person maximum assist. In addition the resident was always incontinent of bowel.

Record review revealed the facility admitted Resident #87, on 03/03/2021, with the diagnoses of Paraplegia, Autonomic Dysreflexia, and Neuralgia. Review of the Quarterly Minimum Data Set (MDS), dated 05/12/2021, revealed the facility assessed for cognitive patterns with the Brief Interview for Mental Status (BIMS) with a score of fifteen (15). The facility assessed the resident to be interviewable. The facility's mobility assessment included the use of a wheelchair. Transfers and bed mobility required two (2) person maximum assist. In addition, the resident was always incontinent of bowel.

Interview with Resident #87, on 05/14/2021 at 12:04 PM, revealed he/she had activated the call light, on 04/26/2021, in the AM to start his/her bath. The resident stated that long wait times for staff's response to call lights was normal. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 21	F 558		

resident stated he/she told the Social Worker that the aides refused to come into the room. Resident #87 stated he/she needed a brief changed, and had waited a long time for staff. The resident stated he/she became emotional, and the Social Worker wrote up a grievance. However, the resident stated call light response did not change. Continued interview with the resident revealed staff left him/her up in the chair until 1:00 AM and he/she had to call the facility to connect to the station to contact staff because staff did not attach the call light to his/her chair. In addition, he/she stated to have initiated the timer on his/her phone when one aide worked who refused to come into his/her room. The resident stated the wait time was three (3) hours and he/she reported this to the director (Administrator). Resident #87 stated staff did not want to answer his/her call light because they considered him/her difficult. The resident stated he/she just wanted to be treated like a human and receive the care he/she needed to get better.

Review of Resident #87 Progress Note, dated 03/18/2021 at 5:53 PM, revealed the resident's call light was on, and Social Services responded, the resident reported he/she needed a brief change and became very emotional. The Social Worker completed a grievance form.

Interview with LPN #4, on 04/26/2021 at 1:18 PM, revealed the Transitional Care Unit (TCU) Hall for acute cases which could include residents with rehabilitation needs, recovery from acute illnesses, and transition to Long Term Care (LTC) and for new residents with complex care needs. The LPN revealed one nurse and one aide were assigned to the unit. She stated many residents required two (2) staff, and they did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 22	F 558		

enough staff to cover the floor. The LPN stated resident care often took up to thirty (30) minutes, and took both staff off the floor, and they could not hear resident call bells. The LPN stated staff was supposed to come help from other hallways. However, other staff could not hear call bells from other halls. LPN #4 stated acceptable response time to call bells included five (5) to seven (7) minutes. However, twenty (20) to thirty (30) minutes was to long for residents, and this could cause a resident to fall because they become impatient. LPN #4 stated the call bell (call light) was the resident's life line for help. The LPN stated because she helped the aides with resident care, she often could not get her duties completed by the end of shift. Continued interview revealed LPN #4 stated she had voiced her concerns to the scheduler and to the director. However, no changes had been made to the schedule. The LPN revealed she attended the in-service provided by the facility for call bell response and expectations. However, the LPN stated staff could not meet the policy's (facility's) expectations.

Observation, on 05/05/2021 at 4:15 PM, revealed the call module on NF2 alarmed and showed room 204, Resident #84's room, activated for 15 minutes and 29 seconds. While the module alarmed staff sat at the desk or charted. Staff identified included LPN #3 and Certified Nursing Assistant (CNA) #12. Continued observation revealed the CNA did not look up from the computer. The LPN addressed a phone call, reviewed the monitor, and caught two (2) therapists and asked for help. The two (2) therapists entered room 204. Upon exit from Resident #84's room staff identified themselves as the Occupational Therapist (OT) and Physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 25	F 558		

alarmed without response. Continued interview revealed the UM conducted spot audits, as well as official observational audits without significant findings of excessive wait times.

Interview with the Center Nurse Executive (CNE), on 04/26/2021 at 11:50 AM, revealed the facility was adequately staffed. The CNE revealed she expected staff to help each other, and staff from the 300 and 400 halls to help the TCU. The CNE stated staff had not come to her with concerns of not being able to complete their tasks or answer call lights because of staffing.

Further interview with the CNE, on 05/05/2021 at 9:15 AM, revealed she came to the facility in October 2020. She stated her role included to ensure staff provided best practice and care to the residents. The CNE stated call light audits were initiated with complaints from residents that staff were slow to respond to call lights and she initiated them in late 2020 and early 2021. She stated normal call wait times was ten (10) to twelve (12) minutes. She revealed when the new Center Executive Director (CED) came in March, he requested more audits of call lights. She revealed she gave an in-service to staff in February 2021 when earlier audits revealed some long wait times, but they were not excessive. She stated the in-service included the policy for call lights and staff's expectations which included to answer call lights first and to do paper work second. The CNE stated she expected staff to ensure all residents could reach their call light, and staff responded to call lights timely and followed policy. She stated the facility staffed the floors adequately to meet residents' needs and answer call lights. She stated this included night shift when one nurse and one aide would have up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 26	F 558		

to thirty (30) residents because most residents slept and their needs were minimal. She revealed she requested the night supervisors to monitor call light responses. However, she did not provide the supervisors with audit tools with directions to document only to observe. She revealed residents did not report 2 and 3 hours wait times for call light response or staff who did not want to care for certain residents. Furthermore she stated she did not request a report from the supervisors of the call light observations. The CNE further revealed the call light audit could not be accurate without second and third shift documented observations. She stated the call light audits were to be used for Quality Assurance (QA).

Interview with the CED, on 05/05/2021 at 10:00 AM, revealed he came to the facility March 2021. He stated on the very first day, observations revealed staff sat at the nurses' stations and walked past residents' rooms with call lights activated. The CED stated residents' call lights blared, and staff continued to sit at the desk or continued to walk past without response. He revealed he observed this for several days and met with the CNE, discussed goals, and expectations. Continued interview revealed the goals included to make staff accountable for performances, to take care of the residents, i.e. call lights, and to ensure staff took care of the residents. However, he stated the facility's goals included to change the mentality to less paper more clinical care. He revealed the staff required intense education which begun with the hiring of a new educator. The CED further revealed the facility did not have an electronic system to run electronic call light reports. He stated he initiated a call light audit, adjusted the staff's pattern, and initiated all department heads to address call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 558	Continued From page 27 lights and notify staff of the resident's request if they could not resolve it. However, he revealed he reviewed the completed call audits and did not identify that the audits had not been completed on second and third shift; had not completed the sections of what the care need was; or resident's interview. He stated he could not answer if the call light audit was adequate to provide information for QA. However, he revealed he expected staff to follow facility policy and care for the residents.	F 558		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 28	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 29	F 585		

abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and the facility's policy review it was determined the facility failed to follow the grievance process and failed to follow-up with residents regarding the facility's efforts or plans to resolve grievances for one (1) of eighty-seven (87) sampled residents (Resident #1).

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 30	F 585		

Review of the facility's policy, OPS204 Grievance/Concern, revised 07/01/2019, revealed it was the policy of the facility to ensure that any patient (resident) or patient representative has the right to express a grievance/concern without fear of restraint, interference, coercion, discrimination, or reprisal in any form and to assure prompt receipt and resolution of patient/representative grievance/concern.

Review of the Grievance/Concern Report Form, revised 03/01/2018, revealed the top section included information regarding the complaint. Review of the second section revealed documentation of the investigation, actions taken, and signature of person that completed the investigation. The resolution section, the last section, included if resolved, follow-up if not resolved, and how the facility reported. In addition, the lower section included a line for the signature of the person completing the form with the signature of the individual that filed the complaint.

Review of Resident #1's Grievance Form, dated 03/16/2021, revealed the concern was reported to Social Services. Per review, the "resident states that the Center Executive Director (CED) informed (him/her) that (he/she) could not leave on weekends anymore when (he/she) was informed by the Center Nurse Executive (CNE) (he/she) could. The resident reported the resident across the hall went home three (3) days, but (he/she) can't anymore." Further review revealed the designated department to take action on the resident's concern was the CED. Further review revealed the CED signed off having received the grievance on 03/16/2021 with an undated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 31	F 585		

"resolved" date. Continued review revealed the box was checked "no" without an explanation related to the question, "Was grievance/concern confirmed." Additionally, the resolution of the grievance/concern was that the policy related to the "Leave of Absence" policy was discussed with the resident. Further review revealed the CED met with the resident face to face and was signed off as resolved on 03/19/2021.

Review of the facility's policy titled, "Review of the Leaves of Absence (LOA) during the Pandemic," dated 11/08/2020, revealed the facility expected the residents and family members would inquire about the possibility of leaving the facility to go home with family members for part of the day. Further review revealed residents were strongly discouraged from leaving the facility despite the potential risks during the day or for overnight leave for any reason other than medically necessary the following would apply: the resident and family member would be provided an explanation of the risk of leaving the facility and potential consequences. Additionally, the resident would be provided the "Resident Outing Agreement" and would be reviewed and signed by both the resident and family member who was escorting the resident and it would be placed in the resident's medical record.

Review of the "Resident Outing Agreement," dated 08/24/2020, revealed that when a resident plans to leave the Center accompanied and transported by family or friend for a medical appointment or other outing, the resident and any companions were required to: notify the Center in advance about the day, time, and duration of outing, follow proper infection prevention practices, meet at the front entrance to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 32	F 585		

facility, wear a mask at all times for the duration of the outing, adhere to social distancing practices, avoid large gatherings, and follow good hand hygiene procedures. The resident had to sign and their family member/friend saying they agreed to these conditions.

Review of Resident #1's Outing Agreement revealed the resident and family signed the agreement on 11/24/2020.

Record review revealed the facility admitted Resident #1, on 11/23/2018, with the diagnoses of Quadriplegia, Hypertension, Bipolar Two (2) disorder, Adjustment disorder, Post-traumatic stress disorder, Chronic Respiratory Failure, Anxiety disorder, Chronic pain syndrome, Stage Four (4) pressure ulcer, and Nicotine Dependence.

Review of the Annual Minimum Data Set (MDS), dated 01/27/2021, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) and determined he/she was interviewable.

Observations, on 04/22/2021 at 2:45 PM, revealed Resident #1 in his/her room listening to music. The resident was groomed in gray sweats, without odor, sitting in an electric wheelchair.

Interview with Resident #1, on 04/22/2021 at 2:45 PM, revealed he/she filed a grievance with the facility, but the facility told him/her he/she was not allowed to leave the facility without providing him/her an explanation. The resident stated that he/she felt like he/she was being held against his/her will.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 33	F 585		

Interview with the Social Service Director (SSD), on 05/07/2021 at 6:19 PM, revealed to her knowledge, no one was allowed to leave the facility. Further interview revealed she was not aware of any policy that prevented the residents from leaving the facility,only relied on information that was given to her by the Center Executive Director (CED). Per interview, she would normally assist with the grievance process; however, the CED wanted to handle Resident #1's grievance. She further stated the resident's grievance concerns related to leaving the facility should have been resolved, with an explanation provided to the resident.

Interview with the Center Nurse Executive (CNE) on 05/11/2021 at 5:05 PM, revealed that for the grievance process the grievance goes to the SSD and she logs them in and distributes them to the person responsible for it. She stated she did not know why the SSD was told they go straight to the CED with Resident #1's grievances. The CNE stated she had never told Resident #1 that he/she could not leave the facility. She stated she told the resident that it would depend on Centers for Disease Control and Prevention (CDC) guidelines. Based upon grievance policy Resident #1 did not receive a resolution to their grievance.

Interview with the CED, on 05/11/2021 at 5:20 PM, revealed that he strongly discouraged residents from going out for anything other then medical necessities. He said with Resident #1's noncompliance and COVID-19 positivity numbers being high at the time that he strongly encouraged the resident to not leave facility. He said he had a conversation with Resident #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 34 other residents about leaving. He said that they did talk about the grievance in QA/QAPI (Quality Assurance and Performance Improvement). He said that when deciding if a grievance has been resolved they talked with the resident and if the resident though it had been resolved, then was resolved. The CED stated he liked to resolve the grievances within twenty-four (24) hours. Continued interview revealed he felt like Resident #1's grievance was addressed.	F 585		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; 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 system to ensure residents were free from physical abuse for	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 35	F 600		

twenty-four (24) of eighty-seven (87) sampled residents; Resident #2, Resident #3, Resident #8, Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, Resident #15, Resident #16, Resident #19, Resident #20, Resident #21, Resident #25, Resident #26, Resident #28, Resident #37, Resident #38, Resident #45, Resident #52, Resident 56, Resident #61, Resident #85 and Resident #86. Nineteen (19) of the twenty-four (24) residents resided on the Memory Care Unit (MCU).

The facility admitted Resident #61 to the facility's MCU (Memory Care Unit), on 12/17/2019 with a primary diagnosis of unspecified Dementia without behavioral disturbance. Additionally, the resident was diagnosed with Adjustment Disorder with depressed mood, on 06/16/2020, as his/her secondary diagnosis. Record review revealed on 10/02/2020, Resident #61 was sent to the hospital for an evaluation related to a resident-to-resident altercation, involving physical abuse. The resident was diagnosed with a fractured right proximal Humerus (long bone of upper arm). This incident occurred during the facility's noncompliance, however, the State Survey Agency (SSA) did not have documented evidence the facility reported the incident.

1. Interviews with staff, who witnessed the altercation between Resident #21 and Resident #61, on 10/02/2020 at approximately 5:30 PM, revealed Resident #61 was in a group activity in the common area and became tearful, had a crying episode, and exited the common area independently, seeking his/her room. Staff witnessed the resident cry, leave the common area, and move towards his/her room, which was adjacent to the common area. Resident #61 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 36	F 600		

standing in the doorway of Resident #21's room and continued to cry. Subsequently, Resident #21 was pacing/walking up and down the hallway and approached Resident #61 at his/her (Resident #21's) doorway. Resident #21 initiated an argument and yelled at Resident #61. Resident #21 shoved Resident #61 causing Resident #61 to lose his/her balance. Resident #61 fell backwards into the doorframe and down to the floor, landing on his/her right side.

Further interview with staff on the MCU, revealed Resident #21 had a history of tearfulness, crying, and irritability. Continued interviews revealed Resident #61 exhibit paced ambulation, on the MCU (hallway, common area, and into other residents' rooms). The resident had a history of physical and verbal abuse and intrusion of other resident's personal space.

2. Record review and interview revealed Resident #85 and Resident #86 were roommates on the MCU. Resident #85 had verbal behaviors such as yelling out and Resident #86 exhibited physical behaviors such as combativeness and would be resistive to care. On 04/22/2021, Resident #86 struck Resident #85 with a television while in their shared room. Subsequently, upon assessment on 04/25/2021 the nurse identified scattered bruising and swelling to Resident #85's right hand. Orders were obtained for an x-ray. The x-ray results showed a right 5th metacarpal (bone in the hand) fracture.

3. Closed record review revealed Resident #45 and Resident #52 were ambulating in the hallway of the Memory Care Unit (MCU), on 03/18/2020 at approximately 12:50 PM, when they approached each other. Resident #45 and #52

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 37	F 600		

grabbed each other's arms, subsequently Resident #45 had a bruise on his/her right forearm

4. Record review and interview revealed on 12/15/2020 Resident #10 and Resident #11 were sitting in the common area outside of the dining room when Resident #10 yelled out loud, then Resident #11 hit him/her in the face with a closed fist causing redness and swelling.

5. Record review revealed Resident #15 and Resident #16 had a verbal altercation during a scheduled smoke break on 12/24/2020 which later lead to a physical altercation. Continued review and interview revealed CNA #4 witnessed Resident #16 kick Resident #15 in the chest.

6. Record review revealed Resident #8 and Resident #9 were roommates on the MCU. Continued review revealed on 10/20/2020 Resident #9 squeezed Resident #8's wrist resulting in a small bruise. Per interviews with staff the altercation was reported by Resident #8 and was unwitnessed.

7. Record review revealed Resident #37 reported Resident #38 struck him/her in the chest. Resident #38 reported he/she struck Resident #37 to keep Resident #37 out of his/her (Resident #38's) room.

8. On 10/28/2020, in the MCU common area, facility staff observed Resident #2 slap Resident #21 who in return slapped Resident #2. The MCU staff separated the residents, assessed for injuries, and MCU staff provided 1:1 supervision for Resident #2 after the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 600	Continued From page 38	F 600		

9. Record review revealed on 11/21/2020 Resident #2 pushed Resident #19 causing Resident #19 to lose his/her balance and step on Resident's #20 foot.

10. Record review revealed on 03/10/2021 Resident #2 slapped Resident #3 on the face, leaving a red mark, while on 1:1 supervision.

11. Record review revealed on 03/09/2021 Resident #2 struck Resident #19, Resident #25, and Resident #26. The facility provided 1:1 supervision after the incident.

12. Record review revealed on 03/10/2021 Resident #2 struck Resident #3 leaving a red mark. Resident #2 was under 1:1 supervision at the time of the incident.

13. Record review revealed on 03/24/2021 Resident #2 struck Resident #21 in the left arm. The facility provided 1:1 supervision to Resident #2 after the incident.

14. Record review revealed staff observed Resident #12 kiss Resident #13 on the lips.

15. On 04/23/2021, Resident #56 was observed to hit Resident #28 on the leg while in the common area.

The facility's failure to have an effective system to take immediate action to prevent further abuse to ensure all residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substance Quality of Care (SQC) were identified at 42 CFR 483.12,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 40	F 600		

limited to: Abuse Prohibition Policy; how staff should report their knowledge related to allegations; what constituted abuse, neglect and misappropriation; dementia management and resident abuse prevention; and understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Review revealed actions to prevent abuse included providing residents, families and staff with information on how to and to whom they may report concerns, and identifying, correcting and intervening in situations in which abuse was more than likely to occur. Further review revealed staff who identified or witnessed abuse would report immediately to their supervisor, who would report immediately to the Center ED. An employee alleged to have committed the act of abuse would be immediately removed from duty pending investigation. If the suspected abuse was resident to resident, the resident who was threatened or attacked another would be removed from the setting or situation and an investigation would be completed. Per policy, the facility was responsible for identifying residents who had a history of disruptive or intrusive interaction or exhibited behaviors that made them more likely to be involved in an altercation.

Review of the facility's Enhanced Patient Supervision: Continuous one to one (1:1) policy, revised 11/01/2019, revealed 1:1 supervision was utilized to provide safety of the resident and other residents. 1:1 supervision was implemented for behaviors that included sexual, agitation, and violent behaviors or residents that required close monitoring to ensure safety such as substance abuse withdrawal or acute delirium. The policy revealed the facility provided 1:1 supervision with a specifically assigned staff member to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 41	F 600		

resident, staff, and visitor safety. Facility staff used the Continuous 1:1 Supervision Flowsheet for documentation of 1:1 supervision.

1. Record review revealed the facility admitted Resident #21 to the Memory Care Unit (MCU), on 01/01/2020 with a primary diagnosis of Alzheimer's Disease. Additional diagnoses included Senile Degeneration of the Brain, Depressive Episodes, Anxiety Disorder, Psychotic Disorder with Delusions, Dementia without behavioral disturbance, and Adjustment Disorder. Further review revealed the resident had a medical and financial Power of Attorney (POA).

Review of Resident #61's CCP (Comprehensive Care Plan), initiated on 02/27/2020, revealed the resident exhibited symptoms of psychosis related to delusions; whispering, screaming, and throwing items while in his/her room. The goal was for the resident to demonstrate increased stability. Interventions included but were not limited to: provide consistent, trusted caregivers and structured daily routine; approach the resident in a calm, unhurried manner, reassure as needed; and monitor the resident's response to medications.

Review of Resident #61's Minimum Data Set (MDS) Quarterly Assessment, dated 07/11/2020, revealed the resident usually had the ability to express ideas, wants, and make himself/herself understood. Per the Assessment, the resident usually had the ability to understand verbal content of others. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four (4), which indicated severely impaired cognitive skills for daily decision-making. Further review of the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 42	F 600		

Assessment revealed the facility assessed the resident under Section E, to have no depression symptoms, no signs or symptoms of delirium, no potential indicators of psychosis, and no behavioral symptoms present.

Additional review of Resident #61's CCP, initiated on 09/16/2020, revealed the resident had potential for psychosocial distress related to multiple medical problems and diagnoses of: Dementia without behavior disturbance, Adjustment Disorder with depressed mood, and Major depressive disorder. The resident exhibited tearfulness, crying, irritability, and wandering. The goal was for the resident to show no signs or symptoms of psychosocial distress. The interventions included but were not limited to: complete behavior monitoring documentation if behavior was exhibited; psychological services; observe for signs and symptoms of psychosocial distress (tearfulness, crying, irritability); and Social Service visits as necessary.

Review of Resident #61's Physician's Orders, dated October 2020, revealed an order, dated 07/21/2020, for Risperidone (antipsychotic medication) 0.25 milligrams (mg) by mouth two (2) times a day for Mood Disorder. Further review revealed the resident had an order, dated 09/25/2020, which stated, "Is the resident behavior free? If behavior present (tearful, crying irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors."

Review of Resident #61's Progress Notes, dated 10/01/2020 through 10/02/2020, revealed no documented evidence of a behavior (tearful, crying, irritability), interventions, or outcomes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 43	F 600		

However, interview with direct care staff on the MCU revealed they were aware the resident was tearful and crying on 10/02/2020 at approximately 5:30 PM. However, they were not knowledgeable of person centered interventions developed by the IDT (Interdisciplinary Team), to support the resident and reduce the expression/distress of the behaviors; including behavior monitoring.

Additional review of Resident #61's Progress Notes, dated 10/02/2020 at 5:38 PM, completed by Licensed Practical Nurse (LPN) #37, revealed the resident had an altercation with Resident #21 and lost his/her balance and landed to the floor. Per the Note, the Unit Supervisor was notified and she stayed with the resident sitting on the floor until help arrived.

Review of the Risk Management System (RMS) Event Summary Report, completed by LPN #36, revealed on 10/02/2020 at 6:38 PM, Resident #21 had a resident-to-resident altercation with alleged abuse, and he/she was the victim. Additionally, the Activities Assistant, on the MCU, witnessed Resident #21 push Resident #61 down causing injury. Continued review revealed Resident #61 had a BIMS' score of four (4), and Resident #21 had a BIMS' score of three (3). Further, the Activities Assistant witnessed the residents get into a verbal altercations and then Resident #21 pushed Resident #61 to the ground. Per the Report, the root cause of the altercation was impaired cognition and Resident #21 became angry and tried to stop Resident #61 from entering his/her room. Corrective Action was to place Resident #21 on 1:1 until directed by IDT and send Resident #61 to the emergency room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 44	F 600		

Review of Resident #61's "After Care Instruction" from the acute care hospital Emergency Room that he/she was transferred to, dated 10/02/2020, revealed the resident's Humerus (the long bone in the upper arm) was fractured. Continued review revealed a fracture healed in six (6) to eight (8) weeks. Additionally, the main treatment for this type of fracture was a sling, to keep the arm adequately immobilized. Further, follow up with an orthopedic doctor was required.

Review of the facility's Long Term Care Facility-Self Report Incident Form/Initial Report, dated 10/02/2020, signed by the previous Center Executive Director (CED), revealed an Allegation of Physical Abuse had occurred on 10/02/2020 between Resident #21 and Resident #61. The Physician, POA, Department of Community Based Services (DCBS), and Local Law Enforcement were notified of the alleged abuse on 10/02/2020. Additionally, Resident #21 was witnessed to push Resident #61 to the floor. Resident #61 complained of right shoulder pain. The residents were separated and assessed and an investigation was initiated. Per the report, review of Resident #61's history, revealed the resident was diagnosed with Dementia without behavior disturbance, and Adjustment Disorder with depressed mood.

Review of Certified Nurse Aide (CNA) #8's witness statement, dated 10/06/2020, revealed Resident #61 was upset on 10/02/2020 prior to the resident-to resident altercation involving physical abuse. Per the Statement, Resident #61 was snappy towards other residents on 10/02/2020. Additionally, she was aware that Resident #21 could be violent when provoked and walked the hallways. Further review revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 45	F 600		

did not witness the actual event that took place on 10/02/2020, only the behaviors leading up to the incident.

Interview with CNA #8 (nine {9} months on MCU), on 04/22/2021 at 4:15 PM revealed on 10/02/2020 around 5:00 PM, she was in the common room watching residents in a group activity. CNA #8 stated Resident #61 left the common room upset and crying. However, she did not report this to the nurse, because it was a normal behavior that the resident had many times each day and everyone knew the resident had the behavior all the time. The CNA stated when the resident left the common room, he/she tried to enter Resident #21's room (room right beside Resident #61's room). Continued interview revealed she could see Resident #61's room from the common room where she was standing. CNA #8 stated Resident #61 continued to cry in the hallway by Resident #21's doorway. The CNA stated at the same time Resident #21 was observed with paced ambulation up and down the hallway. Per interview, Resident #21 became more agitated when Resident #61 was crying and was near his/her room. Continued interview revealed she then heard a commotion (yelling and movement) and staff ran to Resident #21 and Resident #61; however, she did not witness what happened.

Review of the MCU Activities Assistant's witness statement, dated 10/02/2020, revealed at approximately 5:05 PM, he witnessed a physical altercation between Resident #21 and Resident #61.

Interview with Activities Assistant (seven {7} months on the MCU), on 04/22/2021 at 4:10 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 46	F 600		

revealed on 10/02/2020 around 5:00 PM, he was in the hallway near resident # 61's room working on an activities calendar, which was close to Resident #61's and Resident #21's rooms. Per interview, he saw Resident #61 standing by the calendar in the hallway and then ambulate to his/her her room. At that time, Resident # 21 walked passed him to Resident #61 and immediately Resident #21 and Resident #61 started yelling at one another. Per interview, the residents were yelling, but only the first words in the sentences were audible because they were cutting one another off. The residents were yelling, "No, you can't; Yes, I can." The residents were verbally telling at one another. However, he was unable to attempt redirection before Resident #21 had pushed Resident #61 in the chest, knocking the resident off balance, which caused the resident to fall backwards towards the door, then along the wall in the hallway and onto the floor. Additionally, the residents were immediately separated, and Resident #21 was placed on 1:1 with a staff. Further interview revealed Resident #61 did not have any obvious injuries at first, but shortly after the incident, he/she was sent to the Emergency Room because he/she verbalized pain in his/her right arm. He stated since he had worked on the MCU, Resident #21 was ambulatory and paced up and down the hallways and in the common areas continuously most days. Additionally, he stated he was aware the resident would become defensive towards others residents at times when their paths crossed. Per interview, he was aware the resident had been physically aggressive towards others too. Continued interview revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most days. He stated he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 47	F 600		

not report the resident's behaviors at that time to the nurse because the nurse was already aware.

On 04/26/2021 at 2:25 PM and on 05/11/2021 at 10:30 AM, SSA attempted to contact LPN #36, via telephone; she documented the RMS Event Summary Report, on 10/02/2020 at 5:38 PM.

On 04/26/2021 at 2:27 PM, SSA attempted to contact the previous Center Executive Director, via telephone.

Interview with the Memory Care Program Director (MCPD), on 04/26/2021 at 3:00 PM, revealed she had worked at the facility as a Social Worker for one (1) year and had been the MCPD for six (6) months. However, she was not working on the MCU when the abuse occurred between Resident #21 and Resident #61. She stated in her role as a Social Worker, she was not responsible for Social Services on the MCU, that was the responsibility of the previous MCPD.

Interview with the facility's Physician, on 05/05/2021 at 2:10 PM revealed the facility was responsible to ensure residents were free from physical abuse by following the facility's Abuse Policy. Per interview, she expected the nurses and aides to identify, document and report observed behaviors. The Physician stated communication amongst the direct caregiver staff and consistent documentation in the medical record related to behaviors was essential to ensure a safe environment for residents.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed she had worked at the facility for seven (7) months. Per interview, residents should be provided a safe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 48	F 600		

environment free from abuse. Continued interview revealed staff were educated on the facility's Abuse Policy and she expected the Policy to be maintained to prevent abuse from happening. Additionally, the Quality Assurance (QA) /Quality Assurance Performance Improvement (QAPI) Committee discussed abuse investigations monthly. Further, she expected staff to identify and report behaviors to licensed nurses who should document the exhibited behaviors, in a Progress Note, including the behavior, the intervention, and the response. Continued interview revealed without behaviors being identified, reported, and documented, the IDT could not properly support and reduce expression/distress to the residents and provide a safe environment.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed he had worked at the facility for three (3) months. Per interview, residents should be free from abuse. Continued interview revealed his expectation was the facility was responsible to prevent abuse, and if it did happen, to follow the facility's policy and keep the residents safe. Additionally, he provided oversight to all allegations of abuse in the facility and ensured staff were provided training on the Abuse Policy. Per interview, he expected direct caregivers to identify and report behaviors and provide monitoring and supervision to the residents and document in the medical record. The CED stated when a behavior was exhibited he expected direct caregivers to implement an intervention/action to prevent or minimize the behaviors and to maintain a safe environment.

2. Record review revealed on 04/22/2021,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 49	F 600		

Resident #86 became combative and resistive to care while in the hallway of the MCU. Interviews revealed staff took Resident #86 to his/her room to help calm him/her down. Further review revealed Resident #86 struck Resident #85 with a television while in their shared room. Subsequently, upon assessment on 04/25/2021, the nurse identified scattered bruising and swelling to Resident #85's right hand, new orders were obtained for an x-ray, results showed a right 5th metacarpal (bone in the hand) fracture.

Record review revealed Resident #85 and Resident #86 were roommates on the MCU. Review of Resident #85's clinical record revealed the resident had verbal behaviors such as yelling out. Resident #86 exhibited physical behaviors such as combativeness and resistive to care.

Review of the RMS Event Summary Report, dated 04/22/2021 at 10:30 PM, completed by Licensed Practical Nurse (LPN) #14, revealed after the altercation between Resident #85 and Resident #86, Resident #86 was removed from the area, placed on 1:1 increased supervision, and was transferred to an acute care facility for a psychiatric evaluation.

Review of the Situation-Background-Assessment-Recommendation (SBAR) Communication Form, dated 04/22/2021 at 11:48 PM, revealed after the altercation with Resident #86, staff were to monitor and observe Resident #85 for signs and symptoms of distress.

Review of the RMS Event Summary Report completed by Registered Nurse (RN) #1, dated 04/25/2021 at 6:00 AM, revealed the nurse was notified of new bruising to Resident #85's right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 50	F 600		

hand and immediately assessed the resident. Continued review revealed Resident #85 could not verbalize what happened to his/her hand but denied pain at that time.

Review of the After Hours On-Call Physicians Services, dated 04/25/2021 at 10:52 AM, revealed the on-call physician was notified of new bruising and swelling over the medial part of Resident #85's right hand. Further review revealed an order was received for a right hand x-ray.

Review of the Radiology Results, dated 04/25/2021 at 1:52 PM, revealed Resident #85 suffered an acute fracture involving the right 5th distal metacarpal (broken bone in the hand) with mild displacement.

Record review revealed the facility admitted Resident #86 on 03/19/2021 to the "14-Day Quarantine Unit," per the facility's policy due to COVID-19. Continued review revealed the resident's diagnoses included Dementia without Behaviors, Parkinson's disease, Muscle Weakness, Hallucinations and Repeated Falls.

Review of the Admission MDS Assessment, dated 03/25/2021, revealed Resident #86 was not assessed for a BIMS status. Continued review revealed mood concerns were not assessed, and he/she exhibited no behaviors at the time of the assessment.

Continued record review revealed Resident #86 was placed on a 1:1 increased supervision while on the 14-Day Quarantine Unit due to increased falls. Interview with the CNE (Center Nurse Executive), on 05/12/2021 at 7:20 PM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 51	F 600		

the Interdisciplinary Team (IDT) made the decision to move Resident #86 to the MCU due to increased activities to help divert him/her from falling.

Review of the care plan, dated 03/22/2021, revealed Resident #86 had impaired thought processes related to Dementia. Interventions included redirection, personalize his/her room with familiar items, create a calm/smoothing environment, and speak in a normal-toned voice.

Review of the 1:1 documentation prior to his/her room change, dated 03/27/2021, revealed Resident #86 exhibited behaviors such as hitting, kicking, and resistive to care at 1:00 AM, 1:30 AM, 2:00 AM, 2:30 AM, 3:00 AM, 3:30 AM, and 5:30 AM. Further review revealed on 04/06/2021 at 10:00 AM, Resident #86 exhibited behaviors such as screaming/disruptive sounds. Review of the care plan revealed the facility failed to identify these behaviors and failed to create a care plan and interventions to address these behaviors.

Review of Progress Notes, dated 03/25/2021 at 2:30 AM, revealed Resident #86 was attempting to get out of bed on rounds and was unable to be redirected. Continued review of the Progress Notes, dated 04/22/2021 at 3:37 AM, revealed Resident #86 was wandering the hall and exit seeking, was unable to be redirected and became agitated, and was noted to be banging on the unit door.

Review of the RMS Event Summary Report, dated 04/22/2021 at 10:30 PM, revealed Resident #86 became agitated related to Resident #85 yelling out and hit him/her with a small television monitor. Continued review revealed no injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 52	F 600		

were noted at the time of the altercation and staff were unable to redirect Resident #86. Further review revealed Resident #86 was placed on 1:1 and was transferred to an acute care facility for a psychiatric evaluation and treatment. Upon return to the facility, Resident #86 was moved off the MCU and placed on 1:1 supervision related to increased agitation and behaviors.

Interview with Certified Nurse Aide (CNA) #8, on 05/12/2021 at 2:32 PM, revealed she worked the majority of her shifts on the MCU. Continued interview revealed Resident #85 was alert and was known to scream and yell. She stated she was aware of the resident's diagnosis of Schizophrenia and the resident would hallucinate at times. CNA #8 stated she had previously sat with Resident #86 while he/she was on 1:1 supervision due to being at risk for falls. She stated at times he/she could become agitated with staff and attempt to get out of bed or his/her wheelchair and was hard to redirect. Further interview revealed she has seen the resident become resistive to care and that would make Resident #86 combative. Continued interview with CNA #8 revealed after the facility moved Resident #86 into Resident #85's room, Resident #86 did not like going into his/her room to have care provided to him/her due to Resident #85 screaming and yelling. Additionally, she revealed Resident #86 could become agitated with loud noises.

Continued interview with CNA #8, on 05/12/2021 at 2:32 PM, revealed on the night of the altercation, 04/22/2021, Resident #86 stated he/she needed to use the restroom but refused to use his/her private restroom due to Resident #85 screaming, so care was provided in the shower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 53	F 600		

room. CNA #8 revealed after dinner and medication pass (around 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 putting residents to bed. CNA #8 stated there was not enough staff on the MCU to provide proper supervision to the residents. Further interview revealed after she obtained assistance from CNA #19, they continued their rounds and assisted residents to bed.

Interview with CNA #19, on 05/12/2021 at 3:30 PM, revealed she was asked by CNA #8 to come and assist with rounds and placing residents in bed on the MCU. CNA #19 stated she was in a resident's room performing care when she heard some noise in the hallway. She stated she stepped out in the hallway and noticed Resident #86 trying to enter another room and the nurse was attempting to redirect, and guide him/her further down the hallway toward his/her room. Continued interview revealed while back in the room she heard screaming from the hallway and hurried to complete her care and exited the room. Further interview revealed LPN #14 was yelling for help and stated Resident #86 was hitting Resident #85 with the television and Resident #85 was screaming out. CNA #19 stated she ran in the room and scooped up Resident #85 in her arms and carried him/her into another resident's room where he/she would be safe.

Interview with Certified Medication Technician (CMT), on 05/12/2021 at 11:30 AM, revealed prior to Resident #86's move to the MCU, Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 54	F 600		

#86 was known to become combative and resistive to care.

Interview with LPN #5, on 05/12/2021 at 11:45 AM, revealed prior to Resident #86 moving to the MCU he/she was a fall's risk and was placed on 1:1 supervision. She stated that Resident #86 could be aggressive at times and resistive to care.

Interview with LPN #14, on 05/12/2021 at 4:45 PM, revealed on the night of the altercation on 04/22/2021, Resident #86 started to get out of his/her wheelchair, when trying to redirect the resident, he/she became combative, and was trying to hit her. She stated she took Resident #86 back to his/her room due to combativeness and that Resident #85 was in his/her bed at this time. LPN #14 stated that she and the supervisor were in Resident #86's room and he/she was blocking them from leaving the room, trying to hit and kick them. Continued interview revealed they distracted Resident #86 and were able to get out of the room. LPN #14 revealed shortly after leaving the room, she heard Resident #85 yell and she went immediately back to the residents' room. She stated she saw Resident #86 standing over Resident #85, while in bed, with a television in his/her hand and she saw Resident #86 strike Resident #85 on the leg. Continued interview revealed she yelled for help and was able to take the television out of Resident #86's hands. The LPN stated CNA #19 was able to safely remove Resident #85 from the room. She stated at that time Resident #86 was kneeling at the end of Resident #85's bed and seemed to have tired himself/herself out. LPN #14 stated she did not receive report of any behaviors prior to her shift regarding Resident #86, but she was aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 55	F 600		

he/she had become aggressive with staff prior to moving to the MCU.

Interview with RN #1, on 05/12/2021 at 8:15 AM, revealed when she arrived to the facility in the morning for her shift on 04/25/2021, the CNA notified her that she found blood on Resident #85's sheet. Continued interview revealed she entered Resident #85's room and completed a head to toe assessment to attempt to find the source of the blood. She stated that Resident #86 (roommate prior to the altercation) had abrasions on his/her arms and they determined that was where the blood originated. Further interview revealed upon the head to toe assessment she noted bruising and swelling to Resident #85's right hand. Additionally, upon these findings she notified the physician and received a new order for an x-ray.

Interview with the Director of Social Services, on 05/12/2021 at 4:00 PM, revealed the facility determined to move Resident #86 to the MCU through discussions in the morning meetings and in clinical meeting. Further interview revealed she was not aware of any physical aggression or behaviors exhibited by Resident #86 before the altercation with Resident #85 on the MCU.

Interview with the CNE, on 05/12/2021 at 7:20 PM, revealed she expected the facility's abuse and neglect policies and procedures to be followed by staff. She continued she was not aware that Resident #86 was having behaviors, and she expected staff to notify her. The CNE stated behaviors should have been documented in the record so the facility could have placed interventions to help identify the triggers and assist with decreasing aggressive behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 56	F 600		

She stated she was not aware that staff were afraid of Resident #86 during the altercation. She stated if the IDT was aware that Resident #86 had behaviors, the process for room changes would have been different. She stated that during the IDT, it was not discussed that Resident #85 preferred not to have roommates, as per the care plan.

Interview with CED, on 05/12/2021 at 6:36 PM, revealed the decision was made to move Resident #86 to MCU due to there being more activities for him/her to participate in to keep him/her distracted from falling. The CED stated he thought the move was good and appropriate. Continued interview revealed staff did not communicate to him or the CNE about Resident #86's behaviors prior to the move. He revealed behaviors should have been documented so the IDT could have implemented interventions to help decrease the behaviors. Continued interview revealed the Memory Care Program Director failed to communicate with the IDT of the ongoing issues with Resident #85 and Resident #86. He stated if he had known of the behaviors and roommate issues the facility would have tried to find the root cause of the problem and would not have moved Resident #86 rooms.

3. Closed record review revealed Resident #45 and Resident #52 were ambulating in the hallway of the Memory Care Unit (MCU), on 03/18/2020 at approximately 12:50 PM, when they approached each other. Resident #45 and #52 grabbed each other's arms, subsequently Resident #45 had a bruise on his/her right forearm.

Record review revealed Resident #45 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 57	F 600		

Resident #52 no longer resided in the facility.

Closed record review revealed the facility admitted Resident #52 to the MCU, on 03/03/2011, with diagnoses that included Alzheimer's Late Onset, Lack of Coordination, Psychotic Disorder with Delusions, Cognitive Communication Deficit, Major Depressive Disorder, Anxiety, Dementia with Behavior Disturbances and Unspecified Psychosis.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/17/2020, revealed Resident #52 was assessed to have adequate hearing and vision, was able to make his/her needs known and could understand others. Continued review of the MDS revealed the facility assessed Resident #52 to have a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), which indicated the resident had severely impaired cognition. Further review of the MDS revealed Resident #52 had no behaviors identified. The facility assessed Resident #52 to require setup help only with walking in the corridor. Additionally, per the MDS, Resident #52 had prescribed antipsychotics for seven (7) out of seven (7) days during the assessment period.

Review of the Physician's Orders, dated 03/03/2011, revealed Resident #52 was admitted with the discharge plan for long term placement. Continued review revealed staff were to document if Resident #52 exhibited behaviors such as yelling, cursing at staff, and paranoia. Further review revealed staff were to monitor for side effects of psychotherapeutic medications and pain. Continued review revealed Resident #52 had orders for Depakote two-hundred and fifty (250) mg three (3) times a day for Dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 58	F 600		

with Behaviors, and Seroquel twenty-five (25) mg twice a day for Dementia.

Review of Resident #52's care plan, dated 06/03/2019, revealed Resident #52 has a history of negative behaviors, including physical aggression with staff/peers, depression, anxiety and delusional type behaviors. Continued review revealed interventions included: allow him/her to vent feelings, approach in a calm manner, manage any unmet needs, document interventions and responses, and increase supervision when in the common area. Further review revealed the facility failed to update the care plan after the physical altercation with Resident #45.

Review of the Risk Management System (RMS) Event Summary Report, dated 03/18/2020 at 12:40 AM, revealed a CNA witnessed two (2) residents walk up to each other on the unit and grabbed each other's arms. Further review revealed the residents were immediately separated, and notifications were made to the provider, the CNE and CED and assessments were completed. Interview with the CNE, dated 05/11/2021 at 2:15 PM, revealed the facility could not provide contact information for the CNA that witnessed the altercation.

Record review revealed the facility admitted Resident #45 to the MCU, on 12/18/2019, with diagnoses that included Dementia with Behaviors.

Review of the Quarterly MDS, dated 12/24/2019, revealed the facility assessed Resident #45 to have adequate hearing and clear speech; able to express needs and wants; usually understood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 59	F 600		

verbal content and had impaired vision. Continued review of the MDS revealed Resident #45 had a BIMS of eight (8) which indicated the resident had moderately impaired cognition. Further review of the MDS revealed Resident #45 had no behaviors noted. The facility assessed Resident #45's MDS to require limited assistance for walking in the corridor and had received antianxiety medications for seven (7) out of seven (7) days.

Review of the Physician's Orders, dated 06/04/2014, revealed Resident #45 was admitted with the discharge plan for long term care placement and pain monitoring. Further review revealed Resident #45 was ordered Buspar five (5) mg twice a day for Anxiety.

Review of Skin Check form, dated 03/16/2020 at 10:00 PM, revealed Resident #45 had no new skin issues prior to the altercation with Resident #52. Continued review of Skin Check form, dated 03/18/2020 at 1:40 PM, revealed after the altercation with Resident #52, Resident #45 had reddened/bruised area to the right forearm.

Review of the RMS Event Summary Report, dated 03/18/2020 at 12:40 PM, revealed staff separated Resident #45 and #52 immediately after the altercation. Continued review revealed notifications were made to the provider, CNE and CED. Resident #45 was placed on 1:1 supervision, however, the facility failed to provide documentation regarding this increased supervision.

Interview with RN #15, on 05/11/2021 at 2:06 PM, revealed she was an agency nurse, but only worked there for fifteen (15) days. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 60	F 600		

interview revealed she was the nurse on duty and completed the RMS Event Summary Report, but she was unable to recall the altercation between Resident #45 and Resident #52.

Interview with the CED, on 05/11/2021 at 2:15 PM, revealed the facility could not recall the Certified Nurse Assistant (CNA) nor could they provide a phone number for her. Per review of the RMS Event Summary Report, the CNA separated the residents and provided increased supervision.

4. Record review revealed on 12/15/2020 after lunch service, Resident #10 and Resident #11 were sitting in the common area outside of the dining room when Resident #10 yelled out loud, then Resident #11 hit Resident #10 in the face with a closed fist causing redness and swelling.

Review of the SBAR Communication Form, dated 12/15/2020 at 6:45 PM, revealed ice was applied to the left side of Resident #10's face after the altercation with Resident #11.

Record review revealed the facility admitted Resident #11 on 01/10/2020 with diagnoses that included Schizophrenia and Major Depressive Disorder.

Review of the Quarterly MDS Assessment, dated 12/02/2020, revealed Resident #11's BIMS was not assessed due to the resident being rarely/never understood. Continued review revealed the facility assessed Resident #11 to show no mood disturbances and no behaviors. Further review of the MDS revealed the facility assessed Resident #11 to have Depression and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 61	F 600		

Schizophrenia.

Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated November and December 2020 and January 2021, revealed no documented evidence that Resident #11 exhibited behaviors.

Review of the care plan, dated 09/25/2020, revealed Resident #11 would shake his/her fists when told that he/she could not have certain foods due to being on a therapeutic diet.

Interview with CNA #12, on 04/22/2021 at 2:30 PM, revealed Resident #10 was known for screaming and yelling loud. She stated Resident #11 would become aggressive with staff due to him/her being on a specialized diet and not being able to eat regular textured food. Continued interview revealed she had not known any other altercations with Residents #10 and #11 either with each other or with other residents. Further interview revealed CNA #12 was taking residents out of the dining room while Resident #10 and Resident #11 were sitting in the common area and she heard Resident #10 yell. CNA #12 continued that the nurses ran toward Resident #10 and Resident #11 and separated them immediately, but they did not see the physical contact made.

Interview with LPN #5, on 04/22/2021 at 3:05 PM, revealed she was sitting at the nurse's station charting while Resident #10 and Resident #11 were sitting in the common area. Continued interview revealed she heard Resident #10 yell out and she looked up and saw Resident #11 hit Resident #10 in the face. She continued that she immediately ran toward the residents and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 62	F 600		

separated them. Further interview revealed she completed skin assessments and a change of condition and made the appropriate notifications. Additionally, she stated Resident #11 was placed on 1:1 supervision and ice was placed to Resident #10's face.

5. Record review revealed Resident #15 and Resident #16 had a verbal altercation during a scheduled smoke break on 12/24/2020 which lead to a physical altercation. CNA #4 witnessed Resident #16 kick Resident #15 in the chest.

Interview with Resident #15, on 04/14/2021 at 10:55 AM, revealed that he/she and Resident #16 were outside during a smoke break when Resident #16 became verbally aggressive with a CNA. Continued interview revealed Resident #15 confronted Resident #16 and told him/her to calm down and to quit talking to the CNA in that manner. Further interview revealed staff wheeled Resident #16 back inside due to continuing the verbal aggression toward the CNA. Resident #15 stated after the smoke break, he/she was in his/her wheelchair by the nurse's medication cart waiting for the nurse to come out of a resident's room so he/she could request pain medication. Continued interview revealed he/she saw Resident #16 coming toward him/her and he/she told him/her (Resident #16) to stop. Resident #15 stated he/she put his/her arms up to keep Resident #16 from hitting him but instead Resident #16 came forward, wheeling Resident #15 backward in his/her wheelchair. Resident #15 stated at that time Resident #16 raised his/her foot and kicked him/her in the chest. Additionally, Resident #15 stated at that time the CNA's were present and the nurse exited the room to help separate them. Resident #15 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 63	F 600		

the CNE came and assessed him/her to ensure he/she was okay. Continued interview revealed Resident #16 was moved to a room on a different unit and their smoke times were changed. Resident #15 stated he/she had not had any other altercations with Resident #16 and did not see him/her anymore.

Record review revealed the facility admitted Resident #16 on 06/17/2020 with diagnoses that included Cerebral Infarction, Right Hemiparesis, Bipolar Disorder, Major Depressive Disorder, and Anxiety.

Review of the Quarterly MDS Assessment, dated 06/24/2020, revealed the facility assessed Resident #16 to have a BIMS' of fifteen (15) which indicated the resident was cognitively intact. Continued review revealed the facility assessed Resident #16 to have no behaviors. Review of Resident #16's functional status revealed he/she was able to self-propel in his/her wheelchair on the unit.

Review of the care plan, dated 06/18/2020, revealed Resident #16 had a history of and current behavior of expressing negative views of all caregivers. Interventions included complete behavior monitoring, evaluate the triggers of the behaviors, explain all care, remove the resident from the environment if needed, if resident becomes resistive postpone care, and allow time for expression of feelings.

Interview with Resident #16, on 04/14/2021 at 10:35 AM, revealed he/she became verbally aggressive with the CNA during their scheduled smoke break and he/she was taken back inside. Continued interview revealed he/she did kick

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 64	F 600		

Resident #15 in the chest in the hallway. Resident #16 stated staff separated them and changed his/her room.

Interview with CNA #4, on 04/20/2021 at 9:55 AM, revealed he was the CNA on duty the day of the altercation. CNA #4 stated Resident #15 was sitting at the nurse's medication cart when Resident #16 wheeled up to him/her and tried to fight. CNA #4 stated he did witness Resident #16 kick Resident #15, but immediately separated them. Further interview revealed the nurse called the CNE and moved him/her to another unit and their smoking times were changed.

Attempts were made to contact CNA #6, a witness to the incident, on 04/20/2021 at 9:56 AM and 1:57 PM without success.

Interview with RN #2, a witness per facility record, on 04/20/2021 at 10:31 AM, revealed she could not recall the incident between Resident #15 and Resident #16.

6. Record review revealed Resident #8 and Resident #9 were roommates on the MCU. Continued review revealed on 10/20/2020 Resident #9 squeezed Resident #8's wrist resulting in a small bruise. Per interviews with staff the altercation was reported by Resident #8 and was unwitnessed.

Review of the SBAR Communication Form, dated 10/20/2020 at 1:45 PM, revealed Resident #8 and Resident #9 were involved in an unwitnessed altercation in their room resulting in a small bruise to Resident #8's right wrist. Continued review revealed Resident #9 was walking to his/her shared restroom when Resident #8 advised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 65	F 600		

him/her that breakfast was not ready yet. Resident #9 then grabbed Resident #8 by his/her wrist. Resident #9 released Resident #8's wrist and sat down on the bed. Continued review revealed Resident #8 reported the incident to the nurse outside their room.

Interview with Resident #8, on 04/14/2021 at 2:15 PM, revealed he/she had been in the facility for four (4) months. Continued interview revealed he/she could not recall the incident with Resident #9.

Record review revealed the facility admitted Resident #9 on 02/07/2020 with diagnoses that included Dementia with Behaviors, Alcohol Dependence with Alcohol Induced Dementia, Alcohol Induced Persisting Amnestic Disorder, Major Depressive Disorder, Wernicke's Encephalopathy, Impulsiveness, and Depressive Episodes.

Review of Resident #9's Quarterly MDS Assessment, dated 07/31/2020, revealed the facility assessed him/her to have a BIMS score of four (4), which indicated severely impaired cognition. Continued review revealed Resident #9 had no mood disturbances nor behaviors during the assessment period.

Review of the Physician's Orders, dated 05/09/2020, revealed an order for staff to monitor for behaviors.

Review of the care plan, dated 09/19/2017, revealed Resident #9 had the potential to exhibit physical behaviors related to history of alcohol abuse, impaired cognition, and a history of aggression toward others. Interventions included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 66	F 600		

observe for behaviors, explain all care, observe for non-verbal signs of physical aggression, listen to the resident and assist in trying to deescalate, approach Resident #9 in a calm, unhurried manner, observe new/changed/discontinued medications for side effects.

Observations of Resident #9, on 04/14/2021 at 11:45 AM, 04/15/2021 at 9:20 AM, and 04/16/2021 at 8:30 AM, revealed he/she was in a private room on a different unit. Resident #9 appeared to be resting in bed with the television playing.

Interview with Resident #9, on 04/14/2021 at 11:45 AM, revealed his/her care was good since admitted to the facility. Continued interview revealed Resident #9 remembered Resident #8, but he/she could not recall the altercation of the resident grabbing his/her wrist.

7. Record review revealed Resident #37 reported to the nurse on 01/25/2020 that Resident #38 hit him/her in the chest. Further record review revealed Resident #38 stated he/she hit Resident #37 to keep him/her out of his/her room.

Review of Resident #37's Progress Notes revealed on 01/25/2020, Resident #37 reported to LPN #10 that Resident #38 hit him/her in the chest on the Memory Care Unit. Resident #38 stated he/she tapped Resident #37 on the shoulder to keep him/her out of his/her room and to prevent his/her belongings from being taken. Facility staff separated the residents and no injuries were assessed.

Review of the clinical record revealed the facility admitted Resident #37 on 01/14/2020 to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 67	F 600		

MCU, with diagnoses that included Alzheimer's Disease, Secondary Parkinsonism, and Anxiety Disorder.

Review of the Minimum Data Set (MDS), dated 01/21/2020, revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of nine (9), which revealed mildly impaired cognitive status.

Review of Resident 37's Risk Management System (RMS) Event Summary Report, dated 01/25/2020, completed by LPN #10, revealed the event was a resident to resident altercation with an alleged abuse victim. Additional review revealed the corrective action was separation of the residents, assessment for injuries. Resident #38 was placed on 1:1 supervision, and Resident #37 was treated with Ibuprofen (anti-inflammatory medication for pain). Further review revealed the facility substantiated the unwitnessed event as abuse with the root-cause as Resident #37 had entered Resident #38's room.

Interview with Resident #37, on 05/03/2021 at 1:30 PM, revealed he/she did not remember another resident hitting him/her in the chest.

Review of the facility's Long Term Care Facility-Self Report Incident Form/Initial Report, dated 01/25/2020, revealed Resident #37 informed LPN #10 he/she was looking into Resident #38's room to greet him/her and Resident #38 punched him/her in the left side of the chest.

Review of the facility's Long Term Care Facility-Self Report Incident Form/Five (5) day Follow up/Final Report, dated 01/29/2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 68	F 600		

revealed Resident #38 told LPN #10 that he/she hit Resident #37. Interview with LPN #10 revealed Resident #37 stated a (man/woman) hit him/her and this person was verified to be Resident #38. The Social Services Director spoke with Resident #38, on 01/27/2020, and the resident stated that he/she did not intend to hurt Resident #37, but he/she was attempting to keep Resident #37 out of his/her room. The MCU Director interviewed Resident #37 on 01/27/2020 and no signs of psychosocial distress were noted.

Closed record review revealed the facility admitted Resident #38 on 12/29/2019 to the MCU with diagnoses that included Dementia with Behavioral Disturbance, Antisocial Personality Disorder, and Psychotic Disorder with Delusions.

Review of the Progress Notes, dated 12/29/2019 through 02/05/2020, revealed Resident #38 was resistive to care, easily agitated, cursed/yelled at facility staff, and frequently refused care. Further review revealed the facility transferred Resident #38 on 01/27/2020 to a psychiatric facility for evaluation.

Review of Psychiatry Notes, dated 12/31/2019 and 01/22/2020, revealed Resident #38 displayed behaviors, which included altered thought process, paranoid, anger directed towards staff, physical/verbal aggression, and poor impulse control. On 12/31/2020, Resident #38 received a prescription for Olanzapine (an antipsychotic) and staff were instructed on strategies to decrease likelihood of aggression that included eating in his/her room and participation in preferred activities.

Review of the Comprehensive Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 69	F 600		

(MDS), dated 01/05/2020, revealed Resident #38 was assessed to have a Brief Interview of Mental Status (BIMS) score of fourteen (14), which revealed the resident was cognitively intact. Further review revealed the resident had not displayed behaviors such as psychosis, refusal of care, or disorganized thinking.

Review of Resident #38's Comprehensive Care Plan (CCP,) initiated on 12/29/2020, revealed the focus included the potential to exhibit physical behaviors with a goal that included effective coping skills and acceptable ways to express frustration, impatience and/or anger. b Interventions for physical behaviors included for the resident to seek staff for distressed mood, observe resident for nonverbal signs of aggression, monitor resident's response/side effects to psychotropic medications, and provide a calm environment.

Unsuccessful attempts to contact Licensed Practical Nurse (LPN) #10, were made on 05/04/2021 at 2:00 PM and 05/06/2021 at 2:15 PM. Resident #38 reported the incident to LPN #10.

Interview with CNA #13, on 05/04/2021 at 8:54 AM, revealed Resident #37 wandered throughout the unit up and down the MCU halls.

Interview with LPN #1, on 05/06/2021 at 10:13 AM, revealed Resident #38 was placed on the MCU due to his/her elopement risk. He stated Resident #38 had many behaviors that included agitation, argumentative with staff, cursing at staff, and refusal of personal hygiene care.

Interview with the former Director of the MCU, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 70	F 600		

05/05/2021 at 9:35 AM, revealed Resident #38 displayed aggressive behaviors toward facility staff. He stated Resident #38 allowed him to assist with his/her care and he had not witnessed any behavioral disturbances. The former Director of the MCU stated Resident #38 responded well to one on one (1:1) activities and did not do well in large groups due to agitation. He stated the facility had tools such as closing the door or posting a stop sign on the door to prevent unwanted entry into another resident's room.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed the definition of physical abuse as any action that resulted from physical touch such as hitting or kicking. She stated verbal abuse included cursing, yelling, or degrading a resident.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed he defined abuse as any unwanted physical or verbal interaction involving facility staff and residents. He stated residents came to the facility to be care for and maintain safety.

8. Record review revealed on 10/28/2020 in the MCU common area, staff observed Resident #2 slap Resident #21, and then Resident #21 slapped Resident #2. The MCU staff separated the residents, assessed for injuries, and MCU staff provided 1:1 supervision for Resident #2 after the incident.

Review of the clinical record revealed the facility admitted Resident #21 on 01/01/2020 with diagnoses that included Alzheimer's Disease, Dementia without Behavioral Disturbance, Psychotic Disorder with Delusions, and Anxiety Disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 71	F 600		

Review of Resident #21's Quarterly MDS, dated 10/18/2020, revealed a BIMS score of three (3) which indicated severe cognitive impairment.

Review of Resident #21's CCP, initiated on 01/02/2020, revealed the focus included physical behaviors toward another resident with a goal to prevent harm to self or others. The review revealed interventions for physical behaviors that included staff redirection with agitation and offer distractions or activities.

Interview with Resident #21, on 04/14/2021 at 2:01 PM, revealed he/she was slapped on the face by another resident. Resident #21 did not remember the other resident's name.

Review of the clinical record revealed the facility admitted Resident #2 on 08/31/2020 with diagnoses that included Bipolar Disorder, Psychotic Disorder with Delusions, and Frontotemporal Dementia.

Review of Resident #2's Progress Notes, dated 10/28/2020 at 2:46 PM, completed by LPN #6, revealed Resident #2 hit another resident in the dining room. Further review revealed the residents were separated.

Review of Resident #2's MAR, dated October 2020, revealed there was an order to monitor the resident for behaviors which included refusal of care twice daily with documentation that revealed the resident did not have any behaviors present.

Review of Resident #2's Comprehensive MDS, dated 01/09/2021, revealed a BIMS score was not assessed and the resident had severely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 72	F 600		

impaired cognitive skills for daily decision-making. The facility's assessment revealed Resident #2's exhibited behaviors included rejection of care one (1) to three (3) days a week and wandering that occurred four (4) to six (6) days of the week.

Review of Resident #2's CCP, initiated on 08/14/2020, revealed the resident had the potential for psychosocial distress with a goal that included the resident would exhibit no signs of psychosocial distress daily. The care plan revealed interventions that staff would observe for sign of psychosocial distress; Social Service Visits as needed; and evaluation by Psychiatry Services.

Review of Resident #2's RMS Event Summary Report, dated 10/28/2020, completed by LPN #7, described the event as "combative behavior." The report revealed the MCU Activities Assistant witnessed the event. The report revealed the root cause was determined to be Resident #2's psychiatric diagnoses of Bipolar Disorder, Major Depressive Disorder, and Psychotic Disorder. The report revealed the corrective action was the placement of Resident #2 on 1:1 supervision.

Observation of Resident #2, on 04/23/2021 at 1:35 PM, revealed the resident sitting in a chair clapping his/her hands with a drink on the table in front of him/her watching a television program.

Attempted to interview Resident #2, on 04/19/2021 at 3:28 PM, but the resident did not respond.

Interview with the Activities Assistant, on 04/15/2021 at 3:33 PM, revealed he was conducting a group activity in the common area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 73	F 600		

on the MCU when Resident #21 was talking to Resident #2 and Resident #2 stood up and slapped Resident #21. He stated Resident #21 slapped Resident #2 in return. The Activities Assistant stated he approached the residents to help separate them.

Interview with CNA #14, on 04/20/2021 at 9:36 AM, revealed Resident #21 walked over and started talking to Resident #2. She stated Resident #2 stood up, slapped Resident #21 on the face, and Resident #21 slapped Resident #2 back. CNA #14 stated she called for help, and went over to separate the residents.

Attempted to contact the former CED, on 05/05/2021 at 3:27 PM and 05/06/2021 at 9:31 AM.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed their goal was the safety of the residents. He stated the facility's staff adequately supervised the MCU residents. The CED further stated the facility staff learned from unpreventable occurrences.

9. Record review revealed on 11/21/2020, Resident #2 pushed Resident #19 in the common area on the MCU, causing Resident #19 to step on Resident #20's foot. The MCU staff removed Resident #2 from the common area. Resident #20 stated Resident #19 had stepped on his/her foot and was complaining of pain. The physician ordered an x-ray on Resident #20's foot and revealed no fracture.

Review of Resident #2's Progress Notes, dated 11/20/2020, revealed during a regulatory visit completed by the Medical Physician, Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 74	F 600		

became agitated, verbally abusive, cursing, and combative with the physical examination.

Review of Resident #2's Comprehensive MDS, dated 01/09/2021, revealed a BIMS score was not assessed and the resident had severely impaired cognitive skills for daily decision-making. The assessment revealed Resident #2 exhibited behaviors that included rejection of care and wandering.

Review of Resident #2's CCP, initiated on 08/31/2020, revealed focuses that included physical aggression toward another resident, initiated on 10/28/2020. The goal included; the resident was to have no conflicts with other residents and acceptance of staff's redirection and interventions. The interventions included: approach resident in a calm, supportive manner, and remove resident from the situation to allow time to calm before returning to previous area.

Review of the Continuous 1:1 Supervision documentation, dated 11/18/2020 at 8:00 AM, 10:30 AM, and 1:30 PM, completed by CNA #14, revealed Resident #2 displayed behaviors that included hitting, cursing, and screaming at others. The facility did not provide the requested Continuous 1:1 Supervision documentation for 11/19/2020 through 12/31/2020.

Review of Resident #2's RMS Event Summary Report, completed by LPN #6 on 11/21/2020 at 10:39 AM, revealed the event was described as resident-to-resident altercation without abuse. The report revealed Resident #2 was on 1:1 observation in the MCU dining area watching television and Resident #19 walked in front of Resident #2 causing him/her to push Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 75	F 600		

#19. Resident #19 then stepped on Resident #20's left big toe. The corrective action included redirection of Resident #2 and ensured staff kept him/her at a safe distance from the other residents.

Observation of Resident #2, on 04/23/2021 at 9:00 AM, revealed the resident sitting in a chair in the hall with a sitter on the floor sitting next to Resident #2. Resident #2 was not interviewable.

Record review revealed the facility admitted Resident #19 on 05/01/2018 with diagnoses that included Vascular Dementia with Behavioral Disturbance and Alzheimer's Disease.

Review of Resident #19's Comprehensive MDS, dated 03/18/2021, revealed a BIMS score of three (3), which indicated severe cognitive impairment.

Observation of Resident #19, on 04/15/2021 at 2:45 PM, revealed the resident was in the common area with a walker, dressed appropriately, and participated in an exercise activity.

Interview with Resident #19, on 04/15/2021 at 8:15 AM, revealed he/she remembered someone pushing him/her. However, he/she could not identify who pushed him/her or when it occurred.

Record review revealed the facility admitted Resident #20 on 07/13/2018 with diagnoses to include Alzheimer's Disease and Dementia without Behavioral Disturbance. Record review revealed Resident #20 had an x-ray of his/her left foot after it was stepped on by Resident #19 on 11/21/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 76	F 600		

Review of Resident #20's Progress Notes, dated 11/21/2020, revealed another resident stepped on the resident's left foot. A skin assessment performed by LPN #6 revealed no bruising, swelling, or lacerations. Further review revealed LPN #6 documented the x-ray was negative for fractures of the left foot.

Review of Resident #20's Comprehensive MDS, dated 03/01/2021, revealed a BIMS score of three (3), which indicated severe cognitive impairment.

Interview with CNA #16, on 04/20/2021 at 3:46 PM, revealed she was the 1:1 sitter for Resident #2 on 11/21/2020. She stated Resident #2 got up from his/her chair in the common area and pushed Resident #19, which caused him/her to sway a little bit and he/she took a step backwards. CNA #16 stated she did not see Resident #19 step on Resident #20's foot. She stated Resident #2 could be quick in his/her movements without any warning signs.

Interview with CNA # 14, on 04/20/2021 at 9:36 AM, revealed she did not remember documenting Resident #2's behaviors on the Continuous 1:1 Supervision form. She stated she witnessed Resident #2 reach around her to hit another resident on the MCU, but could not remember when it occurred.

Attempted to contact Licensed Practical Nurse (LPN) #10, on 05/04/2021 at 2:00 PM and 05/06/2021 at 2:15 PM.

Interview with RN #1, on 04/15/2021 at 3:10 PM, revealed she observed Resident #2 numerous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 77	F 600		

times attempt to hit others, but she or other staff prevented him/her from making contact with other residents. She stated at times Resident #2 displayed loud clapping, or a look on his/her face, and other times there were no warning signs of his/her agitation/behaviors.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed staff were re-educated to ensure the 1:1 sitters provided adequate space between Resident #2 and the other residents on the MCU.

Interview with the CED, on 05/11/2021 at 10:04 AM, revealed residents' families sent their loved ones to the facility to receive care and to be kept safe. The CED stated with the sitter's re-education, it was reiterated no cellular phone use when assigned to 1:1 supervision of a resident as he had observed a staff on a cellular phone, and distracted from the task of 1:1.

10. Record review revealed on 01/22/2021, Resident #2 slapped Resident #3 while walking past him/her in the hall on the MCU. Resident #2 was on 1:1 observation at the time and Sitter #1 was walking behind Resident #2. Staff separated the residents and assessments revealed no injuries. RN #3 provided Sitter #1 re-education for the responsibilities for 1:1 supervision.

Review of Resident #2's Progress Notes, dated 01/22/2021 at 10:56 AM, revealed the MCU LPN documented Resident #2 slapped Resident #3 as he/she walked past him/her in the hallway. The review revealed Resident #2 was on 1:1 supervision at the time related to a history of previous behaviors.

Review of Resident #2's CCP, initiated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 78	F 600		

08/31/2020, revealed a focus for physical aggression towards other residents with a goal that included the resident would not have conflicts with other residents and to have acceptance of staff redirection and interventions. The CCP review revealed interventions for 1:1 supervision with staff within close personal space, approach resident in a calm manner, encourage resident to return to room for agitation to allow time to calm, and redirect resident to maintain a safe distance from other residents.

Review of Resident #2's psychiatry evaluation, dated 10/22/2020, revealed Resident #2 was resistive to care, combative, and hitting staff. Staff would re-approach to administer the prescribed Risperdal injections. The recommendation was to continue the same treatment of Risperdal twenty-five (25) mg injection every two (2) weeks.

Observation of Resident #2, on 04/14/2021 at 1:48 PM, revealed the resident sitting on the side of bed eating lunch with a sitter in a chair at the bedside. Resident #2 was not interviewable.

Record review revealed the facility admitted Resident #3 to the MCU on 01/20/2021 with diagnoses that included Dementia with Behavioral Disturbance and Psychotic Disorder with Delusions.

Review of Resident #3's Progress Notes, dated 01/22/2021, revealed a skin assessment completed by MCU LPN with no concerns identified.

Review of the Comprehensive MDS, dated 01/27/2021, revealed Resident #3 had a BIMS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 79	F 600		

score of five (5), which indicated severe cognitive impairment. The facility assessed the resident with physical behaviors directed towards others.

Observation of Resident #3, on 04/14/2021 at 1:51 PM, revealed he/she was groomed, dressed, and walking down the hall with another resident.

Interview with Resident #3, on 04/23/2021 at 9:10 AM, revealed he/she did not remember another resident slapping him/her.

Review of the facility's Long Term Care Facility-Self Reported Incident Form/Initial Report, dated 01/26/2021, revealed on 01/22/2021 Resident #2 reached out and slapped Resident #3 as they passed in the hallway. Resident #2 had a BIMS score of 99 (not assessed) and Resident #2's was five (5). The residents were separated and assessed for injuries with none noted. Staff were instructed to redirect Resident #2 away from other residents.

Review of the facility's Long Term Care Facility-Self Reported Incident Form/Final Report, dated 01/26/2021, revealed Sitter #1 stated the incident happened without warning. Further review revealed staff were re-educated to ensure Resident #2 was at least arm's length from other residents and the importance of redirection for Resident #2. The facility substantiated the incident as abuse.

Interview with Sitter #1, on 04/19/2021 at 4:00 PM, revealed she was the 1:1 sitter for Resident #2 on 01/20/2021. She stated she was walking in the hall behind Resident #2. Resident #3 walked up to Resident #2, wanted to show him/her something, and Resident #2 slapped Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 80	F 600		

on the face. Sitter #1 stated she was aware Resident #2 had a history of hitting other residents. She stated the facility's goal was to protect the residents from abuse.

Attempted to contact MCU LPN, on 04/20/2021 at 9:22 AM and 05/03/2021 at 11:32 AM.

Interview with RN #3, on 04/22/2021 at 11:03 AM, revealed he was in the facility on 01/22/2021 and spoke with Sitter #1 after the altercation between Residents #2 and #3. He stated Sitter #1 did not have a reason why she was walking behind Resident #2. He stated the sitter was re-educated to redirect Resident #2 away from others to prevent him/her form hitting others. RN #3 stated he communicated with Sitter #1 that 1:1 observation was to prevent Resident #2 from hitting other residents.

Interview with the Assistant Director of Nursing Services (ADNS), on 04/22/2021 at 10:09 AM, revealed he re-educated staff on 01/26/2021 to keep the resident on 1:1 away from other residents and redirect others away from the resident.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed Resident #2 had impulsive and unpredictable behaviors. She stated Sitter #1 and the nurse caring for the resident on 01/22/2021 received re-education to avoid walking behind Resident #2, but instead beside or in front of him/her.

11. Record review revealed on 03/09/2021 at approximately 5:55 PM, Resident #2 was in the MCU common area, stood up, and hit Residents #19, Resident #25, and Resident #26 before staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 81	F 600		

could intervene. Resident #2 was place on 1:1 continuous supervision until transfer to the hospital for psychiatric evaluation.

Review of Resident #2's Progress Notes, dated 03/09/2021 at 5:28 PM, revealed documentation by MCU LPN that Resident #2 continued to hit staff and other residents. The MCU LPN documented the CED was notified of the behaviors. The LPN documented a Change in Condition (CIC) that revealed physical aggression, notification of the physician, and an order was received to transport the resident to the hospital for evaluation. Resident #2 was transported to the hospital at 7:01 PM on 03/09/2021.

Review of the Psychiatry Notes, dated 03/09/2021, revealed Resident #2 was not on 1:1 observation at the time of the incident, had not had any behaviors, and showed improvement with "Geodon" treatment.

Review of Resident #2's RMS Event Summary Report, dated 03/09/2021, completed by a MCU LPN, revealed the event was described as combative behavior. The summary stated Resident #2 made contact with Residents #19, #25, and #26. Immediate interventions included Resident #2 was placed on 1:1 observation and transferred to the hospital. The report revealed the root cause of the event was related to Resident #2's diagnoses associated with combative behaviors.

Observation of Resident #2, on 04/14/2021 at 11:08 AM, revealed the resident sitting in a chair in the Common Area, the Activities Assistant was reading a book, and CNA #9 was sitting in a chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 82	F 600		

next to the resident. Resident #2 was observed clapping loudly. Additional observation of Resident #2, on 04/26/2021 at 11:10 AM, revealed the resident was groomed and dressed, lying in bed with his/her eyes open, with a 1:1 sitter at bedside.

Record review revealed the facility admitted Resident #19 on 05/01/2018 with diagnoses that included Vascular Dementia with Behavioral Disturbance and Alzheimer's Disease.

Review of the Progress Notes, dated 03/09/2021, completed by the MCU LPN at 7:22 PM, revealed Resident #19 was hit on the arm. The nurse assessed the resident for injuries, and slight redness of his/her arm was noted.

Review of Resident #19's Comprehensive MDS, dated 03/18/2021, revealed a BIMS score of three (3), which indicated severe cognitive impairment.

Record review revealed the facility admitted Resident #25 to the Memory Care Unit, on 06/27/2018, with diagnoses that included Alzheimer's Disease, Psychotic Disorder with Delusions, Anxiety, and Dementia with Behaviors.

Review of Resident #25's Progress Notes, dated 03/09/2021 at 7:24 PM, completed by MCU LPN, revealed another resident walked up to him/her smacked and yelled at him/her. The residents were separated and Resident #25's assessment revealed redness to his/her arms. Resident #25 was not interviewable.

Record review revealed the facility admitted Resident #26 to the Memory Care Unit, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 83	F 600		

03/11/2013, with diagnoses to include Hemiplegia, Hemiparesis, Vascular Dementia, Visual Loss, and Aphasia.

Review of the Progress Notes, dated 03/09/2021, completed by the MCU LPN revealed Resident #26 was sitting in a chair when Resident #2 hit him/her. The nurse performed an assessment that revealed no injuries.

Review of Resident #26's Quarterly MDS, dated 02/18/2021, revealed Resident #26's BIMS score was three (3), which indicated severe cognitive impairment.

Observation of Resident #26, on 04/15/2021 at 2:46 PM, revealed the resident was groomed, dressed, lying in bed with eyes closed, and a wheelchair was present at the bedside.

Attempted to interview Resident #26, on 04/15/2021 at 2:46 PM, revealed he/she did not answer questions appropriately.

Attempted to contact the nurse for Residents #2, #19, #25, and #26 for 03/09/2021, on 05/01/2021 at 10:00 AM and on 05/03/2021 at 9:01 AM.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed Resident #2's behavior improved after medication changes. Further interview revealed after a suggestion by the Director of the MCU, there was a sitter free trial period that began on 02/24/2021. The CNE stated the facility provided a 1:1 sitter for Resident #2 prior to transfer to the hospital on 03/09/2021.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed Resident #2's behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 84	F 600		

management had been difficult and they were constantly trying new interventions or activities to distract the resident and, therefore, address the behaviors. He stated the facility's goal was to keep the residents safe.

12. Record review revealed on 03/10/2021 at approximately 1:30 PM, Resident #2 walked down the hall on the MCU and slapped Resident #3 on the face that left a red mark on the left side of Resident #3's cheek. After separation of the residents, the nurse remained with Resident #2 for 1:1 supervision.

Review of the Progress Notes, dated 03/10/2021, revealed Resident #2 slapped Resident #3 as they were passing in the hallway. The MCU LPN removed Resident #2 from the area and stayed with the resident. A new order was received from the psychiatrist for Geodon (an antipsychotic) ten (10) mg intramuscular injection daily as needed for three (3) days. The Nurse's Notes, dated 03/10/2021 at 2:29 PM, revealed the MCU Director called other facilities to check for placement but was unsuccessful in finding relocation. The MCU Director's note revealed Resident #2 returned to the facility on 03/10/2021 at 1:00 AM after an evaluation on 3/09/2021 with no medication changes. A follow up visit by the Medical Physician, signed on 03/10/2021 at 5:10 PM, revealed staff had reported the resident had hit staff and other residents on 03/09/2021. The encounter note revealed the plan for staff to obtain lab work, a urinalysis to check for an infection, and to follow up with psychiatry.

Review of Resident #2's Physician Orders, revealed a new order on 03/10/2021 for Geodon ten (10) mg IM every twenty-four (24) hours as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 85	F 600		

needed for agitation for three (3) days.

Review of Resident #2's MAR, dated March 2021, revealed administration of as needed Geodon on 03/11/2021 at 9:45 AM and on 03/12/2021 at 9:15 AM. The MAR revealed documentation of Geodon ten (10) mg IM daily for Schizophrenia administered daily from 03/01/2021 through 03/10/2021, when the order was discontinued; and Geodon capsule twenty (20) mg twice daily by mouth, started on 03/11/2021 at 9:00 PM.

Review of the Continuous 1:1 Supervision documents, dated 03/10/2021, revealed Resident #2's 1:1 observation was restarted on 03/10/2021 after the incident with Resident #3.

Review of the most recent Psychiatry Note, dated 03/09/2021, revealed Resident #2 was not having any behaviors reported by nursing, and showed improvement with the Geodon treatment.

Observation of Resident #2, on 04/29/2021 at 8:54 AM, revealed resident lying in bed with gown on and his/her eyes were open. Observed sitter present at the bedside.

Attempted to interview Resident #2, on 04/14/2021 at 1:48 PM, but resident did not answer any questions.

The facility admitted Resident #3, on 01/20/2021 to the MCU, with diagnoses to include Dementia with Behavioral Disturbance and Psychotic Disorder with Delusions. Record review revealed on 03/10/2021, Resident #2 slapped Resident #3 on the face.

Review of Resident #3's Progress Notes, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 86	F 600		

03/10/2021, completed by ADNS at 4:14 PM, revealed a CIC note for a change in skin color/condition with no mental or functional status changes noted and no new orders. Further review revealed a skin assessment documented by the MCU LPN, on 03/10/2021 at 4:55 PM, revealed resident had redness to the left side of his/her face.

Review of the Comprehensive MDS, dated 01/27/2021, revealed Resident #3 had a BIMS score of five (5), which indicated severe cognitive impairment with physical behaviors directed towards others.

Review of Resident #3's RMS Event Summary Report, dated 03/10/2021, completed by the MCU LPN, revealed Resident #2 hit Resident #3 on the cheek as Resident #2 walked past Resident #3 in the hall on the MCU, which left a red mark on Resident #3's cheek. The MCU LPN separated the residents, assessed Resident #3, and remained with Resident #2 on 1:1 supervision. The report revealed the root cause of the incident was due to Resident #2's diagnoses and combative behaviors.

Observation of Resident #3, on 04/23/2021 at 9:10 AM, revealed resident was walking down the hall with another resident.

Review of the facility's Long Term Care Facility-Self Report/Final Report, dated 03/15/2021, revealed Resident #2 was placed on fifteen minute checks with 1:1 supervision, psychiatry services reviewed Resident #2's medications, modified his/her medications, and updated the care plan. The investigation report revealed Resident #2 had Psychotic Disorders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 87	F 600		

with Delusions and Bipolar Disorder with mood fluctuations expected at times.

Attempted to contact Resident #2's nurse for 03/10/2021, on 05/01/2021 at 10:00 AM and on 05/03/2021 at 9:01 AM.

Interview with the MCU Director, on 04/20/2021 at 10:01 AM, revealed the goal of the 1:1 supervision of Resident #2 was to keep him/her safe and the other residents safe on the unit. She stated she had communicated with other facilities for alternative placement for Resident #2, but was unsuccessful. The MCU Director stated the sitters were aware to either redirect residents or others away from Resident #2 to ensure their safety because Resident #2 had unpredictable behaviors.

Interview with the facility's Psychiatrist, on 04/22/2021 at 2:44 PM, revealed he conducted telemedicine visits with Resident #2 regularly via video conference and his Medical Assistant who came to the facility. He stated Resident #2 had many behaviors and he was attempting to find the right medication to address his/her behaviors. The Psychiatrist stated the facility reported behaviors/incidents and he spoke with facility staff regularly regarding Resident #2's care.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed they conducted a medication review and consulted with the Psychiatrist who increased Resident #2's Geodon medication dose. She stated staff had been educated to ensure Resident #2 was at least an arm's length away from others. The CNE stated staff have tried various activities such as a busy blanket, which has zippers and buttons as a distraction for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 88	F 600		

Resident #2.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed the daily Interdisciplinary Team (IDT) meetings included discussions regarding Resident #2's behaviors and they brainstormed to find new interventions to address the behaviors and the cause of them.

13. Record review revealed on 03/24/2021 at approximately 4:00 PM, Resident #2 hit Resident #21 on the left arm in the MCU Common Area. Facility staff separated the residents and the nurse assessment revealed Resident #21 did not have any injuries. Resident #2 was on 1:1 supervision when the altercation took place.

Review of Resident #2's Progress Notes, dated March 2021, revealed a Social Service Note, on 03/15/2021 at 3:49 PM, which stated Resident #2 was agitated and displayed aggressive behaviors when others got to close to him/her. Resident #2 was placed back on 1:1 observation until ambulance transportation arrived to send the resident to the hospital for evaluation. The review revealed Resident #2 remained in the hospital from 03/15/2021 and returned to the facility on 03/22/2021. A CIC note, on 03/24/2021 at 4:00 PM, completed by the MCU LPN, revealed Resident #2 was having aggressive behaviors. The MCU LPN contacted the Psychiatrist, on 03/24/2021 at 4:45 PM, and received a new order to increase Geodon to forty (40) mg twice daily and place the resident on 1:1 observation.

Review of Resident #2's Physician Orders, dated 03/22/2021, revealed an order for Ativan (medication to treat Anxiety) one half (0.5) mg every six (6) hours as needed for anxiety and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 89	F 600		

Geodon twenty (20) mg twice daily.

Review of Resident #2's MAR, dated March 2021, revealed a dose of Ativan, ordered as needed, was given on 03/25/2021. However, review of the MAR revealed staff documented the resident did not have any behaviors since return from the hospital on 03/22/2021.

Review of Resident #2's Psychiatry Notes, dated 03/24/2021, revealed resident had behaviors earlier in the day, which included agitation and aggression toward other residents. The note revealed Resident #2 was behavior free when residents stayed out of his/her space and the facility decided to ensure staff were close to prevent other residents from getting too close.

Review of Resident #2's RMS Event Summary Report, dated 03/24/2021, completed by the MCU LPN, revealed the event was described as resident-to-resident altercation with alleged abuse-aggressor. The report revealed Resident #2 grabbed Resident #21 by the arm, hit his/her arm multiple times. The root cause revealed Resident #2 had several diagnoses related to behaviors.

Observation of Resident #2, on 04/14/2021 at 11:08 AM, revealed Resident #2 sitting in a chair clapping loudly in the Common Area with the 1:1 sitter sitting in a chair adjacent to the resident.

Review of the clinical record revealed the facility admitted Resident #21 on 01/01/2020 with diagnoses to include Alzheimer's Disease, Dementia without Behavioral Disturbance, Psychotic Disorder with Delusions, and Anxiety Disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 90	F 600		

Review of Resident #21's Progress Notes, dated 03/24/2021 at 3:30 PM, documented by the MCU LPN, revealed Resident #21 was sitting in the television room and another resident hit Resident #21 multiple times on the arm. The MCU LPN separated the residents. A skin assessment performed by the MCU LPN, on 03/24/2021 at 3:30 PM, revealed no skin injuries or wounds were noted.

Review of Physician Orders, as of 03/24/2021, revealed Resident #21 was prescribed Namenda (medication for Dementia). Additional orders included monitoring resident twice daily for behaviors with documentation of exhibited behaviors in the nurse's note.

Review of Resident #21's Quarterly MDS, dated 05/03/2021, revealed a BIMS score of two (2) which indicated severe cognitive impairment.

Observation of Resident #21, on 04/14/2021 at 2:01 PM, revealed the resident was walking around the unit with another resident.

Interview with Resident #21, on 04/14/2021 at 2:01 PM, revealed he/she did not remember being hit by another resident.

Review of the facility's Long Term Care Facility-Self Reported Incident Form/Combined Incident/Final Report, dated 03/24/2021, revealed Resident #2 hit Resident #21 in the Common Area on the MCU. Staff separated the residents with removal of Resident #2 from the area. The report revealed Resident #2 was placed on 1:1 supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 91	F 600		

Attempted to contact the nurse assigned to MCU, on 04/20/2022 at 11:25 PM, but was unable to leave a message.

Interview with CNA # 15 on 04/20/2021 at 11:21 AM, revealed she provided 1:1 observation to Resident #2 after the incident and was instructed to make sure he/she did not hit anyone.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed CNA #15 on 03/24/2021 was not a regularly scheduled sitter for Resident #2, but was informed of his/her behaviors. The CNE stated Resident #2 responded well to certain staff members so they tried to ensure the same staff provided the 1:1 supervision. She stated the Interdisciplinary Team (IDT) was constantly brainstorming to come up with new techniques or diversional activities for Resident #2.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed the facility would provide 1:1 supervision for Resident #2 as long as the aggressive/combative behaviors were present. He stated the facility had ordered a battery powered, life-like cat and dog to see if Resident #2 would respond to them.
14. Review of the facility's abuse policy defined sexual abuse as non-consensual sexual contact of any type with a resident.

Review of the facility's Dementia: Care of Patient policy, dated 11/28/2016 and revised 02/28/2021; revealed residents would be evaluated as part of the nursing assessment process for the presence of cognitive loss/dementia upon admission/re-admission, quarterly, with change of condition, or change of cognitive status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 92	F 600		

Further review revealed interdisciplinary (IDT) assessments of the person's abilities and background were completed in order to provide care and assistance tailored to his/her individual needs. Residents were to be monitored for safety of self and others to include intrusive wandering.

Record review revealed the facility admitted Resident #12, on 02/06/2020. The facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of five (5), which indicated severely impaired cognition.

Record review revealed the facility admitted Resident #13's on 09/10/2019. The resident had a Brief Interview of Mental Status (BIMS) score of two (2), which indicated severely impaired cognition.

Review of Resident #12's Progress Notes, dated 09/21/2020, completed by Licensed Practical Nurse (LPN) #34, revealed the resident commented to staff that he/she could not have the opposite sex in his/her room and he/she was a grown up and should be allowed to have someone in his/her room, if they wanted to have someone in his/her room.

Review of Resident #12's Quarterly Minimum Data Set (MDS) Assessment, dated 10/07/2020, revealed the facility assessed the resident to have a BIMS score of five (5) out of fifteen (15), which indicated the resident had severe cognitive impairment. Additionally, the resident usually had the ability to understand others and make himself/herself understood. Continued review of the Assessment revealed the resident had no behavior symptoms present. Record review revealed the resident required limited assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 93	F 600		

and or supervision with his/her Activities of Daily Living (ADL), with the support of one (1). Further, the resident was assessed to use a wheelchair and have a wander guard alarm on for daily use.

Review of Resident #12's Progress Note, on 10/18/2020, completed by LPN #34, revealed staff observed Resident #12 attempt to hold Resident's #13's hand; the resident was easily redirected. Continued review of Resident #12's Progress Notes, on 10/19/2020, completed by LPN #34, on 10/19/2020, revealed the facility started Resident #12 on 1:1 supervision for concerns of sexually inappropriate behaviors. However, there was no documented evidence of a resident-to-resident Alleged Sexual Abuse incident between Resident #12 and Resident #13, on 10/19/2020.

Further review of Resident #12's Care Plan, initiated on 10/19/2020, revealed the resident had tendency to exhibit sexual expression. The goals included: resident will demonstrate effective coping skills related to sexually inappropriate behavior kissing another resident, redirect resident to alternative activity or location thru next review. Interventions included: put the resident in a place where they will not demonstrate any signs of psychosocial distress; allow time for resident to express feelings; provide empathy, encouragement and reassurance; Social Services visits to provide support as needed; divert resident by giving alternate objects or activities; and to listen to resident and try to calm him/her.

Review of Resident #12's Progress Note, dated 10/27/2020, completed by LPN #34, revealed staff observed Resident #12 make several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 94	F 600		

attempts to enter Resident #13's room to hold the resident's hand. Further, Resident #12 informed staff he/she asked Resident #13 to get married and he/she had the right to hold hands with the resident. Resident #12 was on 1:1 supervision at that time.

Review of the Progress Note, dated 10/28/2020, completed by LPN #34, staff observed Resident #12 attempt to enter Resident #13's room. Further review revealed Resident #12 informed staff if Resident #13 wanted Resident #12 to touch him/her it was not up to staff to say no, because the two (2) of them were to get married.

Review of Resident #13's medical records revealed the facility admitted the resident on 09/10/2019, with diagnoses of Dementia with behaviors and Psychotic disorder with delusions.

Review of Resident #13's Progress Notes, dated 10/21/2020, completed by LPN #41, revealed the resident followed another resident, on the MCU, and "antagonized" the resident, and asked the resident if he/she could go to his/her room.

Review of Resident #13's Annual MDS Assessment, dated 10/23/2020, revealed the facility assessed the resident had a BIMS of two (2) out of fifteen (15), which indicated the resident had severe cognitive impairment.

Continued review of Resident #13's Progress Notes, four (4) days after the resident-to-resident Alleged Sexual Abuse, on 10/23/2020, completed by LPN #34, revealed the resident was involved in a kiss on the lips with Resident #12. Additionally, Resident #13 reported it was okay the kiss happened, but he/she did not remember it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 95	F 600		

Further review revealed no signs of distress were present.

Additional review of Resident #13's CCP, on 10/19/2020, revealed the resident had a tendency to exhibit sexually inappropriate behavior related to cognitive loss/Dementia. The resident was noted to have given another resident a "peck on the lips." The goal was that the resident would demonstrate effective coping skills related to sexually inappropriate behavior, kissed another resident; redirect self to alternative activity or location. Interventions included: evaluate need for Psych/Behavioral Health Consultation; Social Service visits to provide support as needed; divert resident with alternative objects/activities; listen to resident and try to calm resident; and remove resident from environment as needed.

Review of the facility's Long Term Care Facility-Self Report Incident Form/Initial Report, dated 11/01/2020, fourteen (14) days after the incident, which was reported to the State Survey Agency revealed an Allegation of Sexual Abuse had occurred on 11/01/2020 between Resident #12 and Resident #13. The Physician, POA, and Department of Community Based Services (DCBS) were notified of the alleged sexual abuse on 11/01/2020. Per the Report, Resident #12 was witnessed to kiss Resident #13 a "peck kiss on the lips." Further, Resident #12 was placed on 1:1 Supervision. Continued review of the Report, revealed Resident #12's had a BIMS score of five (5) and it was noted that Resident #13 had a BIMS score of ninety-nine (99).

Review of LPN #37's witness statement, dated 10/19/2020, revealed she observed Resident #12 and Resident #13 have a "peck, kiss on the lips."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 96	F 600		

Residents were separated and Resident #12 was placed on 1:1 Supervision. Resident #13 was redirected to the common area. The other LPN on duty, notified the POA, doctor and management team.

On 04/26/2021 at 3:00 PM, SSA attempted to LPN #34, via telephone.

On 04/26/2021 at 3:05 PM, SSA attempted to LPN #12, via telephone.

On 04/26/2021 at 2:27 PM, SSA attempted to contact the previous Center Executive Director, via telephone.

Observation on 04/26/2021 at 8:45 AM, revealed Resident #12 and #13 unsupervised in Resident #13's room. Resident #12 was seated in a wheelchair and Resident #13 was seated in a chair. It appeared the residents talked and read to each other. Staff was present across the hall and the door was open.

Phone interview with Nurse Assistant (NA) #1, on 04/21/2020 at 7:20 PM, revealed she worked at the facility from March 2020 to October 2020. Per interview, she provided 1:1 supervision for Resident #12, after the alleged sexual abuse. However, the facility did not educate/train her on what to do for 1:1 supervision of the resident. Continued interview revealed she was only told to sit with the resident in the common area and his/her room. Additionally, NA #1 stated Resident #13 would follow Resident #12, call him/her "honey," attempt to hold the resident's hands, and try to get the resident to come to his/her room.

Interview with CNA #11, on 04/22/2021 at 3:35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 97	F 600		

PM, revealed she worked night shift and was told to keep an eye on Resident #12 and Resident #13 because they would try to go in each other's room. Per interview, Resident #12 would become mad at staff when he/she was redirected and not allowed in Resident #13's room.

Interview with LPN #25, on 04/22/2021 at 11:10 AM, revealed she previously was the Unit Manager of the MCU. Additionally, she provided 1:1 supervision for Resident #12 on 10/24/2020. Further interview revealed she stated residents who were cognitively impaired could not consent to have sexual relationships because they could not understand the responsibilities that come with that type of relationship.

Interview with facility's Psychiatrist, on 04/22/2021 at 3:00 PM, revealed a resident with a BIMS score of ninety-nine (99) would not be able to give consent of any kind because they were severely cognitively impaired. Additionally, he revealed he should be involved in any assessment that determined if residents in the MCU were able to consent to a sexual relationship and it would be rare for such a relationship to be okay.

Interview with Memory Care Unit Program Director (MCPD) who had been in that role since October 2020, on 04/23/2021 at 10:35 AM, revealed prior to becoming the MCPD, she worked as the Social Service Assistant in the main facility from January 2020 to October 2020. Per interview, Resident #12 and Resident #13 needed consent to have a relationship because they both had low BIMS scores which indicated they suffered cognitive impairments and the inability to make such decisions. Additionally, she reported she did not use any resources to reach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 98	F 600		

the conclusion that consent could be given for the two (2) residents who were cognitively impaired. Further, she reported she discussed her concerns with the current CNE and the previous CED and they made the final decision, that Resident #12 and Resident #13 could have a relationship that included holding hands and a peck kiss on the lips as per established by each individual POA. Per interview, the MCPD reported she did not know what the State Operations Manual (SOM) was when asked if she had reviewed it to make a determination who if anybody could give consent for cognitively impaired residents to have sexual relations/relations.

Interview with Resident #12's POA, on 04/26/2021 at 7:20 PM, revealed he was contacted by the facility to ask for consent for relationship for his family member and he told the facility "No," he did not consent for Resident #12 to have a relationship with another resident in the facility. Additionally, he informed the caller he was not comfortable with that, and the resident's spouse was still alive and the resident had Dementia. Per interview, he revealed he could not recall the name of the person that called because it was some time ago. The POA stated he would have told the facility "absolutely not" if there had been any mention of sexual relationships discussed.

Interview with Resident #13's POA, on 04/27/2021 at 1:35 PM, revealed the MCPD called and informed the POA another resident on the MCU had given his family member a peck kiss on the lips. Additionally, the POA reported he informed MCPD as long as his family member was safe and happy he was fine with Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 99	F 600		

#13's present relationship with another resident, if it was strictly a friendship; however at no time was it described as something sexual. Per interview, he described sexual contact to include tongue kissing, touching over the clothes, touching of the genitalia and kissing over the body. The POA revealed a peck of a kiss was okay with him and not sexual. Further, he revealed he was never informed his family member had been in bed with a resident of the opposite gender and was not okay with that. Continued interview revealed he would have wanted to know why another resident would be allowed in his family member's room, or his family member would be allowed in another resident's room. Per interview, Resident #13 had been raped fifty (50) years ago and when he still provided care for the family member, he/she became very angry if anyone of the opposite gender touched him/her; even if his family member knew the person.

Additional interview with MCPD, on 04/29/2021 at 3:30 PM, revealed residents on the MCU had impaired cognition and required constant supervision. Per interview, residents with a BIMS score of eight (8) or lower could not make sound decisions and required a POA to make decisions on their behalf. Continued interview revealed residents with impaired cognition required consent to have sexual relationships. Additionally, she did not consider a companionship of sitting together, holding hands, or a kiss as sexually inappropriate behavior. Continued interview revealed she was aware that Resident #13 had aggressive behaviors prior to the Alleged Sexual Abuse, in October 2020, towards Resident #12; he/she would follow Resident #12 around the MCU and would ask

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 100	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 101	F 600		

Interview with the CED, on 05/04/2021 at 3:45 PM, revealed sexual contact as anything unwanted by another resident and if a resident could not consent, it was considered the same. Additionally, it was the facility's job to protect all residents especially those residents on the MCU because they were a vulnerable population. Per interview, there was increased potential for residents with impaired cognition to be involved in any type of relationship. Continued interview revealed he was unsure if the POA or guardian could give consent for a resident in MCU to have sexual relationships but stated the IDT should be involved in the decision making process. Further, residents have rights and to ensure those rights were met, it should be an IDT decision. However, he was not aware of Resident #12 and Resident #13's relationship until the SSA informed him during the investigation of the Alleged Sexual Abuse. Per interview, residents on the MCU should not be involved in any type of relationship due to the resident's impaired cognitive impairments.
15. Record review revealed on 04/23/2021, Resident #56 became agitated and hit resident #28 on his/her leg.

Review of the facility's Long Term Care Facility-Self Report Incident Form/Initial Report, dated 04/23/2021, revealed Resident #56 and Resident #28 were watching TV in the common area when Resident #56 became agitated and made contact with Resident #28's leg. Per review, the residents were separated immediately.

Review of the Five (5) day Facility's Investigation Report, dated 04/28/2021, revealed Resident #56 was sent to the hospital three (3) days after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 102	F 600		

incident due to unresponsiveness to his/her progressing brain tumor. Per review, this contributed to the resident's behavior, as well as, the Urinary Tract Infection (UTI). Further review revealed Resident #56 would come back to the facility with hospice and was non-ambulatory.

Review of Resident #28's Quarterly Minimum Data Set (MDS) Assessment, dated 02/26/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating severe cognitive impairment.

Review of Resident #28's Skin Assessment, dated 04/23/2021, revealed no injuries noted.

Review of Resident #56's medical record revealed the facility admitted Resident #56, on 04/08/2020, with diagnoses which included Schizo-Effective Disorder, Bipolar Disorder, Anxiety, Dementia without Behaviors, and Major Depressive Disorder.

Review of Resident #56's Annual MDS Assessment, dated 04/06/2021, revealed the facility assessed the resident to have a BIMS' score of thirteen (13) out of fifteen (15), which indicated the resident was cognitively intact. Additional review of the MDS Assessment revealed the facility assessed the resident under Section E, to have no physical and/or verbal behaviors towards others within the last review period.

Observation and interview with Resident #56, on 05/05/2021 at 9:00 AM, revealed he/she was aware of Resident #28 and thought the incident happened a long time ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 103	F 600		

Interview with the Business Office Manager (BOM), on 05/06/2021 at 12:25 PM, revealed she has had education related to abuse. She stated that when abuse occurs between a resident-to-resident, it would be reported immediately to the nurse supervisor and/or Administrator. Continued interview with the BOM revealed she was unaware of the date of the first incident, but believed it occurred sometime prior to lunch. She stated she was checking temperatures of staff and/or visitors who entered the facility and overheard the residents arguing over a wallet. She stated Resident #56 reported that Resident #28 took his/her wallet. Continued interview revealed a few days later, on the second incident, Resident #56 was talking to someone (unidentified) and Resident #28 thought Resident #56 was talking about him/her. Per interview, the residents began to argue which lead to Resident #56 "smacking" Resident #28 on the leg. The BOM stated there was no force behind the hit, but it would have still been considered abuse. Per interview, she stated she was the only witness in both incidents and immediately separated the residents. She further stated she reported the incident to the Administrator.

Interview with the CNE, on 05/06/2021, at approximately 10:00 AM, revealed the Administrator was responsible for investigating the resident-to-resident altercation between Resident #28 and Resident #56. Per interview, the CNE reported there were no witnesses to the incident, other than the BOM.

Interview with the CED, on 05/06/2021, at approximately 10:15 AM, revealed he reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 104	F 600		

the incident to the State Survey Agency, as it would be considered abuse.

Review of the IJ Removal Plan revealed the facility implemented the following:

1. Resident #56 and #28 were immediately separated by the Scheduler upon the discovery of the event on 04/23/2021. The CED and CNE were immediately notified of the event by the Scheduler on 04/23/2021. The initial report was sent in to the SSA regarding Residents #56 and #28 on 04/23/2021 by the Center Executive Director. Resident #56 and #28 were reassessed on 04/23/2021 by the Registered Nurse (RN).

The Director of Social Services updated the plan of care for Residents #56 and #28 on 04/23/2021 to reflect the current needs of the residents.

The Social Service Director reassessed Residents #56 and #28 on 05/12/2021 to determine Psychosocial Wellbeing, no concerns noted.

2. Residents #21 and #2 were immediately separated by Licensed Practical Nurse (LPN) upon the discovery of the event on 03/24/2021. Resident #2 was on one to one observation. The CED and CNE were immediately notified of the event by the Nurse on 03/24/2021. The initial report was sent in to the SSA regarding Residents #21 and #2 on 03/24/2021 by the Center Executive Director.

Residents #21 and #2 were reassessed on 03/24/2021 by the Licensed Practical Nurse (LPN). No concerns were noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 105	F 600		

The Assistant Director of Nursing (ADNS) reassessed Resident #21 and Resident #2 on 05/11/21 to determine any psychosocial wellbeing issues.

3. Residents #2 and #3 were immediately separated by the LPN upon the discovery of the event on 03/10/2021. Resident #2 was on one to one observation. The CED and CNE were immediately notified of the event by the Nurse on 3/10/2021. The initial report was sent in to the SSA regarding Residents #2 and #3 on 03/10/2021 by the Center Executive Director.

Residents #2 and #3 were reassessed on 03/10/2021 by the RN. No concerns were noted. The ADNS reassessed Residents #2 and #3 on 05/11/2021 to determine psychosocial wellbeing, no concerns were noted.

4. Resident #2, Resident #19, Resident #25, and Resident #26 were immediately separated by the LPN upon the discovery of the event on 03/09/2021.

Resident #2 was on one to one observation. The CED and CNE were immediately notified of the event by the Nurse on 03/09/2021.

The initial report was sent in to the SSA regarding Resident #2, Resident #19, Resident #25, and Resident #26 on 03/09/2021 by the Center Executive Director.

Resident #2 was sent to the acute care facility for evaluation and returned to the Center with no new orders.

Resident #2, Resident #19, Resident #25, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 106	F 600		

Resident #26 were reassessed on 03/09/2021 by the LPN. No concerns were noted.

The Social Service Director reassessed Resident #2, Resident #19, Resident #25, and Resident #26 on 03/10/2021 to determine Psychosocial wellbeing with no issues noted.

5. Residents #2 and #3 were immediately separated by the RN upon the discovery of the event on 01/22/2021. Resident #2 was on one to one observation. The CED and CNE were immediately notified of the event by licensed nurses on 01/22/2021. The initial report was sent in to the SSA regarding Residents #2 and #3 on 01/22/2021 by the Center Executive Director.

The Social Service Director reassessed Residents #2 and #3, on 01/28/2021, to determine Psychosocial wellbeing. No issues were noted.

6. Residents #2 and #21 were immediately separated by the licensed nurse upon the discovery of the event on 10/28/2020. The CED and CNE were immediately notified of the event by the LPN on 10/28/2020. The initial report was sent in to the SSA regarding Residents #2 and #21 on 10/28/2020 by the Center Executive Director.

Residents #2 and #21 were reassessed on 10/28/2020 by the LPN. No concerns were noted.

7. Residents #15 and #16 were immediately separated upon the discovery of the event on 12/24/2020. The CED and CNE were immediately notified of the event by the LPN on 12/24/2020. The initial report was sent to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 107	F 600		

SSA regarding Residents #15 and #16 on 12/24/2020 by the Center Executive Director.

Residents #15 and #16 were reassessed on 12/24/2020 by the RN. No concerns were noted. The Social Service Director reassessed Residents #15 and #16 on 12/28/2020 to determine psychosocial wellbeing, no issues noted.

8. Residents #11 and #10 were immediately separated by a LPN upon the discovery of the event on 12/15/2020. The CED and CNE were immediately notified of the event by the nurse on 12/15/2020. The initial report was sent in to the SSA regarding Residents #11 and #10 on 12/15/2020 by the Center Executive Director.

Residents #11 and #10 were reassessed on 12/15/2020 by the LPN, Resident #10 had bruising and swelling on the side of his/her face.

The Social Service Director reassessed Residents #11 and #10 on 12/16/2020 to determine psychosocial well-being, no issues noted.

9. Residents #19 and #20 were immediately separated by a LPN upon the discovery of the event on 11/21/2020. The CED and CNE were immediately notified of the event by a LPN on 11/21/2020. The initial report was sent in to the SSA regarding Residents #19 and #20 on 11/21/2020 by the Center Executive Director.

Residents #19 and #20 were reassessed on 11/21/2020 by the LPN. Orders for x-rays was obtained for Resident #20. No injuries were noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 108	F 600		

The Social Service Director reassessed Residents #19 and #20, on 11/25/2020, to determine Psychosocial well-being, no issues were noted.

10. Residents #61 and #21 were immediately separated by LPN upon the discovery of the event on 10/02/2020. The CED and CNE were immediately notified of the event by the LPN on 10/02/2020. The initial report was sent in to the SSA regarding Residents #61 and #21 on 10/02/2020 by the Center Executive Director.

Residents #61 and #21 were reassessed, on 10/02/2020 by the LPN. No concerns were noted.
The Social Service Director assessed Residents #61 and #21, on 10/08/2020 to determine psychosocial harm had occurred with no issues noted.

11. Resident #86 and Resident #85 were immediately separated by LPN upon the discovery of the event, on 04/22/2021. The CED and CNE were immediately notified of the event by the LPN, on 04/22/2021. The initial report was sent in to the SSA regarding Residents #86 and #85, on 04/22/2021 by the Center Executive Director.

The Social Service Director assessed Residents #86 and #85 on 04/23/2021 to determine psychosocial harm had occurred with no issues noted.

12. On 05/11/2021, The Center Executive Director (CED), and Center Nurse Executive (CNE), notified the Medical Director of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 109	F 600		

immediate jeopardies An ad Hoc Quality Assurance Performance Improvement Committee (QAPI) meeting was conducted with the CED, CNE, and Medical Director at this time for recommendations developing the action plan including audits, reeducation, and compliance monitors for residents at risk for abuse/neglect.

13. On 05/11/2021, the Vice President of Clinical operations contacted the Quality Improvement Organization (QIO) for behavior element support.

14. On 05/12/2021, the Senior Director from the (Corporate) National Specialty Practices Team conducted reeducation with the SSD, Center Executive Director (CED), CNE, NPE, Unit Managers ADNS, Nursing Supervisor regarding the facility's policy, Behaviors: Management of Symptoms and that each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care to protect residents against serious injury, serious harm, or death. Additionally, the reeducation included De-escalate Challenging Situations and Behaviors: How to Respond when Dementia Causes Unpredictable Behavior obtained from the Quality Improvement Organization (QIO) with a posttest requiring a 100% grade. Any newly hired SSD, CNE, CED, NPE, and or UM will receive education and complete a posttest to verify understanding by the National Specialty Practices Team or CQS.

15. Starting 05/14/2021, the Social Service Director (SSD), Social Worker (SW), Center Nurse Executive (CNE), Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 110	F 600		

Nursing Service (ADNS), Memory Support Program Manager and/or Unit Manager (UM) will review the progress notes of residents presenting with behaviors in the clinical morning meeting to determine the need for behavioral health services daily times two (2) weeks including weekends and holidays then three (3) times per week times (2) weeks then weekly for eight (8) weeks then every other week times eight (8) weeks then monthly times (1) month then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the behavioral needs of the residents are met with any corrective action upon discovery.

16. On or before 05/19/2021, the Social Services Director (SSD), Social Worker, Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Nurse Practice Educator (NPE), Registered Nurse, (RN) and or Licensed Practical Nurses (LPN) will conduct an audit of residents' records presenting with behaviors to include signs of frustration, agitation, and anger such as physical or verbal behavioral symptoms directed toward others and/or not directed at others to determine the need for a behavioral health consultation. Additionally, behavior rounds were conducted to determine the need for behavioral health consultation.

17. On or before 05/19/2021, the Center Nurse Executive (CNE), Unit Managers, UM, CED, NPE, ADNS, and HR would provide re-education to all nursing staff, including agency staff regarding the facility's policy, Behaviors: Management of Symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 111	F 600		

18. On or before 05/19/2021, the CNE, ADON, NPE, Unit Managers will provide reeducation for nurses to complete a thorough investigation when a behavior occurs to identify the triggers in order to develop a person centered care plan with a post- test requiring a 100% grade. A passing grade of 100% was required. Staff not available during this time frame to include agency staff will be provided re-education including post- test by the Unit Managers and or CNE upon day of return to work. New hires including agency staff will be provided education and a posttest during orientation by the CNE, NPE or Unit Managers.

19. The Center Nurse Executive (CNE) or Assistant Director of Nursing Service (ADNS), Unit Manager (UM), Licensed Nurse, Certified Nursing Assistant, Mental Health Provider or Nurse Practitioner would conduct behavior rounds to determine that behaviors were managed appropriately with corrective action upon discovery weekly times four (4) weeks, bi-weekly times four (4) weeks then monthly times four (4) months then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the behavioral needs of the residents were met with any corrective action upon discovery.

20. The CED and/or CNE would review results of the audits and interviews daily to ensure concerns identified were addressed upon discovery.

21. The SSD, SW and/or CNE would report the review findings daily until the Immediate Jeopardy was removed to the Quality Assurance Performance Improvement Committee which consists of the Center Executive Director, Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 112	F 600		

Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in servicing until the issue was resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Interview with the Social Service Director (SSD), on 05/21/2021 at 5:30 PM, revealed she updated Resident #56's care plan to have staff check on the resident. Continued interview revealed the resident was no longer in the facility and was placed on Hospice. She further stated the care plan was not updated for Resident #28 on 04/23/2021, but on 04/20/2021, related to the resident's behavior of taking other resident's items. Continued interview with the SSD revealed she followed up with the residents on 05/12/2021 and the residents expressed no concerns related to their Psychosocial Wellbeing.

2. Interview with the CNE, on 04/29/2021 at 9:17 AM and the CED on 04/30/2021 at 3:12 PM, revealed they were notified by the MCU LPN #43, on 03/24/2021. Record review, dated 03/24/2021, revealed the MCU LPN separated, assessed Resident #2 and #21 for injuries, and notified the CNE and CED of the event.

Interview with the ADNS, on 05/22/2021 at 3:00 PM, revealed he visited with Resident #2 and Resident #21 on 05/11/2021, and determined no psychosocial distress from the incident on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 113	F 600		

03/24/2021. Record review revealed the ADNS evaluated Residents #2 and #21 for psychosocial wellbeing and determined no concerns.

3. Interview with the CNE, on 04/29/2021 at 9:17 AM, and the CED, on 04/30/2021 at 3:12 PM, revealed they were notified by LPN #43, on 03/10/2021.

Record review revealed LPN #43 assessed both residents for injuries and notified the CED and CNE of the incident on 03/10/2021.

Interview with the ADNS, on 05/22/2021 at 3:00 PM, revealed he visited with Resident #2 and Resident #3 on 05/11/2021, and determined no psychosocial distress from the incident on 03/10/2021.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed he sent the initial report to the SSA on 03/10/2021.

4. Interview with the CNE, on 04/29/2021 at 9:17 AM, and the CED on 04/30/2021 at 3:12 PM, revealed they were notified by LPN #43 on 03/09/2021. Record review revealed LPN #43 notified the CED and CNE of the incident on 03/09/2021. On 03/09/2021, LPN #43 assessed Residents #19 and #25 with redness noted to his/her arm and Resident #26 was assessed with no injuries noted.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed he sent the initial report to the SSA on 03/09/2021.

Record review revealed LPN #43 transferred Resident #2 to the hospital on 03/09/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 114	F 600		

Further record review revealed Resident #2 returned to the facility on 03/10/2021 at 1:00 AM with no new orders.

Interview with the SSD, on 05/22/2021 at 5:09 PM, revealed she assessed Residents #19, #25, and #26 on 03/10/2021 for psychosocial distress by talking with them with no concerns noted. Record review revealed the SSD assessed Residents #19, #25, and #26 on 03/10/2021 for psychosocial status and no concerns were noted.

5. Interview with the CNE, on 04/29/2021 at 9:17 AM, and the CED on 04/30/2021 at 3:12 PM, revealed they were notified by LPN #43, on 01/22/2021.

Interview with the CED on 04/30/2021 at 3:12 PM, revealed he sent an initial report to the SSA of the event.

6. Interview with LPN #6, on 04/20/2021 at 11:11 AM, revealed he assisted in the separation of Residents #2 and #21. He stated the residents were assessed with no injuries noted.

Record review revealed LPN #6 assessed the residents for injuries with no concerns noted.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed she was notified by LPN #6 of the incident on 10/28/2020.

7. Record of the residents' skin assessment revealed Residents #15 and #16 were assessed by the CNE, on 12/24/2020, per review, there were no concerns identified.

Interview with the SSD, on 05/21/2021 at 5:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 115	F 600		

PM, revealed she assessed the residents for Psychosocial needs and no concerns were identified.

8. Review of the residents' skin assessments, dated 12/15/2020, revealed Resident #10 had a bruise/swollen face.

Interview with the Social Service Director, on 05/21/2021 at 6:21 PM, revealed she recalled assessing Resident #10, but did not recall a bruise to the resident's face. She stated she noted the resident was not in any pain. She further stated she assessed the resident's psychosocial wellbeing on 12/16/2020 and noted no concerns.

9. Review of Residents #19 and #20's clinical record revealed the residents were assessed without injuries noted.

Interview with the SSD, on 05/21/2021 at 6:21 PM, revealed she reassessed Residents #19 and #20 and noted no psychosocial concerns.

10. Review of Resident #61 and #21's skin assessment, dated 10/02/2020, revealed no concerns noted.

Review of Social Service Notes, dated 10/08/2020, revealed no psychosocial harm was noted.

11. Review of the SSD Progress Notes, dated 04/23/2021, revealed no Psychosocial harm was noted.

12. Review of the Ad Hoc (Impromptu) QAPI sign-in sheet revealed the Center Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 116	F 600		

Director (CED), Center Nurse Executive (CNE), and Medical Director met on 05/11/2021 to discuss the immediate jeopardy.

Interview with the Medical Director, on 05/22/2021 at 5:30 PM, revealed the facility immediately notified him by phone with both notations of jeopardies. The Director revealed the facility held an immediate Ad-HOC QAPI to discuss the information, formulate education to staff, and audits for compliance. Continued interview revealed the facility updated him daily on the progress of education, audits, and any changes which were warranted after review of the information. The director stated the committee will review all abated jeopardies audits monthly for at least six (6) months, longer if warranted.

13. Interview with Quality Improvement Organization, on 05/22/2021 at approximately 3:40 PM, revealed she had worked with the VPCO with setting up training for the Memory Care Unit. Per interview, she lived out of state and much of the training was provided virtually.

14. Telephone interview with the Vice President of Clinical Operations (VPCO), on 05/22/2021 at 5:14 PM, revealed she was the VPCO for Division two (2) which covered the facilities located in Kentucky. Per interview, the VPCO stated she and the Clinical Quality Specialist (CQS) reviewed the jeopardy tags and discussed education the facility would need to address the tags. She further stated she reached out to the Quality Improvement Organization (QIO) and worked with QIO to develop education/re-education materials. The VPCO stated she provided education to the Clinical Quality Specialist (CQS) to provide the plan for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 117	F 600		

educating/reeducating management staff. She further stated she came to the facility on Sunday, 05/16/2021, to help develop the Quality Improvement Plan, which would include the assessments.

Interview with the Director of Memory Support and Education, on 05/22/2021 at approximately 5:30 PM, and the Senior Director of Social Work Practice, at approximately 5:45 PM, revealed they provided education, virtually to the management team on 05/12/2021. Per interview, the education was recorded and could be used for future trainings. Further interview revealed the training addressed the resident's behaviors and potential triggers, deescalating behaviors. The Director of Memory Support and Education and the Senior Director of Social Work Practice stated the management team were provided a posttest.

Review of the attendance roster and posttests revealed the SSD, CNE, CED, NPE, Unit Managers, ADNS, and Nursing Supervisors were reeducated with one-hundred percent (100%) on the posttest by 05/12/2021.

Interview with the Unit Manager (UM), on 05/21/2021 at 2:50 PM, Nurse Practice Educator (NPE), on 05/21/2021 at approximately 4:30 PM, Social Service Director (SSD), on 05/21/2021 at 5:20 PM, Medical Director, on 05/22/2021 at 5:30, Center Executive Director (CED) and Center Nursing Executive (CNE), on 05/22/2021 at 6:30 PM, revealed they were provided education, via Zoom, to address the concerns related to the residents' behaviors and abuse. Per interview, they were provided a posttest and received one-hundred percent (100 %).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 118	F 600		

Interview with the CQS, on 05/22/2021 at 3:06 PM, revealed she reached out to the Vice President of Clinical Operations (VPCO) in regards to working with the Director of Memory Support and Education, as well as, the Senior Director of Social Work Practice, since they had experience working with residents with behaviors. Continued interview with the CQS revealed they discussed the residents, potential triggers, and de-escalating behaviors. Continued interview revealed management was provided a posttest, which she administered and signed off on.

15. Review of the Audit Tool for F600, beginning 05/14/2021, revealed Registered Nurse (RN) #14, Center Nurse Executive (CNE), and the Memory Care Support Director signed of as having completed the audits.

Interview with the Senior Rapid Response Manager/Memory Care Support Director, on 05/22/2021 at 12:09 PM, revealed she worked with the National Team and was currently the interim Memory Care Support Director. Per interview, she stated she had completed the audit tool for the residents on the Memory Care Unit. She further stated she audited Resident #31 daily for any recognized behaviors.

16. Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she completed behavioral rounds on the residents to determine if they presented with behavioral symptoms directed towards others and/or had a need for behavioral health consultation. Per interview, those residents who were identified as having behavioral concerns were referred to psych services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 119	F 600		

17. Review of the attendance roster and posttest revealed nursing staff including agency staff were educated on the facility's Behavior Management Policy and De-escalation of Challenging Situations and Behaviors: How to Respond when Dementia Causes Unpredictable Behavior with a one-hundred percent (100%) on the posttest on or before 05/19/2021. Staff not available during this time would receive the education upon the day of return to work provided by the Unit Managers or the CNE.

Interview with the CNE, on 05/22/2021 at 3:00 PM, revealed educating staff was an ongoing process and was provided the first day the employee returned to work.

Interviews with Certified Nursing Assistant (CNA) #14, on 05/21/2021 at 1:40 PM, CNA #34, on 05/21/2021 at approximately 1:43 PM, CNA #23, on 05/21/2021 at 1:45 PM, CNA #13, on 05/21/2021 at 1:45 PM, Licensed Practical Nurse (LPN) #14 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, Registered Nurse (RN) #1 on 05/21/2021 at 2:00 PM, CNA #19, on 05/21/2021 at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, CNA#36, on 05/22/2021 at 6:20 PM, and CNA #35, on 05/22/2021 at 7:05 PM, revealed they were educated on residents with behaviors, how to document the behaviors, and de-escalating the residents with the behaviors. Additionally, interviews revealed management staff provided the education.

18. Interviews with Licensed Practical Nurse (LPN) #14, on 05/21/2021 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, and Registered Nurse (RN) #1 on 05/21/2021 at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 600	Continued From page 120 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 600		
F 656 SS=J	Develop/Implement Comprehensive Care Plan 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	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 121 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the Centers for Medicare and Medicaid Services' (CMS), "Resident Assessment Instrument (RAI) Manual 3.0," it was determined the facility failed to have an effective system to develop and implement a care plan with individualized, person centered care needs related to behavior symptoms to include specific behaviors, supervision, monitoring and interventions to reduce expressions/distress, for seven (7) of eight-seven (87) sampled residents; Resident #2, Resident	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 656	Continued From page 122	F 656		

#3, Resident #12, Resident #13, Resident #21, Resident #61, and Resident #86.

1. Review for Resident #21's medical record revealed incidents on 10/28/2020, 10/25/2020, 10/10/2020, and 10/02/2020 in which Resident #21 intruded the personal space of other residents, slapped Resident #2, showed anger towards another resident, patted a resident on the face, pacing behaviors, arguments with another resident, pushing a resident down onto the floor. All incidents occurred on the Memory Care Unit (MCU).

Continued review revealed the Comprehensive Care Plan (CCP), initiated on 01/14/2020, the resident was at risk for complications related to use of psychotropic drugs with an intervention to complete behavior monitoring documentation if the resident exhibited behaviors. However, staff interviews and review of the medical record revealed discrepancies in behavior monitoring on the MAR and Progress Notes.

Additionally, there was no documented evidence a Care Plan (CP) was developed with individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the each exhibited behavior.

2. Review for Resident #61's medical record revealed on 10/02/2020, Resident #61 had a tearful, crying episode and a verbal argument with another resident, on the MCU.

Review revealed the Comprehensive Care Plan (CCP), initiated on 01/14/2020, revealed the resident was at risk for complications related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 123	F 656		

use of psychotropic drugs with an intervention to complete behavior monitoring documentation if the resident exhibited behaviors. However, staff interviews and review of the medical record revealed discrepancies in behavior monitoring on the MAR and Progress Notes.

Continued review revealed no documented evidence the Care Plan (CP) was developed with individualized resident behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the each exhibited behavior until 10/08/2020, six (6) days after the abuse; further, the CCP was not developed to include verbal behaviors directed towards others.

3. Review of Resident #86's 1:1 documentation prior to his/her room change, to the MCU, dated 03/27/2021, revealed Resident #86 exhibited behaviors such as hitting, kicking, and resistive to care; however review of the resident's care plan revealed no documented evidence the care plan was developed with person-centered individualized interventions to address the resident's behaviors. (Refer to F-600 and F-740)

The facility's failure to have an effective system in place to ensure development and implementation of the care plan with individualized person centered care needs related to behavior symptoms to include specific behaviors, supervision, monitoring and interventions to reduce expressions/distress is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 05/07/2021, and was determined to exist on 03/27/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 656	Continued From page 124	F 656		

The facility provided an acceptable Allegation of Compliance (AoC) on 05/20/2021 alleging removal of the Immediate Jeopardy on 05/20/2021. The State Survey Agency determined the Immediate Jeopardy was been removed 05/20/2021, as alleged, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes.

The findings include:

Review of the policy, Person-Centered Care Plan, revised 07/01/2019, revealed the facility developed and implemented a comprehensive, individualized care plan within seven (7) days after completion of the comprehensive assessment for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, nutrition, and mental and psychosocial needs identified in the comprehensive assessment. Additionally, the care plan would be reviewed and revised by the Interdisciplinary Team (IDT), after each assessment (quarterly and comprehensive) and as needed to reflect the response to care and changing needs and goals. Per policy, care plan review and revision assisted residents to attain or maintain the highest practicable physical, mental and psychosocial well-being, and to eliminate or mitigate triggers that may cause re-traumatization of the resident' and to promote positive communication between resident, resident representative, and the IDT to obtain the resident's input and optimize clinical outcomes. Further, the comprehensive person-centered care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 125	F 656		

plan was developed for each resident and described the services that would be furnished; services required but not provided due to the resident's right to refuse. Per policy, the resident's care plan was customized to each individual resident's preferences and needs and communicated to appropriate staff.

Review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0," dated October 2017, revealed the Comprehensive Care Plan was an interdisciplinary communication tool and must include measurable objectives and time frames and must describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI Manual stated the care plan must be reviewed and revised on an ongoing basis to reflect changes in the resident and the care the resident received.

1. Resident #21 was admitted to the facility's MCU on 01/01/2020 with a primary diagnosis of Alzheimer's Disease. Additional diagnosis included Senile Degeneration of the brain, Depressive Episodes, Anxiety Disorder, Psychotic Disorder with Delusions, Dementia without behavioral disturbance, and Adjustment Disorder. Further, the resident had a medical and financial Power of Attorney (POA).

Review of Resident #21's Comprehensive Care Plan (CCP), initiated on 01/14/2020, revealed the resident was at risk for complications related to use of psychotropic drugs. The goal was for the resident to have the smallest, most effective dose without side effects. Interventions included but were not limited to if the resident exhibited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 126	F 656		

behaviors, complete behavior monitoring documentation, dated 01/14/2020. Other interventions included to observe for changes in mental status and functional level and report to the Medical Director (MD) as indicated, dated 01/14/2020; and observe for continued need of medication as related to behaviors and mood, dated 01/14/2020.

However the facility failed to ensure individualized resident behaviors and behavior stressors were identified and specific interventions were developed to support and reduce expression/distress for the behaviors identified and documented in Resident #21's medical record. Further, the facility failed to implement the residents CCP by not completing behaviors monitoring documentation with exhibited behaviors.

Observations of Resident #21, by the State Survey Agency (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 resident rooms, with intermittent, paced ambulation. Additionally, the resident was intrusive of other resident's personal space for any residents' path he/she crossed. Review of the CCP, initiated on 01/14/2020, revealed if the resident exhibited behaviors to complete behavior monitoring documentation. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors from the noted dates and times (paced ambulation, intrusion of others personal space).

Interview with the Activities Assistant (seven

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 127	F 656		

{7}months on the MCU), on 04/22/2021 at 4:10 PM, revealed since he worked on the MCU, Resident #21 was ambulatory and paced up and down the hallways, and in the common areas continuously, most days. Additionally, he was aware the resident would become defensive towards other residents at times when their paths crossed, and he was aware Resident #21 had been physically aggressive towards others too. Continued interview 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 person centered interventions to support the resident and reduce expression/distress of the behaviors. Further, he was not familiar with Resident #21's CCP and was not aware Resident #21's had crying behaviors on this date.

Interview with CNA #2 (seven {7} months on the MCU), on 04/26/2021 at 10:45 AM, revealed since she began working on the MCU, Resident #21 walked up and down hallway, all over the MCU, all the time. Continued interview revealed she looked at the CCP as guide to know what care each resident needed. However, she was not familiar with Resident #21's CCP related to behaviors. Additionally, she was not aware of the resident's behaviors such as intrusion of personal space, or verbal or physical behaviors directed towards others. Per interview, she did not know if Resident #21's CCP specified the resident's behaviors, the resident's responses to stressors, or listed person centered interventions to support the resident and reduce expression/distress of the behaviors. Further, she did not report or document Resident #21's behavior of pacing to the nurse, because everyone knew the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 128	F 656		

did it all the time.

Interview with Registered Nurse (RN) #6 (one {1} month on the MCU), on 04/26/2021 at 2:30 PM, revealed she followed Physician's Orders and the CCP when providing care to residents. Per interview, she expected aides to report resident behaviors to her immediately so she could document and staff could intervene with interventions to support the resident's behaviors to ensure the resident received safe, quality of care. Continued interview revealed she was familiar with Resident #21's behavior of paced ambulation on the halls continuously; however, she was not aware that the resident had any behaviors such intrusion of others personal space on 04/26/2021 or any other time. Further, she was not aware of the CCP for Resident #21 that listed the resident's specific behaviors, the resident's responses to stressors, or listed person centered interventions to support the resident and reduce expression/distress of the behaviors. However, direct care nurses were responsible to ensure the CCP was implemented and accurate with changes in the resident; if the CCP was not developed to address the resident's behaviors and a behavior was identified the CCP at that time should be developed to include the behaviors and interventions.

Interview with RN #1 (four {4} months on the MCU), on 04/28/2021 at 2:30 PM, revealed the CCP was followed by the IDT to ensure each resident's individualized care needs were met. Per interview, if a CCP intervention stated if the resident exhibited behaviors to complete behavior monitoring documentation, she expected aides to report to her if they witnessed/observed a behaviors and she would mark "Yes" on the MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 129	F 656		

and make a narrative free text Progress Note about what the behavior action was. Additionally, it was important to follow the CCP and provide ongoing monitoring and documentation of resident behaviors for safety of the residents and 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 for Resident #21 on 04/28/2021. Continued interview revealed she was not aware if Resident #21 had a behavior CCP that specified the resident's specific 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 #9, (two {2} years on MCU), on 04/28/2021 at 3:11 PM, revealed she used the CCP to know what care a resident needed. Additionally, Resident #21 had aggressive behaviors towards other; the resident would grab staff's arms and squeeze them tight and the resident was defensive towards other residents when they were in his/her path. Continued interview revealed the resident would raise his /her voice, intrude other resident's personal space, and put his/her hands on others. Further, the resident walked up and down the hallway, in rooms and the common rooms all the time. However, she was not aware of the resident's CCP specifying those behaviors or listing person centered interventions to support the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 130	F 656		

when he/she was exhibiting behaviors. Per interview, she did not report behaviors observed on this date (paced ambulation and in others personal space), to the nurse because she was already aware of them.

Interview with Agency CNA #19 (two {2} years on the MCU), on 04/30/2021 at 3:30 PM, revealed the Kardex/Care Plan was a guide she used to know what care each resident needed. Per interview, Resident #21 always walked up and down the hallways and got into other peoples space since he/she was admitted to the MCU; however, CNA #19 was not aware if the resident had a CCP that specified the resident's specific behaviors or approaches to implement when he/she exhibited a behavior. Further, when behaviors occurred she reported to the nurse; but today, she did not report to the nurse that Resident #21 had walked the hallway and intruded other resident's space, all day, because all staff knew the resident had this behavior.

Further, review of the CCP, revealed no documented evidence the facility developed individualized residents' behaviors and identified behavior stressors or specific interventions to support and reduce expression/distress after the each exhibited behavior. The facility failed to implement the CCP and ensure complete behavior monitoring documentation with exhibited behaviors as evidence by the MAR and Progress Note with no documentation of behaviors (paced ambulation and intrusion of others space).

Review of the MAR, dated 04/01/2021-04/30/2021, revealed an order dated 11/06/2020, is the resident behavior free? YES or NO (if NO and behavior is present, document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 131	F 656		

type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease. Additional review revealed five (5) times in April "YES" was documented indicating a behavior was present. However, review of the Progress Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

Continued review of Resident #21's Progress Notes, dated 03/06/2021 at 12:18 PM, by LPN #30, revealed the resident displayed physical behaviors directed towards others almost daily, and verbal behaviors, directed towards others almost daily. Additionally, other behaviors, not directed towards others almost daily and wandering almost daily which posed a significant risk and was intruding on others. However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the each documented behavior on the 03/06/2021.

Review of Resident #21's MAR, for November and December,2020, and January, February and March, 2021 revealed an order dated 11/06/2020, is the resident behavior free? Continued review revealed six (6) instances in November, 2020, and eleven (11) times in December, 2020 that indicated behaviors present, however, there was no documented evidence of a behavior exhibited, the interventions, or outcomes. Review revealed thirteen (13) instances in January, 2021, six (6) incidents in February, 2021, and ten (10) incidents in March, 2021 that indicated behaviors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 132	F 656		

present, however there was no documented evidence of a behavior exhibited, the interventions, or outcomes. The facility failed to implement the CCP and ensure complete behavior monitoring documentation with exhibited behaviors.

Review of Resident #21's CCP revealed on 11/09/2020, the resident exhibited physical behaviors towards another resident. On 11/05/2020, the resident exhibited behaviors of refusal of care, throwing items, cursing and yelling at others, and wandering around the unit. The goal was for the resident to not harm self or others. The interventions included to distract the resident with frequent activities; observe the resident frequently; talk to the resident to assess his/her understanding; and redirect the resident when attempting to provide care or he/she invades others personal space. However, there was 1) no documented evidence in the Progress Notes or the MAR for the listed exhibited behaviors on 11/05/2020 and 2) no documented evidence the individualized residents' behavior stressors were identified.

Review of Resident #21's MAR, dated 10/01/2020-10/31/2020, revealed no documented evidence of behavior monitoring ordered for Resident #21. However, review of the Progress Notes in October 2020 revealed documented evidence of exhibited behaviors; however, the CCP did not reflect that the individualized residents' behaviors and residents' behavior stressors or evidence specific interventions were developed to support and reduce expression/distress.

Review of Resident #21's Progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 133	F 656		

Notes/Physician's Progress Note, dated 10/29/2020 revealed the on-call provider was notified on 10/28/2020 after hours, that the resident had aggressive behaviors and an altercations with another resident. Per the Physician's Progress Note, the aggressive behaviors were due to dementia and were resolved at the time of the assessment. There was no further documented evidence of Resident #21's aggressive behaviors with another resident in the Progress Notes for 10/28/2020.

However, review of Risk Management System (RMS) Events Summary Report, completed by LPN #34, on 10/28/2020 at 10:40 AM, revealed Resident #21 had a resident-to-resident altercation with alleged abuse. Per report, Resident #21 walked into the common room beside Resident #2 and asked the resident "what's going on in here?" Resident #2 then slapped Resident #21 in the face. Resident #21 then slapped Resident #2 in the face. Staff witnessed the altercation and immediately separated the residents.

Additional review of Resident #21's Progress Note, dated 10/25/2020 at 12:24 PM, by LPN #1, revealed the resident had three (3) red scratch marks on his/her upper chest. There was no further documented evidence of how the resident sustained the scratches in the Progress Notes.

However, review of RMS Events Summary Report, completed by LPN #38, revealed on 10/25/2020 at 4:00 AM, reveled Resident #21 had a resident-to-resident altercation with alleged abuse. Per Report, Resident #21 reported that Resident #26 scratched him/her. Additionally, LPN #38 witnessed Resident #21 walk down the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 134	F 656		

hallway and patted Resident #26 on the cheek. Resident #26 then scratched Resident #21 on his/her cheek.

Continued review of Resident #21's Progress Notes, dated 10/10/2020 at 5:39 PM, by LPN #36, revealed the resident showed anger towards his/her roommate and stated get out of my room, you don't live here, several times. The resident was immediately redirected however after several minutes became upset again with the roommate and required the roommate to be removed from the room.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the behaviors exhibited on 10/10/2020, 10/25/2020, or 10/28/2020.

Review of Resident #21's Progress Note, dated 10/09/2020 at 10:00 AM, by LPN #36, revealed the Interdisciplinary Team (IDT) discussed the resident's recent event of pushing another resident down, causing injury. The discussion was made to remove 1:1 supervision at this time, related to the resident having impaired cognition, no recollection of the event, or anger towards others.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 135	F 656		

10/09/2020.

Further review of Resident #21's CCP, initiated on 10/08/2020, six (6) days after an abuse incident (10/02/2020), revealed the resident exhibited physical behaviors towards another resident. The resident had a diagnosis of Alzheimer's Disease, Anxiety Disorder, and Psychotic Disorder. The goal was the resident would not harm him/herself or others. Interventions included but were not limited to: Distract the resident with activity based on preference, dated 10/08/2020; Observe frequently and redirect when agitated, dated 10/08/2020; and talk to the resident to assess understanding of the situation, dated 10/08/2020.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors (yelling directed at others) and behavior stressors identified or specific interventions to support and reduce expression/distress after the 10/02/2020 abuse were staff identified specific resident behaviors.

Further review of Resident #21's Progress Notes, dated 10/02/2020 at 7:09 PM, by LPN #37, revealed an aide noted the resident yelled at another resident and pushed another resident down to the ground. New interventions included 1:1 supervision.

Review of Risk Management System (RMS) Event Summary Report, completed by LPN #36, revealed on 10/02/2020 at 6:38 PM, Resident #21 had a resident-to-resident altercation with alleged abuse. Additionally, the Activities Assistant, on the MCU, witnessed Resident #21 push Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 137	F 656		

resident had the behavior all the time.

However, review of Resident #21's CCP, initiated on 01/14/2020, revealed the resident was at risk for complications related to use of psychotropic, (revised on 10/02/2020), to include resident-to-resident altercation; Resident #21 was the aggressor. Additional review revealed the intervention were revised on 10/02/2020, to include 1:1 supervision. However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the each documented behaviors of paced ambulation, wandering into other residents rooms, and verbal or physical behaviors directed towards others, until 11/09/2020, thirty-eight (38) days after the resident-to-resident abuse, on 10/02/2020. The facility also failed to implement the CCP and ensure complete behavior monitoring documentation with exhibited behaviors.

2. Resident #61 was admitted to the facility's MCU on 12/17/2019 with a primary diagnosis of unspecified Dementia without behavioral disturbance. Additionally, the resident was diagnosed with Adjustment Disorder with depressed mood, on 06/16/2020, as his/her secondary diagnosis. Further, the resident had a medical and financial POA.

Review of Resident #61's CCP, initiated on 02/27/2020, revealed the resident exhibited symptoms of psychosis related to delusions; whispering, screaming, and throwing items while in the resident room. The goal was for the resident to demonstrate increased stability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 138	F 656		

Interventions included but were not limited to: provide consistent, trusted caregivers and structured daily routine; approach the resident in a calm, unhurried manner, reassure as needed; and monitor the resident's response to medications.

Additional review of Resident #61's CCP, initiated on 09/16/2020, revealed the resident had potential for psychosocial distress related to multiple medical problems and diagnosis of: Dementia without behavior disturbance, Adjustment Disorder with depressed mood, and Major depressive disorder. The resident exhibited tearfulness, crying, irritability and wandering. The goal was for the resident to show no signs or symptoms of psychosocial distress. The interventions included but were not limited to: complete behavior monitoring documentation if behavior was exhibited; Psychological services; observe for signs and symptoms of psychosocial distress (tearfulness, crying, irritability); and Social Service visits as necessary.

Review of Resident #61's MAR, dated 10/01/2020-10/31/2020, revealed no documented evidence of behavior monitoring for Resident #61. However, review of the Progress Notes in October 2020 revealed documented evidence of exhibited behaviors such as tearfulness and crying.

Review of Resident #61's Progress Notes, dated 10/02/2021 at 5:38 PM, completed by LPN #37, revealed the resident had an altercation with Resident #21 losing his/her balance and landing on the floor.

Review of Risk Management System (RMS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 139	F 656		

Event Summary Report, completed by LPN #36, revealed on 10/02/2020 at 6:38 PM, Resident #61 had a resident-to-resident altercation with alleged abuse. Further, the Activities Assistant, on the MCU, witnessed Resident #21 and Resident #61 get into a verbal altercation and Resident #21 pushed Resident #61 to the ground.

However, there was no documented evidence of the behaviors exhibited leading up to and during the altercation, including yelling or crying, which were identified by staff who witnessed the altercation.

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 observed Resident #61 leave the dining room upset and crying. Further, the resident continued to cry in the hallway by Resident #21's doorway; however, she did not report the resident's behavior to the nurse, because it was a normal behavior that the resident had many times each day and everyone knew the resident had the behavior all the time.

Interview with Activities Assistant, 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 #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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 140	F 656		

Additionally, he was not familiar with Resident #61's CCP and was not aware he had failed to implement Resident #61's CCP by not reporting or documenting the residents behaviors. Further, on 10/02/2020 he observed Resident #61 crying and yell at Resident #21.

Further, review of Resident #61's CCP, revealed the facility failed to develop the resident's CP to include the resident-to-resident physical altercation on 10/08/2020, six (6) days after the abuse (10/02/2020). Continued review revealed the resident was pushed down by another resident which could potentially cause psychosocial distress. The resident was diagnosed with Dementia without behavior disturbance and Major Depressive Disorder. The goal was for the resident to show no signs of psychosocial distress. Interventions included but were not limited to: encourage interaction with peers; engage in his/her life in the facility; and observe for signs and symptoms of psychosocial distress (tearfulness, crying, irritability). However, there was no documented evidence the facility developed or implemented individualized residents' behaviors (yelling directed towards others) and behavior stressors identified or specific interventions to support and reduce expression/distress after the verbal altercation leading to the abuse on 10/02/2020.

Review of Resident #61's MAR, dated 04/01/2021 through 04/30/2021, revealed an order dated 09/25/2020, for "is the resident behavior free?" If behavior present (tearful, crying, irritability), document type, interventions and outcomes in Progress Notes; every day and night shift for behaviors. Additional review revealed each day 6:00 AM - 2:00 PM and 10:00 PM - 6:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 141	F 656		

"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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 142	F 656		

AM, revealed since she had worked on the MCU, Resident #61 had cried all the time. Continued review revealed she looked at the CCP as guide to know what care each resident needed. However, she was not familiar with Resident #61's CCP related to behaviors. Additionally, she was 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. Further, she did not report Resident #61's behavior of crying to the nurse, because everyone knew the resident cried all the time.

Interview with Registered Nurse (RN) #6, on 04/26/2021 at 2:30 PM, revealed she followed Physician's Orders and the CCP when providing care to residents. Per interview, she expected aides to report resident behaviors immediately to her so she could document and staff could intervene with interventions to support the resident's behaviors to ensure the resident received safe, quality of care. Continued interview revealed she was familiar with Resident #61's behavior of becoming tearful and crying intermittently every day. However, she was not aware if the resident had a CCP that specified the resident's specific behavior, the resident's responses to stressors, or listed personal centered interventions to support the resident and reduce expression/distress of the behaviors. Additional interview revealed, direct care nurses were responsible to ensure the CCP was implemented and accurate with changes in the resident; if the CCP was not developed to address the resident's behaviors and a behavior was identified the CCP at that time should be developed to include the behaviors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 143	F 656		

interventions. Further, she did not document the resident's behavior every time he/she cried or became tearful because it was so frequent. She was not aware the resident was crying at the time of the interview.

Interview with RN #1, on 04/28/2021 at 2:30 PM, revealed the CCP was followed by the IDT to ensure each resident's individualized care needs were met. Per interview, if a CCP intervention stated if the resident exhibited behaviors, complete behavior monitoring documentation, she would expect aides to report to her if they witnessed/observed a behaviors and she would mark "Yes" on the MAR and make a narrative free text Progress Note about what the behavior action was. Additionally, it was important to follow the CCP and provide ongoing monitoring and documentation of resident behaviors for safety of the residents and 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 #61 cried continuously; however, she was not aware of and had not documented any behaviors for the resident on 04/28/2021. Continued interview revealed she was not aware of Resident #21 having a behavior CCP that specified the resident's specific 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 #9, on 04/28/2021 at 3:11 PM, revealed she used the CCP to know what care a resident needed. Additionally, shortly after Resident #61 was admitted to the MCU, he/she began to have tearful crying episodes on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 144	F 656		

regular day to day basis. Per interview, the resident would cry in the middle of a meal, during activities and during care. Additionally, the resident would attempt to go to his/her room when they became tearful. However, on 04/28/2021 staff had not reported behaviors (tearful or crying), nor had she observed those behaviors. Per interview, she did not report behaviors observed on this date (paced ambulation and in others personal space), to the nurse because she was already aware of them.

Interview with Agency CNA #19, on 04/30/2021 at 3:30 PM, revealed the Kardex/Care Plan was a guide she used to know what care each resident needed. Per interview, she did not always report behaviors to the nurse because Resident #61 always cried and everyone knew the resident had this behavior. Further, she tried to console the resident and distract him/her to help stop crying; however, she was not aware if the resident had a CCP that specified the resident's specific behaviors or approaches to implement when he/she exhibited a behavior. Further, when behaviors occurred she reported to the nurse; but today, she did not report to the nurse that Resident #61 had cried on and off, all day, because all staff knew the resident had this behavior.

Interview with the Memory Care Program Director (MCPD), on 04/26/2021 at 3:00 PM, revealed she had worked at the facility as a Social Worker for one (1) year and had been the MCPD for six (6) months. Per interview, she expected the CCP to have individualized residents' behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress. Continued interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 145	F 656		

revealed it was the responsibility of the direct care nurse, to ensure the CCP was developed to include exhibited behaviors and to also ensure the CCP was implemented related to behavior monitoring and documentation of exhibited behaviors. Additionally, she was aware of Resident #61's tearfulness and crying all the time and Resident #21's paced ambulation and intrusion of other resident's space. However, she was not aware the resident had a resident-to-resident altercation or that the CCP's were not developed to include the resident's exhibited behaviors, behaviors stressors or individualized interventions. Further, she was involved in the Clinical IDT meetings which reviewed behaviors and ensured care was developed to meet the needs of the residents; however, the CCP's for Resident #21 and Resident #61 had not been developed to include individualized residents' behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress. The MCPD stated it was important to develop the CCP to include individualized behavior and interventions to ensure all staff had that information and to ensure resident safety.

Interview with the Clinical Reimbursement Coordinator (CRC), on 04/29/2021 at 3:00 PM, revealed she developed the CCP, using the Minimum Data Set (MDS) Assessments, and the direct care nurses developed the CCP between MDS Assessments for changes in a resident's status, including behaviors. Continued interview revealed she gathered information from resident observations, staff interviews and review of the medical record when she was developing the CCP. Per interview, she was not aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 146	F 656		

Resident #21 had ongoing behaviors such as paced ambulation and intrusion of other residents space. Additionally she was not aware Resident #21 had been involved in resident-to-resident altercations as the aggressor and victim or had verbal and physical behaviors directed towards others. Continued interview revealed she was not aware Resident #61 had daily episodes of tearfulness and crying or had been involved in a resident-to-resident altercation and had verbal behaviors directed towards others. Further, the CRC stated the CCP should be an accurate reflection of individualized resident-centered care needs to ensure quality care and safety; and, the CCP should have been developed to include individualized residents' behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress.

Interview with the in facility Physician, on 05/05/2021 at 2:10 PM, revealed residents should have a CCP developed to include individualized resident behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress. Additionally, residents should receive behavior care and services through collaboration of the IDT per the CCP. Further, she expected direct care nurses and aides to identify, document, implement action, and report behaviors exhibited by residents consistently.

Interview with the facility contracted Psychiatrist, on 05/05/2021 at 4:22 PM, revealed he expected facility nursing staff to develop and implement a CCP to include individualized resident behaviors and behavior stressors identified and specific interventions developed to support and reduce

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 147	F 656		

expression/distress, for residents with behaviors. Further interview revealed the Psychiatrist expected the facility staff to have knowledge of the resident's behaviors and habits and to ensure they knew how to intervene and implement interventions to support the residents when they were exhibiting behaviors.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 AM, revealed the MDS Nurse was responsible to develop and revise the CCP with the MDS Assessment, and the direct care nurses were responsible to develop and implement the CCP with any changes in a resident's status, behaviors, between MDS Assessments. Per interview, the CCP should be updated/developed on the same day a change in the resident's status was noted. The CNE stated when Resident #21 and Resident #61 exhibited behaviors, the Care Plan should have been updated/developed to include individualized residents' behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress. Further interview with the CNE revealed the CCPs should have been implemented to include consistent complete behavior monitoring documentation each time the residents exhibited and staff identified behaviors, per the CCP.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed the MDS Nurse was responsible for developing and revising the CCP with the MDS Assessments, and all nurses were responsible for updating/revising the care plan with or with changes in the resident's condition, status, or behaviors, between MDS Assessments. Additionally, the CCP should be developed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 148	F 656		

include individualized resident behaviors and behavior stressors identified and specific interventions developed to support and reduce expression/distress; this ensured staff knew how to provide necessary care for the individualized resident. Continued interview revealed Resident #21 and Resident #61's CCP should have been developed to include all exhibited behaviors. Further, he stated direct care nurses should have implemented the CCP and documented behaviors each resident exhibited. Further, the CED stated if the IDT had been informed of Resident #21 and Resident #61's ongoing behaviors, it would have triggered implementation of interventions related to behaviors, reduce the risk or prevent behaviors.

3. The facility admitted Resident #86 on 03/19/2021 with diagnoses to include Dementia without Behaviors, Parkinson's disease, Muscle Weakness, Hallucinations and Repeated Falls. Further review revealed Resident #86 was placed on 1:1 supervision due to repeated falls.

Review of the Minimum Data Set (MDS), dated 03/25/2021, revealed Resident #86 was not assessed for a Brief Interview for Mental status (BIMS). Continued review revealed he/she exhibited no behaviors at the time of assessment. Continued review of the MDS revealed the facility administered to Resident #86 antipsychotics for seven of seven (7/7) days during the assessment period. Further review revealed he/she had active diagnoses of Non-Alzheimer's Dementia and Parkinson's disease.

Review of progress notes, dated 03/25/2021 at 2:30 AM, revealed Resident #86 was attempting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 149	F 656		

to get out of bed and was unable to be redirected. Continued review of the progress notes, dated 04/22/2021 at 3:37 AM, revealed Resident #86 was wandering the hall and exit seeking, was unable to be redirected and became agitated, and was noted to be banging on the unit door.

Review of the 1:1 documentation, dated 03/27/2021, revealed Resident #86 exhibited behaviors such as hitting, kicking, and was resistive to care at 1:00 AM, 1:30 AM, 2:00 AM, 2:30 AM, 3:00 AM, 3:30 AM, and 5:30 AM. Further review revealed on 04/06/2021 at 10:00 AM, Resident #86 exhibited behaviors such as screaming/disruptive sounds.

Review of the care plan, dated 03/22/2021, revealed no care plan developed regarding behaviors of aggression and agitation. Continued review revealed the resident had impaired thought processes related to Dementia with interventions to include redirection, personalize Resident #86 room with familiar items, create a calm/smoothing environment, and speak in a normal-toned voice.

Review of Resident #86's Physician's orders, dated 03/25/2021, revealed an order for Carbidopa-Levodopa twenty-five-one hundred (25-100) milligrams (mg) three (3) times a day for Parkinson's, Aricept ten (10) mg daily for Dementia, Seroquel twenty-five (25) mg at bedtime for mood conditions, and Xarelto fifteen (15) mg for prevention of blood clots.

Interview with the Clinical Reimbursement Coordinator (CRC), on 05/12/2021 at 4:21 PM, revealed nursing staff had access to the care plan, and nursing had the ability to develop a care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 150	F 656		

plan at any time. She revealed it was important to develop care plans on identified concerns so the staff can properly care for the residents. Further interview revealed the IDT did not discuss developing a care plan for behaviors related to Resident #86. She revealed the IDT was not aware of any behaviors prior to his/her altercation with Resident #85. She revealed Resident #86's care plan should have been developed but was unsure why it was not and she was responsible for doing that.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed the CRC was responsible for developing and updating the care plan using the MDS Assessment, and the staff nurses were responsible for developing and updating the care plans with any changes in resident conditions between MDS assessments. Continued interview revealed the care plan should be updated on the same day that the changes were identified. Further interview revealed when Resident #86 exhibited aggression and resistance to care, the staff nurses should have developed a care plan addressing those behaviors.

Interview with the CED, on 05/11/2021 at 3:25 PM, revealed the CRC was responsible for developing the care plan with the MDS Assessment and all staff nurses were responsible for developing the care plan with changes to the resident's status between MDS assessments. Further interview revealed Resident #86's care plan should have been developed to address concerns with his/her behaviors of aggression and resistance to care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 151	F 656		

4. Record review revealed on 01/22/2021 at approximately at 10:56 AM, while walking down the hall on the Memory Care Unit (MCU), Resident slapped Resident #3 on the face. Resident #2 was on one to one (1:1) supervision at the time of the incident and Sitter #1 was walking behind Resident #2. Sitter #2 stated she grabbed Resident #2's hand and called for staff assistance.

Review of the clinical record revealed the facility admitted Resident #2 on 08/31/2020 to the Memory Care Unit (MCU) with diagnoses to include Bipolar Disorder, Frontotemporal Dementia, and Psychotic Disorder with Delusions.

Review of Physician Orders, dated 08/31/2021 through 11/21/2020, revealed the facility psychiatrist prescribed Resident #2 Risperdal twenty-five (25) milligrams (mg) intramuscular injection every two (2) weeks for Schizophrenia, staff to monitor resident and document behaviors and side effects related to the administration of psychotropic medications.

Review of Resident #2's Comprehensive Minimum Data Set (MDS), dated 01/09/2021, revealed severely impaired cognitive skills for daily decision making; a Brief Interview of Mental Status (BIMS) was not assessed. The facility assessed Resident #2 for behaviors to include rejection of care one (1) to three (3) days a week and wandering that occurred four (4) to six (6) days a week.

Review of Resident #2's Care Plan, initiated on 08/31/2020, revealed interventions for 1:1 supervision initiated on 10/28/2020 and an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 152	F 656		

intervention was initiated on 11/21/2020 to redirect resident away from residents, and staff to provide a safe distance between the resident and others residents on the unit.

Observation of Resident #2, on 04/14/2021 at 11:08 AM, revealed resident sitting in a chair in the common area, clapping at times, and tremors observed of both arms.

Interview with Sitter #1, on 04/19/2021 at 4:00 PM, revealed she was aware Resident #2 had a history of hitting other residents and staff. She stated before the incident on 01/22/2021 she did not have any warning Resident #2's was going to slap Resident #3. Sitter #1 stated Registered Nurse #3 educated her to avoid walking behind the Resident #2 but instead beside or in front of him/her. She stated the care plan provided directions for care provided to the residents such as safety interventions and failure to follow interventions could result in an injury.

Interview with Registered Nurse (RN) #1, on 04/23/2021 at 1:35 PM, revealed the care plan included interventions to keep the resident safe and when the care plan was not followed, it interfered with resident safety.

Interview with the MDS Coordinator, on 04/26/2021 at 2:05 PM, revealed the nurses and CNA's utilized the care plan to provide safe resident care. The care CNA Kardex (included information for the level assistance needed to provide care) was populated by information from the care plan.

Interview with the Nurse Practice Educator (NPE), on 04/26/2021 at 2:34 PM, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 153	F 656		

following the care plan was important ensure the highest level of function for the residents and provided individualized interventions for the concern or problem identified.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed not following the care plan could result in a resident not getting the proper care. The CNE stated the sitter did not keep Resident #2 away from others and walking behind Resident #2 was not effective in monitoring his/her behaviors. She stated Sitter #1 was re-educated on 01/22/2021 to redirect Resident #2 or redirect the other residents away from Resident #2 and walk beside or in front of resident.

Interview with the Center Executive Director (CED), on 04/30/2021 at 3:12 PM, revealed the care plan identified the focus or problem and how the clinical team could provide the best care. He stated resident care would suffer and not receive the proper care without proper care plan implementation.

5. Record review revealed on 03/09/2021, Resident #2 was in the MCU common area and hit Residents #19, #25, and #26. Staff removed Resident #2 from the area and the nurse assessed Residents #19, #25, and #26 with no injuries noted. The facility placed Resident #2 on 1:1 supervision.

Review of the clinical record revealed the facility admitted Resident #2 on 08/31/2020 to the MCU with diagnoses to include Frontotemporal Dementia, Bipolar Disorder, and Psychotic Disorder with Delusions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 154	F 656		

Review of Physician Orders, dated 01/01/2021 through 03/09/2021, revealed the Resident was ordered Geodon ten (10) mg intramuscular injection daily for Schizophrenia on 01/29/2021 and Aricept five (5) mg daily for Dementia was ordered on 02/17/2021.

Review of Resident #2's Care Plan, initiated on 08/31/2020, revealed an intervention initiated on 11/21/2020 that included for staff to redirect resident away from residents, and to provide a safe distance between the resident and the other residents.

Review of the Progress Notes, dated 02/24/2021, revealed the 1:1 supervision was discontinued due to the absence of Resident #2's behaviors.

Review of Resident #2's Comprehensive MDS, dated 01/09/2021, revealed a BIMS was not assessed and the resident was assessed as severely impaired cognitive skills for daily decision making. The facility assessed Resident #2 for behaviors to include wandering that occurred four (4) to six (6) days of the week and rejection of care one (1) to three (3) days a week.

Review of the clinical record revealed the facility admitted Resident #19 on 05/01/2018 with diagnoses to include Alzheimer's Disease and Vascular Dementia with Behavioral Disturbance.

Review of Resident #19's Comprehensive MDS, dated 03/18/2021, revealed a BIMS score of three (3), which indicated severe cognitive impairment and no behaviors.

Review of the Progress Notes, dated 03/09/2021,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 155	F 656		

revealed Resident #19 was hit on the arm, the nurse assessed for injuries, and slight redness of his/her arm was noted.

Record review revealed the facility admitted Resident #25 to the MCU, on 06/27/2018, with diagnoses to include Dementia with Behaviors, Alzheimer's Disease, and Psychotic Disorder with Delusions.

Review of the Progress Notes, dated 03/09/2021, revealed Resident #2 walked up to Resident #25 and smacked his/her arm. The nurse assessed Resident #25 on 03/09/2021 with no serious injuries and some redness was noted to his/her arm.

Review of the clinical record revealed the facility admitted Resident #26 to the Memory Care Unit, on 03/11/2013, with diagnoses to include Hemiplegia, Hemiparesis, Vascular Dementia, Visual Loss, and Aphasia.

Review of the Quarterly MDS, dated 02/18/2021, revealed Resident #26's BIMS score was three (3), which indicated severe cognitive impairment and no behaviors were present.

Observation of Resident #2, on 04/15/2021 at 2:44 PM, revealed resident sitting on side of bed in his/her room. Observed 1:1 sitter at bedside.

Interview with Certified Nurse Assistant (CAN) #9, on 04/19/2021 at 3:02 PM, revealed she observed Resident #2 walk past and hit Residents #19, #25, and #26. She stated Resident #2 did not have a sitter on the same day before the incident. CNA #9 stated the care plan provided information regarding behaviors and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 156	F 656		

assisted staff in providing care.

Attempted to contact the MCU nurse, on 05/01/2021 at 10:00 AM and on 05/03/2021 at 9:01 AM, who worked on 03/09/2021.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed the MCU staff separated the residents on 03/09/2021. She stated the staff tried to socially distance Resident #2 from the other residents as per his/her care plan, but Resident #2 was quick in his/her actions as he/she walked past and slapped Residents #19, #25, and #26. She stated the care plan was revised to include 1:1 supervision for safety.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed the staff following the care plan ensured the proper treatment of the residents. He stated Resident #2 had behaviors that were unpredictable. The CED stated the IDT members discussed incidents and brainstormed for new interventions for Resident #2.

6. Record review revealed on 03/10/2021 at approximately 12:56 PM, Resident #2 slapped Resident #3 on the face while in the MCU hallway. Resident #2 was removed from the area. The MCU nurse assessed Resident #3 with a red face after the incident. Resident #2 was then provided 1:1 supervision.

Review of the clinical record revealed the facility admitted Resident #2 on 08/31/2020 to the MCU with diagnoses to include Frontotemporal Dementia, Bipolar Disorder, and Psychotic Disorder with Delusions.

Review of Resident #2's Physician Orders, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 157	F 656		

03/10/2021, revealed orders that included Geodon ten (10) mg daily for three (3) days as needed for agitation and Aricept five (5) mg daily for Dementia.

Review of Resident #2's Care Plan, initiated on 08/31/2020, revealed new interventions dated 03/10/2021 for 1:1 supervision and staff to redirect resident away from other residents or redirect other residents away from him/her.

Review of Resident #2's Comprehensive MDS, dated 01/09/2021, revealed an assessment of severely impaired cognitive skills in daily decision-making. The facility assessed Resident #2 for behaviors that included wandering four (4) to six (6) days of the week and rejection of care one (1) to three (3) days of the week.

Record review revealed the facility admitted Resident #3, on 01/20/2021 to the MCU, with diagnoses to include Dementia with Behavioral Disturbance and Psychotic Disorder with Delusions.

Review of the Comprehensive MDS, dated 01/27/2021, revealed Resident #3 had a BIMS score of five (5), which indicated severe cognitive impairment and physical behaviors directed towards others.

Observed Resident #2, on 04/20/2021 at 9:35 AM, sitting in the common area with the television on and the 1:1 sitter in the next chair.

Attempted to contact the assigned MCU nurse for 03/10/2021, on 05/01/2021 at 10:00 AM and on 05/03/2021 at 9:01 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 158	F 656		

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed the facility updated the care plan to include 1:1 supervision and the facility consulted the psychiatrist. She stated Resident #1 was not redirected from other residents on 03/10/2021, as he/she was not on 1:1 supervision at the time of the incident therefore a safe distance from other residents was not implemented.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed by not following the care plan, resident care suffered and not provided the proper care.

7. Record review revealed on 03/24/2021 at approximately 4:00 PM, Resident #2 slapped Resident #21 on his/her left arm. The residents were separated, the nurse assessed Resident #21, and no injuries were noted.

Review of Resident #2's clinical record revealed the facility admitted resident on 08/31/2020 with diagnoses to include Frontotemporal Dementia, Psychotic Disorder with Delusions and Bipolar Disorder.

Review of Resident #2's Physician Orders, revealed orders dated 03/10/2021 for Aricept ten (10) mg daily for Dementia and Geodon twenty (20) mg twice daily for anxiety, and Ativan (medication to treat anxiety) zero point five (0.5) mg every six (6) hours as needed for Anxiety.

Review of Resident #2's Care Plan, initiated on 08/31/2020, revealed on 03/12/2021 an intervention for medication review by the psychiatrist, encourage resident to return to room to calm for aggressive or behaviors, offer resident a snack if he/she exhibits agitation, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 159	F 656		

redirection of resident from other residents to maintain a safe distance.

Review of Resident #2's Comprehensive Minimum Data Set, dated 01/09/2021, revealed Resident had severely impaired cognitive skills in daily decision-making. The facility assessed Resident #2 for behaviors that included wandering four (4) to six (6) days of the week and rejection of care one (1) to three (3) days of the week.

Review of the clinical record revealed the facility admitted Resident #21 on 01/01/2020 with diagnoses to include Alzheimer's Disease, Dementia without Behavioral Disturbance, Psychotic Disorder with Delusions, and Anxiety Disorder.

Review of Resident #21's Quarterly MDS, dated 10/18/2020, revealed a BIMS score of three (3), which indicated severe cognitive impairment, was able to communicate with others, and revealed no behaviors.

Observation of Resident #2, on 04/14/2021 at 11:08 AM, revealed resident in the common area, clapping, sitting, and walking around with the sitter next to him/her.

Interview with CNA # 15 on 04/20/2021 at 11:21 AM, revealed she provided 1:1 observation to Resident #2 after the incident and was instructed to make sure he/she did not hit anyone.

Attempted to contact the nurse assigned to MCU, on 04/20/2022 at 11:25 PM, but was unable to leave a message.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 160	F 656		

Interview with CNA # 15 on 04/20/2021 at 11:21 AM, revealed she provided 1:1 observation for Resident #2 after the incident and was instructed to make sure Resident #2 did not hit anyone.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed the assigned MCU nurse was not witness to the incident and CNA #15 on 03/24/2021 was not a regularly scheduled sitter for Resident #2, but was informed of his/her behaviors. The sitter was expected to provide a barrier with her body between Resident #2 and other residents.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed the care plan directed facility staff to act as a barrier between Resident #2 and others to prevent the resident from coming in contact with others.

8. Observation of Resident #2, on 04/14/2021 at 1:48 PM, revealed resident sitting on side of bed with tremors/repetitive movement of both arms that interfered with his/her ability to feed self. There was no documentation of the tremors or functional status change, even though MCU staff were aware of the changes. In addition, there was no documentation for notification to the facility Physician or the facility Psychiatrist regarding the tremors.

Review of the clinical record revealed the facility admitted Resident #2 on 08/31/2020 with diagnoses to include Bipolar Disorder, Psychotic Disorder with Delusions, and Frontotemporal Dementia.

Review of the Physician Orders, dated 03/01/2021 through 04/14/2021, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 161	F 656		

Resident #2 had a periodic dose increase of Geodon from ten (10) mg daily to sixty (60) mg in the morning and forty (40) mg at night ordered on 04/01/2021. Further order review revealed orders for staff to monitor resident twice daily for behaviors and side effects related to psychotropic medications with documentation of behaviors/side effects in the medical record.

Review of the Medication Administration Record (MAR), dated 04/14/2021, revealed facility documented no side effects or behaviors for the month of April.

Review of the Progress Notes, dated April 2021, revealed no documentation of arm tremors or a change in Resident #2's functional status or ability to feed self.

Observation of Resident #2, on 04/14/2021 at 1:48 PM, revealed resident sitting on the side of bed with constant tremors/arm movements of both arms. An additional observation, on 04/19/2021 at 3:28 PM, revealed Resident #2 with tremors of both arms.

Interview with CNA #2, on 04/15/2021 at 8:30 AM, revealed Resident#2 had developed shaking in his/her arms that interfered with his/her ability to feed self. She stated the shaking of his/her arms had gradually gotten worse and the nurse and the doctor were aware of her concerns.

Interview with RN #1, on 04/23/2021 at 8:45 AM, revealed she notified the Medical Doctor approximately one (1) week ago regarding Resident #2's arm tremors. She stated the tremors gradually got worse each week. RN#1 stated she had informed the Medical Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 162	F 656		

who made rounds for the Psychiatrist about two (2) weeks ago. She stated the MA observed the resident's tremors and the MA informed her she would notify the Psychiatrist.

Interview with CNA #21, on 04/23/2021 at 1:45 PM, revealed she was present in Resident #2's room when RN#1 brought the psychiatrist's MA into the room to have her observe the arm tremors.

Interview with Licensed Practical Nurse (LPN) #7, on 04/20/2021 at 1:56 PM, revealed she observed the arm tremors and thought it might be caused by the Geodon. LPN #7 stated she notified the physician and received instructions to continue monitoring for the development of additional symptoms. LPN #7 stated she thought the Geodon was causing the tremors.

Interview with the consulting Pharmacist, on 04/22/2021 at 1:49 PM, revealed staff monitored the residents side effects related to psychotropic medications to ensure the lowest effective dose, least amount of side effects, and assisted with the progression of the treatment. She stated side effects for staff to monitor for related to Geodon included movement disorders and over sedation. The Pharmacist stated facility staff had not contacted her Resident #2's Geodon and arm tremors.

Interview with the facility Physician, on 04/21/2021 at 10:03 AM, revealed she was not aware of Resident #2's arm tremors until the ADNS and the CNE notified her on 04/20/2021. She stated she was not aware of Resident #2's arm tremors and difficulty feeding self. The Medical Physician stated her assessment of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 163	F 656		

Resident #1 on 04/20/2021 revealed pronounced arm tremors. She stated she thought the tremors was a symptom of EPS (abnormal side effects such as tremors, slurred speech, muscle restless/inability to keep still, and muscle spasm/abnormal posture related to improper dosing or unusual reactions to antipsychotic medications); she put the medication on hold and informed the nurse to contact the facility Psychiatrist.

Interview with the facility Psychiatrist, on 04/22/2021 at 2:44 PM, revealed the side effects to monitor for Geodon included symptoms of EPS and tremors. He stated the nursing staff had not notified him of Resident #2's arm tremors or his/her change in ability to feed self until 04/21/2021. The Psychiatrist stated he had not assessed Resident #2's response to the recent dose adjustments.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed MCU nurses had not followed Resident #2's care plan by failing to document his/her arm tremors and documentation for medical provider notifications regarding symptoms.

Interview with the CED, on 04/29/2021 at 3:12 PM, revealed failing to implement the care plan could result in the omission of proper care.

9. Review of the facility's Psychotropic Medication Use Policy, revised 11/28/2016, revealed psychotropic medications included any medication that affected the mental processes and behaviors. The policy revealed the facility utilized psychotropic medications with appropriate diagnoses and only after non-medication and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 164	F 656		

medication therapies failed to address behaviors. The policy revealed medications used to treat behaviors included monitoring for risks, benefit, effectiveness, and harm or adverse effects.

Review of the clinical record revealed the facility admitted Resident #3 to the MCU on 01/20/2021 with diagnoses to include Psychotic Disorder with Delusions and Dementia with Behavioral Disturbance.

Review of the Medication Administration Record (MAR), dated 02/01/2021 through 04/15/2021, revealed behavior monitoring every shift and documentation in the nurse's notes with the behaviors observed by staff. The MAR revealed Resident #3 had been free from behaviors.

Review of Resident #3's Physician Orders, dated 02/01/2021 through 04/15/2021, revealed the resident was prescribed Aricept ten (10) mg daily (medication to treat Dementia), Risperdal one (1) mg at bedtime (medication to treat Psychotic Disorders), and Trazadone fifty (50) mg twice daily (for treatment of Psychosis). Further order review revealed an order to monitor resident for behaviors every shift with documentation of behaviors in the nurse's note.

Review of Resident #3's Comprehensive MDS, dated 01/27/2021, revealed a BIMS score of five (5), which indicated severe cognitive impairment and physical behaviors directed towards others. The assessment revealed the resident had received seven (7) days of antipsychotic and seven (7) days of antidepressant medications.

Review of the Care Plan, initiated on 01/21/2021, revealed psychotropic medication interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 165	F 656		

that included monitoring for side effects, behaviors, and changes in mental status or functional level.

Observations of Resident #3, on 04/14/2021 at 1:58 PM and on 04/15/2021 at 2:45 PM, revealed resident appropriately dressed, well groomed, and walking down the hall with another resident.

Attempted to interview Resident #3, on 04/14/2021 at 1:58 PM, revealed resident was alert to person with confusion about time and place.

Interview with RN #1, on 04/23/2021 at 1:35 PM, revealed the care plan provided direction for individualized resident care to ensure physical safety, interventions related to medications such as monitoring for side effects, and behavior issues. She stated staff followed the care plan to ensure resident safety.

Interview with RN #6, on 04/22/2021 at 10:48 AM, revealed staff monitored residents over- sedation and symptoms of EPS with antipsychotic medication administration. Additional interview with RN #6, on 05/20/2021 at 10:39 AM, revealed it was the nurse's responsibility to initiate the orders to monitor the resident for behaviors and side effects with a new order for psychotropic medications.

Interview with Licensed Practical Nurse (LPN) #24, on 04/24/20221 at 3:30 PM, revealed the care plan ensured resident safety and monitoring of psychotropic medications. She stated the MAR included an order for staff to monitor for behaviors and side effects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 166	F 656		

Interview with the consulting Pharmacist, on 04/22/2021 at 1:49 PM, revealed staff monitored for psychotropic medication side effects to assess for the lowest possible dose and evaluate response to the medication.

Interview with the NPE, on 05/20/2021at 10:45 PM, revealed nurse orientation did not include specific education for psychotropic medications/side effects. She stated the new employees received that information from his/her preceptor.

Interview with the MDS Coordinator, on 04/26/2021 at 2:05 PM, revealed monitoring for psychotropic side effects was in the care plan and assisted the provider regarding the effectiveness of the treatment. She stated the orders for behavior and side effect monitoring were standing orders initiated by the staff nurses.

Interview with the CNE, on 04/29/2021 at 9:17 AM, revealed the care plan ensured the resident was properly cared for and areas not included on the care plan resulted in omission of resident care. She stated the nurses or staff on the IDT entered the standing orders for behavior and side effect monitoring to ensure staff assessed and it was included on the care plan.

Interview with the CED, on 04/30/202 at 3:12 PM, revealed the nurses and staff on the clinical team had access to the care plans. He stated the IDT during their daily meetings reviewed new orders to ensure intervention implementation on the care plan.

10. Interview with Licensed Practical Nurse (LPN) #25, on 04/22/2021 at 11:10 AM, revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 167	F 656		

witnessed Resident #12 and #13 in bed together. She reported she removed Resident #13 and took resident to the nurse on duty. LPN #25 reported she was informed that the residents were allowed to be in bed together because the family approved it. LPN #25 believed this happened some time in February 2021. She also revealed, Memory Care Unit (MCU) residents required constant supervision and should never be allowed in the opposite sex's room.

Observation on 04/26/2021 at 8:45 AM, revealed Resident #12 in Resident #13's room. They were seated faced toward the window partially behind the privacy curtain. Resident #12 was in his/her wheelchair and Resident #13 was seated in a chair. Interview with Certified Nurse Assistant (CNA) #13, at the time of observation, revealed it was okay for them to be in the room.

Interview with Certified Nurse Assistant (CNA), on 04/21/2021 at 7:20 PM, revealed Resident #13 was the aggressor. Resident would constantly follow Resident #12, blow kisses, tried to enter his/her room. She also revealed Resident #13 required constant supervision and did not know why he/she was not care planned for it.

Record review revealed the facility admitted Resident #13 on 09/10/2019 with diagnosis of Dementia with behaviors, Psychotic disorder with delusions, Transient Ischemic Attack (TIA), Hypothyroidism, Hypertension, and Osteoporosis.

Review of Resident #13's MDS, dated 10/23/2020, revealed resident had a BIMS of two (2) out of fifteen (15) indicating severe cognitive impairment. The resident required extensive assist with the physical assistance of one (1) staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 168	F 656		

for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #13 required supervision with the physical assistance of one (1) staff to walk in the room, walk in the corridor, locomotion on/off unit and for eating, and the resident was mobile with a walker only. No behaviors noted.

Review of Resident #13's Care Plan revealed the facility created a focus on 10/19/2020 and revised on 10/29/2020 where resident had the potential for psychosocial distress related to an incident where a male resident gave a resident a kiss on the lips. The resident had a diagnosis of Dementia, Major Depressive Disorder and Psychotic Disorder. The goal for this focus was resident will show no signs of psychosocial distress daily thru next review. Interventions were listed as resolved on 10/26/2020 and included encourage activities of choice, meals in dining room and interaction with peers, mental health/Psychiatric services as needed and observe for signs or symptoms of psychosocial distress (tearfulness, crying, etc.).

Continued review of Resident #13's Care Plan revealed the facility created a focus area on 10/19/2020 the resident had the tendency to exhibit sexual expression. The goal was resident will demonstrate effective coping skills related to sexually inappropriate behavior, giving a kiss to a male resident, redirect self to alternative activity. The interventions created 10/19/2020 were listed as, will not demonstrate any signs of psychosocial distress (tearfulness, crying, irritability, etc.), evaluate need for Psych/Behavioral Health Consult, Social Services visits as needed, divert resident by giving alternative objects or activities, and try to keep resident calm. Additionally,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 169	F 656		

resident was to be removed from the environment as needed.

Review of the resident record revealed the facility admitted resident #12 on 02/06/2020 with diagnosis of Non-traumatic Intracerebral Hemorrhage, Dementia without behaviors, Arterial Fibrillation, Hypertension, Congestive Heart Failure, and Adjustment disorder.

Review of Resident #12's Minimum Data Set (MDS), dated 10/07/2020, revealed the facility assessed the resident with a BIMS score of five (5) out of fifteen (15), indicating severe cognitive impairment. The facility assessed the Resident to need supervision and physical assist of one (1) staff for bed mobility independent for locomotion on/off unit, and to eat with set up only needed by staff. Additionally, the facility assessed the Resident for limited assistance with physical assistance of one (1) staff for transfer, to walk in room, to dress, to toilet, and for personal hygiene.

Review of Resident #12's Care Plan revealed resident had a focus area the resident had the tendency to exhibit sexual expression, related to cognitive loss/dementia, resident noted to kiss another resident a peck kiss on the lips, created 10/19/2020 and revised 11/05/2020. The goal listed for this focus was the resident will demonstrate effective coping skills related to sexually inappropriate behavior kissing another resident to alternate activity or location thru next review, created 10/19/2020 and revised 10/27/2020. The interventions listed were the resident will not demonstrate any signs of psychosocial distress, allow time for expression of feelings, provide empathy, encouragement, and reassurance, social services visits to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 170	F 656		

support as needed, divert resident with alternative objects or activities, listen to resident and try to calm, and resident on 1:1 supervision, created 10/19/2020 and revised 11/16/2020.

Interview with Resident #12's Power Of Attorney (POA), on 04/26/2021 at 7:20 PM, revealed the facility contacted him to ask if it was okay for his family member to have a relationship with another resident. The POA revealed he informed the facility it was not okay because Resident #12 was still married and because the resident had Dementia.

Interview with CNA #14, on 04/24/2021 at 9:25 AM, revealed she witnessed Resident #12 and Resident #13 in bed together, on top of the blankets and fully clothed. CNA #14 stated the residents were not supposed to be in each other's room. Resident #12 was placed on 1:1 supervision after this incident. CNA #14 also revealed both residents should have been on continuous supervision once Resident #12's 1:1 ended to ensure they both remained safe.

Interview with Activities Assistant (AA), on 04/23/2021 at 1:50 PM, revealed staff tried to keep all residents in the common area so they could be supervised. He reported Resident #12 and Resident #13 thought of themselves as a couple. He also revealed Memory Care residents should not be in the rooms of residents of the opposite sex.

Interview with Memory Care Program Director (MCPD), on 04/20/2021 at 9:30 AM, revealed concerns of residents in Memory Care having a relationship was new to her and staff. This issue had not arisen prior to Resident #12 and Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 171	F 656		

#13 since she had worked in Memory Care. When MCPD was informed Resident #12 was in Resident #13's room on 04/26/2021, she revealed the residents should not have been in a resident's room and it would have been more appropriate for them to be in the common area so constant supervision could be provided. However, MCPD revealed there were not enough staff to get Resident #13 out of the room because he/she required two (2) staff and there were only two (2) aides and one (1) nurse on the unit. She also revealed all of the Memory Care residents required constant supervision.

Interview with CNA #9, on 04/22/2021 at 4:00 PM, revealed Resident #13 always wanted to be with Resident #12 and that did not stop after Resident #12 was taken off of 1:1 supervision. Resident #13 continued to try to enter Resident #12's room, still tried to get in Resident #12's bed. She revealed once 1:1 supervision was stopped for Resident #12, staff should have continued closer supervision of these two residents. Staff should have kept residents in the common area as much as possible. CNA #9 revealed she did not recall anything on the care plan about supervision.

Interview with Social Service Director (SSD), on 04/20/2021 at 10:10 AM, revealed she did not provide services for the MCU. She did state residents who are cognitively impaired could not consent for themselves and any resident in MCU who tried to have a relationship with another should be kept apart. She revealed it would be important to keep them on different sides at activities and different ends of the hall for rooms. She also revealed the care plan should have been developed to reflect such.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 172	F 656		

Interview with Center Nurse Executive (CNE), on 05/04/2021 at 3:45 PM, revealed Resident #12 and Resident #13 were cognitively impaired and could not decide anything for themselves. She also revealed she expected residents to be in the common area as much as possible because they required lots of direction and supervision. The CNE also reported changes were not made to the Care Plan to remove sexually inappropriate behaviors because she still wanted the residents to be monitored. However, there were no additional interventions developed to account for continued supervision of these two residents.

Interview with Center Executive Director (CED), on 05/04/2021 at 3:45 PM, revealed if Memory Care residents shared a kiss there would be concerns because one of the residents could have related it to a family relationship. He revealed the facility is responsible to protect residents. The CED revealed he did not feel comfortable with any resident in the MCU, "having a relationship" and supervision was a big part of prevention.
Review of the IJ Removal Plan revealed the facility implemented the following:

1. On 05/17/2021, the Center Executive Director (CED), and Center Nurse Executive (CNE), notified the Medical Director of the alleged event. An ad Hoc Quality Assurance Performance Improvement Committee (QAPI) meeting was conducted with the CED, CNE, and Medical Director at this time for recommendations developing the action plan including audits, reeducation, and compliance monitors for residents at risk for abuse/neglect.

2. On or before 05/19/2021, Resident #21's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 173	F 656		

plan focus was updated by a Registered Nurse (RN) to include the specific physical behavior, intrusion of other resident's personal space, pacing the hallway, yelling at another resident, shoving another resident, and wandering into other residents rooms and the interventions were updated to support the residents to reduce expression/distress of the behaviors identified, including physical behavior, intrusion of other resident's personal space, pacing the hallway, yelling at another resident, shoving another resident, and wandering into other resident's rooms.

3. On or before 05/19/2021, Resident #2's care plan was updated by an RN to include providing a safe distance from other residents, one on one supervision, removing the resident from the situation, and for staff to provide a safe distance from other residents.

4. On or before 05/19/2021, Resident #61 was reassessed by a RN for behaviors and documentation was updated to reflect any behaviors that was exhibited, including crying.

5. On or before 05/19/2021, Resident #86 was reassessed for behaviors by a RN including physical aggression and resistance to care and documentation was updated to reflect any behaviors that were exhibited. The IDT discussed the resident's behaviors including physical aggression and resistance to care and a care plan was implemented for his/her behaviors including physical aggression and resistance to care.

6. On or before 05/19/2021, the Social Services Director (SSD), Social Worker, Center Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 174	F 656		

Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Nurse Practice Educator (NPE), and or Licensed Nurses (LN) would conduct an audit of resident's care plans presenting with behaviors to include signs of frustration, agitation, and anger such as physical or verbal behavioral symptoms directed toward others to determine care plans were developed with specific interventions and implemented addressing the behavior with corrective action upon discovery.

7. The Clinical Quality Specialist (CQS) provided education to the CNE regarding the policy that the facility must develop and implement a person centered plan of care for all residents to include residents with behaviors directed toward others, the care plan must include specific interventions to prevent/minimize the behavior, and include the supervision needs of the resident. The reeducation included the need for ongoing monitoring of the care plans and updating interventions to meet the specific needs of the resident. A post-test will be given at the time of re-education to validate understanding.

8. On 05/19/2021, all Licensed Staff will be re-educated by CNE, ADON, UMs, Nurse Supervisors, and/or Charge Nurses regarding the facility must development and implement a person centered plan of care for all residents to include residents with behaviors directed toward others, the care plan must include specific interventions to prevent/minimize the behavior, and include the supervision needs of the resident. The reeducation included the need for ongoing monitoring of the care plans and updating interventions to meet the specific needs of the resident. A post-test will be given at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 175	F 656		

re-education to validate understanding with a passing score of 100%. Licensed Staff not available during this time frame to include agency staff will be provided re-education including post-test by the Nurse Supervisors, NPE, UMs, and/or CNE upon day of return to work. New hires including agency staff will be provided education and a posttest during orientation by the CNE, NPE, Supervisors, or UMs.

9. The Center Nurse Executive, Assistant Director of Nursing, Unit Managers, Nurse Supervisors, Social Worker and/or LN (Licensed Nurse) would conduct audits of residents with newly identified behaviors to determine a care plan was developed and implemented to address the specific behavior daily times two (2) weeks including weekends, then three (3) times a week times (2) weeks, then weekly times eight (8) weeks, then biweekly times (2) months, then monthly times (1) month and then as determined by the QAPI committee with areas identified as a concern corrected upon discovery by CNE, ADON, UM, Nurse Supervisors, or Charge Nurses.

10. The Social Worker, Assistant Director of Nursing Services and/or Center Nurse Executive (CNE) would report the findings daily until the immediate jeopardy was removed to the Quality Assurance Performance Improvement Committee which consisted of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director, and Certified Nursing Aides for any additional follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 176	F 656		

up and/or in servicing until the issue is resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's IJ Plan as follows:

1. Review of the 05/17/2021, Quality Assurance Performance Improvement (QAPI) sign-in sheet revealed it was signed by the CED, CNE, and Medical Director, who met over the phone. Per review, a plan related to the additional deficiencies was discussed.

Interview with the Medical Director, 05/22/2021 at 5:30 PM, revealed the facility immediately notified him by phone with both notations of jeopardies. The director revealed the facility held an immediate AD-HOC QAPI to discuss the information, formulate education to staff, and audits for compliance. The director revealed the facility updated him /daily on the progress of education, audits, and any changes which were warranted after review of the information. The director revealed the committee will review all abated jeopardies audits monthly for at least six (6) months, longer if warranted.

2. Review of Resident #12's care plan, revised 05/14/2021, 05/17/2021, and 05/18/2021 by Social Services (SS) #1, SS #2, and UM/RN #8, revealed the resident was care planned to have a safe distance between other residents. Additionally, his/her care plan revealed excessive noise or close proximity to him/her can result in aggression.

3. Review of Resident #2's care plan revealed it was updated to include providing a safe distance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 177	F 656		

for other residents with increased supervision.

4. Review of Resident #61's care plan, revised on 05/17/2021 by UM/RN #8 and 05/18/2021 by SS#1, revealed the resident's behavior care plan was updated to include residents behavior of being tearful with interventions to include diverting the resident by giving alternative objects or activities and provide a calm well-lit environment.

5. Review of Resident #86's Behavior Care Plan, revised 05/15/2021 by the CNE, revealed the resident's care plan was revised to include physical behaviors and aggression with interventions to include to have increased rest periods, playing country music, and to provide one-to-one activities.

6. Per review of the Behavior Care Plan sheet, dated 05/18/2021 and 05/19/2021, revealed all of the residents were reviewed for behavior care plan updates. Further review revealed the care plans were completed by the CNE, ADNS, NPE, and Registered Nurse (RN) #8.

Interview with RN #8, on 05/21/2021 at 3:30 PM, revealed she updated many of the residents' care plans. Per interview, she revealed this was completed by reviewing the audits, residents progress notes and speak with staff.

7. Review of the CNE's posttest, dated 05/15/2021, revealed education consisted of the care plan process, the interact tools, nursing assessment, physician notification, care delivery process, and the resident's care path review. Further review revealed the CNE passed with one-hundred percent (100 %).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 178	F 656		

Interview with the Clinical Quality Specialist (CQS), on 05/22/2021 at 3:06 PM revealed she provided the education to the CNE. She stated she informed the CNE that if a resident was admitted with behaviors, staff should ensure the resident has a care plan in place. She further stated she went over the process of coming up with effective interventions for the resident. The CQS stated this would come by asking staff what interventions that were used that made the residents behavior better or worse. She further stated she gave the CNE a post-test, which the CNE passed.

Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she was educated by the CQS related to the residents behavior care plans. Per interview, she stated she took a test related resident's care plans and passed the test.

8. Interviews with Licensed Practical Nurse (LPN) #14 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, and Registered Nurse (RN) #1, on 05/21/2021 at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, and LPN #29, on 05/22/2021 at 5:57 PM, revealed they were educated on how to develop and implement the residents care plans related to the residents behaviors. Continued interview revealed they were provided a posttest and passed.

Interview with the CNE, on 05/22/2021 at 3:00 PM, revealed educating staff was an ongoing process and was provided the first day the employee returned to work. Record review revealed staff sign-in roster for care plan education with posttests with a 100% passing score.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 179	F 656		

9. Review of the F656 Audit Tool revealed a column for the residents' name, a column for "review of the progress notes of residents presenting with behaviors, including abusive behaviors in the clinical morning meeting to determine the need for behavioral health services", a column which stated, "If service is needed, has referral been made?" a column which stated conduct audits of behavioral care plans to determine the plan of care was followed and was up to date including revisions." A column which stated, "Review of the resident care plans for new behaviors including hoarding," a column which stated, "Was item care planned? Including specific behaviors, if not update." and a column which stated, "any corrective action implemented?"

Per interview with CNE, on 05/22/2021 at 6:30 PM, she revealed staff would identify any new behaviors and/or preexisting behaviors through reviewing the residents' progress notes. Per interview, she stated this would be completed daily.

10. Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she has audited the residents' progress notes to ensure the residents behaviors were captured for any care plan revisions and/or updates.

Interview with the CNE, on 05/22/2021 at 4:35 PM, revealed she reports the findings from the audits with the CED daily. Continued interview revealed that identified concerns would be taken to the QAPI meeting while the members address concerns related to a resolution. She further stated no other concerns were identified, other than the residents addressed in the immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 180 jeopardy.	F 656		
F 657 SS=J	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 181	F 657		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the facility's policy, and review of the Centers for Medicare and Medicaid Services' (CMS), "Resident Assessment Instrument (RAI) Manual 3.0," it was determined the facility failed to have an effective system to ensure the residents' care plans were reviewed and revised by the interdisciplinary team after each assessment for four (4) of eight-seven (87) sampled residents (Residents #31, #45, #52 and #85).

1. Observation on 04/30/2021 at approximately 4:10 PM, revealed Resident #31 had a cup of medications that were labeled with his/her name to include blood pressure medications, antihistamine, anticonvulsive antidepressants, and pain medications. Further observation revealed the resident had medications that were unlabeled in a cup that were not prescribed to the resident. These medications included medications for urinary retention, enlarged prostate and hair loss, an antidepressant and nerve pain medications, antihypertensive medications, fluid retention medications, and an antibiotic. Interviews with staff revealed the resident had an history of hoarding and rummaging through other residents' property. However, per review of the resident's Comprehensive Care Plan, the facility failed to update his/her care plan to include the resident's behaviors of "hoarding" and "rummaging."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 657	Continued From page 182	F 657		

2. On 04/22/2021, Resident #86 became agitated related to Resident #85 yelling out and hit him/her with a television monitor. Review of Resident #85's Comprehensive Care Plan, revealed the facility failed to update his/her care plan after the altercation with Resident #86.

3. Closed record review revealed Resident #45 and Resident #52 were ambulating in the hallway of the Memory Care Unit (MCU), on 03/18/2020 at approximately 12:50 PM. Resident #45 and #52 grabbed each other's arms, subsequently Resident #45 had a bruise on his/her right forearm. Continued review revealed the facility failed to update Resident #45 and #52's care plan after their resident-to-resident altercation.

Immediate Jeopardy was identified on 05/14/2021 and was determined to exist on 04/22/2021. Immediate Jeopardy was identified in the area at 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F-657 Care Plan Timing and Revision at a scope and severity (S/S) of a "J". The facility's failure to have an effective system in place to ensure care plans were reviewed and revised has caused or is likely to cause serious injury, harm, impairment or death to a resident. The facility was notified of the Immediate Jeopardy (IJ) on 05/14/2021.

The facility provided an acceptable credible Allegation of Compliance (AoC) 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 a "G" while the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 183	F 657		

develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's "OPS416 Person-Centered Care Plan" Policy, dated 07/01/2019, revealed that care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals.

Review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0", dated October 2016, revealed the care plan must be reviewed and revised periodically, and the services provided or arranged should be consistent with each resident's written plan of care. Continued review of the manual, revealed the care plan was driven, not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, a care plan based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. The manual stated a well developed and executed assessment and care plan: re-evaluated the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurred) using the RAI and then modified the individualized care plan as appropriate and necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 184	F 657		

1. Review of Resident #31's clinical record revealed the facility admitted Resident #31 on 05/10/2013 with diagnoses that included Dementia without behavioral disturbance, Alzheimer's, Adjustment disorder with Depressed mood, Psychotic disorder with delusions, and Insomnia.

Observation on 04/30/2021, at approximately 4:10 PM, revealed Resident #31 was observed to have his/her medications in several cups. Many of the medication cups were observed to have the resident's name written on them. However, others were observed to have medications within the cups, without a resident's name noted on the cups. Resident #31 asked the State Survey Agency (SSA Surveyor) to "help" him/her decide which medications to take. The Surveyor notified the Center Nurse Executive (CNE).

Observation on 04/30/2021 at 4:15 PM, revealed the Center Nurse Executive (CNE) and State Survey Agency (SSA) Surveyor entered Resident #31's room. The CNE then asked Resident #31 to show the pills the resident had shown the surveyor. Further observation revealed twenty-two (22) medication cups were found in an unlocked drawer of a cabinet in the resident's room. Some of these cups were labeled with Resident #31's name. Four (4) of the cups contained a total of thirty-seven and a half (37.5) assorted medications. The thirty-seven and a half (37.5) pills were compared to Resident 31's current medications by Registered Nurse #13 and the Center Nurse Executive.

Further observation revealed the medications that were found included: three (3) Eliquis 5 mg (milligram), seven (7) Effexor 37.5 mg- (which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 657	Continued From page 185	F 657		

was an anti-depressant), nine (9) Hydroxyzine 25 mg- (which was an antihistamine)-, four (4) Metoprolol ER 25 mg-(a beta blocker for Hypertension), two (2) Tylenol ES-(used for pain), one (1) Lamotrigine 25 mg- (an anti-convulsant), and eleven (11) that were not Resident 31's pills. The eleven (11) pills were later identified to be: two (2) Mirtazapine- (an anti-depressant), two (2) Clonidine 0.1 mg- (a sedative and hypertensive), one (1) Famotidine- (an antacid), one (1) Glycopyrrolate 1 mg-(an anticholinergic), one (1) Griseofulvin- (an antifungal) , one (1) Finasteride 5 mg-(an urinary retention medication used to treat enlarged prostate and hair loss in men), one (1) Amitriptyline 5 mg- (an antidepressant and used for nerve pain), one E1 (an unidentified medication) Hydrochlorothiazide 20 mg - (an antihypertensive and used for fluid retention), and one (1) Ciprofloxacin 125 mg- (an antibiotic).

Review of Resident #31's Comprehensive Care Plan, revealed that on 07/07/2014, a focus was initiated that stated the resident exhibited inappropriate behaviors of hoarding and rummaging related to the resident's hoarding silverware/medications/washcloths. Interventions included: to learn the resident's hiding places for hoarding and observe resident's room daily and return items/belongings to other residents. However, further review revealed both, the focus and the interventions were resolved on 11/02/2020. Continued review revealed the care plan was not reviewed and revised to add new focus statements or interventions related to hoarding and medications, until the care plan revision was started and completed on 05/26/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 186	F 657		

Interview with Certified Medication Technician (CMT), on 05/04/2021 at 8:39 AM, revealed she worked at the facility for over three (3) years and was familiar with Resident #31 as she had worked with the resident for the last few years. Per interview, she had residents she had to watch because they would get in medication carts as soon as she turned her back. She stated she always made sure her cart was locked with no pills on top. The CMT stated she always watched her residents take their pills and made sure they swallowed them. She stated if the resident refused the medication, she would return it to the cart. The CMT stated she would not leave any medications at bedside for any reason.

Interview with LPN #14, on 05/06/2021 at 3:35 PM, revealed that Resident #31 had behaviors of being a kleptomaniac (irresistible urge to take things). LPN #14 stated she has witnessed Resident #31 rummage through the nursing station looking for things like Kerlix. She said the resident's ex-roommate cursed at Resident #31 because the resident was going through the roommate's drawers and other personal belongings. LPN #14 stated she would expect resident's behaviors to be on the care plan. She said she always watched Resident #31 take his/her pills and she had never left the resident's medications at the bedside.

Interview with the Clinical Record Coordinator (CRC), on 05/12/2021 at 10:26 AM, revealed she was responsible for revising and updating the residents' care plans. Per interview, she was familiar with Resident #31 and revealed the resident had a care plan related to "rummaging" and "hoarding" silverware/medications/and washcloths. Per interview, the CRC stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 187	F 657		

goals, focus, and interventions of the resident's care plan was "care planned", but had been "resolved", as it was no longer a concern for the resident. Continued interview with the CRC revealed the care plan should have been updated to reflect the continued concern of the resident and an intervention to observe the resident "take (his/her)" pills due to the resident's history of 'cheeking" (placing medication to the side of mouth without swallowing) his/her medications.

Interview with the Center Nurse Executive (CNE), on 05/12/2021 at 06:00 PM, revealed that there should have been an intervention in the care plan about watching Resident #31 take pills related to his/her hoarding pills and putting medications in his/her cheeks and spitting them back out. Further interview revealed if Resident #31 had taken the medications, he/she could have gotten sick. She said she was not aware of resident having a history of rummaging through the nursing station drawers either.

2. Review of the clinical record revealed the facility admitted Resident #85 on 01/24/2020 with diagnoses to include Schizophrenia, Muscle Weakness, Bed Confinement, and Reduced Mobility.

Review of the MDS, dated 04/22/2021, revealed Resident #85 was assessed to have a BIMS of three (3) which indicated the resident was cognitively impaired. Continued review revealed Resident #85 had no mood concerns and was not assessed to have behaviors. The facility assessed that Resident #85 required scheduled and as needed pain medication, but at the time of the assessment the resident was not in pain. Further review revealed Resident #85 did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 188	F 657		

have any skin issues at the time of assessment. Additionally, Resident #85 was administered an antipsychotic for seven (7) of seven (7) days.

Review of the resident's care plan revealed Resident #85 exhibited or had the potential to demonstrate verbal behaviors related to his/her diagnosis of Schizophrenia. Resident #85 was used to being in a room alone; would become over stimulated easily; and yell out. Interventions included approach in a calm manner, complete behavior monitoring, observe the nature and trigger of the behaviors, and explain all care.

Review of the Risk Management System (RMS) Event Summary Report, dated 04/22/2021 at 10:30 PM, revealed Resident #86 became agitated related to Resident #85 yelling out and hit him/her with a small television monitor. Continued review revealed no injuries were noted at the time of the altercation

Review of Resident #85's care plan, dated 01/25/2020, revealed the facility failed to revise his/her care plan after the altercation with Resident #86 on 04/22/2021.

3. Review of Resident #52's Face Sheet revealed the facility admitted him/her to the MCU, on 03/03/2011, with diagnoses that included Alzheimer's Late Onset, Lack of Coordination, Psychotic Disorder with Delusions, Cognitive Communication Deficit, Major Depressive Disorder, Anxiety, Dementia with Behavior Disturbances and Unspecified Psychosis.

Review of the Minimum Data Set (MDS), dated 02/17/2020, revealed Resident #52 was assessed to have a Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 189	F 657		

Status (BIMS) of three (3) out of fifteen (15) which indicated the resident was severely cognitively impaired. Further review of the MDS revealed Resident #52 had no behaviors identified.

Review of Resident #52's care plan, dated 06/03/2019, revealed Resident #52 has a history of negative behaviors, including physical aggression with staff/peers, depression, anxiety and delusional type behaviors. Continued review revealed interventions for staff included: allow him/her to vent feelings, approach in a calm manner, manage any unmet needs, document interventions and responses, and increase supervision when in the common area. Further review revealed the facility failed to update the care plan after the physical altercation with Resident #45.

4. Review of Resident #45's Face Sheet revealed the facility admitted him/her to the MCU, on 12/18/2019, with diagnoses that included Dementia with Behaviors.

Review of the MDS, dated 12/24/2019, revealed Resident #45 had a BIMS' score of eight (8) out of fifteen (15) which indicated the resident was, moderately cognitively impaired. Further review of the MDs revealed Resident #45 had no behaviors noted.

Review of Resident #45's care plan, dated 12/18/2019, revealed he/she was at risk for complications related to the use of psychotropic medications, with interventions to monitor for changes in mental status, monitor for continued need for medication, monitor for side effects and notify the physician. Further review revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 190	F 657		

facility failed to update the care plan after the physical altercation, resulting in a small bruise, with Resident #52.

Interview with the Clinical Reimbursement Coordinator (CRC), on 05/12/2021 at 4:21 PM, revealed nursing staff had access to the care plan through the computer system at all times, and any nurse can update the care plan as needed. She stated it was important to update the care plans when the resident's condition changed to ensure staff were providing the best care for them. Continued interview revealed the care plans for Resident #45, Resident #52, and Resident #85 should have been updated after their altercations with other residents. Further interview revealed she was not sure why the care plans were not updated but it would have been her responsibility.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed it was the CRC's responsibility to revise the care plan along with the staff nurses. Continued interview revealed the care plan should be revised with any new changes to the resident's status. Further review revealed Resident #45, Resident #52, and Resident #85's care plans should have been revised after their altercations, to ensure staff were providing the correct care. Additionally, she stated if the care plan was not revised as needed, residents potentially would not receive the proper care.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed the CRC was responsible for revising the care plans along with the staff nurses. Further interview revealed he would expect the care plans for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 191	F 657		

Resident #45, Resident #52, and Resident #85's care plans to be updated after their physical altercations to ensure staff were providing appropriate care.
Review of the IJ Removal Plan revealed the facility implemented the following:

1. On 04/30/2021, Resident #31 was assessed by a license nurse with no issues noted. The physician was notified of the medications found in Resident #31's room. New orders were received to crush the resident's medications that were able to be crushed and non-crushable medications administered whole in apple sauce and verify that medications were swallowed. Additionally, the medications found in Resident #31's room were destroyed immediately upon discovery by the CNE.

2. On or before 05/19/2021, Resident #31's care plan was updated by a RN to reflect inappropriate behaviors of hoarding silverware, medication cups, washcloths and rummaging through other resident rooms and belongings. Interventions were added to the care plan to prevent serious injury, serious harm, and serious impairment or death.

3. On or before 05/19/2021, the Social Services Director (SSD), Social Worker, Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager(UM), Nurse Practice Educator (NPE) and or Licensed Nurses (LN) will conduct an audit of all other residents' care plans with identified behaviors of hoarding and rummaging to determine interventions were appropriate to address the behavior. Corrective action completed upon discovery.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 192	F 657		

4. The Clinical Quality Specialist provided education to the CNE regarding the revision of residents care plans to include residents with behaviors including appropriate interventions to address the behaviors of rummaging and hoarding. A post test was given at the time of re-education.

5. On or before 05/19/2021, all licensed nursing staff were re-educated by the Center Nurse Executive, Assistant Director of Nursing, Unit Managers, LN, and or nurse supervisors regarding the revision of residents care plans to include residents with behaviors including appropriate interventions to address the behaviors of rummaging and hoarding. A post-test was given at the time of re-education with a passing score of 100% required to validate understanding. Licensed Staff not available during this time frame including agency staff will be provided this reeducation/education including post-test upon returning to work or during the orientation period by Center Nurse Executive, Assistant Director of Nursing, Unit Managers, Charge Nurses and or nurse supervisors.

6. The Center Nurse Executive, Assistant Director of Nursing, Unit Managers, nurse supervisors, social worker, and or charge nurses will conduct audits of ten (10) behavioral care plans, including care plans for hoarding and rummaging to determine the plan of care is followed and is up to date including revisions with newly identified behaviors, daily time two (2) weeks including weekends, then three (3) 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 QAPI committee with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 193	F 657		

areas identified as a concern corrected upon discovery by CNE, ADON, UM, nurse supervisors, or charge nurses.

7. The SW, ADNS and/or CNE will report the review findings daily until the immediate jeopardy was removed to the Quality Assurance Performance Improvement Committee which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in servicing until the issue was resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's AOC as follows:

The facility provided an acceptable credible Allegation of Compliance (AoC) on 05/20/2021 that alleged removal of the Immediate Jeopardy (IJ) on 05/20/2021. Review of the AoC revealed the facility implemented the following.

1. On 04/30/2021, Resident #31 was assessed by a license nurse with no issues noted. The physician was notified of the medications found in Resident #31's room. New orders were received to crush the resident's medications that were able to be crushed; non-crushable medications administered whole in applesauce; and, verify that medications were swallowed. Additionally, the medications found in Resident #31's room were destroyed immediately upon discovery by the CNE.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 194	F 657		

2. On or before 05/19/2021, Resident #31's care plan was updated by a RN to reflect inappropriate behaviors of hoarding silverware, medication cups, washcloths and rummaging through other residents' rooms and belongings. Interventions were added to the care plan to prevent serious injury, serious harm, and serious impairment or death.

3. On or before 05/19/2021, the Social Services Director (SSD), Social Worker, Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Nurse Practice Educator (NPE) and or Licensed Nurses (LN) will conduct an audit of all other residents' care plans with identified behaviors of hoarding and rummaging to determine if interventions were appropriate to address the behavior. Corrective action will be completed upon discovery.

4. The Clinical Quality Specialist provided education to the CNE regarding the revision of residents' care plans to include residents with behaviors including appropriate interventions to address the behaviors of rummaging and hoarding. A posttest was given at the time of re-education with a passing score of 100% required to validate understanding.

5. On or before 05/19/2021, all licensed nursing staff were re-educated by the Center Nurse Executive, Assistant Director of Nursing, Unit Managers, LN, and or nurse supervisors regarding the revision of resident's care plans to include residents with behaviors including appropriate interventions to address the behaviors of rummaging and hoarding. A posttest was given at the time of re-education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 195	F 657		

with a passing score of 100% required to validate understanding. Licensed Staff not available during this time frame, including agency staff will be provided this reeducation/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 or nurse supervisors.

6. The Center Nurse Executive, Assistant Director of Nursing, Unit Managers, nurse supervisors, social worker, and or charge nurses will conduct audits of ten (10) behavioral care plans, including care plans for hoarding and rummaging to determine, if the plan of care was followed and up to date including revisions with newly identified behaviors, daily time two (2) weeks including weekends, then three (3) 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 QAPI committee with areas identified as a concern corrected upon discovery by CNE, ADON, UM, nurse supervisors, or charge nurses.

7. The SW, ADNS and/or CNE will report the review findings daily until the immediate jeopardy was removed to the Quality Assurance Performance Improvement Committee which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in servicing until the issue was resolved and then ongoing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 196	F 657		

thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Interview with the Center Nurse Executive on, 05/22/2021 at 12:15 PM, revealed she put the medication in the sharps bin to destroy them as soon as she completed identifying the pills. Interview with Registered Nurse #13 on, 05/21/2021 at 5:00 PM, revealed she assessed Resident #31 head-to-toe including vitals and neuro checks, after the pills were found.

Record review also revealed that a Hospice nurse came to the facility and assessed Resident #31, on 04/30/2021 at 6:32 PM. Interview with the Hospice Physician on, 05/10/2021 at 10:45 AM, revealed that she was made aware of the incident with Resident #31. Record review revealed that there was a physician's order from the Hospice Chief Medical Officer to crush the resident's medications that were able to be crushed and place non-crushable medications whole in applesauce.

2. Record review revealed that on 05/15/2021, Resident #31's care plan was updated by Registered Nurse (RN) #8 to reflect inappropriate behaviors of hoarding silverware, medication cups, washcloths and rummaging through other residents' rooms and belongings. Interventions were added to the care plan to prevent serious injury, serious harm, and serious impairment or death.

3. Record review revealed that starting on 05/15/2021; audits were done of all the residents' care plans with identified behaviors of hoarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 197	F 657		

and rummaging to determine if the interventions were appropriate to address the behavior. This was conducted by the Social Services Director (SSD), Social Worker, Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Nurse Practice Educator (NPE) and or Licensed Nurses (LN). Corrective action was completed upon discovery.

4. Interview with the Clinical Quality Specialist (CQS), on 05/22/2021 at 11:25 PM, revealed she provided education to the Center Nurse Executive regarding the revision of the residents' care plans to include residents with behaviors including appropriate interventions to address the behaviors of rummaging and hoarding.

Review of the posttest revealed the CQS provided education to the CNE regarding the policy for the development and implementation of a person centered care plan for all residents to include residents with behaviors directed towards others, specific interventions to prevent/minimize the behavior and include the supervision needs of the resident with a posttest to validate understanding. Record review revealed a posttest for the CNE was one-hundred (100%) passing score.

5. Review of the posttest, provided by the facility, revealed all licensed staff including agency staff were educated on, or before 05/19/2021 by the CNE, ADON, UM, Nurse Supervisors and/or Charge Nurses regarding the development and implementation of a person centered care plan for all residents to include residents with behaviors directed towards others, specific interventions to prevent/minimize the behavior and include the supervision needs of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 198	F 657		

resident with a posttest with a one-hundred percent (100%) passing score to validate understanding.

Interviews with Licensed Practical Nurse (LPN) #14 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, and Registered Nurse (RN) #1 on 05/21/2021at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, and LPN #29, on 05/22/2021 at 5:57 PM revealed they received education that included development and implementation of the care plan for all residents and included those with behaviors.

Interview with the CNE, on 05/22/2021 at 3:00 PM, revealed educating staff was an ongoing process and was provided the first day the employee returned to work. Record review revealed staff sign in roster for care plan education with posttests with a one-hundred percent (100%) passing score. Per review, seventy-four (74) staff members were educated.

6. Record review revealed that the Center Nurse Executive, Assistant Director of Nursing, Unit Managers, nurse supervisors, social worker, and or charge nurses conducted audits of ten (10) behavioral care plans, including care plans for hoarding and rummaging to determine if the plan of care was followed and up to date, including revisions with newly identified behaviors, daily since 05/20/2021.

Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she audited the residents' behavioral care plans and made the needed revisions when necessary. Per interview, concerns were identified and brought to the QAPI meeting for discussion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 199 7. Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she would continue with the audits and address concerns with QAPI until the concerns were resolved.	F 657		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure professional standards were met related to medication administration to meet the needs of the residents. This failure effected one (1) of eighty-seven (87) residents, Resident #31. The facility admitted Resident #31, on 05/10/2013, with diagnoses that included Dementia with without behavioral disturbance, Alzheimer's, Adjustment disorder with Depressed mood, Psychotic disorder with delusions, and Insomnia. The facility's care plan for Resident #31, initiated on 08/16/2017, noted Resident #31 would cheek and spit out his/her medication at	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 200	F 658		

times and was a hoarder. Interviews with staff revealed they were aware Resident #31 exhibited hoarding behaviors and was infatuated with medication cups. Observation, on 04/30/2021 at 4:15 PM, revealed twenty-two (22) medication cups in an unlocked drawer of a cabinet in the resident's room. Some of these cups were labeled with Resident #31's name and four (4) cups contained a total of thirty-seven and a half (37.5) assorted medications. Interview with the facility's Pharmacist revealed some of the medications, if consumed by Resident #31 could lead to increased drowsiness, and decreased blood pressure.

The facility's failure to provide services that met professional standards related to medication administration has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 05/07/2021, and was determined to exist on 04/30/2021. The facility was notified of the Immediate Jeopardy on 05/07/2021.

The facility submitted an IJ Removal Plan on 05/20/2021, alleging removal of the Immediate Jeopardy on 05/20/2021. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed as alleged on 05/20/2021, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's "NSG305 Medication:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 201	F 658		

Administration: General" policy, dated 11/01/2019, revealed that when medication was administered staff would assist the resident as needed and remain with the resident until administration was completed. It also stated medications should not be left at the resident's bedside. If the resident refused medications, the medication should be discarded and staff should attempt to administer the medication at a later time.

Review of Resident #31's clinical record revealed the facility admitted Resident #31 on 05/10/2013 with diagnoses that included Dementia with without behavioral disturbance, Alzheimer's, Adjustment disorder with Depressed mood, Psychotic disorder with delusions, and Insomnia.

Review of Resident #31's Comprehensive Care Plan, revealed that on 07/07/2014 the resident was care planned with a focus related to inappropriate behaviors to include rummaging and hoarding silverware/medications/ washcloths. Continued review revealed interventions included to learn the resident's hiding places for hoarding, to observe resident's room daily, and to return items/belongings to other residents. However, both the focus and the interventions were noted "resolved" on 11/02/2020.

Observation on 04/30/2021, at approximately 4:10 PM, revealed Resident #31 was in his/her room with several cups of medications. Many of the medication cups were observed to have the resident's name written on them; however, others were observed to have medications within the cups, without a resident's name noted on the cups. Resident #31 asked the surveyor to "help"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 202	F 658		

him/her decide which medications to take.

On 04/30/2021 at 4:15 PM, the Center Nurse Executive (CNE) and surveyor entered Resident #31's room. The CNE asked to see the medication/pills the resident had shown to the surveyor. The resident was found to have twenty-two (22) medication cups in an unlocked drawer of a cabinet in the resident's room. Some of these cups were labeled with Resident #31's name and four (4) cups contained thirty-seven and a half (37.5) assorted medications. The thirty-seven and a half (37.5) pills were compared to Resident 31's current medications with Registered Nurse (RN) #13 and Center Nurse Executive. The medications identified were: three (3) Eliquis 5 mg (milligram), seven (7) Effexor 37.5 mg, nine (9) Hydroxyzine 25 mg, four and a half (4.5) Metoprolol ER 25 mg, two (2) Tylenol ES, one (1) Lamotrigine 25 mg, and 11 that were not Resident 31's pills. The eleven (11) pills were later identified to be: two (2) Mirtazapine, two (2) Clonidine 0.1 mg, one (1) Famotidine, one (1) Glycopyrrolate 1 mg, one (1) Griseofulvin, one (1) Finasteride 5 mg, one (1) Amitriptyline 5 mg, one (1) Hydrochlorothiazide 20 mg, and one (1) Ciprofloxacin 125 mg.

Interview with RN #13, on 04/31/2021 at 4:50 PM, revealed that Resident #31 was known to cheek pills. She said many of the unidentified pills looked like the resident's roommates medications. She said if staff was not following the basics of watching the resident take their pills, it was bad practice, and they were not following the facility's policy. RN #13 revealed when she administered medication she would make the resident open their mouth to ensure no pills were located in the resident's cheek or anywhere else.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 203	F 658		

Review of an email provided by the Pharmacy's Assistant General Manager, on 05/05/2021 at 8:42 PM, revealed the Assistant General Manager reported Resident #31 had in his/her possession no Level 1 interactions medications; however, there were some Level 2, Level 3, and Level 4 interactions that might be of some concern to the resident. Further review revealed some of the medications would increase drowsiness if taken together, some might lower blood pressure to an extent that could be a problem, and others would generally only interact if taken together for an extended period, as each would likely build up in the system and start interacting upon reaching therapeutic levels.

Interview with the Hospice Physician, on 05/10/2021 at 10:45 AM, revealed she was made aware of the incident with Resident #31 hoarding pills and medication cups. She also stated if staff locked carts, did not leave medications on cart, or at the residents' bedside without watching the resident take them, then there would be no problem with Resident #31 hoarding pills.

Interview with RN #15, on 05/19/2021 at 6:19 PM, revealed she only worked on the Memory Care Unit for a few weeks, around February of 2020. Per interview, RN #15 revealed staff would leave the residents' medications in cups, with their names labeled on them, on top of the nurse's stations. Additionally, she stated she would walk into some of the residents' rooms and find some of the residents' mediations on their bedside table. Lastly, she revealed she would at times open the drawer to the medication cart and find unlabeled cups with medications in them. RN #15 stated staff would sign off and/or leave the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 204	F 658		

unit without administering the medications to the residents, and would sign the Medication Administration Record (MAR) as "administered." She stated it was difficult to determine which medication belonged to which resident and the only way to tell if a resident received the wrong medication or did not receive their medications would be if the resident had an adverse effect. Further interview revealed to her knowledge this had not occurred but the potential was there. She further revealed the nursing staff would prep their medications in advance because of not having enough staff on the unit to administer the residents' medications. RN #15 stated she told Administration at the time of her observations.

Interview with Certified Medication Technician (CMT) #1 on 05/04/2021 at 8:39 AM, with Licensed Practical Nurse (LPN) #14 on 05/06/2021 at 3:35 PM, and with RN #2 on 05/06/2021 at 3:50 PM, revealed that they have never left medications at the bedside. They stated they brought the medications into the room for the resident, explained to the resident what the medications were, and watched the resident take the pills. However, staff could not explain how Resident #31 acquired all of this medication.

Interview with the Center Nurse Executive (CNE), on 05/12/2021 at 06:00 PM, revealed that the process for administering medications was to watch the resident take the medications before leaving the room. She said the facility's policy was not being followed because Resident #31 would not have had that many pills. She further stated there should have been an intervention on Resident #31's care plan to watch the resident take pills related to the resident's putting the medication in cheeks and spitting them back out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 205	F 658		

The CNE stated if Resident #31 had taken all of the pills the resident may have gotten sick and there was potential for harm. The night of the incident she did get the Hospice Nurse to come in and evaluate Resident #31. She said she does not know how Resident #31 got all those medications. It was also not identified who's pills they were. She further stated she was not aware of Resident #31 having a history of rummaging through the nursing station drawers either.

Interview with the Center Executive Director, on 05/12/2021 at 07:33 PM, revealed that medications should never be left at the bedside and staff should make sure the residents were getting their medications and in a timely manner. He stated the facility did identify the pills Resident #31 had and the pharmacist consultant stated the resident could have taken all the medications with no untoward effects. He said the facility's policy about Medication Administration was not followed and that staff was educated immediately following the incident.

Review of the IJ Removal Plan revealed the facility implemented the following:

1. The medications found in Resident #31's room were destroyed after they were identified on 04/30/2021 by the Center Nurse Executive (CNE).

2. Resident #31 was assessed by a license nurse on 04/30/2021, no issues noted.

3. The physician was notified of the medications found in Resident #31's room on 04/30/2021. New orders were received to crush resident's medications that were able to be crushed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 206	F 658		

place non-crushable meds whole in apple sauce and verify that medications were swallowed.

4. An Ad Hoc Emergency QAPI meeting was completed on 05/03/2021 with the medical director to discuss the action plan as a result of medications found at the bedside for further review and recommendations.

5. An audit was conducted of all resident rooms to determine if there were medications in resident rooms on 04/30/2021 by Nurse Supervisor, Center Nurse Executive (CNE), Assistant Director of Nursing (ADNS), and charge nurses with any corrective action upon discovery. No other issues were identified.

6. The Clinical Quality Specialist provided reeducation to the Center Nurse Executive (CNE) on 05/03/2021 regarding the policy NSG305 Medication Administration to include to assist the resident as needed and remain with the resident until administration is complete and to not leave medications at the patient's bedside, with a post-test to validate understanding.

7. The CNE provided reeducation to the Nurse Practice Educator (NPE) on 05/03/2021 regarding the policy NSG305 Medication Administration to include to assist the resident as needed and to remain with the resident until administration is complete and to not leave medications at the resident's bedside, with a posttest to validate understanding.

8. Reeducation was provided to Certified Medication Techs (CMT) and licensed nurses, including agency, beginning on 05/03/2021 by CNE, ADNS, Unit Manager (UM), Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 207	F 658		

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.

11. Results of the observation audits will be submitted by the CED and/or the CNE daily until the immediate jeopardy is removed and continue for six (6) months to the QAPI Committee consisting of the CED, CNE, Assistant Director of Nursing, Activity Director, Housekeeping Director, Admissions Director, Business Office Manager, Food Service Director, Therapy Program Director, Maintenance Director, Social Service Director, Health Information's Coordinator, and Clinical Reimbursement Coordinator, and Certified Nurse Aid for any additional follow-up and/or in-servicing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 208	F 658		

needs until the issue is resolved and ongoing thereafter as determined by the QAPI committee.

The SSA validated the facility implemented the following actions to remove the Immediate Jeopardy:

1. Interview with the Center Nurse Executive on, 05/22/2021 at 12:15 PM, revealed that she put the medication in the sharps bin to destroy them as soon as she was done identifying the pills.

2. Interview with Registered Nurse #13, on 05/21/2021 at 5:00 PM, revealed that she assessed Resident #31 head-to-toe including vitals and neuro checks, after the pills were found. Record review also revealed that a Hospice nurse came to the facility and assessed Resident #31 on 04/30/2021 at 6:32 PM.

3. Interview with the Hospice Physician, on 05/10/2021 at 10:45 AM, revealed that she was made aware of the incident with Resident #31. Record review revealed that there was a physician's order from the Hospice Chief Medical Officer to crush resident's medications that were able to be crushed and place non-crushable meds whole in applesauce.

4. Interview with the Medical Director, on 05/22/2021 at 4:33 PM, revealed that there was an Ad Hoc meeting on 05/03/2021 to talk about Resident #31 that he did attend.

5. Record review revealed the check off sheet used to check each resident's room and who did it. Interview with the Clinical Reimbursement Coordinator, on 05/22/2021 at 11:33 PM, revealed she was involved in the audits of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 209	F 658		

resident rooms. She said they went through resident drawers and rooms with permission including resident bathroom, closets, bedside tables, and locked drawers. The information was then given to the Center Nurse Executive and the Center Executive Director. Interview with the Nurse Practice Educator, on 05/21/2021 at 5:14 PM, revealed that she was also a part of the audits done on all the residents. Interview with the Center Executive Director on, 05/22/2021 at 2:55 PM, revealed that he was a part of the audit that involved looking at all residents rooms, drawers, and bedside tables.

6. Interview with the Clinical Consultant, on 05/22/2021 at 11:25 PM, revealed that she did provide education before anyone else to the Center Nurse Executive on the NSG305 Medication Administration policy. A posttest was also used to validate understanding.

7. Interview with the Center Nurse Executive, on 05/22/2021 at 12:15 PM, revealed that she did provide reeducation to the Nurse Practice Educator regarding the NSG305 Medication Administration policy and also provided her with a posttest on the material.

8. Interview with Nurse Practice Educator, on 05/21/2021 at 5:14 PM, revealed she did provide education regarding the NSG305 Medication Administration Policy to the Certified Medication Technicians and the licensed nurses. She also provided them with a posttest and a competency check off about Medication Administration.

9. Interview on 05/21/2021, with Certified Medication Technician (CMT) #1 at 1:45 PM, Licensed Practical Nurse (LPN) #14 at 1:55 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 210 Registered Nurse (RN) #1 at 2:00 PM, and RN #16 at 2:05 PM, revealed all had received education on Medication Administration and completed a posttest. Interview with LPN #29, on 05/22/2021 at 5:58 PM, revealed that she was educated on Medication Administration and completed a post test. Record review also showed the posttest and competencies that were completed. 10. Interview with the Nurse Practice Educator, on 05/21/2021 at 5:14 PM, the Assistant Director of Nursing, on 05/21/2021 at 5:20 PM, and the Center Nurse Executive, on 05/22/2021 at 12:15 PM, revealed they participated in the Observation Rounds every day. Record review revealed that the Observation Round Audits were conducted daily. 11. Interview with the Center Nurse Executive, on 05/22/2021 at 12:15 PM and the Center Executive Director, on 05/22/2021 at 2:55 PM, revealed that the results of the Observation Round Audits were discussed daily in QAPI.	F 658		
F 725 SS=J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 211	F 725		

at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure sufficient qualified nursing staff were available at all times to provide nursing and related services to meet the residents' care needs in a manner that promoted each resident's rights, physical, mental and psychosocial well-being on the Memory Care Unit (MCU). Additionally, interviews revealed there was limited staff to assist with answering the residents' call lights, which resulted in long wait times for the residents.

Interviews with staff revealed the MCU should be staffed with three (3) Certified Nursing Assistance (CNAs) and a Registered Nurse (RN) due to the increased behaviors on the unit. Interviews and record review revealed Resident-to-Resident altercations on the MCU could have been prevented with additional staff to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 212	F 725		

oversight. Staff interviews revealed they were too short to intervene when residents had increased behaviors. (Refer to F-600, F-658, and F-740).

Review of the facility's call light audits revealed long wait times. Observations of the residents' call lights revealed residents had to wait twenty (20) to thirty (30) minutes for staff to respond. (Refer to F-558)

The facility's failure to have sufficient staffing to provide the residents with their assessed care and service needs in a manner that promotes each resident's rights has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 05/14/2021, and was determined to exist on 04/22/2021. The facility was notified of the Immediate Jeopardy on 05/14/2021.

The facility submitted an IJ Removal Plan on 05/20/2021, alleging removal of the Immediate Jeopardy on 05/20/2021. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed as alleged on 05/20/2021, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy, "Staffing/Center Plan," reviewed 07/16/2019, revealed the Center provided qualified, and appropriate staffing levels to meet the needs of the resident population. The staffing plan included all shifts, seven (7) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 213	F 725		

per week, assuring appropriate staffing levels were scheduled, and maintained.

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.

Review of the facility's FA, dated 04/23/2020, revealed the Average Daily Census (ADC) was one hundred seventy-one (171) residents; twenty-nine (29) on the MCU; fifty-seven (57) on NF1 Unit, fifty-one (51) on NF2 Unit; and thirty-two (32) on Transitional Care Unit (TCU). Additionally, the Average Monthly Admission and Discharge was thirty (30). Per the Assessment, the resident population had disease/conditions and physical and cognitive disabilities such as psychiatric mood disorders, neurological disease, and infectious diseases. Continued review revealed the resident population required special treatments such as respiratory treatments, mental health, medication management, dialysis, and Hospice Care.

Further review of the FA revealed the residents required services and care to support their care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 725	Continued From page 214	F 725		

needs such as Activities of Daily Living, Mental Health and Behaviors, Medications, Pain Management, Infection Prevention and Control, Management of Medical Conditions, Therapy, Nutrition, and Psychosocial support. The facility's staffing plan needed to provide competent support and care for the resident population every day included; one (1) CNE; one (1) Assistant Director of Nursing Services (ADNS); one (1) Registered Nurse (RN) or Licensed Practical Nurse (LPN) Charge Nurse for each shift. Direct Care Unit Staff included: NF1 Unit three (3) CNAs, one (1) RN or LPN; NF2 three (3) CNAs, one (1) RN or LPN; TCU three (3) CNAs, one (1) RN or LPN; MCU two (2) CNAs, one (1) RN or LPN. Other required staff included but was not limited to; one (1) Registered Dietician, one (1) Nurse Practice Educator, one (1) Social Services Director, one (1) Social Services Assistance, one (1) Activity Director, one (1) Captivity Assistant, two (2) Minimum Data Set (MDS) Coordinators, one (1) Rehabilitation Program Manager and seven (7) therapist.

1. Record review and interview revealed, on 04/22/2021, Resident #86 became combative and resistive to care while in the hallway of the MCU. Interviews revealed staff took Resident #86 to his/her room to help calm him/her down. Further review revealed Resident #86 struck Resident #85 with a television while in their shared room. The resident was assessed, on 04/25/2021, and the nurse identified scattered bruising and swelling to Resident #85's right hand, new orders were obtained for an x-ray. The x-ray results revealed the resident had a right 5th metacarpal (bone in the hand) fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 725	Continued From page 215	F 725		

Interview with Certified Nurse Aide (CNA) #8, on 05/12/2021 at 2:32 PM, revealed she worked the majority of her shifts on the MCU. Per interview, CNA #8 stated, on the night of the altercation, 04/22/2021, Resident #86 stated he/she needed to use the restroom but refused to use his/her private restroom due to Resident #85 screaming, therefore, care was provided in the shower room. CNA #8 revealed after dinner and medication pass (around 7:00 PM) Resident #86 was 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 putting residents to bed. CNA #8 stated there was not enough staff on the MCU to provide proper supervision to the residents. Per interview, CNA #8 stated she asked CNA #19 to assist.

Interview with CNA #19, on 05/12/2021 at 3:30 PM, revealed she was asked by CNA #8 to come and assist with rounds and placing residents in bed on the MCU. CNA #19 stated she was in a resident's room performing care when she heard some noises in the hallway. She stated she stepped out in the hallway and noticed Resident #86 trying to enter another resident's room and the nurse was attempting to redirect, and guide him/her further down the hallway toward his/her room. Continued interview revealed while back in the room she heard screaming from the hallway and hurried to complete her care and exited the room. Further interview revealed LPN #14 was yelling for help and stated Resident #86 was hitting Resident #85 with the television and Resident #85 was screaming out. CNA #19 stated she ran in the room and scooped up Resident #85 in her arms and carried him/her into another resident's room where he/she would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 216	F 725		

safe.

Interview with RN #1, on 05/12/2021 at 8:15 AM, revealed when she arrived to the facility in the morning for her shift on 04/25/2021, the CNA notified her that she found blood on Resident #85's sheet. Continued interview revealed she entered Resident #85's room and completed a head to toe assessment to attempt to find the source of the blood. She stated that Resident #86 (roommate prior to the altercation) had abrasions on his/her arms and they determined that was where the blood originated. Further interview revealed upon the head to toe assessment she noted bruising and swelling to Resident #85's right hand.

2. Observation, on 04/30/2021, at approximately 4:10 PM, revealed Resident #31 was in his/her room with several cups of medications. Many of the medication cups were observed to have the resident's name written on them; however, others were observed to have medications within the cups, without a resident's name noted on the cups. Resident #31 asked the State Survey Agency (Surveyor) to "help" him/her decide which medications to take. Interview with the Pharmacist revealed the medications in Resident #31's possession could lead to increased drowsiness, and decreased blood pressure.

Interview with RN #15, on 05/19/2021 at 6:19 PM, revealed she only worked on the Memory Care Unit (MCU) for a few weeks, around February of 2020. Per interview, RN #15 revealed staff would leave the residents' medications in cups, with their names labeled on them, on top of the nurse's stations. Additionally, she stated she would walk into some of the residents' rooms and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 217	F 725		

find some of the residents' mediations on their bedside table. Lastly, she revealed she would at times open the drawer to the medication cart and find unlabeled cups with medications in them. RN #15 stated staff would sign off and/or leave the unit without administering the medications to the residents, and would sign the Medication Administration Record (MAR) as "administered". She stated it was difficult to determine which medication belonged to which resident and the only way to tell if a resident received the wrong medication or did not receive their medications would be if the resident had an adverse effect. She further revealed the nursing staff would prep their medications in advance because of not having enough staff on the unit to administer the residents' medications.

Interview with Registered Nurse #1, on 04/15/2021 at 3:10 PM, revealed she worked the Memory Care Unit (MCU) and was not able to complete her daily charting until the end of the shift. RN #1 stated she was constantly supervising and interacting with the residents to redirect them. She stated she would provide distractions to prevent or intercept behaviors that could result in altercations. RN #1 stated normally the staffing on MCU included one (1) nurse and three (3) CNAs, but on days when staffing included only two (2) CNAs, it was very difficult to provide care and supervise the residents adequately

3. Observation, on 04/23/2021 at 9:55 AM, revealed on the NF2 Unit, the call light monitor showed room 215 waited for staff to respond to his/her call light for over twenty-one (21) minutes.

Record review revealed the facility re-admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 218	F 725		

Resident #22, on 09/17/2020, to room 215 with the diagnoses of Morbid Obesity, Viral Hepatitis, 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.

Interview with Resident #22, on 04/23/2021 at 1:00 PM, revealed he/she called for assistance to the bathroom. The resident stated facility staff regularly responded in thirty (30) to sixty (60) minutes. Resident #22 stated he/she was a member of the resident council and the council complained monthly about the late response of the call lights by staff. The resident revealed the facility staff complained about being short staffed and other residents who required two (2) staff for care. Resident #22 revealed the two (2) staff members would be unavailable for long periods when other residents needed help.

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 (2) staff exited room 321 with one (1) staff entering room 323 at 10:21 AM, to deactivate the alarm. The total time observed without staff on the TCU hallway was thirteen (13) minutes.

Further observation, on 04/26/2021 at 10:28 AM, revealed room 324's light was deactivated. Room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 219	F 725		

323 total wait time was twenty-two (22) minutes and Room 324's total wait time was twenty-eight (28) minutes.

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.

Interview with the CED, on 05/05/2021 at 10:00 AM, revealed the facility had numerous staff call-outs over Easter weekend which required him and other administrative staff to come in and help. The CED stated he could not complete clinical care, but could support staff in other ways and the administrative clinical staff worked with the residents.

5. Record review revealed the facility admitted Resident #87, on 03/03/2021, to room 321 with the diagnoses of Paraplegia, Autonomic Dysreflexia, and Neuralgia. Review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 220	F 725		

Quarterly Minimum Data Set (MDS), dated 05/12/2021, revealed the facility assessed for cognitive patterns with the Brief Interview for Mental Status (BIMS) with a score of fifteen (15) and determined the resident interviewable.

Interview with Resident #87, on 05/14/2021 at 12:04 PM, revealed the resident activated the call light, on 04/26/2021, in the AM to start his/her bath. The resident stated it took staff over three (3) hours to respond to his/her call light. Resident #87 stated it took two (2) aides to care for him/her and staff would have to go find another aide to assist, which extended the staff's time response.

Interview with CNA #37, on 05/20/2021 at 2:40 PM, revealed the facility expected staff to answer call lights immediately. CNA #37 stated residents used their call lights for safety. The CNA revealed residents become impatient, get up and fall when staff do not answer the light timely. CNA #37 stated anyone could answer the call light and they should be answered at least less than 5 minutes. The CNA revealed staff try to answer quickly, however, the facility had residents which required two (2) staff, which took staff off the floor, and may require the nurse. The CNA revealed the scheduler did not look at what it takes to care for the residents on the unit just the number of residents on the floor.

Interview with LPN #3, on 04/20/2021 at 11:25 AM, revealed residents activated the call light for basic needs, and requested help to reposition. The LPN stated the facility expected staff to respond as soon as possible when the resident activated the call light. However, the NF2 unit included numerous residents that required two (2) staff at the bedside which took staff off the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 221	F 725		

and they were unable to respond to the lights. The LPN revealed when this happened the resident's might get hurt, fall, have pain, lay in urine, and have skin breakdown from pressure. Further interview with the LPN revealed the facility had staff shortages "here and there."

Further interview with LPN #3, on 05/05/2021 at 4:22 PM, revealed Resident #84 required extensive assistance for care and required two (2) staff in the room for his/her care. LPN #3 revealed if the facility had enough staff, the residents' call lights would have a "timely" response. The LPN further stated the residents in NF2 required more attention than the administrator realized. LPN #3 revealed agency staff was pulled from providing care to the residents, which increased the residents' call light response.

Interview with LPN #4, on 04/26/2021 at 1:18 PM, revealed the Transitional Care Unit (TCU) was where Long Term Care (LTC) and new admission residents with complex care needs resided. The LPN revealed one nurse and one aide were assigned to the unit, and many residents required two (2) staff, and they did not have enough staff to cover the floor. LPN #4 stated residents' care often took up to thirty (30) minutes, therefore; staff were not able to hear the residents' call lights when they went off. The LPN revealed an acceptable response time for call lights included up to seven (7) minutes. The LPN revealed twenty (20) to thirty (30) minutes was too long for the residents to wait, and could cause a resident to fall because they became impatient. LPN #4 revealed the call light for the residents could be a life line for help. She further revealed the facility expected nurses to help aides with resident care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 222	F 725		

because the facility did not want to have two (2) aides on the halls. Further interview revealed she often could not get her duties completed by the end of shift. The LPN stated she voiced her concerns to the scheduler and to the director. However, the facility did not make any changes and treatments were not always done. However, LPN #4 stated staff could not meet the facility's expectations when the schedule had minimal staff with high acuity residents.

Interview with Registered Nurse (RN) #2, on 05/21/2021 at 2:45 PM, revealed the RN worked at the facility numerous years. The RN stated the facility worked short staffed and the responses to the residents' call lights were delayed up to thirty (30) to forty-five (45) minutes when the aide and nurse were in a resident's room providing wound care or a transfer with a mechanical lift. RN #2 stated the units had numerous residents which required two (2) staff and long periods of time for care. The RN revealed the facility did not schedule for those residents and the staff got behind, with answering call lights and responding to residents' accidents/incidents.

Interview with the facility Physician, on 05/05/2021 at 2:10 PM, revealed staffing in the facility was not consistent and she could not always find answers to her questions about residents. She stated staff would tell her they were not familiar with the resident, they did not know the resident, that they were new or the resident was normal; which made it hard to ensure accurate information about the residents related to care.

An additional interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 223	F 725		

revealed she had worked at the facility for seven (7) months. Per interview, staffing was determined by the residents' census and needs of the residents. Additionally, she stated that she, the CED and the Staffing Coordinator were responsible to ensure sufficient staffing in the facility. Further, she had no concerns with staffing levels in the facility and stated staffing was adequate to provide care to the residents.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed the MCU was staffed adequately. She stated she had instructed the MCU nurses to avoid charting at the nurse's station but to take a laptop out in the common area to observe the residents while charting.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed following the previous Recertification Survey, administration at the corporate level overstaffed the facility. He stated the staffing was later reduced and staff complained about the reduction in staffing. The CED stated the normal staff present on the MCU included one (1) managing nurse, two (2) CNAs, and a sitter for one on one (1:1) observation. He stated the MCU Director and the Activities Assistant were present for a portion of the day to observe the residents. The CED stated the nurse, CNAs, the sitter, the Activities Assistant, and the MCU Director resulted in a one (1) to five (5) staff to resident ratio, which was acceptable

Interview with the Medical Director, on 05/12/2021 at 10:25 AM, revealed staffing was a problem in the facility. Per interview, the turnover rate of nursing staff and administrative staff in the facility was high. Additional interview revealed he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 224	F 725		

felt with the low staffing levels in the facility it was difficult for staff to provide necessary care to the high acuity residents. Further interview revealed he was not involved in the screening/admission selection of new residents, but he had voiced his concern related to staffing and quality of care for the facility's population to the CED.

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Review of the IJ Removal Plan revealed the facility implemented the following:

1. The Staffing Coordinator and Center Nurse Executive (CNE) obtained staff to cover all units according to resident acuity and care needs upon discovery.

2. On or before 05/19/2021, the Regional Vice President of Operations (RVPO) reviewed the Nursing Home Administrator's Job Description and CFR 483.35 which stated the facility would have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with facility assessment required at 483.35 with the Center Executive Director (CED). He reviewed the information to verify the CED's understanding of responsibility including the intent of the tags cited with a posttest by the RVPO to ensure the facility's systems were in place to adequately address specific resident needs and care issues. Any new CED will receive education and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 225	F 725		

complete a posttest to verify understanding by the RVPO.

3. The Staffing Coordinator, Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, and/or Unit Managers will review staffing needs, using the labor management tool which consists of the hours per patient per day (HPPD) for three (3) days, assignments for all shifts to ensure staff were available to provide care and services as per the care plan for all residents daily for twenty-four (24) weeks including weekends and holidays, to include obtaining additional or rearranging staff to meet the needs of the residents, ensure call lights were answered timely, and supervision needs of the residents were met to prevent injury/accidents then ongoing thereafter as determined by the Quality Assurance Performance Improvement.

4. The CED will monitor personnel assigned to each unit daily to ensure the facility has sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and individual plans of care. They will consider the number, acuity and diagnoses of the facility's resident population in accordance with the Facility's Assessment required at 483.35 to prevent serious injury, serious harm, or death in the facility.

5. The CED will report findings daily, until the immediate jeopardy has been removed, to the Quality Assurance Performance Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 226	F 725		

Committee which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Food Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or inservicing until the issue was resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Interview with the CED and CNE, on 05/22/2021 at 6:30 PM, revealed staffing was reviewed daily to ensure all units were covered to meet the residents' acuity and care needs. Further interview revealed this was completed by reviewing the residents' diagnoses and required level of care. Continued interview revealed the facility's assessment would be utilized as required by Regulations.

2. Interview with the RVPO, on 05/22/2021 at 3:35 PM, revealed he went over the job description with the CED since taking over on 05/17/2021. Per interview, he discussed the staffing requirements as per the facility's assessment. He further stated the CED was provided a posttest and scored one-hundred (100%) percent to show understanding of the information administered.

Review of the posttest, dated 05/15/2021, revealed the test was administered by the RVPO, which included the CED's job description and understanding of responsibility including the intent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 227	F 725		

of the tags cited. Further review revealed the CED made one-hundred percent (100%) and it was signed off by the RVPO on 05/19/2021.

Interview with the CED, on 05/22/2021 at 6:30 PM, revealed he was provided education related to the Per Patient Day (PPD) (Calculating the daily number of hours of care per resident/day) to determine the staffing needed for the day. Additionally, he stated the education included how to determine the residents acuity and the census to determine the number of staff needed to care for the residents. He further reveled this education was provided by the FRVPO who gave the posttest related to staffing and received a passing score. Additionally, he stated his job description was discussed and his responsibilities related to providing oversight of the facility.

3. Interview with the Business Office Manager (BOM), on 05/22/2021 at 4:06 PM, revealed she met daily with the Center Executive Director (CED) and the Center Nurse Executive (CNE), otherwise called their "Labor Meeting," to discuss the staffing for the previous day, the current day, and the projected staffing for the next day. Per interview, she stated they met everyday. The BOM revealed they looked at the Hour Per Patient Day (HPPD) to determine the staffing needed for the day. The BOM stated this was calculated by taking the number of staffing hours and dividing them by the census to come up with the projected staffing for the day. Continued interview revealed the findings would be reported to QAPI until the issues was resolved.

4. Interview with the CED, on 05/22/2021 at 6:30 PM, revealed he would monitor the HPPD related to the residents' census and their acuity to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 228 determine if the staffing needs were met and to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. 5. Interview with the CED, on 05/22/2021 at 6:30 PM, revealed the findings related to staffing would be reported daily to QAPI until the immediate jeopardy was removed. He further stated no concerns were identified. Interview with the BOM, on 05/22/2021 at 4:06 PM, revealed she attended all of the QAPI meetings. She stated staffing was discussed in every meeting.	F 725		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). 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 complete yearly performance review for three (3) of three (3) sampled Certified Nursing Assistants (CNAs #20, #34 and #39) employed with the facility greater than twelve (12) months. The findings include: Review of the facility's policy, Performance Appraisal, revised 03/29/2021, revealed	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 229	F 730		

managers met with regular full time, part-time, and regular casual employees to complete a performance appraisal or have a performance based conversation. The performance review measured results, established development opportunities, and set goals for the coming year. This applied to all employees. In addition, in-service education to employees would be provided to staff based on the outcome of staff reviews.

Review of employees' records for CNA's #20, #34 and #39 revealed the facility did not complete performance reviews for 2018, 2019 and 2020. In addition, the facility could not produce performance reviews from other sources (online records).

Interview with CNA #20, on 05/22/2021 at 2:20 PM, revealed she had been employed at the facility since 1989. The CNA stated the facility should complete a review yearly; however, it had been a long time, years, since her last review. CNA #20 stated if the facility did not provide her with feedback she would not know where improvement was needed.

Interview with CNA #34, on 05/22/2021 at 5:15 PM, revealed she had been employed for over five (5) years. The CNA revealed she could not remember the last time an annual review was completed. CNA #34 stated reviews should be completed yearly. She stated the reviews provided opportunities to learn their positive and negative performance skills which allowed them to improve resident care, services and personal growth with her profession.

Interview with CNA #39, on 05/22/2021 at 5:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 230 PM, revealed the facility should complete an annual review every twelve (12) months. CNA #39 stated she had been employed at the facility for many years; however, her annual review was overdue by around eight (8) months. The CNA stated if the staff did not ask the facility about their review, it would not be completed. In addition, she stated the facility needed to set goals for staff to grow and learn. Interview with the Center Nurse Executive (CNE), on 05/22/2021 at 5:15 PM, revealed the facility should complete a yearly review for all CNA's and all staff. The CNE stated the review evaluated a staff member's performance, strengths, weaknesses, and set goals for the employee. She further stated tracking when reviews were due was the responsibility of the facility's human resource office. However, it was also her responsibility to ensure the reviews were completed and to request a performance review report.	F 730		
F 740 SS=J	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 231	F 740		

by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure individualized residents' behaviors and behavior stressors were identified and specific interventions were developed to support and reduce expression/distress, for three (3) of eighty-seven (87) sampled residents (Resident #21, Resident #61 and Resident #86).

1 Review of Resident #21's medical record revealed the resident had several incidents of behaviors directed towards others. On 10/02/2020, Resident #21 had paced ambulation up and down the hallway, initiated a verbal argument with another resident, intruded another resident's personal space and shoved another resident down onto the floor, all the incidents occurred on the MCU. On 10/10/2020, Resident #21 showed anger towards his/her roommate several times. On 10/25/2020, Resident #21 intruded another resident's personal space and patted him/her on the face. On 10/28/2020, the resident intruded Resident #2's personal space, slapped another resident in the face and cussed at the resident, on the MCU (Memory Care Unit) .

However, the facility failed to develop a plan of care for Resident #21 that identified underlying causes for the resident's specific behaviors, the resident's responses to stressors, and person centered interventions to support the resident to reduce the expression/distress of the specific behaviors that were identified by the facility.

Observations on the MCU, on 04/22/2021, 04/26/2021, 04/28/2021, and 04/30/2021 revealed Resident #21 on the MCU in common rooms, hallways and in other residents' rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 232	F 740		

Resident #21 was observed with paced ambulation up and down the hallways. The resident intruded other residents' personal space. However, review of the Medication Administration Record (MAR), and Progress Notes for Resident #21 revealed no documented evidence of that the exhibited behaviors (paced ambulation, intrusion of others' personal space,) were identified or documented by staff. There was no documented evidence of person centered interventions to support all the resident's behaviors, or to reduce the expression/distress of the known behaviors.

Interviews with staff on the MCU, revealed Resident #21 exhibited paced ambulation, on the MCU (hallway, common area, and into other residents' rooms) daily, prior to the 10/02/2020 resident to resident altercation and since then, the behaviors were ongoing. Per interviews, the resident would pace until he/she was exhausted and had to rest. Continued interviews revealed the resident had a history of physical and verbal abuse directed towards others and intrusion of other residents' personal space. However, they were not aware of the underlying causes of the resident's behaviors; unaware of the resident's responses to stressors; and, were not knowledgeable of person centered interventions developed by the Interdisciplinary Team (IDT), to support the resident and reduce the expression/distress of the behaviors. Per interview, direct care staff were not involved in the Clinical IDT meeting that discussed resident behaviors. Further, unlicensed staff revealed they did not report the resident's behaviors each time they occurred because the resident's behaviors were normal. Per interviews with licensed staff, each behavior should be charted on the MAR, and in the Progress Notes; however,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 233	F 740		

not all behaviors were documented because they did not have time to document that often, as Resident #21 had continuous pacing and intrusive behaviors.

2. Review of Resident #61's medical record revealed the resident had verbal behaviors directed towards others.

On 10/02/2020, Resident #61 was tearful and crying and had a verbal altercation with another resident, on the MCU.

Additionally, interviews with staff on the MCU, revealed Resident #61 exhibited episodes of tearfulness and crying on a daily basis. Per interviews, the resident would become tearful and cry for unknown reasons intermittently throughout the day. However, staff were not aware of the underlying causes for the resident's behaviors, and were unaware of the resident's responses to stressors, and were not knowledgeable of person centered interventions developed by the IDT, to support the resident and reduce expression/distress of the behaviors. Per interview, direct care staff were not involved in the Clinical IDT meeting that discussed resident behaviors. Further, unlicensed staff revealed they did not report the resident's behaviors each time they occurred because the resident's behaviors were normal. Per interviews with licensed staff, each behavior should be charted on the MAR, and in the Progress Notes; however, not all behaviors were documented because they did not have time to document that often; Resident #61 had intermittent tearfulness and crying behaviors.

However, the facility failed to have an effective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 234	F 740		

system that identified and addressed the underlying causes for Resident #61's specific behaviors (yelling directed at others), the resident's responses to stressors, and person centered interventions to support the resident to reduce the expression/distress of the specific behaviors that were identified by the facility.

Observations on the MCU, on 04/22/2021, 04/26/2021, 04/28/2021, and 05/05/2021 revealed Resident #61 on the MCU in the common rooms, and in his/her room with continued tearful, crying episodes. However, review of the MAR and Progress Notes revealed no documented evidence staff identified the exhibited behaviors and documented per the Comprehensive Care Plan or Physician's Orders.

Interview with the Memory Care Program Director (MCPD) revealed the facility failed to maintain Behavior Rounds per the facility's policy, on the MCU. Additionally, residents on the MCU with behaviors documented in the medical record were discussed daily, in the Clinical IDT meeting. However, residents with known behaviors were not discussed in the Clinical IDT meeting, unless staff notified the MCPD of concerns prior to the IDT meeting. Per interview, she was aware direct care nurses failed to document known behaviors in the medical record. However, she had not implemented action to correct the issue. Further, she was not aware direct care staff no longer documented behaviors on a Behavior Flow Sheet.

3. Resident #86, was admitted to the "14-Day Quarantine Unit", on 03/19/2021. The resident was placed with a one-to-one (1:1) sitter at that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 235	F 740		

time, due to his/her increased falls while on the Quarantine Unit. Review of the 1:1 sitter documentation log revealed Resident #86 exhibited behaviors to include hitting, kicking, resistance to care, and screaming/yelling.

Clinical record review revealed the facility failed to identify these behaviors and transferred Resident #86 to the MCU, on 04/06/2021, placing him/her in the room with Resident #85. Review of the Risk Management System (RMS) Event Summary Report, dated 04/22/2021, revealed Resident #86 was exhibiting aggression and resistance to care in the hallway of the MCU, staff redirected Resident #86 to his/her room where he/she picked up a television monitor and struck his/her roommate, subsequently Resident #85 suffered from a right 5th metacarpal fracture.

The facility's failure to have an effective system in place to ensure individualized resident's behaviors and behavior stressors were identified and specific interventions were developed to support and reduce the expression/distress has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 05/07/2021, and was determined to exist on 04/06/2021.

The facility provided an acceptable credible Allegation of Compliance (AoC) 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 a "G" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 236	F 740		

to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy and procedure titled, "Behaviors: Management of Symptoms," revised 11/01/2019, revealed residents exhibiting behavioral symptoms would be individually evaluated to determine the behavior. Per policy, the interdisciplinary team (IDT) would identify underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the resident's behavior. Additionally, residents who displayed or were diagnosed with mental disorders or psychosocial adjustment difficulty received appropriate treatment and services to correct the problem or to attain the highest practicable mental and psychosocial well-being. Continued review revealed staff would use non-pharmacological interventions as first line approach to managing behaviors; which would be addressed in the Care Plan. Behavior Monitoring and Interventions Flow Record would be used for residents exhibiting behavioral symptoms (e.g., verbal or physical abusive, socially inappropriate/disruptive, resist care, wandering, etc.); implement non-pharmacological interventions as initial intervention; Behavior rounds are recommended as a best practice to identify and manage behavioral symptoms (refer to Behavior Rounds Best Practice). Further, the purpose was to identify, prevent, and manage behavioral symptoms by: use non-pharmacological approaches as initial interventions and ongoing; promote a therapeutic and safe environment for residents and staff; monitor outcomes of Care Plan interventions, to minimize the use of psychotropic medications for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 237	F 740		

residents with behavioral symptoms and/or dementia.

Review of the facility's protocol, titled "Behavior Rounds Best Practice", revised November 2013, revealed Behavior Rounds were conducted twice monthly and at minimum monthly and the purpose was to promote the use of non-pharmacological interventions for behavioral challenges. Additionally, Behavior Rounds was the opportunity for team members to discuss the care of residents in the facility. Per protocol, the nursing facility's representatives involved with the rounds included but were not limited to the Director of Nursing, Nurse Unit Managers, Social Services, Recreation, Program Director, Certified Nursing Assistants, Nurse Practitioner, and Medical Director, Attending Physician, Nurse Practitioner, and the Mental Health Provider. The process protocol was that the Nurse Unit Manager or designee developed and maintained a resident list and notified the IDT of residents for review during Behavior Rounds. Residents for review included but were not limited to: residents currently exhibiting change in behavior; residents with behavioral incidents which occurred in the past month; residents who received as needed (PRN) medications due to behavior change; newly admitted residents receiving psychoactive medication; and residents with current psychiatric consultation or recent psychiatric hospitalization. Further, during Behavior Rounds, the IDT would identify whether the behavior was new; the length of time the behavior had been exhibited; time of day and frequency of behavior; what happened/where did it happen/and who was involved; and current interventions/outcomes. Per protocol, the Behavior Monitoring and Intervention Flow Record was used to identify and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 238	F 740		

discuss root case (e.g., potential triggers, unmet needs) or behavioral disturbances and effectiveness of non-pharmacological interventions. Per protocol, Questions to Consider in IDT Behavior Rounds for review included: ruling out underlying medical and physical causes and treatment to determine the root cause of the behaviors; was the resident and resident representative consulted about prior life patterns; were non pharmacological, person centered interventions tried, and results documented; were specific target behaviors identified, were caregivers aware of target behaviors and were desired outcomes documented?

1. Record review revealed the facility admitted Resident #21 to the MCU, on 01/01/2020 with a primary diagnosis of Alzheimer's Disease. Additional diagnoses included Senile Degeneration of the brain, Depressive Episodes, Anxiety Disorder, Psychotic Disorder with Delusions, Dementia without behavioral disturbance, and Adjustment Disorder. Further review revealed the resident had a medical and financial Power of Attorney (POA).

Review of Resident #21's Comprehensive Care Plan (CCP), initiated on 01/14/2020, revealed the resident was at risk for complications related to use of psychotropic drugs. The goal was for the resident to have the smallest most effective dose without side effects. Interventions included but were not limited to: If the resident exhibits behaviors, complete behavior monitoring documentation, dated 01/14/2020; Observe for changes in mental status and functional level and report to the Medical Director (MD) as indicated, dated 01/14/2020; and Observe for continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 239	F 740		

need of medication as related to behaviors and mood, dated 01/14/2020.

Further review of the CCP, initiated on 04/08/2020, revealed the resident was at risk for distressed/fluctuating mood symptoms related to Psychiatric Disorder and Dementia. The goal was for the resident to demonstrate an improved mood state as evidenced by a calmer appearance, and happier demeanor. The interventions included but were not limited to: Encourage the resident to seek staff support for distressed mood, dated 04/08/2020; Refocus the resident with something positive, dated 04/08/2020; and encourage the resident to participate in activity preference, dated 04/08/2020.

However the facility failed to ensure individualized resident behaviors and behavior stressors were identified and specific interventions were developed to support and reduce expression/distress for the behaviors identified and documented in Resident #21's medical record.

Review of Resident #21's Physician's Orders, revealed an order dated 11/06/2020, for "Is the resident behavior free?" YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's disease. Further review revealed an order dated 03/18/2021, for Risperdal (antipsychotic medication) 0.25 milligrams (mg), by mouth, two (2) times a day for Anxiety.

Review of Resident #21's Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 240	F 740		

(MDS) Quarterly Assessment, dated 07/18/2020 revealed the resident usually had the ability to express ideas, wants, and make himself/herself understood. Per the Assessment, the resident usually had the ability to understand verbal content of others. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) indicating severely impaired cognitive skills for daily decision-making. Additionally, the resident was assessed to have no depression symptoms, no signs or symptoms of delirium, no potential indicators of psychosis, and no behavioral symptoms present. Continued review revealed the resident was ambulatory with one (1) person physical assistance and required limited assistance of two (2) staff for transfers between surfaces. Further, the resident had no pain and had one (1) non-injury fall since the previous assessment.

Further review of the medical record revealed discrepancies in documentation related to Resident #21's behavior monitoring on the MAR, Progress Notes and CCP.

Review of Resident #21's Progress Notes, dated 05/01/2021-05/03/2021 revealed no documented evidence of behaviors exhibited. Additional review revealed the resident was diagnosed with a Urinary Tract Infection (UTI) on 05/01/2021. Further, observations on those dates and after, revealed Resident #21 was more lethargic than previously noted, not pacing on the MCU and resting in bed at times throughout the day.

Observations of Resident #21, 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 on 04/30/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 241	F 740		

2:30 PM, revealed the resident on the MCU in common rooms, hallways and in rooms. Resident #21 was observed with intermittent paced ambulation up and down the hallways and in common areas. Further observation revealed the resident was intrusive of other residents' personal space for any resident's path that he/she crossed. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (paced ambulation, intrusion of others personal space) on those specific dates and times.

Interview with Activities Assistant (had worked seven {7} months on the MCU), on 04/22/2021 at 4:10 PM revealed since he had worked on the MCU, Resident #21 was ambulatory and paced up and down the hallways, and in the common areas continuously, most days. Additionally, he was aware the resident would become defensive towards others residents at times when their paths crossed. Per interview, he was aware the resident had been physically aggressive towards others too. Continued interview revealed he monitored behaviors ongoing and reported observed behaviors to the nurse. However, he was not aware of the underlying cause of these behaviors, the resident's responses to stressors, and was not knowledgeable of person centered interventions developed by the IDT to support the resident and reduce the expression/distress of the behaviors. Continued interview revealed he did not report the resident's behaviors at "this time" to the nurse because the nurse was already aware of the behavior. Per interview, he was not involved with the Clinical IDT meeting that discussed residents' behaviors.

Interview with Certified Nursing Assistant (CNA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 242	F 740		

#8 (nine {9} months on the MCU), on 04/22/2021 at 4:15 PM revealed aides could document observed behaviors in the Electronic Health Record (EHR); however, it was facility practice to report all behaviors to the nurse on the MCU, and the licensed nurse would document the resident's behavior. Additionally, since she had worked on the MCU, Resident #21 was independent with ambulation and continuously paced up and down the hallways, in rooms and in the common areas. However, she did not report or document the behaviors because it was the resident's common behavior and everyone knew he/she paced all the time. Continued interview revealed she was aware the resident would also attempt to interact with other residents, which was unwelcome and required redirection. Per interview, Resident #21's behaviors included "sundowning", where in the evenings he/she would ask where the kids were and would say he/she was afraid the kids were at home. Further, the resident's behaviors included agitation in the evenings, and the resident would be an aggressor and attempt to push wheel chairs out of his/her way and become defensive if other residents were in his/her path.

Interview with CNA #2 (seven {7} months on the MCU), on 04/26/2021 at 10:45 AM, revealed since she had worked on the MCU, Resident #21 walked up and down the hallway, all over the MCU, all the time. Additionally, she was not aware of the resident's behaviors such as intrusion of others' personal space, or verbal or physical behaviors directed towards others. Further, she did not report Resident #21's behavior of pacing on the MCU to the nurse, because "everyone knows" the resident does it all the time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 244	F 740		

for Resident #21 on 04/28/2021.

Interview with CNA #9, (two {2} years on MCU), on 04/28/2021 at 3:11 PM revealed shortly after Resident #21 was admitted to the MCU, he/she had aggressive behaviors towards others. Per interview, the resident would grab staff's arms and squeeze them tight and the resident was defensive towards other residents when they were in his/her path. The resident would raise his/her voice, intrude other residents' personal space, and put his/her hands on others. Additionally, the resident walked up and down the hallway, in rooms and the common area rooms all the time. However, she did not report the behaviors that had been observed "today" (paced ambulation and in others' personal space), to the nurse because she was already aware of them.

Interview with Agency CNA #19 (two {2} years on the MCU), on 04/30/2021 at 3:30 PM revealed when behaviors occurred she reported to the nurse. However, "today", she did not report to the nurse that Resident #21 had walked the hallway and intruded other residents' space, all day, because all staff knew the resident had this behavior. CNA #19 stated Resident #21 had always walked up and down the hallways and got into other peoples' space since he/she was admitted to the MCU. Further, she should have reported the behavior to the nurse.

However, interview with direct care staff on the MCU revealed they were not aware of the underlying causes for the resident's behavior, the resident's responses to stressors, and were not knowledgeable of person centered interventions developed by the Interdisciplinary Team (IDT), to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 245	F 740		

support the resident and reduce the expression/distress of the behaviors. Per interviews, they were not involved in the Clinical IDT meeting that discussed resident behaviors and they were not aware of Behavior Rounds.

Review of the MAR, dated 04/01/2021-04/30/2021, revealed an order dated 11/06/2020, which stated, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease. Additional review revealed five (5) times in April "YES" was documented indicating a behavior was present." Per the MAR, the behaviors were present on the following dates at 5:30 AM: 04/05/2021; 04/13/2021; 04/14/202; 04/23/2021; 04/27/2021. However, review of the Nurses Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

Interview with LPN #24, on 04/27/2021 at 2:10 PM, revealed she documented "YES" behavior with no Nursing Note documentation, on 04/13/2021, 04/14/2021, and 04/27/2021 at 5:30 AM. Per interview, she should have made a Nurse Progress Note with all "Yes" responses on the MAR, to include the behavior action exhibited, the intervention staff implemented and the resident's response/outcome to the intervention. Further, Resident #21 was exhibiting paced ambulation on the MCU when she documented "Yes" on the MAR.

However, review of the CCP, revealed no documented evidence the facility developed or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 246	F 740		

implemented individualized resident's behaviors and behavior stressors identified or specific interventions to support and reduce the expression/distress after each documented behavior on the MAR.

Continued review of Resident #21's Nurses Notes, dated 03/06/2021 at 12:18 PM, by LPN #30, revealed the resident had physical behaviors directed towards others almost daily. Verbal behaviors, directed towards others almost daily. Other behaviors, not directed towards others was also almost daily. Wandering daily or almost daily and posed a significant risk and was intrusive of others.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized resident's behaviors and behavior stressors identified or specific interventions to support and reduce the expression/distress after identified behaviors in the 03/06/2021 Progress Note.

On 04/26/2021 at 2:15 PM, attempted to contact LPN #30, via telephone. LPN #30 documented behaviors for Resident #21 in a Progress Note, on 03/06/2021 at 12:18 PM.

Review of Resident #21's MAR, dated 03/01/2021-03/31/2021, revealed an order dated 11/06/2020 which stated, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease." Additional review revealed eight (8) times in March "YES" was documented indicating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 247	F 740		

a behavior was present. Per the MAR, on the following dates at 5:30 AM: 03/09/2021; 03/10/2021; 03/11/2021; 03/14/2021-03/17/2021; and on 03/31/2021. Further review revealed "YES" at 5:30 PM on the following dates: 03/09/2021 and 03/16/2021.

However, review of Resident #21's Nurses' Notes, for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

On 04/26/2021 at 2:12 PM, attempted to contact LPN #14, via telephone. LPN #14 documented "YES" for behavior with no Nursing Note documentation, on 03/14/2021 through 03/17/2021 at 5:30 AM.

Further review of the CCP, revealed no documented evidence the facility developed or implemented individualized resident's behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after the each documented "YES" behavior on the MA

Review of Resident #21's MAR, dated 02/01/2021-02/28/2021, revealed an order dated 11/06/2020. The Order stated, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease." Additional review revealed six (6) times in February "YES" was documented indicating a behavior was present and four (4) opportunities to document a behavior was blank. Per the MAR, there were blanks on the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 248	F 740		

dates at 5:30 AM: 02/16/2021; 02/21/2021-02/22/2021. Continued review revealed "YES" at 5:30 PM on the following dates: 02/01/2021; 02/02/2021; and, 02/15/2021. Further, the following dates were blank: 02/08/2021 at 5:30 PM; 02/11/2021 at 5:30 AM; 02/12/2021 5:30 AM and 5:30 PM, indicating the nurse failed to document if behaviors were present or not present during this shift. However, review of the Nurses' Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

On 04/26/2021 at 2:17 PM, attempted to contact LPN #2, via telephone. LPN #2 documented "YES" for behaviors with no Nursing Note documentation, on 02/01/2021 and 02/15/2021 at 5:30 PM.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after each documented behavior on the MAR.

Review of Resident #21's MAR, dated 01/01/2021-01/31/2021, revealed an order dated 11/06/2020, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease." Additional review revealed thirteen (13) times in January "YES" was documented indicating a behavior was present and one (1) opportunity to document a behavior was blank. Per the MAR,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 249	F 740		

on the following dates at 5:30 AM: 01/12/2021; 01/19/2021. Continued review revealed "YES" at 5:30 PM on the following dates: 01/04/2021-01/05/2021; 01/11/2021-01/12/2021; 01/16/2021-01/18/2021; 01/26/2021; 01/29/2021-01/31/2021. Further review revealed the following date(s) were blank: 01/26/2021 at 5:30 AM, indicating the nurse failed to document if behaviors were present or not present during this shift. However, review of the Nurses Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

On 04/26/2021 at 2:17 PM, attempted to contact LPN #2, via telephone; she documented "YES" behavior with no Nursing Note documentation, on 01/04/2021, 01/05/2021, 01/16/2021, 01/18/2021 and 02/15/2021 at 5:30 AM.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors and behavior stressors identified or specific interventions to support and reduce the expression/distress after each documented behavior on the MAR.

Review of the MAR, dated 12/01/2020-12/31/2020, revealed an order dated 11/06/2020, which stated, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's Disease." Additional review revealed eleven (11) times in December "YES" was documented indicating a behavior was present

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 250	F 740		

and two (2) opportunities to document a behavior were blank. Per the MAR, on the following dates at 5:30 AM: 12/02/2020; 12/06/2020. Continued review revealed "YES" at 5:30 PM on the following dates: 12/02/2020; 12/03/2020; 12/04/202; 12/06/2020; 12/07/202; 12/10/2020; 12/11/2020; 12/19/2020; 12/20/2020; and 12/31/2020. Further, the following dates were blank: 12/20/2020-12/21/2020 at 5:30 AM, indicating the nurse failed to document if behaviors were present or not present during this shift. However, review of the Nurse's Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

On 04/26/2021 at 2:17 PM, attempted to contact LPN #2, via telephone; she documented "YES" for behaviors with no Nursing Note documentation, on 12/19/2020, 12/20/2020, and 12/31/2020 at 5:30 PM.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized resident's behaviors and behavior stressors identified or specific interventions to support and reduce expression/distress after each documented behavior on the MAR.

Review of the MAR, dated 11/01/2020-11/30/2020, revealed six (6) times in November "YES" was documented indicating a behavior was present and four (4) opportunities to documented a behavior were blank. Per the MAR on 11/13/2020 at 5:30 AM. Continued review revealed "YES" at 5:30 PM on the following dates: 11/09/2020; 11/30/2020. Further, the following dates were blank: 11/06/2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 251	F 740		

11/07/2020, 11/10/2020 and 11/24/2020 at 5:30 AM, indicating the nurse failed to document if behaviors were present or not present during this shift. However, review of the Nurses Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

On 04/26/2021 at 2:20 PM, attempted to contact LPN #2, via telephone; she documented "YES" behavior with no Nursing Note documentation, on 11/13/2020 at 5:30 AM.

However, review of Resident #21's CCP, revised on 11/09/2020, revealed the resident exhibited behaviors of (refusal of care, throwing items, cursing and yelling at others, and wandering around the unit) on 11/05/2020. However, 1.) there was no documented evidence in the Progress Notes or the MAR for exhibited behaviors on 11/05/2020 and 2.) no documented evidence the individualized resident's behavior stressors were identified until four (4) days later, on 11/09/2020; and no documented evidence specific interventions were developed to support and reduce expression/distress.

Review of Resident #21's MAR, dated 10/01/2020-10/31/2020, revealed no documented evidence of behavior monitoring for Resident #21. However, review of the Progress Notes in October 2020 revealed documented evidence of exhibited behaviors. Review of the CCP did not reflect the resident's individualized behaviors and resident's behavior stressors or evidence specific interventions were developed to support and reduce expression/distress.

Review of Resident #21's Risk Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 252	F 740		

System (RMS) Events Summary Report, completed by LPN #34, on 10/28/2020 at 10:40 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?", Resident #2 then slapped Resident #21 in the face. Resident #21 then slapped Resident #2 in the face. Staff witnessed the altercation and immediately separated the residents. Resident #21 was visibly upset, cussing and crying. Further review revealed no other documentation on the RMS Event Summary Report. The summary of the investigation was blank.

However, review of the CCP, revealed no documented evidence the facility ensured individualized residents' behaviors and behavior stressors were identified and specific interventions were developed to support and reduce expression/distress after the 10/28/2020 altercation with physical behaviors direct towards others.

Review of Resident #21's RMS Events Summary Report, completed by LPN #38, revealed on 10/25/2020 at 4:00 AM, Resident #21 had a resident-to-resident altercation with alleged abuse, and he/she was the victim. Continued review revealed Resident #21 reported that Resident #26 scratched him/her. Additionally, LPN #38 witnessed Resident #21 walk down the hallway and when he/she saw Resident #26, patted him/her on the cheek. Per the report, Resident #26 then scratched Resident #21 on his/her cheek. Further, the investigation's conclusion was the abuse was not substantiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 253	F 740		

based on Resident #26's statement that he/she did not like Resident #21 touching him/her on the cheek and took offense by the contact. Per the report, corrective action was the residents were redirected.

Review of Resident #21's CCP, revealed a revision to interventions in the focus: the resident exhibited physical behaviors towards another resident. The revision was made on 10/25/2020, to include redirect the resident when he/she attempted to provide care to others, or invaded others residents' personal space.

Continued review of Resident #21's Progress Notes, dated 10/10/2020 at 5:39 PM, by LPN #36, revealed the resident showed anger towards his/her roommate and stated get out of my room, you don't live here, several times. The resident was immediately redirected however after several minutes became upset again with the roommate and required the roommate to be removed from the room.

However, review of the CCP, revealed no documented evidence the facility ensured individualized residents' behaviors and behavior stressors were identified and specific interventions were developed to support and reduce the expression/distress after the 10/10/2020 Progress Note to identify anger directed towards others.

Review of Resident #21's Progress Note, dated 10/09/2020 at 10:00 AM, by LPN #36, revealed the Interdisciplinary Team (IDT) discussed the resident's recent event of pushing another resident down, causing injury. The discussion was made to remove 1:1 supervision at this time,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 254	F 740		

related to the resident having impaired cognition, no recollection of the event, or angry towards others.

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 directed towards others.

Additional review of Resident #21's CCP, initiated on 10/08/2020, revealed the resident exhibited physical behaviors towards another resident. The resident had diagnoses of Alzheimer's Disease, Anxiety Disorder, and Psychotic Disorder. The goal was the resident would not harm himself/herself or others. Interventions included but were not limited to: Distract the resident with activity based on preference, dated 10/08/2020; Observe frequently and redirect when agitated, dated 10/08/2020; and talk to the resident to assess understanding of the situation, dated 10/08/2020.

However, review of the CCP, revealed no documented evidence the facility developed or implemented individualized residents' behaviors (yelling directed at others) and behavior stressors identified or specific interventions to support and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 255	F 740		

reduce the expression/distress after the 10/02/2020 resident-to-resident altercation.

Review of Resident #21's Progress Note/ Administration Note, dated 10/06/2020 at 12:26 PM, by the previous Assistant Administrator, revealed he spoke with the resident's POA related to a pending room change and the POA voiced concern about the resident's sun-downing behaviors towards potential roommates. The Assistant Administrator assured the POA the selected roommate was a previous roommate and the residents were known to get along. Further, the Assistant Administrator noted if complications arose, necessary adjustments to room assignments would be made.

On 04/26/2021 at 2:27 PM, attempted to contact the facility's previous Assistant Administrator, via telephone; he documented the Note on 10/06/2020 at 12:26 PM.

However, review of the CCP, revealed no documented evidence the facility ensured individualized residents' behaviors and behavior stressors were identified and specific interventions were developed to support and reduce expression/distress after the 10/06/2020 Progress Note identifying sun-downing behaviors.

Further review of Resident #21's Risk Management System (RMS) Event Summary Report, completed by LPN #36, revealed on 10/02/2020 at 6:38 PM, Resident #21 had a resident-to- resident altercation with alleged abuse, and he/she was the aggressor. Additionally, the Activities Assistant, on the MCU, witnessed Resident #21 push Resident #61 down causing injury. Continued review revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 256	F 740		

resident had a history of verbal and physical abuse and intrusion of personal space of others. Further, the root cause of the altercation was that Resident #21 was cognitively impaired and difficult to redirect. Per the Report, Resident #21 attempted to go into another resident's room and intervened/pushed Resident #61 down. Corrective Action was to place Resident #21 on 1:1 until directed by IDT.

However, review of the CCP revealed there was no documented evidence the individualized resident's behaviors and behavior stressors were identified or other specific interventions were developed to support and reduce the expression/distress of paced ambulation, wandering into other residents' rooms, and verbal or physical behaviors directed towards others.

2. Record review revealed the facility admitted Resident #61 to the MCU, on 12/17/2019 with a primary diagnosis of unspecified Dementia without behavioral disturbance. Additionally, the resident was diagnosed with Adjustment Disorder with depressed mood, on 06/16/2020, as his/her secondary diagnosis. Further, the resident had a medical and financial POA.

Review of Resident #61's CCP, initiated on 02/27/2020, revealed the resident exhibited symptoms of psychosis related to delusions; whispering, screaming, and throwing items while in his/her room. The goal was for the resident to demonstrate increased stability. Interventions included but were not limited to: Provide consistent, trusted caregivers and structured daily routine; Approach the resident in a calm, unhurried manner, reassure as needed; and monitor the resident's response to medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 257	F 740		

Additional review of Resident #61's CCP, initiated on 09/16/2020, revealed the resident had potential for psychosocial distress related to multiple medical problems and diagnoses of: Dementia without behavior disturbance, Adjustment Disorder with depressed mood, and Major depressive disorder. The resident exhibited tearfulness, crying, irritability and wandering. The goal was for the resident to show no signs or symptoms of psychosocial distress. The interventions included but were not limited to: Complete behavior monitoring documentation if behavior was exhibited; Psychological services; Observe for signs and symptoms of psychosocial distress (tearfulness, crying, irritability); and Social Service visits as necessary.

However, the CCP was not developed to include specific interventions to support and reduce expression/distress or tearfulness and crying.

Review of Resident #61's Minimum Data Set (MDS) Quarterly Assessment, dated 07/11/2020, revealed the resident usually had the ability to express ideas, wants, and make himself/herself understood. Per the Assessment, the resident usually had the ability to understand verbal content of others. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four (4) which indicated severely impaired cognitive skills for daily decision-making. Further, the resident was assessed to have no depression symptoms, no signs or symptoms of delirium, no potential indicators of psychosis, and no behavioral symptoms present.

Review of Resident #61's Physician's Orders,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 258	F 740		

dated April 2021, revealed an order, dated 07/21/2020, for Risperidone (antipsychotic medication) 0.25 milligrams (mg) by mouth, two (2) times a day for Mood Disorder. Further, the resident had an order, dated 09/25/2020, for "Is the resident behavior free?" If behavior present (tearful, crying irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors.

Review of Resident #61's MAR, dated 10/01/2020-10/31/2020, revealed no documented evidence of behavior monitoring for Resident #61. However, review of the Progress Notes in October 2020 revealed documented evidence of exhibited behaviors such as tearfulness and crying. However, the CCP did not reflect the individualized resident's behaviors and resident's behavior stressors or evidence that specific interventions were developed to support and reduce the expression/distress.

Additional review of Resident #61's Progress Notes, dated 10/02/2020 at 5:38 PM, completed by LPN #37, revealed the resident had an altercation with Resident #21 losing his/her balance and landing on the floor. Per the Note, the Unit Supervisor was notified and she stayed with the resident sitting on the floor until help arrived.

Review of the Risk Management System (RMS) Event Summary Report, completed by LPN #36, revealed on 10/02/2020 at 6:38 PM, Resident #61 had a resident-to- resident altercation with alleged abuse, and he/she was the victim. Additionally, the Activities Assistant, on the MCU, witnessed Resident #21 and Resident #61 get into a verbal altercation and Resident #21 pushed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 259	F 740		

#21 to the ground. Continued review revealed the root cause of the alteration was that Resident #61 was attempting to enter Resident #21's room and the resident became angry and pushed the resident down, causing injury. Per the Report, the Corrective Action was to place Resident #21 on 1:1 until directed by IDT, and send Resident #61 to the emergency room.

Interview with CNA #8, on 04/22/2021 at 4:15 PM revealed on 10/02/2020 around 5:00 PM, she was in the common area on the MCU, watching residents in a group activity. Per interview, Resident #61 left the dining room upset and crying; 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 resident had the behavior all the time. Additionally, when the resident left the common area, Resident #61 tried to enter Resident #21's room (room right beside Resident #61's room). Continued interview revealed she could see Resident #61's room from the common room where she was standing. Resident continued to cry in the hallway by Resident #21's doorway. Further, at the same time Resident #21 was observed with paced ambulation up and down the hallway. Per interview, Resident #21 became more agitated when Resident #61 was crying and was near his/her room. Continued interview revealed she then heard a commotion (yelling and movement) and all staff ran to Resident #21 and Resident #61; however, she did not witness what happened.

Review of Resident #61's CCP, revealed the facility failed to develop the resident's Care Plan to include the resident-to-resident physical altercation on 10/08/2020, six (6) days after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 260	F 740		

abuse. Continued review revealed the resident was pushed down by another resident which could potentially cause psychosocial distress. The resident was diagnosed with Dementia without behavior disturbance and Major Depressive Disorder. The goal was for the resident to show no signs of psychosocial distress. Interventions included but were not limited to: Encourage interaction with peers; Engage in his/her life in the facility; and observe for signs and symptoms of psychosocial distress (tearfulness, crying, irritability). However, there was no documented evidence the facility developed or implemented individualized residents' behaviors (yelling directed towards others) and behavior stressors identified or specific interventions to support and reduce the expression/distress after the verbal altercation leading to the abuse.

Interview with the Activities Assistant, on 04/22/2021 at 4:10 PM revealed on 10/02/2020 around 5:00 PM, he was in the hallway near Resident # 61's room working on an Activities calendar, which was close to Resident #61's and Resident #21's rooms. Per interview, he saw Resident #61 standing by the calendar in the hallway and then ambulated to his/her her room. At that time, Resident # 21 walked passed him to Resident #61 and immediately they started yelling at one another. Per interview, the residents were yelling but only the first words in the sentences were audible because they were cutting one another off. He stated the residents stated, "No you can't." Yes I can." Continued interview revealed the residents were verbally telling one another they could not come in Resident #61's room or stand near the room. However, he was unable to attempt redirection before Resident #21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 261	F 740		

pushed Resident #61 in the chest, knocking the resident off balance, which caused the resident to fall backwards towards the door, then along the wall in the hallway and to the ground. Additionally, the residents were immediately separated, and Resident #21 was immediately placed on 1:1 with a staff. Resident #61 was not at first obviously injured but was shortly after the incident sent to the Emergency Room because he/she verbalized pain in his/her right arm. Further interview revealed since he had worked on the MCU, Resident #21 was ambulatory and paced up and down the hallways, and in the common areas continuously, most days. Additionally, he was aware the resident would become defensive towards other residents at times when their paths crossed. Per interview, he was aware the resident had been physically aggressive towards others too. Continued interview revealed that since he had worked on the MCU, Resident #61 had tearful and crying episodes intermittently throughout the day, most days. Further, he did not report the resident's behaviors at that time to the nurse because the nurse was already aware.

Additional review of Resident #61's Minimum Data Set (MDS) Quarterly Assessment, dated 03/25/2021 revealed the resident usually had the ability to express ideas, wants, and make himself/herself understood. Per the Assessment, the resident usually had the ability to understand verbal content of others. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) indicating severely impaired cognitive skills for daily decision-making. Further, the resident was assessed to have no depression symptoms, no signs or symptoms of delirium, no potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 262	F 740		

indicators of psychosis, and no behavioral symptoms present.

Observations of Resident #61 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 on 04/30/2021 at 2:30 PM, revealed the resident on the MCU in the common rooms, hallways and in his/her room tearful and crying. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (tearful, crying) on those specific dates and times.

Additional review of Resident #61's MAR, dated 04/01/2021 through 04/30/20201, revealed an order dated 09/25/2020, for " Is the resident behavior free?" If behavior present (tearful, crying, irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors. Additional review revealed each day 6:00 AM - 2:00 PM and 10:00 PM -6:00 AM , "YES" was documented indicating the resident was behavior free every day and night shift, except 04/10/2021 at 6:00 AM-2:00 PM, which was blank.

Additional 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.

However, interview with direct care staff on the MCU revealed they were aware the resident was tearful and crying but they were not knowledgeable of person centered interventions developed by the Interdisciplinary Team (IDT), to support the resident and reduce the expression/distress of the behaviors; including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 263	F 740		

behavior monitoring.

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 days. Further, he did observe the resident with behaviors at this time.

Interview with Certified Nursing Assistant (CNA) #8, on 04/22/2021 at 4:15 PM revealed since she had worked on the MCU it was common for the resident to exhibit crying tearful episodes on a daily basis; therefore she did not report or document the behavior because it was the resident's common behavior and everyone knew he/she cried all the time.

Interview with CNA #2, on 04/26/2021 at 10:45 AM, revealed since she had worked on the MCU, Resident #61 cried all the time. Further, she did not report Resident #61's behavior of crying to the nurse, because everyone knew the resident cried all the time.

Interview with RN #6, on 04/26/2021 at 2:30 PM, revealed Resident #61's behavior was he/she was tearful and would cry intermittently every day. However, she did not document the resident's behavior every time he/she cried or became tearful because it was so frequent. Further, she was not aware the resident was crying at the time of the interview.

Interview with RN #1, on 04/28/2021 at 2:30 PM revealed she was aware that Resident #61 cried continuously; however, she was not aware of and had not documented any behaviors for the resident on 04/28/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 264	F 740		

Interview with CNA #9, on 04/28/2021 at 3:11 PM revealed shortly after Resident #61 was admitted to the MCU, he/she began to have tearful crying episodes on a regular day to day basis. Per interview, the resident would cry in the middle of a meal, during activities and during care. Additionally, the resident would attempt to go to his/her room when he/she became tearful. However, on 04/28/2021 staff had not reported observed behaviors (tearful or crying), to her and she had not observed those behaviors either.

Interview with Agency CNA #19, on 04/30/2021 at 3:30 PM revealed she did not always report behaviors to the nurse because Resident #61 always cried and everyone knew the resident had this behavior. Further, she tried to console the resident and distract him/her to help stop the crying.

Interview with the Memory Care Program Director (MCPD), on 04/26/2021 at 3:00 PM, revealed she had worked at the facility as a Social Worker for one (1) year and had been the MCPD for six (6) months. Per interview, she expected all behaviors to be documented in a Progress Note by the licensed nurse to include the behaviors, the intervention and the response. However, nurses did not always make that happen and she would make the Progress Note if she was aware of the behavior. Additionally, she expected a three (3) day follow up Progress Note, with any behavior observed to ensure interventions were effective and the resident's response. Per interview, there were Behavior Flow Sheet Records at the nursing station, in a binder for residents with known behaviors that all direct care staff were responsible to document behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 265	F 740		

However, she was not aware the binder was empty and there were no Behavior Flow Sheet Records since October 2020. Continued interview revealed she rounded each morning and visualized residents and spoke with nursing staff, on her way to her office when she entered the facility. She would also review any Progress Notes if the nurse informed her of any behaviors that happened while she was at home; however, unless nursing staff told her about a resident with behaviors she did not review Progress Notes. Further, each morning Monday through Friday, the Clinical IDT would review any documented behaviors to ensure interventions were in place and made necessary changes. Per interview, Resident #61 cried all the time and staff attempted to anticipate his/her needs. Continued interview revealed Resident #21 had paced ambulation and constantly walked up and down the hallway and in the common areas and would be intrusive of other residents' space. However, she did not expect nurses to document every time Resident #61 cried or Resident #21 paced or got into another resident's space because they would be charting twenty (20) plus times a day and would not get anything else done. Per the MCDP, the facility was responsible to ensure all residents with known behaviors had care individualized per their specific behaviors and behavior stressors identified and specific interventions developed to support and reduce their expression/distress.

Interview with the facility's Physician, on 05/05/2021 at 2:10 PM revealed residents should receive behavior care and services through collaboration of the IDT. Additionally, she expected direct care nurses and aides to identify, document and report observed behaviors. Per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 266	F 740		

interview, the IDT should develop and implement individualized interventions and re-assess them for effectiveness. Continued interview revealed she was not aware of behaviors rounds per the IDT in the facility. She stated she relied on verbal communication with the staff or documentation in the medical record to know what behaviors residents exhibited. However, staffing in the facility was not consistent and she could not always find answers to her questions about residents. She stated staff would tell her they were not familiar with the resident, they did not know the resident, they were new or the resident was normal. Continued interview revealed when that happened she would talk to the CNE and try to figure out if she was aware of anything going on with the resident. Further, interview revealed she stated Resident #21 and Resident #61 were stable.

Interview with the facility's contracted Physiatrist, on 05/05/2021 at 4:22 PM revealed he expected facility nursing staff to document all behaviors in some form or fashion. Per interview, nursing documentation would be helpful to know those things that were going on with the resident. Additionally, he stated he felt the nursing staff were good about calling him with behaviors changes with residents and was quite a bit surprised that the documentation was lacking if observations of behaviors were present. Further, he stated he felt if staff had not documented known behaviors, this could create a problem. However, he stated if he treated a problem there would not be documentation to support it or he wouldn't know to treat a problem because it was not documented. Continued interview revealed on 04/29/2021, nursing staff had reported to him that Resident #21 was stable and review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 267	F 740		

resident's Nurses Notes revealed no documented evidence the resident had any behaviors. Additionally, on 05/05/2021, he had seen Resident #61 on 02/23/2021, and the resident was crying. He stated he noted there was no documented evidence of nursing notes related to behaviors when he reviewed the medical record. The Physiatrist stated nursing staff told him the resident was stable. Continued interview revealed he had seen Resident #61, on 05/05/2021; however, he had not reviewed the resident's record "yet" or spoke with nursing staff.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed she had worked at the facility for seven (7) months. Per interview, residents should receive and the facility should provide the necessary behavioral health care and services. Additionally, the facility's Policy and Protocols should be followed to ensure residents received necessary care and services. However, the facility deviated from the Behavior Management of Symptoms policy. The Behavior Rounds Best Practice protocol was not maintained per the outline and the Behavior Monitoring and Interventions Flow Record was no longer utilized in the facility. The CNE stated the Rounds and Flow record had not been utilized since October 2020 after implementation of the Plan of Correction. Continued interview revealed the IDT discussed documented behaviors in the Monday through Friday Clinical meeting. However, unless the MCPD brought information related to undocumented behaviors to the daily Clinical meeting, the behaviors would not be reviewed by the IDT. Further, all behaviors should be documented by direct care staff, if a resident exhibited behaviors, in a Progress Note, including the behavior, the intervention, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 268	F 740		

response. It was important for all staff to know what specific behaviors a resident had to assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, through individualized necessary care. Per interview, the IDT should review behavior documentation and develop approaches for each resident to address underlying causes of behaviors and evaluate the effectiveness and the resident's responses to interventions and stressors; without behaviors being documented, the IDT could not properly support and reduce the expression/distress to the residents. Review of Resident #21's behaviors documentation in the medical record, and in summary per staff interviews with the CNE revealed the resident's behaviors should have been reported and documented. If Resident #21's behaviors would have been documented in the medical record, there was potential that the behavior effect could have been less for the residents and other residents on the MCU. Review of Resident #61's observed behaviors with the CNE revealed those tearful/crying behaviors exhibited should have been identified by direct care staff, reported and documented in the medical record. Continued interview revealed she felt the facility's failures were communication between direct care staff, MCPD and the IDT; the information about behaviors on the MCU were not brought to the IDT's attention and walking rounds on the MCU only gave the CNE a snap shot of the residents.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed he had worked at the facility for three (3) months. Per interview, he expected the IDT to work together to manage behavior issues for all residents with behaviors. Additionally, he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 269	F 740		

expected the facility's Policy and Protocols related to behaviors to be followed and revised as necessary if known to be inaccurate. Continued interview revealed he expected direct caregivers to identify and report behaviors and provide monitoring and supervision to the residents and document in the medical record. Per interview, the IDT would discuss all documented stressors and interventions and recommend actions to prevent or minimize the behaviors. Further, the IDT tried to round throughout the facility Monday through Friday in the mornings before Clinical meeting, to check on resident concerns; however, unless the IDT was aware of behaviors the rounds would focus on cleanliness and any grievance the resident might have. Continued interview revealed the Quality Assurance (QA)/Quality Assurance Performance Improvement (QAPI) Committee discussed behaviors monthly; however, the QA/QAPI committee had not reviewed Resident #21 and #61's behaviors.

3. Record review revealed the facility admitted Resident #86 on 03/19/2021 with diagnoses that included Dementia without Behaviors, Parkinson's disease, Muscle Weakness, Hallucinations and Repeated Falls. Continued review revealed Resident #86 was on 1:1 supervision upon admission to the facility due to increased falls. Further review revealed staff documented aggressive behaviors prior to being transferred to the Memory Care Unit (MCU) where he/she was the aggressor in a physical altercation involving a television resulting.

Review of the Minimum Data Set (MDS), dated 03/25/2021, revealed Resident #86 was not assessed for a Brief Interview for Mental Status. Continued review revealed mood concerns were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 270	F 740		

not assessed, and the resident exhibited no behaviors at the time of the assessment. Continued review of the MDS revealed Resident #86 was administered antipsychotics and diuretics seven (7) of the last seven (7) days. Further review revealed the resident had active diagnoses of Non-Alzheimer's Dementia and Parkinson's disease.

Review of the care plan, dated 03/22/2021, revealed Resident #86 had impaired thought processes related to Dementia with interventions to include redirection, personalize Resident #86's room with familiar items, create a calm/smoothing environment, and speak in a normal-tone voice. Further review revealed the facility failed to develop a care plan addressing Resident #86's behaviors exhibited prior to transferring to the MCU involving combativeness and resistive to care.

Review of the 1:1 documentation log dated 03/27/2021, revealed Resident #85 exhibited behaviors such as hitting, kicking, and resistive to care at 1:00 AM, 1:30 AM, 2:00 AM, 2:30 AM, 3:00 AM, 3:30 AM, and 5:30 AM. Further review revealed on 04/06/2021 at 10:00 AM, Resident #86 exhibited behaviors such as screaming/disruptive sounds.

Review of Progress Notes, dated 03/25/2021 at 2:30 AM revealed Resident #86 was attempting to get out of bed and was unable to be redirected. Continued review of the Progress Notes, dated 04/22/2021 at 3:37 AM, revealed Resident #86 was wandering the hall and exit seeking, was unable to redirect and became agitated, and was noted to be banging on the MCU door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 271	F 740		

Record review revealed the facility failed to identify increased aggression and agitation related to Resident #86's 1:1 supervision documentation log before he/she was moved to the MCU.

Interview with CNA #8, on 05/12/2021 at 2:32 PM, revealed prior to Resident #86's move to the MCU, he/she could be resistive to care and had the potential to be combative with staff.

Interview with the CMT, on 05/12/2021 at 11:30 AM, revealed Resident #86 exhibited behaviors described as combative and resistive to care prior to his/heraltercation with Resident #85.

Interview with LPN #5, on 05/12/2021 at 11:45 AM, revealed prior to his/her move to the MCU, Resident #86 could be aggressive at times and resistive to care.

Interview with RN #1, on 05/12/2021 at 8:15 AM, revealed she notified the Memory Care Program Director of her concerns with Resident #86 moving to the MCU due to his/her high falls risk and continuous attempts to get out of bed and his/her wheelchair.

Interviews with the CNE, dated 05/12/2021 at 7:20 PM, revealed she was not made aware of Resident #86's behaviors prior to his/her move to the MCU and would expect staff to notify her. She continued that his/her behaviors should have been documented in the medical record so the IDT could identify the behaviors and known triggers so interventions could have been in place to decrease the aggressive/combative/resistive to care behaviors exhibited by Resident #86.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 740	Continued From page 272	F 740		

Interview with the CED, on 05/12/2021 at 6:36 PM, revealed he was not aware of Resident #86's behaviors prior to his/her move the to MCU. He continued Resident #86's behaviors should have been documented so the IDT could have interventions in place to help decrease his/her behaviors. Further interview revealed it was the Memory Care Program Director's responsibility to bring these identified behaviors to the IDT meetings to be discussed. He revealed that staff "did not know what they were talking about" when the SSA identified Resident #86's behaviors through interviews.
Review of the IJ Removal Plan revealed the facility implemented the following:

1. On 05/11/2021 at 1:00 PM, The Center Executive Director (CED), and Center Nurse Executive (CNE), notified the Medical Director to discuss the Immediate Jeopardy citations. An ad Hoc Quality Assurance Performance Improvement Committee (QAPI) meeting was conducted with the CED, CNE, and Medical Director for recommendations developing the action plan including audits, reeducation, and compliance monitors for residents at risk for behavioral health services.

2. On 05/11/2021 Vice President of Clinical Operations contacted the Quality Improvement Organization (QIO) for behavior element support.

3. On 05/12/2021, a contract was signed with PPL Therapeutic Services PPLC to provide behavioral health services including individualized treatment plans and interventions based on interpersonal interactions with mental health assessments of each resident. The goal of the collaboration would be Behavioral symptom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 740	Continued From page 273	F 740		

management and interventions.

4. On 05/12/2021, the Senior Director from the (Corporate) National Specialty Practices Team conducted reeducation with the SSD, Center Executive Director (CED), CNE, NPE, Unit Managers ADNS, and Nursing Supervisor regarding the facility's policy, Behaviors: Management of Symptoms, and that each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Additionally, the reeducation included De-escalate Challenging Situations and Behaviors: How to respond when Dementia Causes unpredictable Behavior obtained from the Quality Improvement Organization (QIO) with a posttest requiring a one-hundred percent (100%) grade. Any newly hired staff would receive education and complete a posttest to verify understanding by the National Specialty Practices Team or CQS.

5. Starting 05/14/2021, the SSD, SW, Center Nurse Executive(CNE), Assistant Director of Nursing Service (ADNS), Memory Support Program Manager and or Unit Manager (UM) would review the Progress Notes of residents presenting with behaviors in the clinical morning meeting to determine the need for behavioral health services. This would be completed daily times two (2) weeks including weekends and holidays then three (3) times per week times two (2) weeks then weekly for eight (8) weeks then every other week times eight (8) weeks then monthly times (1) month then ongoing thereafter as determined by the Quality Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 740	Continued From page 274	F 740		

Performance Improvement (QAPI) Committee to ensure the behavioral needs of the residents were met with any corrective action upon discovery.

6. On or before 05/19/2021, the PLLC services would evaluate Resident #21's behaviors, and behavior stressors would be identified with specific interventions developed that would be added to the resident's care plan to reduce behaviors including behaviors directed toward other residents. Additionally, the Interdisciplinary Team (IDT) provided Behavior Management monitoring documentation for Resident #21 and the Medication Administration Records (MAR) were updated.

7. On or before 05/19/2021, Resident #86's behaviors and behavior stressors would be identified and specific interventions would be developed and added to the care plan to reduce behaviors including behaviors directed toward other residents.

8. By 05/19/2021, the Social Services Director (SSD), Social Worker, Center Nurse. Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Nurse Practice Educator (NPE) and or Licensed Nurses (LN) will conduct an audit of all residents' records presenting with behaviors to include signs of frustration, agitation, and anger such as physical or verbal behavioral symptoms directed toward others and/or not directed at others, to determine the need for a behavioral health consultation and revise the behavior care plan for the fifteen (15) affected residents. Additionally, a plan was instituted to ensure the care plans of all the residents with identified behaviors would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 740	Continued From page 275	F 740		

revised.

9. On or before 05/19/2021, the Center Nurse Executive (CNE) Unit Managers and/or charge nurses would provide re-education to all licensed nursing staff, including agency staff regarding the facility's policy, Behaviors: Management of Symptoms and that each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Reeducation also included Tips to De-escalate Challenging Situations and Behaviors: How to Respond when Dementia Causes Unpredictable Behavior obtained from the Quality Improvement Organization (QIO).

Additionally, the SSD, Social Worker, CNE, ADONS, Unit Manager, Nurse Practice Educator (NPE) and/or Charge Nurse would provide re-education for nurses to complete a thorough investigation when a behavior occurs to identify triggers in order to develop a person centered care plan.

A passing grade of one-hundred percent (100%) was required. Staff not available during this time frame to include agency staff will be provided re-education including posttest by the Unit Managers and or CNE upon day of return to work. New hires including agency staff will be provided education and a posttest during orientation by the CNE, NPE or Unit Managers.

10. The Center Nurse Executive (CNE) or Assistant Director of Nursing Service (ADNS), Memory Support Program Manager, Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 276	F 740		

Manager (UM), Licensed Nurse, Certified Nursing Assistant, Mental Health Provider or Nurse Practitioner would conduct behavior rounds to determine that behaviors were managed appropriately with corrective action upon discovery weekly times four (4) weeks, bi-weekly times four (4) weeks then monthly times (4) months then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the behavioral needs of the residents were met with any corrective action upon discovery.

11. The CED and/or CNE would review results of audits and interviews daily to ensure concerns identified were addressed upon discovery.

12. The SSD, SW and/or CNE would report the review findings monthly times six (6) months to the Quality Assurance Performance Improvement Committee which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Interview with the Medical Director, on 05/22/2021 at 4:33 PM, revealed the Center Executive Director and the Center Nurse Executive (CNE) notified him by phone in regards to the notification of Immediate Jeopardy on 05/11/2021. He revealed the facility held an Ad-HOC QAPI meeting to discuss with the committee and plan the way the facility would remove the immediacy of the jeopardy, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 740	Continued From page 277	F 740		

included education, audits, and monitoring behaviors.

2. Review of the Vice President of Clinical Operations' (VPOC) statement, undated, revealed the VPOC contacted the QIO on 05/11/2021 at approximately 11:00 AM and left a telephone message with the QIO. Continued review revealed she received a call back from someone representing the Kentucky QIO and stated the QIO would be out of the office until 05/17/2021, but another advisor would begin to gather training materials and audit tools in reference to her request for assistance surrounding behavioral interventions, training and education. Further review revealed an email was sent to the CED, CQS, and present VPOC.

Interview with the Quality Improvement Organization (QIO), on 05/22/2021 at 4:00 PM, revealed the VPCO contacted the QIO division to request support for behavior education and care.

3. Review of the signed Therapeutic Services Agreement, signed by the CED and President of the company, dated 05/12/2021, revealed they would provide medically necessary therapeutic services to the facility's residents. Further review revealed the provider and facility staff would cooperate to ensure that residents' needs would be served in an effective and efficient manner.

Interview with the Clinical Quality Specialist (CQS), on 05/22/2021 at 3:06 PM revealed that in an effort to address the residents' behaviors on the Memory Care Unit, the "Group" suggested signing a contract for therapeutic services.

4. Interview with the Director of Memory Support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 278	F 740		

Clinical Support and Education, on 05/22/2021 at 2:37 PM, revealed she provided education to the management team, by way of Zoom, on 05/12/2021. Per interview, the education consisted of information related to residents' behaviors and why the behaviors occur. She stated she discussed de-escalating the residents with changing situations. Further interview revealed the session was recorded and could be used for future use. The Director of Memory Support Clinical Support and Education stated she was working with the facility in reviewing the residents' charts as she had access to the facility's records.

Interview with the Senior Director of Social Work Practice and Education, on 05/22/2021 at approximately 2:40 PM, revealed she was contacted by the CQS to work with the staff's understanding of Dementia Care. She stated the information was provided by way of Zoom, on 05/12/2021. She stated the policy and procedure for nursing management was reviewed. Further interview with the Senior Director of Social Work Practice revealed she explained to staff that "all" behavior had meaning and staff should look for the causes, history, and diagnoses of the residents. She further revealed the education covered how to have more of an individualized approach to care planning. She stated the facility had signed a contract with a local provider to assist with the residents' behaviors "in house". Additionally, she stated she had partnered with the Director of Memory Clinical Support and Education and would be reviewing the residents' charts remotely.

5. Record review revealed the facility's audit tools, dated 05/14/2021 through 05/21/2021, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 279	F 740		

the facility's clinical management team reviewed daily progress notes for behaviors to determine the need for services with signatures of the clinical team attendees.

Interview with the UM, on 05/20/2021 at 4:00 PM, revealed the clinical team reviewed behaviors documented by staff to address with clinical services, care plan intervention or further assessments. The team printed daily reports for behaviors on all high profile residents with behavior progress notes, medication records, and random progress notes on residents with low profile behaviors to review.

Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she pulled the residents' clinical notes daily. She stated she reviewed the notes to determine if there were any new or existing behaviors. Per interview, this began on 05/14/2021.

6. Resident #21 was seen by the Therapeutic Services and his/her care plan was revised, on 05/17/2021, by Social Services (SS) #1 and SS #2. Resident was provided behavior management monitoring.

7. Review of Resident #86 behavioral care plan revealed the facility reviewed and/or revised the resident's focus, goals, and/or interventions for known behaviors for staff to monitor. Additionally, the residents were seen by the Therapeutic Service Group.

Review of Resident #86's Comprehensive Care Plan revealed the CNE revised the resident's care plan on 05/16/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 280	F 740		

Interview with the Social Service Director (SSD), on 05/21/2021 at 5:30 PM, revealed she completed many of the care plan updates for behaviors; however the Corporate Social Services reviewed the residents' care plans and updated as needed.

8. Review of the audit tool revealed staff would conduct visual observation rounds to determine if staff were meeting the behavioral care needs of five (5) residents with behaviors. Further review revealed a column for the resident's name, a column which stated, "Conduct visual observation rounds to determine if staff were meeting the behavioral care needs of residents with behaviors, Yes or No. Further review revealed there was a column, which stated, "Conduct visual observation rounds to determine if staff were meeting the behavioral care needs of residents with dementia. Yes or No."

Interview with the Director of Regulatory Compliance (DRC), on 05/22/2021 at 6:30 PM, revealed on 05/19/2021 the facility initiated audits for behaviors for fifteen (15) identified residents with known behaviors.

Interview with the, Senior Rapid Response Manager, on 05/22/2021 at 12:09 PM, revealed she was the acting "Program Manager" for the Memory Care Unit (MCU). She stated visual behavior observations/rounds were performed on the residents. Further interview revealed she has audited the residents' Progress Notes. She stated if she found any concerns in the notes, she would write a supplementary note or would follow up with the nurse.

9. Interviews with Licensed Practical Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 281	F 740		

(LPN) #14 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, and Registered Nurse (RN) #1 on 05/21/2021 at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, revealed they were educated on how to investigate incidents related to residents with behaviors. Additional interviews revealed they were educated on the residents' behaviors, how to work with residents with behaviors, to include de-escalating the behaviors. Further interview revealed they would document the residents' behaviors. Per interviews, they were provided a posttest and received a passing score.

Interview with the NPE, on 05/21/2021 at 3:50 PM, revealed the DRC provided education to the administrative team for behaviors and dementia. Continued interview revealed the NPE educated clinical and non-clinical staff .

10. Interview with the Senior Response Manager, on 05/22/2021 at 12:09 PM, revealed she conducted the behavior rounds on the residents. Per interview, she stated she selected the residents at random and audited throughout the day.

11. Interview with the CNE and CED, on 05/22/2021 at 6:30 PM, revealed they reviewed the audits from the behavioral rounds and would look over the audit tools for any concerns identified.

12. Interview with the CED, on 05/22/2021 at 6:30 PM, revealed the audits were presented in morning meeting. He stated concerns were identified and the residents' care plans with appropriate interventions were put in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 282	F 758		
F 758 SS=G	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 758	Continued From page 283	F 758		

prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

This REQUIREMENT is not met as evidenced by:
Based observation, interview, record review, and policy review, it was determined the facility failed to ensure residents received psychotropic medications with adequate side effect monitoring, actions taken for adverse reactions, and as needed (PRN) orders included a fourteen (14) day stop date for two (2) of eighty-seven (87) sampled residents, (Resident #2 and Resident #3).

Resident #2 had an order for Ativan zero point five (0.5) milligrams (mg) to be given, every four (4) hours as needed for anxiety/agitation with no stop date. Observation of Resident #2, on 04/14/2021 at 1:48 PM, revealed resident had tremors of both upper extremities.

Resident #3 was prescribed Trazadone (medication for Psychosis) one-hundred (100) mg daily. Review of Resident #3's the plan of care, revealed staff were directed to monitor for side effects and document on the behavior monitoring flowsheet. However, record review and interview revealed this did not occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 284	F 758		

The findings include:

Review of the facility's Psychotropic Medication Use Policy, revised 11/28/2016, revealed psychotropic medications included any medication that affected the mental processes and behaviors. The policy revealed psychotropic medications were used with appropriate diagnoses and only after non-medication and medication therapies failed to address the behaviors. The policy revealed as needed (PRN) psychotropic medications were limited to fourteen (14) days and not renewed without re-evaluation from the prescribing practitioner. Facility staff were to monitor the resident's behaviors with triggers, symptoms, and episodes documented on a document titled, "Behavior Monitoring Chart/Record."

1. The facility admitted Resident #2 to the Memory Care Unit, on 08/31/2020, with diagnoses to include Bipolar Disorder, Psychotic Disorder with Delusions, and Frontotemporal Dementia.

Review of Resident #2's Physician Orders, dated 04/06/2021, revealed an order for Ativan zero point five (0.5) mg tablet every four (4) hours as needed for anxiety/agitation, however, the order did not have a stop date. Additional orders included Geodon twenty (20) mg capsule twice daily for Schizophrenia with an increase to forty (40) mg twice daily on 03/24/2021 and increased to sixty (60) mg in the morning and forty (40) mg at night on 04/01/2021. Further order review revealed an order, dated 08/31/2020, to monitor resident for psychotherapeutic medication side effects twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 285	F 758		

Review of the Medication Administration Record (MAR), dated 03/01/2021 through 04/20/2021, revealed the nurses had monitored for behaviors and side effects related to psychotropic medications. The documentation for monitoring for side effects revealed Resident #2 had no side effects related to psychotropic medications.

Review of Resident #2's Progress Notes, dated 03/01/2021 through 04/20/2021, revealed no documentation of side effects related to psychotropic medications.

Review of Resident #2's Comprehensive Care Plan (CCP), initiated on 08/31/2020, revealed psychotropic medication interventions that included monitoring for changes in mental status and functional level and report to physician; monitor for continued need of medication as related to behavior and mood, and monitor and notify the physician for side effects.

Review of Resident #2's Psychiatry Progress Notes, dated 03/02/2021, 03/09/2021, and 03/24/2021, revealed documentation of no side effects or extrapyramidal side effects (abnormal side effects such as tremors, slurred speech, muscle restlessness, and muscle spasms related to improper dosing or unusual reactions to antipsychotic medications) were observed during telehealth visits or reported by nursing staff.

Attempted to interview Resident #2, on 04/14/2021 at 1:48 PM, but resident did not respond to questions.

Observation of Resident #2, on 04/14/2021 at 1:48 PM, 04/15/2021 at 8:15 AM, and 04/20/2021 at 9:35 AM, revealed notable tremors to upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 758	Continued From page 286	F 758		

extremities.

Interview with Certified Nurse Aide (CNA) #2, on 04/15/2021 at 8:30 AM, revealed Resident #2 was able to independently feed self until about two (2) weeks ago due to shaking of the arms. CNA #2 stated the doctor and the nurses were aware of the shaking of the arms.

Interview with CNA #20, on 04/23/2021 at 1:35 PM, revealed she was in the room when RN #1 brought the psychiatrist's Medical Assistant in the room to have her observe Resident #2's tremors.

Interview with Registered Nurse (RN) #1, on 04/23/2021 at 8:45 AM, revealed she had notified the Medical Assistant (MA) who rounds for the Psychiatrist using a tablet for video visits. She stated she took the MA into Resident #2's room approximately three weeks ago on a Thursday, the day she comes to the facility, and showed her the tremors. RN #1 was concerned because each week the tremors had gradually gotten worse and the sitters were feeding the resident. She stated she had informed the facility Medical Physician and was told to monitor the resident.

Interview with Licensed Practical Nurse (LPN) #7, on 04/20/2021 at 1:56 PM, revealed Resident #2's upper extremity tremors had been present for the past couple of weeks. She stated she notified the medical doctor and was not concerned since the resident did not have abnormal mouth movements. LPN #7 received directions from the doctor to monitor and notify for worsening of tremors or additional symptoms. She stated she did not document the notification in the progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 758	Continued From page 287	F 758		

Interview with Registered Nurse (RN) #6, on 04/22/2021 at 10:48 AM, revealed side effects from antipsychotic medications included sedation, loss of appetite, tremors, and pill rolling (involuntary movement of fingers/hands that makes it appear one is rolling a pill between the finger and thumb). She stated Resident #2's arms had been shaking for about a month. RN #6 stated a PRN psychotropic medication without an end date could result in over sedation or result in a medication order that was no longer needed.

Interview with the contracted Pharmacist, on 04/22/201 at 1:49 PM, revealed the pharmacy did not provide any education to the facility about psychotropic medications and the side effects. She stated a quarterly AIMS (Abnormal Involuntary Movement Scale) assessment, completed on 03/22/2021, revealed no abnormalities. The Pharmacist stated the repetitive movement of arms/tremors could have been from the increase in the Geodon dose over the past month.

Interview with the Nurse Practice Educator (NPE), on 04/26/2021 at 2:34 PM, revealed she did not provide specific education with new employee orientation on the topic of psychotropic medications and side effects.

Interview with the Assistant Director of Nursing Services (ADNS), on 04/22/2021 at 10:09 AM, revealed during the morning IDT meeting they reviewed new orders to ensure they followed the facility policy, such as reason or diagnosis for a prn medication and stop dates for prn psychotropic medications. However, had not identified issues related to Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 288	F 758		

Interview with the Medical Physician, on 04/21/2021 at 3:56 PM, revealed the ADNS informed her yesterday regarding Resident #2's tremors. The Medical Physician stated she assessed Resident #2 on 04/20/2021, and noted pronounced tremors of upper extremities, which she considered EPS. She stated she was not notified of resident's inability to feed himself/herself due to arm tremors. She directed floor staff to hold Geodon and contact the psychiatrist for further directions. The Medical Physician stated it was concerning the nurses did not recognize or notify the physician of the symptoms.

Interview with the Psychiatrist, on 04/22/2021 at 2:44 PM, revealed he had recently increased Resident #2's Geodon dose due to agitation/combative behaviors. The Psychiatrist stated EPS could include Parkinson-like tremors and akathisia (feeling of muscle quivering, restlessness, and inability to sit still). He stated the facility notified him on 04/21/2021 of Resident #2's arm tremors and it was most likely from the prescribed Geodon, which he discontinued. The Psychiatrist stated facility staff had not notified him before yesterday of the gradually worsening tremors. He stated the nurses should have communicated and documented the side effects.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed staff monitored for side effects of psychotropic medications twice daily. She stated side effects from Geodon could be tremors, tongue rolling, and pill rolling. The CNE stated the ADNS notified her last week of Resident #2's arm tremors and the nursing staff should have been documenting the tremors. She stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 289	F 758		

entered a prn psychotropic medication into the computer system, staff had to manually enter the stop date. The CNE stated when a stop date was not specifically entered, the field auto refilled to indefinite. She stated that was what happened when she entered the Ativan order on 04/06/2021; it was overlooked.

Interview with the Center Executive Director (CED), on 4/30/2021 at 3:12 PM, revealed it was a concern the nurses caring for Resident #2 did not document the side effects or document the notification to the psychiatrist or the medical doctor regarding the tremors and inability to eat independently.

2. The facility admitted Resident #3 to the Memory Care Unit on 01/20/2021, with diagnoses to include Dementia with Behavioral Disturbance and Psychotic Disorder with Delusions.

Observation of Resident #3, on 04/14/2021 at 1:51 PM, revealed he/she was well groomed, appropriately dressed, and walking down the hall with another resident.

Review of the Comprehensive Minimum Data Set, dated 01/27/2021, revealed Resident #3 had a Brief Interview for Mental Status score of five (5), which indicated severe cognitive impairment with physical behaviors directed towards others.

Attempt to interview Resident #3, on 04/14/2021 at 1:51 PM, revealed he/she did not respond appropriately to questions.

Review of Resident #3's Comprehensive Care Plan, initiated on 01/21/2021, included a focus for complications related to psychotropic medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 290	F 758		

with a goal for resident to have the smallest dose without side effects. The CCP review revealed interventions for a gradual dose reduction, documentation on behavior monitoring flowsheet, monitor for functional/mental status changes with notification of the physician, monitor for side effects, provide diversional activities, and refer to psychiatry as needed.

Review of Resident #3's Physician's Orders, dated 01/20/2021 through 04/14/2021, revealed orders that included Aricept (medication for Dementia) five (5) mg daily, Trazadone (medication for Psychosis) one-hundred (100) mg daily, and monitor resident for behaviors every shift with documentation in the nurse's notes if present.

Review of Resident #3's MAR, dated 01/20/2021 through 04/14/2021, revealed nursing had administered Trazadone as ordered.

Review of Resident #3's Progress Notes, dated 01/20/2021 through 04/14/2021, revealed no evidence staff had assessed the resident for behaviors.

Record review revealed no evidence of a form titled, Behavior Monitoring Chart/Record, in which staff were to use in order to document behaviors such as triggers, symptoms, side effects of the medication Trazadone.

Interview with RN #6, on 04/22/2021 at 10:48 AM, revealed it was the nurse's responsibility to enter the orders for behavior monitoring and monitoring for side effects from psychotropic medications in the clinical record. However, this had not been completed for Resident #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 291	F 758		

Interview with Licensed Practical Nurse (LPN) #24, on 04/24/2021 at 3:30 PM, revealed it was important to monitor the residents for psychotropic medication side effects because it allowed the prescriber to monitor for effectiveness of the medication or the need for modifications.

Interview with the Minimum Data Set (MDS) Coordinator, on 04/26/2021 at 2:05 PM, revealed licensed staff entered orders for side effect monitoring to assist with adequate dosing of psychotropic medications. She stated the omission of monitoring for psychotropic medication side effects could be life threatening. She stated the lack of side effect documentation meant it was not done.

Interview with the NPE, on 04/26/2021 at 2:34 PM, revealed monitoring for psychotropic medication side effects appeared on the MAR and staff documented in a nurse's note if side effects were present. The progress note would then alert the Interdisciplinary Team (IDT) for any side effects exhibited.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed the order to monitor for side medication side effects was a standing order that required staff to enter information into the clinical record. She stated during the morning (IDT) meetings, they reviewed new orders and she often entered the orders for behavior and side effect monitoring related to psychotropic medications.

Interview with the CED, on 04/30/2021 at 3:12 PM, revealed the failure to monitor the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 292 for side effects related to psychotropic medications could result in a lapse in care.	F 758		
F 835 SS=K	Administration 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. 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 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. The facility's failure to maintain substantial compliance, since the 10/09/2020 Recertification survey, in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656 and F657); 42 CFR 483.35 Nursing Services (F725); 42 CFR 483.40 Behavioral Health (F740); 42 CFR 483.70 Administration (F835); and, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). Observations, interview and record review	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 293	F 835		

revealed the facility's administration failed to use its resources to provide quality care and services to meet the needs of the residents (Refer to F600, F656, F657, F725, F740, F835 and F867). In addition, the facility failed to maintain standard levels of care and services to the residents (Refer to F550, F558, F585, F658, F730, F758, and F842).

The facility's failure to provide an effective administration to ensure care and services related to state and federal regulations guideline for the care and services to the residents has caused or is likely to cause serious injury, harm, impairment or death to residents.

Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600, at a scope and severity of a "K"; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 and F657, at a scope and severity of a "J"; 42 CFR 483.35 Nursing Services, F725, at a scope and severity of a "J"; 42 CFR 483.40 Behavioral Health, F740, at a scope and severity of a "J"; 42 CFR 483.70 Administration, F835, at a scope and severity of a "K"; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a scope and severity of a "K". The Immediate Jeopardy was determine to exist on 03/27/2021 and the facility was notified of the Immediate Jeopardy on 05/07/2021.

Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600).

The facility provided an IJ Removal Plan on 05/20/2021, alleging removal of the Immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 294	F 835		

Jeopardy on 05/20/2021. The State Survey Agency determined the Immediate Jeopardy was removed on 05/20/2021, as alleged, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

An additional repeat deficiency, from the 10/09/2020 Recertification survey, was identified in the area of 42 CFR 483.10 Resident Rights, F585 at a scope and severity of a "D".

The findings include:

Review of the Job Description for the Center Executive Director (CED), effective 01/01/2016, revealed the CED's operational responsibilities included to ensure policies and procedures for the facility were followed to prevent abuse. The facility would create an environment where staff members were highly engaged and focused on providing the highest level of clinical care and compassion to patients, residents, and families. The CED would administer and coordinate all activities of the facility to assure the highest degree of quality of care was consistently provided to residents, subject to the rules and regulations promulgated by government agencies to ensure residents received the proper services.

Review of the 10/09/2020 Recertification Survey and the 05/22/2021 Recertification Survey revealed the facility failed to be administrated in manner to provide quality care and services. The facility was cited at actual harm and immediate Jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 295	F 835		

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 AM, revealed she was apart of the administration. She stated her job was to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently. She further stated the Clinical Quality Specialist (CQS) was in the building weekly and provided additional resources and education to her. Per interview, she stated the CQS explained to her how the lack of administration involvement contributed to the deficient practices that were identified.

Interview with the Clinical Quality Specialist (CQS) on 05/22/2021 at 3:06 PM, revealed she went over the CNE's responsibilities with her and went over the deficient practice identified. Continued interview revealed going over the state and federal regulations was part of the review with the CNE.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed he was responsible for ensuring the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. He further revealed his job description was reviewed by the former Regional Vice President of Operations upon hire. The CED stated he was responsible for the care needs of the residents and supervision of the staff.

Continued interview with the CED, on 05/11/2021 revealed he was aware of the deficiencies cited during the 10/09/2020 survey and believed the facility addressed the concerns through continued audits and discussions through Quality Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 296	F 835		

(QA). Per interview, the CED revealed there was no documented evidence the facility continued the audits related to abuse, care plans, and residents' behaviors. Further interview revealed staffing was addressed in QAPI and they were working on hiring more nurses by increasing the shift differentials with modified compensation to compete with agency staff.

Interview with the former Regional Vice President of Operations (RVP), on 05/12/2021 at 8:21 AM, revealed her current role was to provide support to the CED. Continued interview with the RVP revealed she was unaware of the concerns identified within the facility.

Interview with the Regional Vice President of Operations (RVPO), on 05/22/2021 at 3:35 PM, revealed he became the RVPO on 05/17/2021. Per interview, the RVPO stated he would provide oversight to the CED and CNE and would be watching over the daily operations of the facility. He stated the reason why the facility had repeat deficient practice cited was because of the change in CED and CNE. He further stated he was working with the CED to help him understand his role as the Administrator.

Review of the IJ Removal Plan revealed the facility implemented the following:

1. The Regional Vice President of Operations(RVPO) would review the CED job description and 483.70 to ensure effective administration/resident well-being requirements were met. He stated a facility must be administered in a manner that enabled it to use its resources effectively and efficiently. The RVPO would discuss this with the CED, on or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 297	F 835		

before 05/19/2021, to verify his understanding of his responsibilities including the intent of the tags cited at F600, F656, F657, F725, F740, F835, and F867 and to ensure the facility's systems were in place.

2. A posttest would be completed to validate understanding. The CED would continue to ensure the facility was administered effectively and efficiently to attain and maintain the highest practicable physical, mental, psychosocial well-being of the residents. He stated as part of the facility's governing body, along with the Center Nurse Executive (CNE), they would efficiently oversee and ensure that appropriate plans of action were in place to correct quality deficiencies.

3. The RVPO and/or Clinical Quality Specialist would review the quality assurance performance improvement (QAPI) committee minutes monthly times six (6) months and ongoing thereafter with additional audits to be conducted based on recommendations from the QAPI committee for additional follow up and/or in-servicing.

4. The CED or CNE would submit audits to the Quality Assurance Performance Improvement committee consisting of the CED, CNE, Assistant Director of Nursing, Activity Director, Housekeeping Director, Admission Director, Business Office Manager, Food Service Director, Therapy Program Director, Maintenance Director, Social Services Director, Health Information's Coordinator and Clinical Reimbursement Coordinator and Certified Nurse Aid for any additional follow up and/or in-servicing needs until the issue was resolved and ongoing thereafter as determined by the QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 298 The SSA validated the facility implemented the following actions to remove the Immediate Jeopardy: 1. Interview with the Regional Vice President of Clinical Operations (RVPO), on 05/22/2021 at 3:35 PM, revealed the former RVPO went over the CED's job description with him, prior to him accepting the position as the RVPO. However, he had reinforced the education by going over the ACED job description to understand his role as the administrator. 2. Review of the posttest, administered and signed by the CED on 05/15/2021, revealed the CED was educated on administration. The RVPO signed-off on the test on 05/19/2021. 3. Interview with the CQS, on 05/22/2021 at 3:06 PM, revealed she had attended all the QAPI committee meetings, which were meeting daily, until the Immediate Jeopardy has been removed. Per interview, the QA minutes would be reviewed and signed-off by her for six (6) months. 4. Interview with the CED and CNE, on 05/22/2021 at 6:30 PM, revealed they submitted the audits to the QAPI committee until the concern was resolved.	F 835		
F 837 SS=K	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding	F 837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 837	Continued From page 299 the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the 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 and operation of the facility. This was evidenced by the facility's failure to maintain substantial compliance, since the 10/09/2020 recertification survey, in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656 and F657); 42 CFR 483.35 Nursing Services (F725); 42 CFR 483.40 Behavioral Health (F740); 42 CFR 483.70 Administration (F835); and, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). Observations, interview and record review revealed the facility's governing body failed to ensure residents were free from abuse and ensure resident behaviors were addressed; failed to ensure sufficient nursing staff to ensure adequate supervision of residents and provide	F 837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 837	Continued From page 300	F 837		

services to meet the residents' needs; failed to ensure residents' care plans were revised and implemented; and, failed to ensure the facility was effectively managed with an effective quality assurance program to maintain substantial compliance. (Refer to F600, F656, F657, F725, F740, F835 and F867).

The facility's failure to provide an effective governing body responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents.

Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600, at a scope and severity of a "K"; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 and F657, at a scope and severity of a "J"; 42 CFR 483.35 Nursing Services, F725, at a scope and severity of a "J"; 42 CFR 483.40 Behavioral Health, F740, at a scope and severity of a "J"; 42 CFR 483.70 Administration, F835, at a scope and severity of a "K"; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a scope and severity of a "K". The Immediate Jeopardy was determine to exist on 03/27/2021 and the facility was notified of the Immediate Jeopardy on 05/07/2021.

Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600).

The facility provided an IJ Removal Plan on 05/20/2021, alleging removal of the Immediate Jeopardy on 05/20/2021. The State Survey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 837	Continued From page 301	F 837		

Agency determined the Immediate Jeopardy was removed on 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 develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

An additional repeat deficiency, from the 10/09/2020 recertification survey, was identified in the area of 42 CFR 483.10 Resident Rights, F585 at a scope and severity of a "D".

The findings include:

Review of the facility's policy titled, "Governing Body: Centers," revised on 11/20/2019, revealed it was the facility's policy to have a governing body that consists of the Center Executive Director, Center Nurse Executive, and the Regional Vice President of Operations or Regional Executive Director of the Center's administrative service provider. The governing body was legally responsible for establishing and implementing policies regarding the management and operation of the Center and appointing a licensed administrator for the management of the Center and maintenance of the Quality Improvement Performance Improvement (QAPI) program.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 AM, revealed the Governing Body would include the CED as she reported to him. She further revealed the CED went over her job duties and she was aware of her responsibilities. She stated she had worked at the facility since 10/13/2020. Per interview, the CNE revealed she was aware of the deficiencies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 302	F 837		

cited during the last Recertification Survey on 10/09/2020. However, she was not aware of the residents' behaviors, but should have been.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed he had worked at the facility for three (3) months. Per interview, the governing body was responsible to establish and implement policy(s) regarding the management and operation of the facility, and consisted of the CED, CNE, and the Regional Vice President of Operations (RVPO). Additionally it was his responsibility, as the CED, to ensure all processes established by the governing body were maintained, to include the QAA/QAPI program. Continued interview revealed the CED was aware of the previous Plan of Correction for the recertification in October 2020, and multiple facility reported incidents, which occurred prior to his arrival at the facility; however, he was not fully aware of the extent of systemic issues.

Interview with the former Regional Vice President of Operations (RVP), on 05/12/2021 at 8:21 AM, revealed she had worked with the facility since 12/28/2020. Per interview, the RVP revealed she was part of the governing body, as per the facility's policy. She stated her current role was to provide support to the CED; however, she revealed the policy updates, procedures, revisions, were completed at a higher level than her. Continued interview with the RVP revealed she was unaware of the concerns identified within the facility, but could offer coping, guidance, and education if needed.

Interview with the Regional Vice President of Operations (RVPO), on 05/22/2021 at 3:35 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 837	Continued From page 303	F 837		

revealed he became the RVPO on 05/17/2021. Per interview, the RVPO stated he was the head of the governing body. He stated since becoming the RVPO, he had reviewed the facility's audits and the training given to staff. The RVPO stated he would provide oversight to the CED and CNE and would be watching over the daily operations of the facility. Per interview, the RVPO stated the only way to "fix" this would be to have continuity of staff. He conveyed the reason why the facility had repeat deficient practice cited was because of the change in CED and CNE adding, "I'm asking for a ten (10) year contract," to build the management team. Continued interview revealed he had attended the QAPI meetings and offered suggestions to the CED on how to lead through QAPI. He further stated he was working with the CED to help him understand his role as the Administrator.

Review of the IJ Removal Plan revealed the facility implemented the following:

1. As required by regulation, the facility has and will continue to have a governing body The CED, CNE, and Regional Vice President are responsible for establishing and implementing policies regarding the management and operation of the facility. However, the governing body has designated additional oversight members including the Vice President of Clinical Operations and the Director of Regulatory Compliance who will audit and verify the plan of correction, compliance with regulation and facility policies through on site monitoring and random audits. These designated members will hold the CED and CNE accountable to the ongoing implementation of the abatement plan and POC until compliance is attained and maintained with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 837	Continued From page 304	F 837		

respect to the cited deficiencies as well as all requirement of participation.

2. Additional support has been provided and will continue to be provided from the regional corporate team consisting of the Senior Director of Clinical Operations, International with a Infection Control Certification , Practice Development Manager, Director of Regulatory Compliance, Clinical Quality Specialists, Vice President of Clinical Operations and the Regional Executive Director providing reeducation, chart reviews, care plan revisions, behavior monitoring rounding, resident and staff interviews related to behaviors, grievance process and Abuse policy education.

3. The Director of Regulatory Compliance and the Vice President of Clinical Operations will provide weekly oversight to determine the abatement plan and POC are implemented and continue to be maintained and sustained by the CED and CNE. Additionally, QAPI meetings, Labor meetings and AOC review are being conducted daily.

The SSA validated the facility implemented the following actions to remove the Immediate Jeopardy:

1. Interview with the Vice President of Clinical Operations, on 05/22/2021 at 5:14 PM, revealed the governing body has always consisted of the CED, CNE, Medical Director, and the Regional Vice President. She further stated she provided additional oversight and receives weekly calls from the facility to discuss the implementation of the AoC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 837	Continued From page 305	F 837		

Interview with the Director of Regulatory Compliance (DRO), on 05/22/2021 at 6:31 PM, revealed on 05/14/2021 she initiated chart audits and assisted with the development of the facility's abatement. The DRO revealed she will work with the facility to complete the POC and the facility will update her weekly with continued audits for compliance and she will attend the monthly QAPI either in person or by teleconference.

2. Interview with the Regional Executive Director, on 05/22/2021 at 5:37 PM, revealed she has been a part of the daily QAPI meetings and went over the facility's policies and the deficient practice with the Management team, as well as, provided education.

Interview with the Practice Development Manager, on 05/22/2021 at 5:43 PM, revealed she assisted the VPCO with the abatement plan. She further stated she had IPADs set up for staff to document and monitor the resident's behaviors. The Practice Development Manager stated she educated staff and went over certain scenarios to train staff on identifying resident's behaviors.

Interview with the Director of Regulatory Compliance, on 05/22/2021 at 6:31 PM, revealed she would continue to review the audits for compliance and would provide oversight.

Interview with the Clinical Quality Specialist (CQS), on 05/22/2021 at 3:06 PM, revealed she provided reeducation and post-test to staff.

Interview with the Senior Rapid Response Manager, 05/22/2021 12:09 PM, revealed weekly calls would be made to the Vice President of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 837	Continued From page 306 Clinical Operations and she would validate the audits. She further stated a weekly meeting would be held with the RVP to discuss the staffing patterns and to review the reports and accountability. She further stated she was rounding and completing chart reviews. 3. Interview with VPCO, on 05/22/2021 at 5:14 PM, and the DRO on 05/22/2021 at 6:31 PM, revealed they would provide oversight to ensure the POC and abatement plan were implemented.	F 837		
F 842 SS=J	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 307	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 308	F 842		

services reports as required under §483.50.

This REQUIREMENT is not met as evidenced by:
Based on observations, interview, record review, and the facility's policy it was determined the facility failed to maintain medical records that were complete and accurate as per professional standards for three (3) of eighty-seven (87) sampled residents (Residents #2, #21 and #61).

Observations on the MCU (Memory Care Unit), on 04/22/2021, 04/26/2021, 04/28/2021, and 04/30/2021 revealed Resident #21 on the MCU in common rooms, hallways and in other residents' rooms. Resident #21 was observed with paced ambulation up and down the hallways. The resident intruded other residents' personal space. However, review of the Medication Administration Record (MAR), and Progress Notes for Resident #21 revealed no documented evidence of the exhibited behaviors had been identified or documented by staff.

Interviews with staff on the MCU, revealed Resident #21 exhibited paced ambulation, on the MCU (hallway, common area, and into other resident rooms) daily, prior to the 10/02/2020 resident to resident altercation and the behaviors were ongoing. Per interviews, the resident would pace until he/she was exhausted and had to rest. Continued interviews revealed the resident had a history of physical and verbal abuse directed towards others and intrusion of other resident's personal space. Per interviews with licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 309	F 842		

staff, each behavior should be charted on the MAR, and in the Progress Notes; however, not all behaviors were documented because they did not have time to document that often; Resident #21 had continuous pacing and intrusive behaviors.

Observations of Resident #61 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 the common rooms, hallways and in his/her room tearful and crying. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (tearful, crying) on those specific dates and times.

Review of Resident #61's MAR, dated 04/01/2021 through 04/30/20201, revealed an order dated 09/25/2020, for "Is the resident behavior free?" If behavior present (tearful, crying, irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors. Additional review revealed each day 6:00 AM - 2:00 PM and 10:00 PM -6:00 AM "YES" was documented indicating the resident was behavior free every day and night shift, except 04/10/2021 6:00 AM-2:00 PM, which was blank.

Additional 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.

Observation of Resident #2, on 04/14/2021 at, 04/19/2021 at 3:28 PM, 04/15/2021 at 3:10 PM, and 04/20/2021 at 9:35 AM with tremors of both arms. RN #1, RN #6, LPN #7, CNA #2, and CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 310	F 842		

#9 were aware of the tremors. Interviews with RN #1 and LPN #1 revealed assessment of Resident #2's tremors and notification to the medical provider, but there was no documentation noted in the clinical record.

The facility's failure to have an effective system in place to ensure staff documented residents' behaviors; and the clinical records were accurate and complete to ensure residents received the necessary care and services is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 05/07/2021, and was determined to exist on 04/01/2021.

The facility provided an acceptable IJ removal Plan (Allegation of Compliance (AoC)) 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 a "G" while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes.

The findings included:

1. Review of Resident #21's Physician's Orders, revealed an order dated 11/06/2020, for "Is the resident behavior free?" YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to Alzheimer's disease. Further review revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 311	F 842		

order dated 03/18/2021, for Risperdal (antipsychotic medication) 0.25 milligrams (mg), by mouth, two (2) times a day for Anxiety.

Record review revealed the facility admitted Resident #21 to the MCU, on 01/01/2020 with a primary diagnosis of Alzheimer's Disease. Additional diagnoses included Senile Degeneration of the brain, Depressive Episodes, Anxiety Disorder, Psychotic Disorder with Delusions, Dementia without behavioral disturbance, and Adjustment Disorder. Further review revealed the resident had a medical and financial Power of Attorney (POA).

Observations of Resident #21, 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 on 04/30/2021 at 2:30 PM, revealed the resident on the MCU in common rooms, hallways and in rooms. Resident #21 was observed with intermittent paced ambulation up and down the hallways and in common areas. Further, the resident was intrusive of other resident's personal space for any residents' path that he/she crossed. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (paced ambulation, intrusion of others personal space) on those specific dates and times.

Review of the MAR, dated 04/01/2021-04/30/2021, revealed an order dated 11/06/2020, which stated, "Is the resident behavior free? YES or NO (if NO and behavior is present, document type, intervention, and outcomes in Nurses Note). Observe for refusal of care, throwing items, cursing, yelling at others, and wandering around the unit related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 312	F 842		

Alzheimer's Disease. Additional review revealed five (5) times in April "YES" was documented indicating a behavior was present." Per the MAR, on the following dates at 5:30 AM: 04/05/2021; 04/13/2021; 04/14/202; 04/23/2021; 04/27/2021. However, review of the Nurses Notes for those dates revealed no documented evidence of a behavior exhibited, type, intervention, or outcomes.

Interview with CNA #2 (seven {7} months on the MCU), on 04/26/2021 at 10:45 AM, revealed since she had worked on the MCU, Resident #21 walked up and down the hallway, all over the MCU, all the time. Additionally, she did not report Resident #21's behavior of pacing on the MCU to the nurse; because "everyone knows", the resident does it all the time. Further, the nurses were responsible to chart behaviors.

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, so she could chart the behaviors and ensure the medical record was accurate. Per interview, it was important to have documentation of identified behaviors so staff could intervene 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.

Interview with RN #1 (four {4} months on the MCU), on 04/28/2021 at 2:30 PM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 313	F 842		

behavior monitoring was completed on the MAR each shift for all residents. Per interview, if a resident had a behavior, then nurses would document "Yes" on the MAR and make a narrative free text Progress Note about what the behavior. Additionally, it was important to have ongoing documentation of resident behaviors for safety of the residents and to ensure interventions were implemented when a resident exhibited a behavior for their well-being and to maintain a healthy environment. Further, RN #1 stated the resident was defensive when another resident approached him/her; however, she was not aware of and had not documented any behaviors for Resident #21 on 04/28/2021.

Interview with CNA #9, (two {2} years on MCU), on 04/28/2021 at 3:11 PM revealed shortly after Resident #21 was admitted to the MCU, he/she had aggressive behaviors towards others. Per interview, the resident would grab staff's arms and squeeze them tight and the resident was defensive towards other residents when they were in his/her path. The resident would raise his/her voice, intrude other residents' personal space, and put his/her hands on others. Additionally, the resident walked up and down the hallway, in rooms and the common area rooms all the time. However, she did not report behaviors that had been observed "today" (paced ambulation and in others' personal space), to the nurse because she was already aware of them. Further nurses were responsible to document behaviors.

2. Record review revealed the facility admitted Resident #61 to the MCU, on 12/17/2019 with a primary diagnosis of unspecified Dementia without behavioral disturbance. Additionally, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 314	F 842		

resident was diagnosed with Adjustment Disorder with depressed mood, on 06/16/2020, as his/her secondary diagnosis. Further, the resident had a medical and financial POA.

Review of Resident #61's Physician Orders, dated April 2021, revealed an order, dated 07/21/2020, for Risperidone (antipsychotic medication) 0.25 milligrams (mg) by mouth, two (2) times a day for Mood Disorder. Further, the resident had an order, dated 09/25/2020, for "is the resident behavior free?" If behavior present (tearful, crying irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors.

Observations of Resident #61 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 the common rooms, hallways and in his/her room tearful and crying. However, review of the MAR and Progress Notes, revealed no documented evidence of the behaviors (tearful, crying) on those specific dates and times.

Additional review of Resident #61's MAR, dated 04/01/2021 through 04/30/20201, revealed an order dated 09/25/2020, for "Is the resident behavior free?" If behavior present (tearful, crying, irritability), document type, interventions and outcomes in Nursing Notes; Every day and night shift for behaviors. Additional review revealed each day 6:00 AM - 2:00 PM and 10:00 PM -6:00 AM "YES" was documented indicating the resident was behavior free every day and night shift, except 04/10/2021 6:00 AM-2:00 PM, which was blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 315	F 842		

Additional 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.

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 days. Further, he did observe the resident with behaviors at this time.

Interview with Certified Nursing Assistant (CNA) #8, on 04/22/2021 at 4:15 PM revealed since she had worked on the MCU Resident #61 it was common for the resident to exhibit crying tearful episodes on a daily basis; therefore she did not report or document the behavior because it was the resident's common behavior and everyone knew he/she cried all the time. Further, it was the nurses responsibility to document behaviors.

Interview with CNA #2, on 04/26/2021 at 10:45 AM, revealed since she had worked on the MCU, Resident #61 cried all the time. Additionally, she did not report Resident #61's behavior of crying to the nurse, because everyone knew the resident cried all the time. Further, the nurses documented all behaviors in the medical record.

Interview with RN #6, on 04/26/2021 at 2:30 PM, revealed Resident #61's behavior was he/she was tearful and would cry intermittently every day. However, she did not document the resident's behavior every time he/she cried or became tearful because it was so frequent. Further, she was not aware the resident was crying at the time of the interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 316	F 842		

Interview with RN #1, on 04/28/2021 at 2:30 PM revealed she was aware that Resident #61 cried continuously; however, she was not aware of and had not documented any behaviors for the resident on 04/28/2021. Further, it was her responsibility to document all behaviors in the medical record to ensure a complete and accurate record.

3. Observation of Resident #2, on 04/14/2021 at, 04/19/2021 at 3:28 PM, 04/15/2021 at 3:10 PM, and 04/20/2021 at 9:35 AM with tremors of both arms. RN #1, RN #6, LPN #7, CNA #2, and CNA#9 were aware of the tremors. Interviews with RN #1 and LPN #1 revealed an assessment of Resident #2's tremors and notifications were sent to the medical provider; however, there was no documentation noted in the clinical record.

Record Review revealed the facility admitted Resident #2 to the MCU, on 08/31/2020, with diagnoses to include Bipolar Disorder, Psychotic Disorder with Delusions, and Frontotemporal Dementia.

Review of Resident #2's Comprehensive MDS, dated 01/09/2021, revealed the resident had severely impaired cognitive skills for daily decision-making. The assessment revealed Resident #2 received medications that included antidepressant, antianxiety, and antipsychotic medications.

Review of Resident #2's Physician's Orders, dated 03/01/2021 through 04/14/2021, revealed orders that included Aricept ten (10) milligram (mg) daily and Zoloft twenty-five (25) mg daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 317	F 842		

Further order review revealed an order for Geodon ten (10) mg intramuscular injection daily with an order change on 03/10/2021 to 10 mg daily for three (3) days as needed for agitation. On 03/11/2021 resident's order for Geodon changed to twenty (20) mg capsule twice daily; on 03/24/2021 the Geodon was changed to forty (40) mg twice daily; and on 04/01/2021. The Geodon dose was modified to sixty (60) mg in the morning and forty (40) mg at bedtime. Additional orders included Ativan 0.5 mg every six (6) hours as needed for anxiety ordered on 03/22/2021 and was changed to 0.5 mg every four (4) hours as needed on 04/06/2021. The order review revealed orders that included to monitor for side effects related to psychotropic medications twice daily and consult the physician or pharmacist as needed and to monitor resident for changes in mental or functional status and report to the physician.

Review of Resident #2's Progress Notes, dated 03/01/2021 through 04/14/2021, revealed no documentation of arm tremors.

Review of Resident #2's Medication Administration Record, dated 03/01/2021 through 04/14/2021, revealed side effect monitoring documentation that revealed no side effects were observed by staff.

Review of Resident #2's Quarterly Abnormal Involuntary Movement Scale (AIMS) assessment, dated 03/22/2021, completed by Registered Nurse #3, revealed an absence of involuntary movements.

Review of the Psychiatry Progress Notes, dated 03/02/2021, 03/09/2021, and 03/24/2021,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 318	F 842		

revealed the absence of side effects or extrapyramidal side effects (EPS-abnormal side effects such as tremors, slurred speech, feeling of muscle restlessness, and muscle spasms related to improper dosing or unusual reactions to antipsychotic medications) during telehealth visits or reported by nursing staff.

Observation of Resident #2 on 04/14/2021 at 1:48 PM, 04/15/2021 at 8:15 AM, and 04/20/2021 at 9:35 AM, revealed notable tremors to the upper extremities.

Interview with Certified Nurse Aide (CNA) #2, on 04/15/2021 at 8:30 AM, revealed Resident #2 had a change in level of function that included the inability to feed self due to arm tremors. She stated the CNA documentation included documentation for the level of assistance required for Activities of Daily Living (ADLs) and the CNAs would not have charted Resident #2's arm tremors.

Interview with CNA #20, on 04/23/2021 at 1:35 PM, revealed she was sitting with Resident #2 on the day RN #1 brought the psychiatrists Medical Assistant to the room to assess the tremors.

Interview with RN #1, on 04/23/2021 at 8:45 AM, revealed she had notified the Medical Assistant (MA) who rounds for the Psychiatrist using a tablet for video visits. She stated she notified the Medical Physician and the Psychiatrist's MA approximately three (3) weeks ago regarding the presence of worsening arm tremors. She stated she did not document the assessment or the notification in the clinical record. RN #1 stated an accurate clinical record assisted with communication of the clinical team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 319	F 842		

Interview with Licensed Practical Nurse (LPN) #7, on 04/20/2021 at 1:56 PM, revealed Resident #2's upper extremity tremors had been present for the past couple of weeks and she had notified the Medical Physician. She stated she did not document the notification in the progress notes.

Interview with RN #6, on 04/22/2021 at 10:48 AM, revealed she had observed Resident #2's arm tremors for about a month. She stated she did not document the presence of side effects on the MAR or in the clinical record, which resulted in an inaccurate record. RN #6 stated the MAR included documentation for monitoring for side effects twice daily.

Interview with the ADNS (Assistant Director of Nursing Services), on 04/22/2021 at 10:09 AM, revealed during the morning IDT (interdisciplinary team) meeting they reviewed new orders to ensure they followed the facility's policy such as reason or diagnosis for a "PRN" (as needed) medication and stop dates for PRN psychotropic medications.

Interview with the Medical Physician, on 04/21/2021 at 3:56 PM, revealed facility staff did not notify her regarding Resident #2's difficulty feeding himself/herself or about the arm tremors. The Medical Physician stated it was concerning the nurses did not document the side effects that had developed either on the MAR or in the nurse's notes.

Interview with the Psychiatrist, on 04/22/2021 at 2:44 PM, revealed he had recently increased Resident #2's Geodon dose due to agitation/combative behaviors. The Psychiatrist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 320	F 842		

stated he communicated with the facility staff via telephone and reviewed nursing documentation. He stated Resident #2's treatment progress was not properly monitored or communicated due to the failure of nursing staff to document Resident #2's arm tremors.

Interview with the Center Nurse Executive (CNE), on 04/29/2021 at 9:17 AM, revealed staff monitored Resident #2 for side effects of psychotropic medications twice daily. She stated accurate documentation revealed the effectiveness of the medications and/or side effects. The CNE stated an accurate clinical record was important because the staff, the Interdisciplinary Team (IDT), and the physicians utilized it to determine the plan of care and/or progress.

Interview with the Center Executive Director (CED), on 4/30/2021 at 3:12 PM, revealed it was concerning the nurses caring for Resident #2 did not document the side effects or document the notification to the psychiatrist or the medical doctor regarding the tremors and inability to eat independently.

Review of the IJ Removal Plan revealed the facility implemented the following::

1. On or before 05/19/2021, the Licensed Nurse or Social Services updated the behavior and psychotherapeutic documentation for Residents #2, #3, #21, #31, #42, #61, and #86. Residents #17, #30, and #73 no longer resided in the facility.

2. On or before 05/19/2021, an audit was conducted on all residents by Licensed Nurse and/or the SSD to determine behaviors including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 321	F 842		

persistent crying, hitting, pushing, scratching, throwing objects, physical aggression and combative behavior were documented in the clinical record with corrective action upon discovery. Additionally, the audit included a review of all residents on psychotherapeutic drugs to determine side effects were monitored and documented with corrective action upon discovery.

3. On or before 05/19/2021, the CNE, NPE and or Regional Educator would conduct reeducation with Licensed Nurses regarding accurate and complete clinical records. The reeducation consisted of completing documentation regarding behaviors including persistent crying, hitting, pushing, scratching, throwing objects, physical aggression and combative behavior are to be documented in the clinical record clinical record when a behavior occurs. Additionally, all residents receiving psychotherapeutic drugs would have side effects monitored and documented accurately in the clinical record. A post-test would be given at the time of re-education to validate understanding with a passing score of 100% to validate understanding. Licensed Staff not available during this time frame to include agency staff would be provided re-education including posttest by the Nurse Supervisors, Nurse Practice Educator, Unit Managers and or CNE upon day of return to work. New hires including agency staff will be provided education and a posttest during orientation by the CNE, NPE, Supervisors, or Unit Managers.

4. The Center Nurse Executive, Assistant Director of Nursing, Unit Managers, nurse supervisors, SW and or LN would conduct audits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 322	F 842		

of ten (10) residents with behaviors to determine the behavior documentation was accurate and complete. Additionally, ten (10) residents receiving psychotherapeutic drugs were monitored for side effects and documented accurately in the clinical record daily for two (2) weeks including weekends and holidays then three (3) times per week times two (2) weeks then weekly for eight (8) weeks then every other week times (8) weeks then monthly times (1) month then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the behavioral needs of the residents were met with any corrective action upon discovery.

5. The CNE and/or ADNS would report the review findings daily until the immediate jeopardy was remove to the Quality Assurance Performance Improvement (QAPI) Committee which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Dining Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in servicing until the issue was resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's IJ removal Plan (AOC) as follows:

1. Record reviews for Residents #2, #3, #21, #31, #42, #61, and #86 revealed they were monitored for behaviors and any side effects from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 323	F 842		

psychotherapeutic medications listed on the Medication Administration Records (MAR). Residents #17, #30, and #73 had been discharged from the facility .

2. On or before 05/19/2021, an audit was conducted on all residents by a Licensed Nurse and/or SSD to determine behaviors including persistent crying, hitting, pushing, scratching, throwing objects, physical aggression and combative behavior were documented in the clinical record with corrective action upon discovery. Additionally, the audit included a review of all residents on psychotherapeutic drugs to determine if the side effects were monitored and documented with corrective action upon discovery.

Interview with the Center Nurse Executive (CNE), on 05/22/2021 at 6:30 PM, revealed ten (10) residents with behaviors and on psychotherapeutic drugs would be monitored. Per interview, the information related to the residents' behaviors would be on the Medication Administration Record (MAR) and the resident's assigned nurse would assess the resident for any behaviors identified. Additionally, the staff would assess for any interventions used and if identified, it would be discussed in a clinical meeting.

3. Interviews with Licensed Practical Nurse (LPN) #14 at 1:55 PM, LPN #22, on 05/21/2021 at approximately 1:59 PM, and Registered Nurse (RN) #1 on 05/21/2021at 2:00 PM, RN #16, on 05/21/2021 at 2:05 PM, and LPN #29, on 05/22/2021 at 5:57 PM revealed they received education on accurate documentation of the medical records. Continued interviews revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 324 they were to monitor the residents' reactions to their psychotherapeutic medications. Staff stated they received a posttest and passed with one-hundred percent (100 %). 4. Review of the F842 audit tool revealed the facility would conduct ten (10) residents with behaviors to determine the behavior documentation was accurate. Further review revealed a column for the date, a column which stated, "audits of ten (10) residents with behaviors to determine the behavior documentation was accurate and complete. A column that stated, "Ten (10) residents receiving psychotherapeutic drugs side effects monitored and documented accurately in the clinical record. Continued review revealed a column which stated, "Were there any concerns noted the resident's documentation--Yes or No." Continued review revealed a column for areas of concern with medications side effects noted--Yes or No." Additionally there was a column that had the auditor's name. Interview with the CNE, on 05/22/2021 at 6:30 PM, revealed she completed audits for a few days and noted the behaviors of the residents. Continued interview revealed the residents' clinical records were updated upon discovery of the behaviors identified. 5. Interview with the CNE and CED, on 05/22/2021 at 6:30 PM, revealed the findings of the audits related to F842 would be reported to QAPI until the concern has been resolved.	F 842		
F 867 SS=K	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 325 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to have an effective system to address system failures through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. The facility failed to identify quality of care deficiencies, and failed to take actions aimed at performance improvement to ensure improvements were realized and sustained. This is evidenced by repeated deficient practice at F-600, F-656, F-657, F-725, F-740, F-835, and F-867. These deficiencies were cited during the 10/09/2020 survey. During the 10/09/2020 survey, Immediate Jeopardy was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), at 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656), and at 42 CFR 483.70 Administration (F835). Substandard Quality of Care was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600). The facility submitted an acceptable Plan of Correction (POC) alleging compliance as of 11/12/2020. However, the facility failed to maintain substantial compliance.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 867	Continued From page 326	F 867		

From 10/02/2020-04/23/2021, continuous incidents of resident-to-resident abuse occurred related to resident behaviors that were not identified and/or care planned. Additionally, the residents on the Memory Care Unit (MCU) were not supervised and/or monitored to prevent the residents from abuse.

On 10/02/2020, Resident #21 approached Resident #61 at his/her (Resident #21's) doorway. This resulted in Resident #21 shoving Resident #61 causing Resident #61 to lose his/her balance. Resident #61 fell backwards into the doorframe and down to the floor, landing on his/her right side.

On 04/22/2021, Resident #86 struck Resident #85 with a television while in their shared room. Subsequently, upon assessment on 04/25/2021 the nurse identified scattered bruising and swelling to Resident #85's right hand. The x-ray results showed a right 5th metacarpal (bone in the hand) fracture. Total census 132.

Additionally, on 05/14/2021, the State Survey Agency (SSA) identified additional areas of Immediate Jeopardy. Immediate Jeopardy was identified in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F656 Develop/Implement Comprehensive Care Plan, at a S/S of a "J" and F657, Care Plan Timing and Revision, at a S/S of a "J", 42 CFR 483.35 Nursing Services, F725 Sufficient Nursing Staff, at a S/S of a "J", 42 CFR 483.70 Administration, F835 Administration, at a S/S of a "K", F837 Governing Body at a S/S of a "K", F842 Resident Records-Identifiable Information at a S/S of a "J", and F867, QAPI/QAA Improvement Activities, at a S/S of a "K". The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 867	Continued From page 327	F 867		

facility was notified of the Immediate Jeopardies on 05/14/2021.

Deficiencies were also cited in the areas of 42 CFR 483.10 Resident Rights, F550 Resident Rights/Exercise of Rights at a S/S of "D", F558, Reasonable Accommodations of Needs/Preferences at a S/S of "E", F 585 Grievances, at a S/S of a "D", and F730 Nurse Aide Perform Review, at a S/S of a "D".

The facility's failure to provide an effective Quality Assurance Performance Improvement (QAPI) committee that identified, corrected and maintained substantial compliance has caused or is likely to cause serious injury, harm, impairment, or death to residents.

Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 05/07/2021 and was determined to exist on 04/22/2021, in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600 at S/S of "K").

The facility provided an acceptable Credible Allegation of Compliance (AoC) 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 on 05/20/2021, as alleged, prior to exit on 05/22/2021, with remaining non-compliance at a Scope and Severity of a "G" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 867	Continued From page 328	F 867		

Assurance Performance Improvement (QAPI) Process," revised on 02/13/2017, revealed the Center was committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the Center's work processes, service lines, and departments. All staff and stakeholders were involved in QAPI to improve the quality of life and quality of care for the patients' (residents') experience. Further review of the policy, revealed the QAPI program was ongoing, integrated, data driven, and comprehensive to address all aspects of care and quality of life. The CED (Center Executive Director)led the Center's QAPI processes and involved departments, staff and stakeholders balancing a culture of safety, quality, and patient centeredness. The QAPI processes and improvements were based on evidence drawing from multiple sources, prioritizing improvement opportunities, and bench marking results against developed targets. Improvement Activities and Performance Improvement Projects were the structure and means through which identified problem areas were addressed. The learning, through applied QAPI plans, was continuous, systematic, and organized.

Review of the Job Description for the Center Executive Director (CED), effective 01/01/2016, revealed the CED responsibilities included the operational responsibility to ensure policies and procedures for the facility were followed to prevent abuse. The facility would create an environment where staff members were highly engaged and focused on providing the highest level of clinical care and compassion to patients, residents, and families. The CED would administer and coordinate all activities of the facility to assure the highest degree of quality of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 329	F 867		

care was consistently provided to residents, subject to the rules and regulations promulgated by government agencies to ensure residents received the proper services.

Review of the Acceptable Plan of Correction (POC) for the 10/09/2020 survey revealed the facility provided education to staff to ensure the residents were protected from abuse. Continued review revealed staff were educated on development/implementation of the care plan, and care plan timing/revisions to the care plans. (F-600, F-656, F-657).

Further review of the POC, survey dated 10/09/2020, revealed the Staffing Coordinator, Center Executive Director (CED), Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), and/or Unit Managers would review the staffing needs for all shifts. Continued review revealed the facility would adopt an "on call' schedule to assist with obtaining and or rearranging staff to cover shifts.

Additional review of the POC, revealed the SSD, SW, Center Nurse Executive (CNE), ADNS, Memory Support Program Manager and/or Unit manager would review the residents' Progress Notes of residents presenting with behaviors during the clinical meetings until the issue was resolved.

Continued review revealed, the CED would continue to ensure the facility was administered effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being of the residents as part of the facility's governing body, along with the Center Nurse Executive and Regional Vice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 330	F 867		

President of Operations (RVPO), would effectively oversee and ensure that appropriate plans of action were in place to correct quality deficiencies, to include F-600, F-656, and F657. Further review revealed the CED would present his findings of the facility's audits to QAPI until the concern was resolved.

Lastly, the POC revealed the Regional Vice President of Operations (RVPO)/designee reeducated the Center Executive Director (CED) by 11/11/2020, who would reeducate members of Interdisciplinary Team on the Quality Assurance Performance Improvement (QAPI) process on or before 11/11/2020, regarding a facility must maintain a quality assessment and assurance committee. Further review revealed the CED and/or CNE would report the facility's audits to QAPI until the issues were resolved.

During the 10/09/2020 Recertification Survey, the facility was cited deficient practice related to "Sufficient Nursing Staff"; "Behavioral Health Services" for failure to assess, document, and provide services to residents with known behaviors; "Administration" for failure to maintain substantial compliance; and "QAPI Program/Plan" for failure to identify and correct deficient practice.

Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed she had worked at the facility since 10/13/2020. Per interview, she stated she was aware of the repeated deficiencies of F600, F656, F657, and F740. The CNE stated she was continuing the audits from the previous Plans of Correction, but she did not discuss the outcomes of the audits with QAPI as per the POC. She further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	4604 LOWE ROAD LOUISVILLE, KY 40220

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F 867	Continued From page 331	F 867		

staff were to complete visual rounds/observations of the residents on the Memory Care Unit, but they did not complete the rounds "frequently"; only gaining a "snap shot" of the residents' behaviors. Additionally, the CNE stated staffing was discussed in QA; however, there were no concerns identified.

Interview with the Center Executive Director (CED), on 05/11/2021 at 3:25 PM, revealed he became the Administrator 02/15/2021. Per interview, he stated the purpose of the QAPI committee was to effectively manage and change care, if necessary, for the residents. He further stated the QAPI committee met monthly and "as needed", adding, "the facility had two (2) Ad Hoc QAPI meetings this week." He further stated he brought the most recent identified jeopardy situations to QAPI to discuss the concerns with Resident #31's medications. The CED stated the Medical Director (MD) attended the QA meetings and was very involved. He revealed other Department Heads attended, including the Center Nurse Executive (CNE), all managers, Social Service Director, Business Office Manager (BOM), Dietitian, Dietary Services, and now Corporate was currently involved, attending in person or via teleconference. Continued interview revealed concerns identified in QAPI included the residents' falls. He further stated the committee addressed the interventions and updated the residents' care plans if needed. The CED stated information obtained for resident care improvement came from partnering with direct care staff, making rounds, and talking to the staff about concerns they were observing with the residents. He stated other resources used were to review any audits developed from the Plan of Corrections (POC) and addressing concerns that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 332	F 867		

came from the POC. He stated the QAPI committee made a good attempt to identify and correct issues, and stated it was a work in progress. Finally, the CED stated he was aware of the prior concerns addressed in the facility's previous POCs, but he was not one-hundred (100) percent aware of all the concerns identified in the facility.

Telephone interview with the Medical Director (MD), on 05/12/2021 at 10:25 AM, revealed he attended the QAPI Process once a month and has been involved with a couple of the ad hoc meetings last week. Continued interview with the MD revealed the QA discussed the POC audits and ongoing concerns with the residents' behaviors.

Interview with the former Regional Vice President (FRVP), on 05/12/2021 at 8:21 AM, revealed she worked with the facility since 12/28/2020. Per interview, the FRVP revealed she provided oversight to the CED. She stated she provided supportive assistance, guidance, and reinforced the procedures, policies and education through communication with the facility's administration. The FRVP revealed the CED and CNE did not "formally" report issues from the facility to her or what they were working on in QAPI. Indirectly, at times, they discussed potential concerns to take to QAPI. Further interview revealed she was not aware of and had not been made aware of what the facility was working on in QAPI.

An additional telephone interview with the Medical Director, on 05/22/2021 at 5:30 PM, revealed the facility immediately notified him by phone related to the identified jeopardies. The MD revealed the facility held an immediate Ad-HOC QAPI to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 333	F 867		

discuss the information, formulate education to staff, and audits for compliance. The MD revealed the facility updated him daily on the progress of education, audits, and any changes which were warranted after review of the information.

Review of the IJ Removal Plan/Allegation of Compliance revealed the facility implemented the following:

1. On 05/16/2021, a Quality Assurance Performance Improvement (QAPI) meeting was held to discuss the action plans including audits, education, and compliance monitors for repeat deficiencies F600, F656, F657, F725, F740, F835, and F867 prior to the alleged compliance date with any corrective action upon discovery.

2. On 05/16/2021, the Regional Vice President of Operations
(RVPO) or designee reeducated the Center Executive Director (CED).

3. By 05/19/2021, a plan of action was developed and implemented by the Quality Assurance Performance Improvement (QAPI) Committee to correct identified repeat quality issues and concerns cited at F600, F656, F657, F725, F740, F835 and F867.

4. On or before 05/19/2021, the CED would reeducate members of the Interdisciplinary Team on the Quality Assurance Performance Improvement (QAPI) process regarding a facility must maintain a Quality Assurance and Performance Committee (QAPI) consisting of the Center Nurse Executive (CNE), a physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 334	F 867		

designated by the facility and at least three (3) other members of the facility's staff to develop and implement appropriate plans of action to correct identified quality deficiencies. Posttests were completed to validate understanding graded by the CED. Members of the Interdisciplinary Team not available during this timeframe will be provided reeducation and complete posttests graded by the CED upon day of return to work. New members of the Interdisciplinary Team will be provided education and complete posttest graded by the CED during orientation.

5. The Regional Vice President of Operations and/or Clinical Quality Specialist (CQS) would review QAPI minutes monthly times six (6) months then ongoing thereafter as determined by the QAPI committee to ensure additional audits were assigned based upon recommendations for additional follow up and/or in-servicing needs.

6. The CED or CNE would report results of the audits for F600, F656, F657, F725, F740, F 835 and F867 monthly times six (6) months to the QAPI committee which consisted of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing Services, Medical Director, Social Service Director, Food Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in servicing until the issue was resolved and then ongoing thereafter as determined by the QAPI committee.

The State Survey Agency validated the implementation of the facility's AOC as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 335	F 867		

1. Review of the Ad-HOC QAPI sign-in sheet, dated 05/15/2021, revealed the deficiencies for F600, F656, F657, F725, F740, F835, and F867 was discussed and all members of the QAPI committee signed in, the Medical Director attended by phone.

Review of the QAPI committee meeting sign-in sheet revealed the facility held Ad-HOC QAPI meetings on 05/16/2021, 05/17/2021, 05/18/2021, 05/19/2021, 05/20/2021, and 05/21/2021.

2. Review of the posttest dated 05/15/2021 revealed the CED was educated on QAPI and passed the test with one-hundred percent (100%). Continued review revealed the Regional Vice President of Operations (RVPO) signed off on the test on 05/19/2021.

Interview with the RVPO, on 05/22/2021 at 3:35 PM, revealed he has provided the CED guidance through observing and sitting through the QAPI meetings. Per interview, he stated he offered the CED suggestions on how to lead and added, "He still needs to make sure the team works together." Continued interview revealed he was helping the CED understand his role as an Administrator. He further stated he signed off on the CED's posttest related to QAPI.

3. Interview with the Medical Director (MD) on 05/22/2021 at 5:30 PM, and CNE and CED; on 05/22/2021 at 6:30 PM, revealed the QAPI meeting held on 05/15/2021 discussed the audits that were in place and all of the cited jeopardy situations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185301	A. BUILDING _____ B. WING _____	C 05/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIS WOODS	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 336	F 867		

Interview with the CED, on 05/22/2021 at 6:30 PM, revealed the plan was developed and implemented by 05/19/2021.

4. Per review of the QAPI sign-in sheets dated 05/15/2021, 05/16/2021, 05/17/2021, 05/18/2021 revealed the QAPI members were educated on QAPI. Additional review revealed the members of QAPI took the posttest on 05/18/2021 and passed with one-hundred percent (100%). Further review revealed the CED sign-off on 05/19/2021.

Interview with Certified Nursing Assistant (CNA) #25, on 05/21/2021 at 6:15 PM, revealed the CNA represented clinical staff on the QAPI committee. The CNA revealed the committee members completed review of QAPI policy and pre and posttests, met daily, reviewed gathered data, discussed ongoing education, and discussed if the committee needed to change the course of education based on the feedback from the audits.

5. Interview with the CQS, on 05/22/2021 at 3:06 PM and RVP, on 05/22/2021 at 3:35 PM, revealed they would sign-off on the QAPI minutes for six (6) months, until the QAPI committee deems no current issues.

6. Interview with the CED and CNE, on 05/22/2021 at 6:30 PM, revealed they would submit all audits related to the deficient practice cited to the QAPI meetings until the issues had been resolved.