PRINTED: 03/31/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>24/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 55	- 1/2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	identified on two (2) s 07/30/2021, and on 0 abated the 07/30/202 second IJ incident ide determined to be IJ or census was 124.  Immediate Jeopardy and was determined to areas of 42 CFR 483. and Discharge, F624 Transfer/Discharge at and 42 CFR 483.21 C Centered Care Plans, Process at scope and was notified of the Im 07/30/2021.  The facility provided a Compliance (AoC) on removal of jeopardy of Survey Agency (SSA) IJ as alleged on 08/03	ey was initiated on uded on 08/24/2021. mediate Jeopardy (IJ) was eparate occasions, on 8/24/2021. The facility 1 incident; however, the entified on 08/24/2021 was ngoing. The facility's was identified on 07/30/2021 to exist on 06/16/2021 in the 15 Admission, Transfer, Preparation for Safe/Orderly a scope and severity of "J", Comprehensive Resident F660 Discharge Planning I severity of "J". The facility mediate Jeopardy on	F 00	,		
	Jeopardy, the SSA in complaint intakes.  Immediate Jeopardy vand was determined tareas of 42 CFR 483. Free of Accident Haza scope and severity of	was identified on 08/24/2021 to exist on 05/10/2021 in the 25 Quality of Care, F689 ards/Supervision/Devices at "J" and 42 CFR 483.21 dent Centered Care Plans,				
ABORATORY		nent Comprehensive Care SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

09/10/2021

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C <b>08/24/2021</b>		
NAME OF P	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 LOWE ROAD LOUISVILLE, KY 40220	1 00/2-1/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 000	Plan Timing and Re of "J"; 42 CFR 483. Services, F745, at s CFR 483.70 Admin at scope and severi Body at scope and Quality of Care, F66 Hazards/Supervision severity of "J". The Immediate Jeopard ongoing.  Additionally, Immediate Jeopard ongoing.  Additionally, Immediate Jeopard Off 16/2021 and is composed and severity conducted during the cited at the highest these tags had recorded at scope and severity conducted during the cited at the highest these tags had recorded at scope and severity conducted on severity of "K". F60 scope and severity of "K". F60 scope and severity been corrected.	everity of "J" and F657 Care evision at scope and severity 40 Behavioral Health scope and severity of "J"; 42 istration, F835 Administration ty of "J", and F837 Governing severity of "J". Substandard identified at 42 CFR 483.25 as Free of Accident in/Devices at scope and facility was notified of the yon 08/24/2021, and is diate Jeopardy and yof Care were identified at 42 on of Medically Related Social erand severity of "J". If you was determined to exist on ongoing.  In and F837 Governing Body and on 05/22/2021, both at of "K". A revisit was not his survey. F835 and F837 will her scope and severity of "K",	F 000				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		185301	B. WING			l	24/2021
NAME OF PR	ROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page		F	000			
	The 08/24/2021 abbr complaints KY00034 KY00034149, KY000 KY00034156, KY000 KY00034329, and KY	34150, KY00034151, 34197, KY00034198,					
		146, KY00034149, 34156 and KY00034198 I with no deficient practice					
	were substantiated widentified.	34329 and KY00034330 ith deficient practice					
F 600 SS=K	Free from Abuse and CFR(s): 483.12(a)(1)	· ·	F	600			
	Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to					
	§483.12(a) The facilit	•					
	9483.12(a)(1) Not us	e verbal, mental, sexual, or					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C 08/24/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDR		1 00/	24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E COSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page physical abuse, corpo involuntary seclusion;	oral punishment, or	F	00			
	by: Based on observatio and review of the faci determined the facility neglect for four (4) of residents (Residents Resident #1 and Resi the Memory Care Uni a verbal altercation be Resident #1 called Re return Resident #7 sp water. Resident #1 re duty.	y failed to prevent abuse or eighteen (18) sampled #1, #7, #17, and #18). ident #7 were roommates on t. On 06/19/2021, there was					
	adjacent on the nursii approximately 5:00 P (LPN) #1 heard raised	ng unit. On 06/24/2021, at M, Licensed Practical Nurse d voices in the hall and alled Resident #18 a "punk."					
	revised 04/09/2021, reprohibited abuse, neg	s policy, "Abuse Prohibition," evealed the facility glect, misappropriation of d exploitation of all residents.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		185301	B. WING			C 08/24/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	facility staff did all the prevent occurrences neglect, exploitation injuries of unknown of property for all results. The shared room wheelchair out of the "bitch". In response small plastic cup of Resident #1.  Record review reveal Resident #1 on 06/1 included Alzheimer's Psychosis, Reduced Behaviors, Mood Distriction Features, and Major Review of the Minim 05/01/2021, reveale Resident #1 to have concerns. Continued assessed Resident Mental Status (BIMS fifteen (14/15) and dognitively intact with Review of the Computated 12/11/2017, rexhibit or had the pobehaviors related to Interventions include conditions and medipsychiatrist services caregivers and structure.	vealed the policy ensured at was within their control to of abuse, mistreatment, involuntary seclusion, source and misappropriation	F 60			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OMPLETED
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b>'</b>	00/2-1/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Interview with Resid AM, revealed he/she with Resident #7, no roommate's name.  Record review revealed the Resident #7 on 03/1 included End Stage Dependent on Dialy disability, and Vasco Behaviors. Continue facility discharged Review of the MDS, the facility assessed vision, hearing or spreview revealed the with a BIMS score of (14/15) and determing cognitively intact, with Review of the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis/her altercation with the CCP, no care plan for behalis with the CC	gs; and, divert resident by activities such as cards.  ent #1, on 07/14/2021 at 9:45 e could not recall the incident or did he/she recall the incident or did he/she recall the aled the facility admitted 7/2021 with diagnoses that Renal Disease (ESRD), sis, Age-Related Physical alar Dementia without ed record review revealed the resident #7 on 07/23/2021.  Idated 06/22/2021, revealed Resident #7 to have no reech concerns. Continued facility assessed Resident #7 fourteen out of fifteen ned the resident was the no behaviors.  Idated 03/18/2021, revealed aviors for Resident #7 prior to ith Resident #1.  Puts were made on 07/19/2021 at 0 AM to contact a CNA e) #19 and Nurse Assistant on the Memory Care Unit on	F 6	00		
	contact the Transition	on Care Unit Unit Manager U UM was scheduled to work				

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		185301	B. WING		08/24/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 4604 LOWE ROAD LOUISVILLE, KY 40220		0/2-4/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	AM, revealed she wo providing care in a realtercation between Foccurred. Further inteveryone's responsible residents to ensure the residents were quick constant eyes on the Interview with Registe 07/15/2021 at 12:51 duty when the altercation was unwith reported the incident Resident #1 and Resident #1 approace reported Resident #7 Continued interview in small damp spot on Fistated she interviewed altercation and he/shicalled him/her a sweath wheelchair was in the up a small plastic cup Resident #1. RN #2 sout of the room and significant with the received experience of the received	reation.  14, on 07/19/2021 at 10:50 rked on the unit and was sident's room, when the Resident #1 and Resident #7 erview revealed it was sility to supervise the ney were safe because some to get up and needed m.  ered Nurse (RN) #2, on PM, revealed she was on ation occurred between ident #7. She stated the nessed and Resident #1 to her. RN #2 stated hed her in the hall and threw water on him/her. revealed RN #2 noticed a Resident #1's shirt. RN #2 and Resident #7 about the ereported Resident #1 ar word because his/her way so Resident #7 picked of water and splashed it on stated Resident #1 stayed she notified her supervisors tion. She immediately "s room and notified the ns of both residents. RN #2 education regarding the se along with who and when ations. Additionally, RN #2 ne's responsibility to ints on the Memory Care Unit	F 60				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		185301	B. WING			C <b>08/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<u>'</u>	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Director, on 07/21/20 was new to the posit stated her role includ were being properly were met. Continued responsibility of all s to supervise residen  Interview with the Co on 07/22/2021 at 3:4 expected staff to cor on the Memory Care behaviors were obse be implemented immade and all actions Continued interview 3:36 PM, revealed R were aggressive resaltercation was not a disagreement.  Interview with the Co 07/30/2021 at 3:04 F staff to supervise reswas expected to che they were safe.  2. Review of the clinifacility admitted Reswith diagnoses that in Disease, Right Below Hemiplegia Affecting Review of Resident 105/21/2021, revealed Interview for Mental	emory Care Program 021 at 2:22 PM, revealed she tion, just two (2) weeks. She ded ensuring the residents supervised and their needs d interview revealed it was the taff on the Memory Care Unit ts.  enter Nurse Executive (CNE), 16 PM, revealed she ntinue to supervise residents e Unit. She stated if erved, interventions were to nediately and notifications is were to be documented. with the CNE, 07/29/2021 at tesident #1 nor Resident #7 idents. She stated this in physical one, just a  enter Executive Director, on PM, revealed he expected his sidents. He stated everyone eck on residents to ensure  ical record revealed the ident #17, on 02/08/2019, included Chronic Kidney with the Knee Amputation, and in the Right Side.  #17's Quarterly MDS, dated d the facility assessed a Brief Status score of fifteen (15) resident was cognitively intact	F 60			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	ge 8	F 60	00		
	System (RMS) Even 06/23/2021, revealed abuse allegation and other as the aggress facility staff deescala immediately separat move was completed involved.  Review of Resident 01/02/2021 and last revealed a focus that history of verbal outleas abusive, inappropriately confront care plan revealed to the 417 would not exhibit others.  Observation of Resident 3:08 PM, revealed the dressed and sitting in the doorway stood in the doorway stood in the doorway stood and stood in the doorway stood and stood in the doorway stood and stood an	#17's Care Plan, initiated on revised on 04/17/2020, t included the resident had a pursts directed at others such				
	stated the Center Ex	the same racial slur. He/she secutive Director was notified as moved to another hall.				
	admitted Resident # diagnoses that include Vascular Dementia v	al record revealed the facility 18, on 04/23/2020, with ded Bipolar Disorder, with Behavioral Disturbance, ccident, Major Depressive opment Disorder of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		185301	B. WING		08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 00/2-7/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 600	revealed an order for 06/22/2021, twice of included yelling, cur impulsiveness with interventions, and routers.  Review of Resident Administration Record June 2021, revealed behaviors that inclus wandering, and imprevealed these behout of thirty (30) day out of thirty-one (31) twenty-seven (27) of June.  Review of Resident revealed on 05/31/2 observed in the hald door arguing with Review of Resident 109/25/2020 and lass revealed a focus the verbal behaviors of impulsiveness. Fur was that Resident 4 outburst directed at revealed intervention	#18's Physician's Orders or behavior monitoring, dated laily for behaviors, which rsing, wandering, and documentation of behaviors, esponse in the Progress  #18's Medication ord (MAR), dated April through d licensed nurses documented ided yelling, cursing, oulsiveness. Further review aviors were observed eight (8) ys in April; fourteen (14) days	F 60	0	
	with identification or remove the residen	rve the nature of the outbursts f possible triggers; staff to t from the area to allow time to eak in a calm, reassuring			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		COMPLETED	
		185301	B. WING _			C 08/24/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Data Set (MDS), da facility assessed the Interview for Mental thirteen (13) out of f the resident was concentrated. Review of Resident System (RMS) Ever 06/23/2021, revealed another resident cal RMS revealed the fa and identified the roclaimed the other cal Further review reveamove for Resident # both residents with Services.  Observation of Resident # Services.  Observation of Resident # 18 groomed, had poor standing in the hall Interview of Resident # 18 name by Resident # 18 name by Resident # 18 name by Resident # 18 Interview with Licen on 07/29/2021 at 8:3	#18's Quarterly Minimum ted 06/28/2021, revealed the resident with a Brief Status (BIMS) score of ifteen (15) and determined gnitively intact.  #18's Risk Management at Summary Report, dated d Resident #18 stated led him/her a "punk." The acility substantiated abuse of cause that both residents alled him/her names first. aled the facility made a room it18 and the facility provided Social and Psychiatric  dent #18, on 07/29/2021 at Resident #18 was dressed, eye contact, and was by the front facility entrance.  at #18, on 07/29/2021 at 9:56 ent #18 did not remember is a name or being called a	F 6				
	remember and said to Resident #18. Sh two (2) residents an	e. She stated she could not he/she was going to "do stuff" he stated she separated the dremoved Resident #18 from terview with LPN #1 revealed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185301	B. WING _				C <b>24/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER		•	460	EET ADDRESS, CITY, STATE, ZIP CODE 4 LOWE ROAD UISVILLE, KY 40220	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	and he/she did not call she stated Resident aggressive verbal betwing racial slurs tow #1 stated in addition facility staff observed signs from residents resident to resident as Interview with the Ce on 07/29/2021 at 3:23 substantiated the verstated her interview with Resident #18 had told did not call him a racing Resident #18 denied name. Further interview history of a stroke. Spreviously called ano and it appeared the residents with a low stated staff were awa provided supervision, appropriately related which could become  Interview with the Ce (CED), on 07/30/202 was unaware of the inhe did not conduct the stated the facility profabuse with staff eduction, respected ensured care was provided care was	but a lot without a reason all other residents names. #17 had a history of haviors by cursing, and ards other residents. LPN to abuse education, the for symptoms or warning to intervene or prevent buse.  Inter Nurse Executive (CNE), 3 PM, revealed she bal abuse allegation. She with Resident #17 revealed d Resident #17 that he/she ial slur. The CNE stated calling Resident #17 a ew revealed the CNE stated ved the resident yell out for a symptom of his/her the stated Resident #17 had ther resident a racial slur ecipients were usually BIMS score. CNE further are of body language,		600 624			
SS=J	i roparation for Gale/	Orderly Hallstol/Daolity		,,,			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		PLETED
		185301	B. WING				C <b>24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			46	REET ADDRESS, CITY, STATE, ZIP CODE 04 LOWE ROAD DUISVILLE, KY 40220	1 00/	Z-1/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 624	CFR(s): 483.15(c)(7) §483.15(c)(7) Oriental discharge. A facility must provide preparation and orien safe and orderly transfacility. This orientation form and manner that understand.  This REQUIREMENT by: Based on interview, the facility's policy it vertically failed to provide and preparation and orien (18) sampled resident safe and orderly disconservation and orien (18) sampled resident safe and orderly disconservation and orien (18) sampled resident safe and orderly disconservation and orien (18) sampled resident safe and orderly disconservation wanting to be facility's Social Serval onger wanting to be facility's Social Worket through the process of guardianship." Continuote was made on 04 author that stated "the guardianship on this in Conservator wants not care medically or firevealed another note 05/01/2021 that state application for this residual care in the conservation for the care in	e and document sufficient station to residents to ensure sfer or discharge from the on must be provided in a tithe resident can  T is not met as evidenced record review and review of was determined the facility document sufficient station for one (1) of eighteen ts (Resident #3) to ensure a marge from the facility.  Siness Office (BO) notes, wealed the Program Director mer Medicaid ices) annotated "son is no Conservator and [the ers (SW)] were going of filing for state sued review revealed another (701/2021 by the same er facility has filed for resident, Current othing to do with his/her plan nancially." Further review er was completed on diguardianship has an sident by the BO Manager."	F	624			

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		185301	B. WING _		0	C 8/ <b>24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 4604 LOWE ROAD LOUISVILLE, KY 40220		012412021
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 624	Resident #3, reveal from the facility he on 06/16/2021, an him/her, however, what was said. Co facility did not give medications before interview revealed administer his/her someone to tell hir needed as he/she monitoring device. revealed when dis had no money and regarding his/her related with the self-before with the revealed the home twenty-four seven, leave by 7:30 AM PM. In addition, the with incontinence medication administer resords, dated 06/presented to the Efrom the Long Ter 06/20/2021; was atten (10) days.	age 13 9:20 AM, interview with aled at the time of discharge /she had been caught smoking d the facility did speak to Resident #3 could not recall ntinued interview revealed the him/her any clothes or his/her eleaving the facility. Further he/she did know how to own insulin but needed m/her how many units he did not have a glucose Additionally, Resident #3 charged on 06/16/2021 he/she if the facility failed to notify him money after he/she was gone.  If revealed the facility ent #3 to an area homeless ransport. Interview and record to documented evidence of on, education related to the form nor was equipment the retherapy to the resident. Homeless Shelter Director eless shelter was not open the homeless person had to and could not return until 4:00 ey did not provide assistance, care, transfers and or stration. Review of hospital 20/2021, revealed Resident #3 D, four (4) days after discharge m Care (LTC) Facility, on dmitted and received care for	F	524		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			1	24/2024
NAME OF P	ROVIDER OR SUPPLIER	199991		4	TREET ADDRESS, CITY, STATE, ZIP CODE  604 LOWE ROAD  OUISVILLE, KY 40220	<u> 1 067.</u>	24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	and Discharge, F624 Transfer/Discharge at and 42 CFR 483.21 Centered Care Plans Process at scope and was notified of the Im 07/30/2021.  The facility provided a Compliance (AoC) or removal of jeopardy of Survey Agency validated alleged on 08/03/202  The findings include:  Review of facility polity Transfer," revised 02/2 and discharge include a bed outside of the obed is in the same physical continued review reviguidance that met state to meet the resident's safe transition to an atthe policy's "process" inter-professional car preparation and orient transfer. Further revied discharging to home, other community base the Discharge Transiting resident. Additionally Transition Plan was pand the estimated plaplaced in the resident.	Preparation for Safe/Orderly to scope and severity of "J", Comprehensive Resident, F660 Discharge Planning to severity of "J". The facility mediate Jeopardy on an acceptable Allegation of 108/11/2021 alleging on 08/03/2021. The State ated abatement of the IJ as 1.  Cy, "Discharge and 101/2019, revealed transfer ed movement of a patient to certified Center whether that hysical plant or not. ealed the policy provided ate and federal regulations, a needs, and to facilitate a alternate setting. Review of	F	624			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220	E	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 624	Continued From pag	ge 15	F 6	524		
	Process," revised 02 residents being discilliving facility or another were given a Discharge Packet. The included a recapitular resident's stay, and resident's status at a Additionally the Pactor all pre-discharge resident's post-discharge plan resident to adjust to environment and what reside along with an another statement of the post-discharge plan resident to adjust to environment and what reside along with an another president to another plan reside along with an another plan resident to adjust to environment and what reside along with an another plan resident to adjust to environment and what reside along with an another plan resident to adjust to environment and what reside along with an another plan resident to adjust to environment and what reside along with an another plan resident to a pla	ket included a reconciliation medications with the narge medications, a of care, which assisted the his/her new living nere the resident planned to by follow up care.				
	with diagnoses to in Behaviors, Type Tw Hypertension (HTN) Gastro-Esophageal Chronic Pain, and T Review of the Psych 06/07/2021 revealed	Reflux Disease (GERD), obacco Use. nology notes, dated d Resident #3 was assessed				
	to have Neurocogni Disruptive-Impulse ( and Personality Disc	Control and Conduct Disorder,				
	document titled, "Or Conservator," revea appointed Conserva Conservatorship wit dispose of property,	#3's medical record revealed der of Appointment of led Resident #3's son was ator with a "limited h specific legal rights to execute instruments, and ctual relationships" on				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY COMPLETED
		185301	B. WING _			C 08/24/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 624	Continued From pag	ge 16	F 6	524		
	regarding Resident revealed the Progra (former Medicaid spannotated "son is no Conservator and [th (SW)] were going th state guardianship." another note was m same author that staguardianship on this Conservator wants of care medically or revealed another not 5/01/2021 that state application for this result of discharging the readditionally, on 07/0 "guardianship has be were made to conta AM and 9:47 AM and and 10:23 AM without Review of the facility #3 had a Conservator protected person), or Review of the most Minimum Data Set (revealed the facility	nothing to do with his/her plan financially." Further review the was completed on sed "Guardianship has an esident by the BO Manager. of being conservator," all prior esident on 06/16/2021. 02/2021 it was noted that een filed." However, attempts ct SW on 07/16/2021 at 9:44 d on 07/20/2021 at 10:21 AM out success.				
	Interview of Mental of fifteen (12/15) and speech or vision. Co facility assessed Redepressed and did r	Status (BIMS) score of twelve d no concerns with hearing, ontinued review revealed the sident #3 to be moderately not exhibit behaviors. Further sident #3 required limited				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185301	B. WING		C 08/24/2021
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		1 00/24/2021	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 624	assistance with one extensive assist of completed to illeting and completed to illeting and completed to illeting and completed to bladder and frequenter further review reveal insulin injections, an opioids. Additionally rehabilitation and placommunity upon discommunity intervention to provious wheelchair with a curevealed Resident #cardiovascular compliagency discommunity upon discommun	(1) person for transfers, one (1) person for dressing, ting personal hygiene. The vealed the facility assessed coasionally incontinent of the incontinent of the incontinent of the incontinent of bowel. The incontinent of bowel and Resident #3 received tidepressants, diuretics, and resident #3's plan included anned to return to the charge.  The rehensive Care Plan (CCP), evealed Resident #3 was at bility to perform Activities of in bathing, grooming, ressing, eating, bed mobility, on, and toileting with an de him/her with a standard ishion. Continued review 3 was at risk for bilications related to his/her yperlipidemia, Coronary ident #3 was at risk for to being prescribed diuretics. The index his/her diagnosis of DM. In the index his in a retraining in the limited in a retraining in the limited in a retraining in the index his/her diagnosis and limited in a retraining in the limited in a retraining in the index his/her diagnosis and limited in a retraining in the limited in a	F 624		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185301	B. WING				0
NAME OF P	ROVIDER OR SUPPLIER	100001	1	46	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220	j 08/.	24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	o5/26/2021, 06/09/20 she documented that dependent.  Attempts were made 07/30/2021 at 2:25 Pithe NP without succe Review of the Occupations of the NP without succe Review of the Occupations of the NP without succe Review of the Occupations of the NP without succe Review of the Occupations walker and minimal a wheelchair for ADLs. discharge recommencertified Occupations included caregiver sureintegration services Equipment (DME) of and hospital bed and Interview with the Cel Assistant, on 07/28/2 he completed therapy while he/she was admicontinued Resident # awareness due to not transfer techniques. Is support would be not assistance with media home management (etc.)  Review of the Physical Summary, dated 03/0 #3 had an activity tole minutes with a goal of the process of the process of the process of the Physical Summary, dated 03/0 #3 had an activity tole minutes with a goal of the process of the process of the physical summary.	/03/2021, 05/19/2021, 21 and 06/16/2021 revealed Resident #3 was wheelchair on 07/29/2021 and M and 1:15 PM, to contact ss.  ational Therapy (OT) dated 03/05/2021, revealed supervision with transfers, ADLs using a wheeled ssistance while seated in a Continued review revealed dations made by the all Therapy Assistant (COTA) pport and community with Durable Medical wheeled walker, wheelchair,	F	624			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C 8/24/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4604 LOWE ROAD LOUISVILLE, KY 40220		0/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 624	Continued From pag	e 19	F 62	24		
	and with walking with review revealed disc made by the Physica caregiver support.	rd for sit to stand transfers n a rolling walker. Continued harge recommendations al Therapist (PT) included				
	9:11 AM, revealed he with Resident #3 who Resident #3 could fur wheelchair or at a sheurther interview revincluded assistance	Assistant, on 07/28/2021 at e completed PT sessions ile admitted. He continued nction appropriately with a nort distance with a walker. ealed caregiver support with medications, using the g someone near to be able to gularly.				
	he/she was prescribe Insulin Lispro (diabet Patch (for hypertens Depakote (for behav medication), Effexor Hydrochlorothiazide (antihypertensive), L medication), Namen Ranolazine for chest diuretic). Further rev revealed the Quality notified the physician discharge orders so	d while admitted to the facility ed Insulin Glargine and tes medication), Clonidine ion, to be applied weekly), iors), Aricept (dementia (antidepressant), (antihypertensive), Imdurinagliptin (diabetes				
	PM, RN #1 on 07/16 Assurance (QA) Nur PM, Consulting Soci	2 on 07/15/2021 at 12:30 /2021 at 11:14 AM, Quality se on 07/16/2021 at 1:45 al Worker on 07/29/2021 at enter Executive Director				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185301	B. WING				0.4/2004
NAME OF PI	ROVIDER OR SUPPLIER	100001	1 2		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2021
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From page (CED) on 07/16/2021 revealed Resident #3 during a non-smoke page the facility informed have revoking their smoking became upset and was that day.  Review of the Dischald completed by the Lice #2 revealed no docur discharge education, Resident #3's medical equipment (Experience) recommended per the Interview with Family AM, revealed the faci #3's discharge via emfurther stated Resided bladder and bowel at wane with Demential brain damage from a thirteen (13) years ag Review of hospital revealed Resident #3 (4) days after dischar (LTC) Facility, on 06/2 Resident #3 was hype 277 (normal reading in	at 11:40 AM, it was was found to be smoking period on 06/16/2021. When im/her the facility was g privileges, Resident #3 anted to leave the facility  rge note, dated 06/16/2021, ensed Practical Nurse (LPN) mented evidence of education related to ations nor any durable DME) that was e OT discharge summary.  #1, on 07/15/2021 at 9:25 lity notified them of Resident hail on 06/16/2021. She in #3 was incontinent of times, and would "wax and and had some previous motor vehicle accident io.  cords, dated 06/20/2021, presented to the ED, four ge from the Longterm Care 20/2021. The ED determined erglycemic with a reading of		624	,		
	urinary tract infection of chest pain, shortne extremity pain. Contin Resident #3 was diag the right lower leg. Ac treated with insulin, b	(UTI), diarrhea, complaints ess of breath, and lower					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>08/24/2021</b>	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4604 LOWE ROAD LOUISVILLE, KY 40220	CODE	00/24/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 624	treat blood pressure.  Interview with Reside AM, revealed at the ti Long Term Care (LTC caught smoking on 06 speak to him/her, how recall what was said. revealed the facility diclothes or his/her med facility. Further interviknow how to administ needed someone to the/she needed as he/monitoring device. Addid not have money in facility failed to notify going to happen to the leaving the facility.  Interview with License on 07/27/2021 at 3:34 Resident #3 all medic narcotics per the physinsulin in the form of a medication list. Continuation showed Resident #3 and he/she verbalized she could not confirm seeming to be "in a rule LPN #2 continued and #3 a couple of screw-properly administer in interview with LPN #2	nt #3, on 07/27/2021 at 9:20 me of discharge from the of facility he/she had been 6/16/2021 and the facility did vever, Resident #3 could not Continued interview of the facility had been 6/16/2021 and the facility did vever, Resident #3 could not Continued interview of the facility he/she did had been 6/2021 and the facility he/she or was given any and the him/her regarding what was be resident's money after facility he/she fa	F	624			
		insulin. Additionally, LPN #2 's discharge felt rushed, ibly not safe.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		185301	B. WING _			C 08/24/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	Continued From pa	ge 22	F 6	24		
	Programs, on 07/27 the shelter, where F to, did not assist in including storage or interview revealed cleave the shelter da check-in for the eve Additionally, she stabehind, staff collect locked box and their local pharmacy whe Further interview rehave the support sta	omeless shelter's Director of 7/2021 at 1:40 PM, revealed Resident #3 was discharged any way with medications of dispensing. Continued Slients at the shelter have to hilly between 7:00-7:30 AM and shining begins at 4:00 PM. Sated if medications were left end them, placed them in a medications were taken to a sere they were destroyed. Evealed the shelter did not saff to assist clients with the from the wheelchair), tinence care.				
	07/29/2021 at 10:13 approached by Res office, desiring discince Continued interview Resident #3's disch homeless shelter. F was not aware that dependent and did management at the Additionally, she redischarge to the hold due to him/her having stated her responsinguide the residents	sonsulting Social Worker, on 3 AM, revealed she was ident #3 on 06/16/2021, in her harge from the facility.  It revealed she helped facilitate arge by contacting the further interview revealed she Resident #3 was insulin not inquire about medication homeless shelter.  It revealed Resident #3's meless shelter was not unsafe and a safe place to go. She boility to offer options and help but ultimately it was Resident e/she had the right to make				
	on 07/22/2021 at 3:	enter Nurse Executive (CNE), 46 PM, revealed she was not 3 could self-administer insulin				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>8/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	111111	S 4	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220		0/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	homeless shelter. Correscident #3 was verscreaming/yelling and leave on 06/16/2021 de-escalate him/her interview revealed the someone at the homedication manager with resident needs. revealed the facility a #3's discharge as saphysician and receiv Resident #3 could ta him, given Resident time.  Interview with the Correct (CED), on 07/30/2020 06/16/2021 Resident CED stated due to Resident #3's rights facility. Further interviewed a physician Resident #3's rights facility. Further interviewed a physician Resident #3 could have help make it the safethat time.  The facility alleged it actions to remove im 1. Resident #3 was confoliologo 1.	eturn demonstrate efore being discharged to the ontinued interview revealed y impulsive, d cussing to staff, wanting to and many staff tried to without success. Further the CNE was not sure if eless shelter assisted with ment or if their staff assisted Additionally, the CNE attempted to make Resident fe as possible, by calling the ing discharge orders so ke his/her medications with #3's verbal agitation at that enter Executive Director at at 3:04 PM, revealed on at #3 was discharged. The desident #3 having a high documents showing a not going to impede on for wanting to leave the view revealed the facility 's order for discharge so ave his/her medications to est discharge for him/her at implemented the following	F 624			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	Continued From pag	ge 24	F 6	24		
	reviewed, on 07/31/planned discharge s discharge trends.  3. The Center Execution 17/10/10/10/10/10/10/10/10/10/10/10/10/10/	ial Services team member 2021, all residents with a since 06/16/2021 to identify utive Director (CED) and CNE				
	Regional Vice Presi Quality Specialist (C safe transfer/discha documentation on the	n and a posttest after the dent (RVP) and Clinical CQS) provided education for a rge with appropriate ne resident's clinical status, edication management 81/2021.				
	team, Assistant Dire (ADNS), Nurse Prac Managers (UM), CE (HRD) and Nurse S	02/2021 the Social Services ector of Nursing Services ctice Educator (NPE), Unit ED, Human Resource Director upervisors completed strest on the safe/orderly of the resident.				
	on or before 08/02/2 transfer/discharge,	y and agency staff completed 2021 education on a safe and education requirements staff were required to complete				
	three (3) times a we planned for dischard to the resident rega medication education	ed resident records daily then sek for resident's who were ge for documented education rding clinical care and on by staff. Identified areas immediately by the team				
	ADNS and Social S	committee reviewed the CNE, ervices team weekly audits for , discharge, and education.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<u> </u>	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	would occur until results the State Survey Agremoval plan by:  1. Record review results and the Resident #3 on 06/1 Interview, on 07/27/Licensed Practical National discharged Resident  2. Interview with the PM, revealed she with planned discharges Interview with Rapid 08/21/2021 at 2:56 linvolved with review alleged.  Interview with the Dicompliance, on 08/2 she was involved with discharges as alleged.  Review of an audit to the Review of t	nal follow-up or re-education solved.  gency (SSA) validated the  vealed the facility discharged 6/2021.  2021 at 3:34 PM, with  Jurse (LPN) #2 revealed she t #3 on 06/16/2021.  CNE, on 08/21/2021 at 3:19 as involved with review of all as alleged.  Response Manager, on PM, revealed she was of planned discharges as  frector of Regulatory 21/2021 at 2:45 PM, revealed th a review of planned	F 6	,		
	08/21/2021 at 3:50 l	Clinical Quality Specialist, on PM, revealed she provided est to the Center Executive NE as alleged.				
	PM, revealed he pa	VP, on 08/21/2021 at 4:15 ticipated in education and and the CNE as alleged.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/2-4/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	Continued From pag	e 26	F 6	524		
	Interview with the CI PM, revealed he rec completed a posttes					
	PM, revealed she re completed a posttes	-				
	_	ords revealed posttests of the CED and CNE.				
	08/20/2021 at 3:24 F	cial Service Specialist, on PM, revealed she received leted a posttest as alleged.				
	08/20/2021 at 4:38 F	urse Practice Educator, on PM, revealed he received leted a posttest as alleged.				
		Jnit Manager, on 08/20/2021 I she received education and t as alleged.				
	08/20/2021 at 1:50 F	urse Weekend Supervisor, on PM, revealed he participated npleted a posttest as alleged.				
	Record review revea staff's names as indi	aled posttests labeled with the cated above.				
		N #6, on 08/18/2021 at 9:25 ceived education and t as alleged.				
	08/20/2021 at 4:04 F	usiness Office Manager, on PM, revealed she received leted a posttest as alleged.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<u> </u>	08/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION CONTROL OF THE APPLICATION	IOULD BE	(X5) COMPLETION DATE
F 624	08/20/2021 at 5:58 A education and complementation are considered as a complementation and complementation and complementation are complementation and complementation are complementation and complementation and complementation are complementation and complementation	y Registered Nurse #5, on M, revealed she received eted a posttest as alleged.  1, on 08/18/2021 at 7:48 AM, d education and completed a ords revealed posttests sed nurses as alleged.  CED, on 08/21/2021 at 3:54 apleted audits of resident e documentation as alleged.  Ords revealed audit sheets ough 08/19/2021, indicating documentation as alleged.  ecords revealed QAPI icated listing discharge	Fe	524		
F 656 SS=G	PM, revealed discha QAPI meetings as al Develop/Implement (CFR(s): 483.21(b)(1) §483.21(b)(1) The faimplement a comprecare plan for each re	Comprehensive Care Plan	F€	556		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		185301	B. WING		08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 656	medical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclustreatment under §48. (iii) Any specialized service provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wiresident's representa (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was asset local contact agencia entities, for this purpo (C) Discharge plans plan, as appropriate,	arcludes measurable armes to meet a resident's ad mental and psychosocial fied in the comprehensive apprehensive care plan must g - are to be furnished to attain ent's highest practicable at psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required s.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its ent's medical record. It the resident and the ative(s)-bals for admission and reference and potential for collities must document as desire to return to the resident and referrals to the sest and/or other appropriate	F 6	56	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 656	by: Based on observati and facility policy re facility failed to deve comprehensive resident	T is not met as evidenced on, interview, record review, view, it was determined the	F 65	56	
	room, unassisted, w get into bed. The re bedside mattress, fe laceration to his/her planned to have the bed. In addition, was take the resident to additional supervision. Observation on 08/1 a mattress on the flo positioned bed. Obs 08/13/2021 at 1:45 I seated in the common helmet, which was of	ident #19 was in his/her hen the resident stood up to sident stepped on his/her ill and hit the wall, causing a scalp. The resident was care mattress up, while out of scare planned to have staff the common area for on.  3/2021 at 1:30 PM, revealed or, by Resident #19's low ervation of Resident #19, on PM, revealed the resident was on area, without his/her are planned to be used for r, observation revealed the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	the resident revealed helmet because it "some periodic provided in the stand. State sunt to assist the resident was determined and was determined areas of 42 CFR 48 Free of Accident Hascope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity and severity of "J". Substandard C42 CFR 483.25 Quancident Hazards/Sand severity of "J". Immediate Jeopard F835 Administration were previously cite scope and severity continued non-com	ing a straw hat. Interview with ad he/she did not like the squished" his/her head.  ident #19 on the Homestead at 10:30 AM, revealed the bed and seated in his/her staff in view of the resident. It ion revealed the resident are wheelchair and attempted veyor called for staff to come int.  If was identified on 08/24/2021 at the identified on 05/10/2021 in the identified on 05/10/2021 in the identified in th	F 6	56		
		practice was identified at 42 om from Abuse, Neglect, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185301	B. WING				24/2024
NAME OF P	ROVIDER OR SUPPLIER	199991	1	40	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220	<u>  US/</u>	24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	at scope and severity previously cited on 05 severity of "K" and as non-compliance, F60 scope and severity of Substandard Quality Freedom from Abuse F600 at a scope and The State Survey Age with IJ existing on 05. The findings include:  Review of the facility! Care Plan, revised 07 facility developed a care plan within seve of the comprehensive plan included measur tables that met the renutrition, and mental The Interdisciplinary care plan and include nurse aid, food and n resident or resident reviewed and revised assessment.  Review of Resident #revealed the facility a 07/24/2020 with diagroup Dementia with Behav Disorder with Delusio Physiological Condition Unspecified Fall, Substantia with Senare Pall, Substantia with Senare Pall, Substantia with Senare Pall, Substantia Pall Substanti	ee from Abuse and Neglect of "D". However, F600 was 6/22/2021 at scope and this represents continued 0 will be cited at the higher i "K", resulting in of Care at 42 CFR 483.12 , Neglect, and Exploitation, severity of "K". ency exited on 08/24/2021 f10/2021 and is ongoing.  s policy, Person-Centered f/01/2019, revealed the comprehensive, individualized in (7) days after completion assessment. The care rable objectives and time sidents medical, nursing, and psychosocial needs. Feam (IDT) prepared the d the physician, nurse, utrition staff, and the expresentative. The facility the care plan after each  19's Medical Record dmitted the resident on noses to include Unspecified ioral Disturbance, Psychotic ins Due to known on, Muscle Weakness, and	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	•	00/24/2021
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	three (3) on 04/26/2 resident was severe Further review rever Status, noted the relimited assistance wassist with locomotic Review of Resident Care Plan, last reviet the focus of the carn history of falls related of safety awareness assistance and crawweakness as evider goal was for the resident side of the bed crawling out of bed Additionally, the resident's care plan have a soft helmet and the resident's care plan have a soft helmet and the resident's helmet and the additionally of Resident's care plan have a soft helmet and the resident's helmet and the r	Status (BIMS) exam score of 021 and determined the ely cognitively impaired. aled Section G, Functional sident was assessed to be vith one (1) person physical	F 6	56		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>8/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIE 4604 LOWE ROAD LOUISVILLE, KY 40220	•	0/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 656	head.  Observation of Reunit, on 08/14/202 resident was out of wheelchair with not continued observation of to stand. State sure to assist the resident has been continued observation of the stand. State sure to assist the resident linterview with Reg 08/21/2021 at 12:0 recall the details of 05/10/2021. She shall be continued assessing Physician, but cour factors which would fall. Further interview with entioning anythin "I just see what was stated the mattres subjective.  Interview with CNA AM, revealed Resisted it would be 1:1 supervision for adding the resident CNA #16 revealed resident fell on 05/had taken the resident recall who, but recall who, but the continued of the con	because it "squished" his/her sident #19 on the Homestead 1 at 10:30 AM, revealed the f bed and seated in his/her staff in view of the resident. ation revealed the resident the wheelchair and attempted rveyor called for staff to come	F	656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	185301 B. WING		С		
NAME OF P	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP C 4604 LOWE ROAD LOUISVILLE, KY 40220		<u>18/24/2021</u>	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	sitting in his/her wobserved the residstep on the edge of located in his/her in back, hitting his/her revealed the resid the force of the fall CNA #16 revealed should be followed by the followed linterview with CNA AM, revealed Resident's bed was further stated whe his/her bed, the mattress would be resident's bed was further stated whe his/her bed, the mattress with Cer #14, on 08/15/202 resident's care pla fall prevention. Per Resident #19 to with the resident with LPN AM, revealed she facility for over two LPN #7 revealed she with sher wheelchair you saw earlier." It get up and walk. The revealed she with the resident she revealed she with the resident she with the revealed she wi	when she noticed Resident #19 heelchair. She stated she lent stand from his/her chair, of his/her mattress that was room, to get into bed, and fell er head on the wall. CNA #16 ent had his/her helmet on, but I made the helmet come off. I the resident's care plans I for the safety of the residents.  A #17, on 08/21/2021 at 11:24 ident #19 was care planned for use he/she liked to roll out of terview revealed the resident's placed on the floor, while the is in the lowest position. She in the resident was out of attress would be moved for  tified Nursing Assistant (CNA) 1 at 10:00 AM, revealed a in should be followed related to be interview, it was important for ear his/her helmet at all times ent was a falls risk. She further	F	356			

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	#7 revealed this woo Resident #19's falls Interview with RN # revealed she was fainterview, the residuchair "quickly." RN a 1:1, but did not have left alone in the half history of falls. She have brought the restation, to provide the further revealed the be followed related common area.  Interview with the F Homestead, on 08/ care plans were dis She stated the nurs care plans and the review and/or revisinterview revealed to	aneeded 1:1 supervision. LPN build be beneficial because of state and the state of sta	F 6	<u> </u>		
	on 08/23/2021 at 1 plans were updated that were needed. were reviewed in clappropriate change	Center Nurse Executive (CNE), 1:03 AM, revealed the care If any time there were changes Per interview, the care plans inical meetings and the is would be made. She further were expectation the care plans				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		(X3) DATE SURVEY COMPLETED	
	_		С	
185301	B. WING		08/24/2021	
	46	604 LOWE ROAD		
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG			
Vice President of Operations, 2:20 PM, revealed it would be	F 656			
rehensive Care Plans omprehensive care plan must an 7 days after completion of re assessment. In interdisciplinary team, that thimited to-physician. The with responsibility for the with responsibility for the with responsibility for the food and nutrition services staff. Oracticable, the participation of the resident's representative(s), but be included in a resident's the participation of the resident representative is determined to the development of the fan. The interdisciplinary is sessment, including both the	F 657			
	IDENTIFICATION NUMBER:	A BUILDING  185301  B. WING  185301  PREFIX TAG  PREFI	STREET ADDRESS, CITY, STATE, ZIP CODE	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185301	B. WING			1	C
NAME OF PI	ROVIDER OR SUPPLIER	100001		STRI 4604	EET ADDRESS, CITY, STATE, ZIP CODE  4 LOWE ROAD  JISVILLE, KY 40220	08.	/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page	e 37	F	657			
	by: Based on interview a determined the facilit care plan for six (6) o sampled residents (R	r is not met as evidenced and record review it was y failed to update/revise the out of twenty-eight (28) desident #20, Resident #7, ent #24, Resident #26,					
	another resident's wa asked the resident to resident. Interview w resident became visil his/her room, then wa tripping over his/her f fracture of the right of was care planned to when in his/her room Additionally, the residence to revised to address the upset nor, was the residence his/her level of assist F689)  On 08/11/2021, while shop, Resident #20 w	oly upset and walked to alked back "at a fast pace" foot causing a closed rbital floor. Resident #20 have an assist of one (1) and/or toileting. dent's care plan was not e resident's "fast pace" when sident care planned for with ambulation. (Refer to e returning from the beauty walked back to his/her unit of one (1) in a group of four					

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		185301	B. WING		0,	C B/ <b>24/2021</b>
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	, 00	312412021
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	supervision when an Resident #20 fell wh Spine C2 minimally fracture. (Refer to F Resident #1 and Re the facility's memory	mbulating off the unit. nich resulted in a Cervical displaced base odontoid 689) sident #7 were roommates on v care unit. On 06/19/2021,	F 65	57		
	move Resident #7's way. Resident #1 c he/she moved the w Resident #1's action small plastic cup of on Resident #1. The Resident #7's Comp	wheelchair out of his/her alled Resident #7 a "Bitch" as wheelchair. In response to as, Resident #7 picked up a water and splashed it at and a facility failed to update/revise brehensive Care Plan after the				
	#26, and #27 reveal related to the reside ambulation/locomote ambulation/locomote limmediate Jeopard and was determined areas of 42 CFR 48 Free of Accident Halbert Scope and severity Comprehensive Research F656 Develop/Imple Plan at scope and severity Plan at scope and severity Plan Timing and Refer of "J"; 42 CFR 483. Administration at scope and severity for the severity of the	ed no updates or revisions ints' level of assistance with ion off the unit.  / was identified on 08/24/2021 in the 3.25 Quality of Care, F689 zards/Supervision/Devices at of "J" and 42 CFR 483.21 sident Centered Care Plans, ement Comprehensive Care everity of "J" and F657 Care vision at scope and severity 70 Administration, F835 ope and severity of "J", and dy at scope and severity of uality of Care was identified at ality of Care, F689 Free of upervision/Devices at scope The facility was notified of the				

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NAME OF PE	ROVIDER OR SUPPLIER	•	•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	were previously cited scope and severity or continued non-complicated at the higher so Additional deficient p CFR 483.12 Freedom Exploitation, F600 Fr at scope and severity previously cited on 0 severity of "K" and as non-compliance, F60 scope and severity or Substandard Quality Freedom from Abuse F600 at a scope and The SSA exited on 0. The findings include:  1. Record review rev. Resident #20 was ob resident #20 was ob resident to return the Resident #20 stated his/her mom. Intervieresident became visil his/her room, then was tripping over his/her fracture of the right of	and F837 Governing Body on 05/22/2021, both at f "K". As this represents iance F835 and F837 will be ope and severity of "K".  ractice was identified at 42 in from Abuse, Neglect, and ee from Abuse and Neglect of "D". However, F600 was 5/22/2021 at scope and is this represents continued 0 will be cited at the higher f "K", resulting in of Care at 42 CFR 483.12 in, Neglect, and Exploitation, severity of "K".  8/24/2021 with IJ ongoing.  aled on 08/07/2021, served with another fer interview, staff asked the walker to the resident and the walker belonged to ew with staff revealed the boly upset and walked to alked back "at a fast pace" foot causing a closed rbital floor. Resident #20 have an assist of one (1)	F	857	DEFICIENCY)		
	Additionally, the residuevised to address the upset nor was the residuevised to address the residuevised the residuevised to address the residuevised to address the resid	and/or tolleting. dent's care plan was not e resident's "fast pace" when sident care planned for with ambulation. (Refer to					

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F 657	the resident was admidiagnoses to included without Behavioral Di Weakness, and Redu Review of Resident # Data Set (MDS) dated he/she was assessed Mental Status (BIMS) was indicative of sever Further review reveal status was assessed encouragement or cu with locomotion on the assessed to have "accomposed for the universident of the care plan have assistance with grooming, personal head mobility, transfer to weakness, chronic cognition, subdural head fracture, and C2 fract resident to improve cobathing, grooming/peeating, bed mobility, toileting. The resident resident to provide assist Further review reveal	20's clinical record revealed itted on 12/17/2019 with a Unspecified Dementia sturbance, Muscle need Mobility.  20's Quarterly Minimum and 06/15/2021, revealed a to have a Brief Interview for a score of three (3), which have encognitive impairment. The resident's functional to be supervision (oversight, eing) with set-up (help only), e unit. The resident was tivity did not occur" with the with no physical help.  20's Comprehensive Care need of Daily Living (ADL's), 19/15/2021, revealed the newas for the resident to ADL care in bathing, ygiene, dressing, eating, locomotion, toileting related	F	657		

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220	•	10/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 657	08/11/2021, revealed limit the risk for falls of falls, and impaired care plan was for the with injury thru the neincluded: Nursing staff to encocommon area while a allow, nursing staff to footwear for proper fi evaluation, and to preinitiated on 08/11/202 Review of Resident # 08/07/2021, revealed forward striking his/h ground. Further reviesustained a laceratio during the fall. Recoresident's diagnosis a head, fall, initial encoclosed fracture of right Observation and inte 08/17/2021 at 6:42 P sitting up in his/her was Transitional Care Un with 1:1 staff. Reside have the cervical coll Interview with Certifical #14, on 08/15/2021 at worked the day Resident's was stated the resident's w	ent #20's Falls e Plan, with revision date of I the care plan focus was to related to weakness, history cognition. The goal of the resident not to have falls ext review. Interventions off to complete orthostatic days related to his/her fall. urage the resident to be in awake as he/she would o evaluate the resident's titing, therapy rehab ovide assist with ambulation, 21.  #20's hospital record, dated If the resident tripped and fell er right forehead against the ew revealed the resident in to his/her right eyebrow red review revealed the at discharge was "an injury of ounter, facial laceration, and int orbital floor".  rview with Resident #20, on M, revealed the resident was wheelchair, on the it (TCU), watching television ent #20 was observed to	F 6	57		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4604 LOWE ROAD LOUISVILLE, KY 40220	CODE	30.2232.1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIAT	
F 657	interview, the resider to CNA #14. Continue Resident #20 was as common area while at to wipe up liquid that floor. When CNA #1 resident on the floor Nurse (LPN) #1 and were assessing the right she did not observe resident was not at right was not fully aware or plan.  Interview with LPN # revealed she observed have the common are stated she though the from the common are stated she though the certain, adding "that normally did, went to to the common area. revealed that when F his/her room, the resident have landed on the Per interview LPN #1 plan should have be resident's "pace/gait' anxious and/or upse.	as his/her mother's. Per at forcibly returned the walker ared interview revealed sked to have a seat in the she went to retrieve a towel was observed on the kitchen 4 returned, she saw the and Licensed Practical another nurse (unidentified) esident. CNA #14 revealed the fall and believed the sk for falls. She stated she of the Resident #20's care  1, on 08/18/2021 at 7:48 AM, and Resident #20 around 6:15 are interview, the resident he/she became anxious. resident got up and walked at the his/her room. LPN #1 are resident might have bathroom, but was not was what the resident the bathroom and returned "Continued interview Resident #20 came out of ident was observed to walk to the common area and and foot and fell. LPN #1 at his/her head, adding the wooden area" of the unit. It revealed the resident's care the revised to address the the when he/she became	F	357		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 08/2	4/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 00/2	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	employed through ag the Homestead Unit on the Homestead Unit on the day of Resider she had been giving resident walked indeproom without assistant observed Resident #2 a fast pace, and it see #20 was "upset". She foot "kind of dragged" his/her foot. LPN #6 "down". LPN #6 state "hit head first" and she from the resident's rig was transferred to the with LPN #6 revealed the residents long and resident's care plans.  Interview with the Product of the with LPN #6 revealed the resident's care plans. Interview with the Product of the with LPN #6 revealed the resident's care plans were disconsidered the should have been revealed the should have been revealed the should have been the should have been this was important for Interview with the Ass (ADON), on 08/19/20	the further stated she was ency and had only worked only twice (2), and she was esidents. LPN #6 revealed the pendently to and from his/her nece. Per interview, LPN #6 20 walking in front of her, at emed as though Resident e observed the resident's and he/she stumbled over revealed Resident #20 went ed she believed the resident esaw the blood coming the eye brow. The resident es hospital. Further interview I she had not worked with ed was unfamiliar with the longram Director of 1/2021 at 4:54 PM, revealed as needed. Continued es residents' care plans wised to show the level of nots required for care. The Minimum Data Set (MDS) eloped accurate coding and en care planned. She stated of the safety of the residents.	F 65			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		185301	B. WING		08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	, 002.22	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 657	plan should have be resident was upset a revision would be to walk at a slower paresident. She state resident down by pothe walker was his/h her. Continued inter added their intervendivert the resident was omeone else had have been been been been been been been be	d that Resident #20's care een revised to state, "If and walk at a faster pace", the e encourage the resident to be and see what upset the d staff could try to calm the desibility telling the resident er mom's walker and redirect eview revealed she would have ention in the behavior section to eighther mom's walker.  The enter Nurse Executive (CNE), enter Nurse E	F 657			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	ATE SURVEY DMPLETED
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	·	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	resulted in a Cervical displaced base odor Review of Resident the resident was addiagnoses that incluwithout Behavioral EWeakness, and Recomplete Review of Resident Data Set (MDS) data he/she was assessed Mental Status (BIMS was indicative of severe and Resident # during the 08/08/2020 Continued review rewith diagnoses to inwithout behavioral dwalking, not elsewher weakness. Further short-term goal for the continued review rewith on level surfaces two an assistive device windependence within revealed on 08/08/2020 was seventy-five feed one or two hands or provides no other as functional task, to as body or help with bar resident's care plan evidence the care plane revidence the care plane resident was additional task, to as body or help with bar resident's care plane evidence the care plane resident was additional task, to as body or help with bar resident's care plane evidence the care plane resident was additional task, to as body or help with bar resident's care plane evidence the care plane resident was a seventy-five feed on the care plane evidence the care plane resident was a seventy-five feed on the care plane evidence the care plane evidence the care plane resident was a seventy-five feed on the care plane evidence the care p	nit. Resident #20 fell which al Spine C2 minimally ntoid fracture. (Refer to F657)  #20's clinical record revealed mitted on 12/17/2019 with ded Unspecified Dementia Disturbance, Muscle luced Mobility.  #20's Quarterly Minimum ed 06/15/2021, revealed do to have a Brief Interview for 6) score of three (3), which were cognitive impairment.  cal Therapy Discharge (708/2021 to 08/11/2021, 20 was seen three (3) days 21 Progress Period. Evealed the resident presented clude unspecified dementia isturbance, difficulty in ere classified, and muscle review revealed the ne resident was to ambulate on-hundred (200) feet without with supervision to increase in the facility. Record review 021, the resident's baseline est with Contact Guard (having in the resident's body but esistance to perform the sistst with steady the resident's lance). Review of the revealed no documented an was updated to reflect the esistance while ambulating on	F 6	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			08/2	24/2021
NAME OF PE	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, 4604 LOWE ROAD LOUISVILLE, KY 40220	ZIP CODE		
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F 657	the emergency room resident had significated bruising. Continued in had a small right from without any mass-eff follow-up confirmed a base odontoid fracture recommended.  Interview with Certifice #15, on 08/13/2021 at Resident #20 walked his/her feet when hear resident was "really of that on the day the resident was assisting the group of residents to interview, CNA #15 at communicating to the needed to "slow dow stated the resident sidents at the beauty shop. Chart first time escorting the shop, so she was un escorted the resident unaware of their care.	#20's hospital record, dated if the resident was brought to for an evaluation. The ant right forehead and facial review revealed the resident stal subdural hematoma fect or midline shift. A can C2 minimally displaced re. A collar was  and Nursing Assistant (CNA) at 2:43 PM, revealed independently and shuffled she walked. She stated the quick". CNA #15 revealed resident fell, on 08/11/2021, at Activity Assistant walk at the beauty shop. Per stated she recalled reresident that he/she in", per interview, the CNA rated "ok" and slowed down. In not recall all the residents suty shop, which was located in but she recalled the resistance with ambulation to IA #15 stated this was the reresidents to the beauty aware how many staff its off the unit and was a plan.	F	657			
	the residents back to	the unit. The Activity ident #23 was observed to					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		185301	B. WING				24/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	<del>27/2021</del>
				46	04 LOWE ROAD		
REGIS W	OODS			LC	DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	fall. He further state #27 were capable of Resident #23 required Assistant revealed to down the hall and the revealed he walked Resident #20 was whe positioned himse resident should any revealed there was Transitional Care U station transitioned Continued interview to Resident #20, "he resident was told by down" and when he resident, the resident interview, the Assist unaware of the lever required while ambit it was important to he plan completed becould change and it with the needs of the Interview with the Phomestead, on 08/2 care plans were dis She stated the nurse care plans and the review and/or revise interview revealed the should have been reassistance the reside Further, she stated	y back to the unit, but did not ed Residents #20, #24, #26, if walking independently, but ed a walker. The Activity the group continued to walk he group had to go right. He next to Resident #23 and walking behind him. He stated elf in a way he could grab the thing occur. Further inteview a place next to the init (TCU) where the nurses' from the wood to the carpet. If revealed Resident #23 stated curry up." Per interview, the interview that fallen on the floor. Per than Director revealed he was all of assistance the residents culating off the unit. He stated have all aspects of the care ause the residents' needs was important to keep up the residents.  I rogram Director of 20/2021 at 4:54 PM, revealed cussed in morning meetings. The wood is a needed. Continued the residents' care plans evised to show the level of the lents required for care. The Minimum Data Set (MDS)	F	657	DEFICIENCY		
	Homestead, on 08/2 care plans were dis She stated the nurs care plans and the review and/or revise interview revealed t should have been reassistance the reside Further, she stated Coordinator had de level of assistance s	20/2021 at 4:54 PM, revealed cussed in morning meetings. es would normally begin the MDS Coordinator would e as needed. Continued he residents' care plans evised to show the level of lents required for care.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b> </b>	00/2-4/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	(ADON), on 08/19/2 and the Center Nursbeen working on up interview, she stated should reflect the leneeded. Further, shassessed to need of should have been restated the Activity Acaditional staff memback to the unit.  Interview with the Con 08/23/2021 at 11 plans were updated that were needed. If were reviewed in cli appropriate changes stated the IDT team would review the call interview with the Vion 08/24/2021 at 2:: his expectation that revised and followed.  2. Review of the fact "Person-Centered CO7/01/2019, revealed reviewed and revised interdisciplinary team Comprehensive Assistance of the state of the comprehensive Assistance of the comprehensive	sisistant Director of Nursing 021 at 3:16 PM, revealed she se Executive (CNE) have dating the care plans. Per district the residents of assistance the resident se stated if the resident's were ne assist. then the care plan exised. Additionally, she esistance should have had bers to escort the residents  enter Nurse Executive (CNE), 103 AM, revealed the care any time there were changes and the se would be made. She further would meet immediately, and re plan and would put an existence plans would be the care plans were to be do by the facility's m (IDT) after each essment, and as needed to response to care and his/her	F 6	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b>I</b>	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Services (CMS), "R Instrument (RAI) M 2016, revealed the revised periodically arranged were to be resident's written pl stated there was a Comprehensive As- or Significant Chan well-developed and utilized to re-evalua- review, the individu	ge 49 ers for Medicare and Medicaid desident Assessment anual 3.0", dated October care plan was reviewed and , and the services provided or e consistent with each an of care. The Manual prescribed interval for sessments (Quarterly, Annual, ge). Review revealed a executed care plan was te a resident's status. Per alized care plan was to be ate and necessary.	F 6	57		
	the resident was act 03/17/2021, with disconsisted Paragraph of the Quar (MDS) Assessment the facility assessed Interview for Menta fourteen out of fifter resident was cognit	terly Minimum Data Set , dated 06/22/2021, revealed d Resident #7 with a Brief I Status (BIMS) score of en (14/15), which indicated the ively intact. Further review assessed Resident #7 to				
	Review of Resident Plan (CCP), dated resident was not ca to his/her altercatio review revealed no	#7's Comprehensive Care 03/18/2021, revealed the re planned for behaviors prior n with Resident #1. Continued documented evidence the was updated/revised after the				

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 50	F 6	57		
	altercation which oc Resident #1.	curred on 06/19/2021 with				
	07/15/2021 at 12:51 was used to keep re resident's care plan different ways to pro ensured the resider Further interview re residents' care plan health record (EHR addition, she reveal updated/revised wh significant change a and social worker coneeded. The RN st update/revise a resimight not get the care	dent's care plan the resident are they needed or required.				
	07/29/2021 at 2:45 working in the facilit resident altercation MDS Coordinator w longer working for tl	corporate MDS Coordinator, on PM, revealed she was not by when the resident to occurred. Per interview, the who had been there was no he facility. She stated s were updated annually,				
	quarterly, or if there could be updated by Social Services and Continued interview plans needed to be residents received to revealed after an all plans were to be up care needs might claurses and Certified needed to be made	was a significant change and y the nurse, nurse managers, l/or the MDS Coordinator. revealed residents' care followed by staff to ensure he proper care. She further tercation, the resident(s)' care dated/revised as a resident's nange. In addition, she stated the Nursing Assistants (CNAs) aware of changes to a to ensure the necessary care				

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		185301	B. WING		C 08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 33/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 657	on 07/29/2021 at 3: and Resident #7 we residents, and the awas just a disagree revealed Resident # behaviors prior to the Continued interview Resident #7 had no behaviors, and the anything like that ha Resident #7's care updated.  3. Review of Resider revealed the resident 90/08/2016, with dia Alzheimer's Disease Muscle Weakness, Review of the resident was assess for Mental Status (Eindicative of severe Review of Section the resident was as person assist with le Review of Resident Plan, last reviewed Activities of Daily Lidocumented evident was revised to show when ambulating of assessed Resident of one person, whe	genter Nurse Executive (CNE), 36 PM, revealed Resident #1 ere neither one aggressive altercation between the two (2) ment, not physical. The CNE #7 displayed no physical he incident with Resident #1. If revealed she believed as at previously exhibited incident was the first time and happened, she did not feel plan should have been ent #23's Medical Record have admitted on agnoses that included ent was admitted on agnoses that included ent #23's Medical Record ent #23's Medica	F 657		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	I	08/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	Alzheimer's Disease Behavioral Disturba Delusions Due to kr Condition, Muscle W Disorder.  Review of Resident 06/24/2021, reveale to have a BIMS scoresident was severe Review of Section Of the resident was ass Assistance of one (10comotion/ambulat Resident #24's Correviewed on 06/29/2 documented eviden was revised regardinunit.  5. Review of Resider revealed the resider 03/18/2021 with diagraphic Unspecified Demen Disturbance, and Es of the resident's Qua 06/24/2021, revealed to have a BIMS score	at was admitted on gnoses that included e, Unspecified Dementia with nce, Psychotic Disorder with ow Physiological leakness, and Anxiety  #24's Quarterly MDS dated do the resident was assessed re of two (2), indicating the ly cognitively impaired. Graph of the unit. Review of the resident's care planting level of assistance off the unit. #26's Medical Record at was admitted on gnoses that included the with Behavioral resential Hypertension. Review	F 6	57			
	the resident was ass no physical help froi locomotion/ambulat Resident #26's Com reviewed on 06/29/2 documented eviden	on off the unit. Review of prehensive Care Plan, last					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		C	X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS	105501	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 4604 LOWE ROAD LOUISVILLE, KY 40220	DDE	08/24/2021
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
Disease, Unspecified Ps Weakness, and Unspece Behavioral Disturbance. Annual MDS assessment revealed the resident was BIMS score of fourteen resident was cognitively G, Functional Status, retassessed to have super physical assist with locounit. Review of the resident restandard cushion, dycer leg rest for locomotion; I documented evidence the planned for the level of a locomotion/ambulation with Registere 08/17/2021 at 3:01 PM, residents' care plan stat assist of one (1) staff, the member would assist the ambulation. Continued staff member should not when they were assesse (1). Further, RN #3 revel Homestead Unit on the revealed she did not see unit to attend the beauty stated the staff who escunit should have notified.	27's Medical Record as admitted on ses to include Alzheimer's sychosis, Muscle ified Dementia without Review of the resident's nt, dated 05/01/2021, as assessed to have a (14), indicating the intact. Review of Section wealed the resident was vision with one (1) person motion/ambulation off the dent's Comprehensive d on 05/05/2021, quired a wheelchair with m under cushion and left however, there was no ne resident was care assistance needed for when off the unit.  Id Nurse (RN) #3, on revealed that when the ed the residents were an at meant one (1) staff e resident with interview revealed one (1) t escort five (5) residents ed to be an assist of one ealed she worked the day of 08/11/2021. She es the residents leave the orted the residents off the	F6	57		

FRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 54 assistance when ambulating, additionally she stated the residents level of assistance should be care planned.  Telephonic interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed today was her first day working as MDS Coordinator at the facility, however, she has worked with MDS for over four (4) years. The MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
REGIS WOODS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREFIX TAG  Continued From page 54 assistance when ambulating, additionally she stated the residents level of assistance should be care planned.  Telephonic interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed today was her first day working as MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the			185301	B. WING _				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 54 assistance when ambulating, additionally she stated the residents level of assistance should be care planned.  Telephonic interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed today was her first day working as MDS Coordinator at the facility, however, she has worked with MDS for over four (4) years. The MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the			1		4604 LOWE ROAD	CODE	, 00:2 ::2021	
assistance when ambulating, additionally she stated the residents level of assistance should be care planned.  Telephonic interview with the Minimum Data Set (MDS) Coordinator, on 08/232021 at 10:40 AM, revealed today was her first day working as MDS Coordinator at the facility, however, she has worked with MDS for over four (4) years. The MDS Coordinator revealed the MDS Assessments drives the Care Plans for the residents. Per interview, the residents who were care planned for an assist of one (1) required the	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD B	D 4.T.E.	N
assistance of one (1) staff to assist with care. Additionally, she stated when a resident was assess for two (2) staff, for transfers, then an assist of two (2) staff should be care planned to assist staff with residents' care. Lastly, the MDS Coordinator revealed that the residents, when care planned for supervision, should have supervision/oversight.  Interview with the Center Executive Director (CED), on 07/30/2021 at 3:04 PM, revealed he would expect staff to update/revise a resident's care plan when it was needed. Continued interview revealed it was important to update the care plan to ensure staff were providing the "most up to date" care for all residents. Additionally, he revealed staff were to always follow the care plan. Further interview revealed the nurse, unit managers, and also social services could update the care plan. He stated the facility educated staff on behaviors and their possible triggers to help deter altercations between residents.  F 660 SS=J Discharge Planning Process F 660 SS=J CFR(s): 483.21(c)(1)(i)-(ix)	F 660	assistance when am stated the residents care planned.  Telephonic interview (MDS) Coordinator, revealed today was Coordinator at the fa worked with MDS fo MDS Coordinator revealed to assessments drives residents. Per intervicare planned for an assistance of one (1 Additionally, she states assess for two (2) states assist of two (2) states assist staff with residence care planned for supsupervision/oversign assist staff with the Coordinator revealed care planned for supsupervision/oversign assist staff with the Coordinator revealed care planned for supsupervision/oversign assist staff with the Coordinator revealed care plan when it was interview revealed it care plan to ensure a up to date" care for a revealed staff were the care plan. He states on behaviors and the deter altercations be Discharge Planning	bulating, additionally she level of assistance should be  with the Minimum Data Set on 08/232021 at 10:40 AM, her first day working as MDS acility, however, she has rover four (4) years. The wealed the MDS the Care Plans for the view, the residents who were assist of one (1) required the easist of one (1) required the staff to assist with care. It is to assist with care. It is to assist with care. It is to assist with care are planned to dents' care. Lastly, the MDS is that the residents, when the enter Executive Director at at 3:04 PM, revealed here are planted was important to update the staff were providing the "most all residents. Additionally, here are always follow the care planter and the facility educated staff the enter and the facility educated staff the possible triggers to help the tween residents.  Process					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 00/2-72021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 660	The facility must de effective discharge on the resident's disconfersion of residents to be act transition them to prove the confersion of factors readmissions. The factors readmissions. The factors readmissions. The factors readmissions. The factors must be confights set forth at 48 (i) Ensure that the discident are identified development of a diresident.  (ii) Include regular reidentify changes that discharge plan. The updated, as needed (iii) Involve the interby §483.21(b)(2)(ii), developing the discidiv) Consider careging and the resident's operson(s) capacity arequired care, as padischarge needs.  (v) Involve the resident representative in the discharge plan and resident representative in the discharge plan and resident representative in the discharge readment preference (vii) Document that about their interest in regarding returning (A) If the resident in to the community, the second of the community, the resident in the community of th	velop and implement an planning process that focuses scharge goals, the preparation ctive partners and effectively post-discharge care, and the leading to preventable facility's discharge planning ensistent with the discharge standard each ed and result in the scharge plan for each ed and result in the scharge plan must be evaluation of residents to at require modification of the edischarge plan must be endischarge plan must be endisciplinary team, as defined in the ongoing process of harge plan. Ver/support person availability or caregiver's/support end capability to perform ent of the identification of the inform the resident end evelopment of the inform the resident and tive of the final plan. ident's goals of care and es. a resident has been asked in receiving information	F 660			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X A. BUILDING		. ,	X3) DATE SURVEY COMPLETED				
		185301	185301 B. WING			C <b>08/24/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 4604 LOWE ROAD LOUISVILLE, KY 40220		0/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 660	(B) Facilities must use comprehensive care appropriate, in resp from referrals to loc appropriate entities (C) If discharge to to not be feasible, the made the determination (viii) For residents with SNF or who are districted to SNF, assist reside representatives in suprovider by using delimited to SNF, HHAP patient assessment measures, and data the data is available the post-acute care assessment data, and data on resource use the resident's goals preferences.  (ix) Document, componities and discharge evaluation must be resident's represent information must be discharge plan to fatto avoid unnecessal discharge or transfer this REQUIREMENT.	made for this purpose.  Ipdate a resident's  Ipdate a resident received  Ipdate a contact agencies or other  Ipdate a community is determined  Ipdate facility must document who  Ipdate and why.  Ipdate and why.  Ipdate a HHA, IRF, or  Ipdate and their resident  Ipdate a post-acute care  Ipdate and their resident  Ipdate and applicable to  Ipdate and applicable to  Ipdate and include in the clinical  Ipdate on a timely basis based  Ipdate on a t	F	660			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4604 LOWE ROAD LOUISVILLE, KY 40220	DDE	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 660	discharge planning p	rocess to ensure the	F 6	660		
	(18) sampled residen					
	Plan revealed no evida discharge transition facility's policy. Conting Resident #3 was at riperform Activities of Ecardiovascular complaiso at risk for falls. Resident #3 was insurplanned to be occasionand was unable to comparticipate in a retrain cognitive loss and limit Review of the Physic 02/11/2021 and 06/07 evidence of a plan to the facility. Review of Notes, dated 04/07/2 05/19/2021, 05/26/20	sk for decreased ability to Daily Living (ADLs), ications, dehydration, and further review revealed alin dependent and was care conally incontinent of bladder gnitively or physically ning program due to aited mobility.  Jan's Notes, dated 1/2021, revealed no discharge Resident #3 from the Nurse Practitioner (NP) 1021, 05/03/2021, 121, 06/09/2021 and no developed plan for				
	Resident #3 was obsomble 16/2021, during a allowed. Facility staff his/her smoking privil the resident became leave the facility. The #3 on 06/16/2021, to cab transport. Howeversure the required deducation and medical completed and documents.	erved smoking on time, smoking was not f informed Resident #3 eges would be revoked, and upset and requested to facility discharged Resident a homeless shelter via a ver, the facility failed to lischarge planning,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING		08/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		0012-4/2021
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 660	given to him/her pri 06/20/2021, four (4 Resident #3 was achospital setting with Hyperglycemia (high insulin therapy, Uril which required intra a Deep Vein Thromanticoagulant therathe hospital for a tell Immediate Jeopard and was determine areas of 42 CFR 48 and Discharge, F62 Transfer/Discharge and 42 CFR 483.21 Centered Care Plan Process at scope a was notified of the 07/30/2021.  The facility provided Compliance (AoC) removal of jeopardy validated abatemer 08/03/2021.  The findings include Review of the facility Planning Process", the facility develope effective discharge residents which for Further review reversidents were asset	ent #3's medications were or to the discharge. On ) days after being discharged, dmitted to an acute care in diagnoses which included the blood sugar) which required the blood sugar) which required the blood sugar) which required the blood sugar in the blood s	F 66			

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STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		185301	B. WING	B. WING		0:	8/24/2021
NAME OF PR	OVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
REGIS WO	ODS				OWE ROAD SVILLE, KY 40220		
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F 660	and was completed a Person-Centered Car residents. Per review process was to assist transitioning to post-of factors which might cre-admission to long revealed all residents to a community based Discharge Transition Packet. Further review (D/C) Transition Plan a recapitulation of the summary of the resid discharge, reconciliated medications with the medications wi	the policy, discharge d on a resident's admission as part of the facility's re Plan process for w, the discharge planning t residents in effectively discharge care, and reduce ause a preventable term care. The policy s who were to be discharged d living setting would have a Plan and a Discharge was to include the following: resident's stay, a final ent's status at time of cion of all pre-discharge resident's post-discharge lischarge plan of care, and scharge residence with any and after discharge.  The policy was to include the following: resident's stay, a final ent's status at time of cion of all pre-discharge resident's post-discharge lischarge plan of care, and scharge residence with any and after discharge.  The policy was to include the following: resident's stay, a final ent's status at time of cion of all pre-discharge resident's post-discharge lischarge plan of care, and scharge residence with any and after discharge.  The policy was to include the following: resident's stay, a final ent's status at time of cion of all pre-discharge resident's post-discharge	F	660			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		185301	B. WING			C <b>08/24/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 660	noted Resident #3's wanted to have that Social Workers (SW be removed along wattempts were made 07/16/2021 at 9:44 / 07/20/2021 at 10:21 success.  Review of Resident dated 02/10/2021, remedications ordered CAD, Type 2 D, HLL Further review reveamedication/treatmer blood glucose monit insulins and oral diadiagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 revealed Resident # ordered for diagnosis of Type 2 reve	m Director of Memory Care Conservator no longer responsibility and the facility's filed for the Conservator to with Guardianship. However, to contact both SW on AM and 9:47 AM and on AM and 10:23 AM without  #3's Physician's Orders, evealed the resident had for his/her diagnoses of D, HTN, and Dementia. aled Resident #3's at orders included fingerstick foring, long and short acting betic medication for his/her DM. Continued review 3 also had medications es which included Bipolar n, and Angina (chest pain).  erly Minimum Data Set dated 05/19/2021, revealed Resident #3 to have impairment as indicated by or Mental Status (BIMS) score fifteen (15) possible. vealed the facility assessed erately depressed with no The MDS noted Resident #3 stance of one (1) person for	F 66				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>08/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4604 LOWE ROAD LOUISVILLE, KY 40220	DDE	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION DATE
F 660	revealed the facility a require insulin injection other diagnoses. Resident #3 was to resident at the facility a community setting.  Review of Resident #Plan, revealed no eva D/C transition plan policy. Continued revas at risk for decreativities of Daily Liv complications, dehydralls. Further review insulin dependent an occasionally incontinuable to cognitively retraining program delimited mobility.  Review of the Physic 02/11/2021 and 06/0 evidence of a plan to facility, or evidence occompleted for the respractitioner (NP) Not 05/03/2021, 05/19/20 and 06/16/2021 revectognitive assessment documented evidence of the NP Notes for the documentation noting wheelchair depender	assessed Resident #3 to cons for his/her diagnosis of essed the resident as medications to treat his/her cord review revealed eceive rehabilitation while a v, and he/she would return to when discharged.  #3's Comprehensive Care idence the facility developed of care, as per the facility's riew revealed Resident #3 ased ability to perform ing (ADLs), cardiovascular tration, and also at risk for revealed Resident #3 was d was care planned to be ent of bladder and was or physically participate in a use to cognitive loss and  #3's Notes, dated 1/2021, revealed no D/C Resident #3 from the of cognitive assessments sident. Review of the Nurse es, dated 04/07/2021, 05/26/2021, 06/09/2021 aled no documentation of a t by the NP's nor any e of Resident #3 requesting in the facility. Further review the above timeframe revealed of Resident #3 was	F	560		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING				24/2021
	NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			4	TREET ADDRESS, CITY, STATE, ZIP CODE 604 LOWE ROAD OUISVILLE, KY 40220	1 0011	2-7/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	name; however, he chad ever been under evaluated the resider revealed he had rece facility 06/16/2021; hremember why facility. The Surveyor attempthe NP on 07/29/202 the attempts were under the NP on 07/29/202 the attempts were under the Program Care Unit, who previfacility's Social Servifacility to another ski Continued review revealed the Program Care Unit, who previfacility to another ski Continued review revealed sent referrals to had sent referrals to had sent referrals to Resident #3's home revealed no evidence Resident #3, as per the Memory Care Unit, or revealed Resident #3'06/14/2021 and state the facility; however, he/she wanted to be after the discussion or referrals to several or smoking friendly facily sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the sent the referrals; so had not wanted to according to the residual to the residual the referrals; so had not wanted to according to the residual the residual the referrals.	e remembered Resident #3's could not recall if Resident #3 his care or if he had ever not. Continued interview eived a phone call from the owever, was unable to y staff had called him.  Interest telephonic contact with 1 and 07/30/2021; however neuccessful.  In Notes, dated 06/14/2021, in Director of the Memory ously had worked in the ces Department, had noted ed to discharge from the liled nursing facility (SNF). It wealed the Program Director three (3) local SNFs, and three (3) SNFs close to town. Further review e of D/C planning for the facility's policy.	F	660			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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F 660	Center Executive Dirmorning meeting or a of response from the contacted. Further in no discussion with the related to beginning the development of a D/O there should have be discharge process. Simitiated the facility's received return calls/facilities she had concevealed she had "up regarding the referral like the resident under discharge process.  Review of the facility planning, revised 02/process began at addicontrary to the Program Review of a Consulting dated 06/15/2021, renoted Resident #3 has transfer to another facilities concevealed another Note 2:23 PM, which noted "found" smoking in the during a break not so review, when the CE smoking privileges disoccurred during the resident requested to	urse Executive (CNE) and ector (CED) during either a afternoon meeting of the lack other facilities she had nterview revealed there was e facility's Management staff the D/C planning process or C plan of care; however, then and she did not start the she stated she would have D/C process if she had messages from the other tacted. Further interview odated" Resident #3 is she had sent, and she felt erstood the facility's  policy for discharge 01/2019, revealed the mission to the facility am Director's interview.  In Social Worker Note, wealed documentation that ad expressed a desire to cility closer to his/her family. It is revealed "referrals had were awaiting return calls" intacted. Continued review the, dated 06/16/2021 timed at date Resident #3 had been the facility's courtyard area theduled for smoking. Per D "suspended" Resident #3's use to the infraction which non smoking time, the	F 66	60		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
	185301	B. WING			C 08/24/2021	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 33/24/2021		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
#3 chose to dischar had made a "reserv at 4:00 PM that day no documented evid Worker had initiated planning process prodischarge.  Interview with the CO7/29/2021 at 10:13 discharge planning to the facility. She re in the facility when I however, "normally discharge care planned return to the commute facility, she note plan. Further interview, when return to the commute facility, she note plan. Further interview and any input with I was not present at the facility at 4:23 Preview of the Note regave discharge paphis/her discharge from Interview with LPN revealed she was the Resident #3 was dis 06/16/2021. She states at 1:00 pm. The states was the resident #3 was dis 06/16/2021. She states was the states was the states was the resident #3 was dis 06/16/2021. She states was the states was the states was the resident #3 was dis 06/16/2021. She states was the resident #3 was dis 06/16/2021. She states was the states was the states was the resident #3 was dis 06/16/2021. She states was the states was the states was the resident #3 was dis 06/16/2021. She states was the states was the resident #3 was dis 06/16/2021. She states was the states was the resident #3 was dis 06/16/2021. She states was the states was the resident #3 was dis 06/16/2021. She states was the states was the resident #3 was dis 06/16/2021. She states was the resident #4 was discovered was discovered was th	ge to a Homeless Shelter and ation" to arrive at the Shelter . However, review revealed dence the Consulting Social of the facility's discharge for to Resident #3's  consulting Social Worker, on a AM, revealed a resident's process started on admission revealed she was not working Resident #3 was admitted; 'she initiated a resident's on admission to the facility.  a resident expressed to unity when discharged from addition the discharge care fiew revealed she updated the aduring the resident's stay, as anged. However, she had not Resident #3's care plan as she that time.  So Note completed by Licensed N) #2, dated 06/16/2021, #3 had been discharged from M on that date. Further revealed no evidence LPN #2 reverse to Resident #3 prior to form the facility.  #2, on 07/27/2021 at 3:34 PM, he nurse on duty when scharged from the facility on ated at the time of discharge	F 66	50			
	Continued From partial discharge planning to the facility. She rin the facility, she note plan. Further interview, when return to the commute facility, she note plan. Further interview with Facility, she note plan. Further interview with Facility with Facility was not present at the facility at 4:23 Preview of a Nurse's Practical Nurse (LP revealed Resident # the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:23 Preview of the Note regave discharge from the facility at 4:24 Preview of the Note regave from the facility at 4:25 Preview of the Note regave from the	TIDENTIFICATION NUMBER:  185301  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  #3 chose to discharge to a Homeless Shelter and had made a "reservation" to arrive at the Shelter at 4:00 PM that day. However, review revealed no documented evidence the Consulting Social Worker had initiated the facility's discharge planning process prior to Resident #3's	ROVIDER OR SUPPLIER  DODS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  #3 chose to discharge to a Homeless Shelter and had made a "reservation" to arrive at the Shelter at 4:00 PM that day. However, review revealed no documented evidence the Consulting Social Worker had initiated the facility's discharge planning process prior to Resident #3's discharge.  Interview with the Consulting Social Worker, on 07/29/2021 at 10:13 AM, revealed a resident's discharge planning process started on admission to the facility. She revealed she was not working in the facility when Resident #3 was admitted; however, "normally" she initiated a resident's discharge care plan on admission to the facility. Per interview, when a resident expressed to return to the community when discharge from the facility, she noted that on the discharge care plan. Further interview revealed she updated the discharge care plan during the resident's stay, as their care needs changed. However, she had not had any input with Resident #3's care plan as she was not present at that time.  Review of a Nurse's Note completed by Licensed Practical Nurse (LPN) #2, dated 06/16/2021, revealed Resident #3 had been discharged from the facility at 4:23 PM on that date. Further review of the Note revealed no evidence LPN #2 gave discharge paperwork to Resident #3 prior to his/her discharge from the facility.  Interview with LPN #2, on 07/27/2021 at 3:34 PM, revealed she was the nurse on duty when Resident #3 was discharged from the facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 a list of his/her medications. Additionally, LPN #2 provided	ROVIDER OR SUPPLIER  DODS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL (REGULATORY OR LSC DENTIFYMO INFORMATION)  Continued From page 64  #3 chose to discharge to a Homeless Shelter and had made a "reservation" to arrive at the Shelter at 4:00 PM that day. However, review revealed no documented evidence the Consulting Social Worker had initiated the facility's discharge planning process prior to Resident #3's discharge planning process started on admission to the facility. She revealed she was not working in the facility, she noted that on the discharge care plan. Further interview revealed she updated the discharge care plan as she was not present at that time.  Review of a Nurse's Note completed by Licensed Practical Nurse's Note completed by Licensed Practical Nurse's Note completed providence (PN) #2, dated 06/16/2021, revealed Resident #3 had been discharge from the facility, at the scheme of the scheme	ROWDER OR SUPPLIER  DODS  SUMMARY STATEMENT OF DEFICIENCIES (ECAN DEFICIENCY MUST RE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64  33 chose to discharge to a Homeless Shelter and had made a "reservation" to arrive at the Shelter at 4:00 PM that day. However, review revealed no documented evidence the Consulting Social Worker had initiated the facility's discharge planning process started on admission to the facility. She revealed she was not working in the facility. She revealed she was not working in the facility, she noted that on the discharge from the facility, when a resident expressed to return to the community when discharged from the facility, she noted that on the discharge care plan our during the resident's stay, as their care needs changed. However, she had not had any input with Resident #3's care plan as she was not present at that time.  Review of a Nurse's Note completed by Licensed Practical Nurse (LPN) #2, dated 06/16/2021, revealed Resident #3 had been discharged from the facility with LPN #2, on 07/27/2021 at 3:34 PM, revealed she was the nurse on duty when Resident #3 pass from the facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 pink in she facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 pink in she facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 pink in she facility on 06/16/2021. She stated at the time of discharge she provided Resident #3 pink of his/her	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3)	(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>08/24/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b>!</b>	00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 660	interview revealed s with any glucose m LPN she failed to di information in the re discharge; however documentation was However, interview 07/27/2021 at 9:20 D/C, the facility did or his/her medication	eedle caps. Continued she did not supply Resident #3 conitoring equipment. Per the ocument the medication esident's record upon his/her she should have ensured the	F 66	60			
	many units he/she a glucose monitorin Resident #3 reveale he/she did not have and the facility faile what was going to h money after leaving	someone to tell him/her how needed as he/she did not have g device. Additionally, ed upon D/C from the facility money nor was given any d to notify him/her regarding nappen to the resident's the facility.					
	#2 revealed no doc discharge education Resident #3's medi medical equipment	censed Practical Nurse (LPN) umented evidence of n, education related to cations nor any durable (DME) that was the OT discharge summary.					
	Programs, on 07/27 the shelter does no including storage of interview revealed cleave the shelter date check-in for the ever Additionally, she sta	omeless shelter's Director of 7/2021 at 1:40 PM, revealed t assist with medications dispensing. Continued clients at the shelter have to have been 7:00-7:30 AM and ening begins at 4:00 PM. ated if medications were left ed them, placed them in a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED			
		185301	B. WING		<b> </b>	C 08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		1 00/2-7/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 660	local pharmacy where Further interview rehave the support statransfers (i.e. to and showers, and incominterview revealed if after time of check if away.  Review of hospital revealed Resident from ED determined Reswith a reading of 27 to one hundred-ten insulin therapy. The and received blood was diagnosed with and received intravet the resident had dia pain, shortness of bigain. Record review diagnosed with a bload received medicular literal plan for Resident from 07/22/2021 at 3: discharge process was admission to the fact plan for Resident from resident's discharge interview revealed to regarding Resident Social Worker to has	are they were destroyed.  vealed the shelter did not aff to assist clients with I from the wheelchair), tinence care. Continued the shelter's beds were full in, they would turn clients ecords, dated 06/20/2021,	F 66	50			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		185301	B. WING_			C 8/24/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4604 LOWE ROAD LOUISVILLE, KY 40220		0/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 660	CNE revealed she trying to remove the aware of the facility Guardianship. Furth facility would not he glucose monitoring him/her with any mis/her care needs a resident's discharesident's nurse rewith the resident a stated the nurse profamily with a copy and also placed a medical record. The #3's discharge had however, the facility could for him/her gand demands to be possible.  Interview with the expension of the CED, on 07/30/22 Resident #3's disconsituation" for disched wanting to leave the CED stated the resident's right to chad a high BIMS simpairment, and we guardian. however had attempted to reconservator. He significant to obtain #3 to ensure the reprovided to him/he the CED stated on	er SNFs on 06/14/2021. The was not aware of the facility e Conservator and was not y attempting to file for ther interview revealed the ave given Resident #3 any equipment; and did not send toney to obtain supplies for . Additionally, she stated during rge from the facility, the viewed a Discharge Summary and/or his/her family. The CNE tovided the resident and/or of the Discharge Summary, copy of it in the resident's are CNE further stated Resident I not been "a good discharge"; by had "tried" to do the best they iven the resident's impatience ave the facility as soon as  Center Executive Director 221 at 3:04 PM, revealed the facility as soon as possible. The facility would not "impede" a discharge from the facility, who core indicating no cognitive the had no documented the centre of the state appointed the state	F				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		185301	B. WING			C <b>08/24/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	· · · · · ·	1 00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 660	actions to remove in 1. Resident #3 was a 06/16/2021.  2. The Center Nurse Response Manager, Compliance, or Soci reviewed, on 07/31/2 planned discharge s discharge trends.  3. The Center Execu completed education Regional Vice Presid Quality Specialist (C safe transfer/dischard documentation on the clinical care, and me instructions, on 07/3  4. On or before 08/0 team, Assistant Dire (ADNS), Nurse Prace Managers (UM), CE (HRD) and Nurse Sueducation and a post transfer/discharge of 5. All licensed facility on or before 08/02/2 transfer/discharge, a to the resident. All side post test.	it #3 at the time.  It implemented the following inmediacy:  discharged from the facility on the Executive (CNE), Rapid Director of Regulatory al Services team member 2021, all residents with a ince 06/16/2021 to identify  It ive Director (CED) and CNE in and a posttest after the dent (RVP) and Clinical QS) provided education for a rige with appropriate the resident's clinical status, edication management 1/2021.  2/2021 the Social Services ctor of Nursing Services tice Educator (NPE), Unit D, Human Resource Director upervisors completed ttest on the safe/orderly	F 66				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION		COMPLETED	
		185301	B. WING			C <b>08/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  4604 LOWE ROAD  LOUISVILLE, KY 40220		00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 660	planned for dischar to the resident regamedication educati would be corrected member.  7. The facility QAP ADNS and Social Sappropriate transfe Upon review addition would occur until results appropriate transfe Upon review addition would occur until results and the state Survey Aremoval plan by:  1. Record review resident #3 on 06/ Interview, on 07/27 Licensed Practical discharged Resident 2. Interview with the PM, revealed she with planned discharges Interview with Rapio 08/21/2021 at 2:56 involved with review alleged.  Interview with the Example Compliance, on 08 she was involved with discharges as alleged.  Review of an audit	eek for resident's who were ge for documented education arding clinical care and on by staff. Identified areas immediately by the team  I committee reviewed the CNE, Services team weekly audits for r., discharge, and education. In the content of	F 66			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			С	
NAME OF PI	ROVIDER OR SUPPLIER	165501	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2021
REGIS WO	OODS				604 LOWE ROAD OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page reviewed.	<del>2</del> 70	F	660			
	08/21/2021 at 3:50 PI	Clinical Quality Specialist, on M, revealed she provided st to the Center Executive E as alleged.					
	PM, revealed he parti	P, on 08/21/2021 at 4:15 cipated in education and nd the CNE as alleged.					
	Interview with the CE PM, revealed he rece completed a posttest						
	Interview with the CN PM, revealed she rec completed a posttest						
	Review of facility recollabeled with names of	ords revealed posttests f the CED and CNE.					
	08/20/2021 at 3:24 PI	al Service Specialist, on M, revealed she received eted a posttest as alleged.					
	08/20/2021 at 4:38 PI	rse Practice Educator, on M, revealed he received eted a posttest as alleged.					
		nit Manager, on 08/20/2021 she received education and as alleged.					
	08/20/2021 at 1:50 PI	rse Weekend Supervisor, on M, revealed he participated pleted a posttest as alleged.					
	Record review reveal	ed posttests labeled with the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	1 00/2-4/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 660	PM, revealed she recompleted a posttes  Interview with the Bu 08/20/2021 at 4:04 Feducation and comp  Interview with Agend 08/20/2021 at 5:58 Feducation and comp  Interview with LPN # revealed she receive post test as alleged.  Review of facility redocumented for licer  6. Interview with the PM, revealed he correcords for discharge  Review of facility reddated 07/31/2021 th review of discharge  7. Review of facility reddated 07/31/2021 th review of discharge  7. Review of facility sign-in sheets as includits in the topic.  Interview with the CIPM, revealed discharge as alleged  Interview with the Riversity with th	cated above.  N #6 on 08/18/2021 at 9:25 ceived education and t as alleged.  Usiness Office Manager, on PM, revealed she received leted a posttest as alleged.  EV Registered Nurse #5, on AM, revealed she received leted a posttest as alleged.  E1, on 08/18/2021 at 7:48 AM, E2 education and completed a  E2 cords revealed posttests E2 nsed nurses as alleged.  CED, on 08/21/2021 at 3:54 E2 edocumentation as alleged.  E3 cords revealed audit sheets E4 rough 08/19/2021, indicating E5 documentation as alleged.  E5 cords revealed QAPI E5 cords revealed Revealed Revealed Revealed Revealed Revealed Revealed Revealed Reveal	F 66			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C			
		185301	B. WING _			08/24/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/2-11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 660	1 3		F 6	60				
F 689 SS=J	QAPI meetings as all Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices	F 6	39				
	as free of accident has \$483.25(d)(2)Each re							
	by: Based on observation and policy review, it is failed to have an effect ensure each resident supervision and devifour (8) of twenty-eig (Residents #20, #19, and #27).	on, interview, record review, was determined the facility ective system in place to t received adequate ces to prevent accidents for ht (28) sampled residents #21, #22, #23, #24, #26,						
		's walker. Per interview,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>08/24/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	1 10001		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	ı	06/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	resident and Reside belonged to his/her revealed the resider walked to his/her ror fast pace" tripping o closed fracture of th #20 was care planne (1) when in his/her reveised to address the upset, nor was the revised to address the upset, nor was the resident #20 walkers taff member of one residents who requires upervision when an Resident #20 fell who Spine C2 minimally fracture.  2. On 05/10/2021, Resident #20 fell who seated in his/her whe resident stood up frostepped on the edge and fell forward, hittoof the wall in his/her to the hospital and rescalp resulting in on was care planned to while out of bed. Ac Resident #19 was of out of his/her wheeled bottom when his/her observation on 08/11 #19 stood up from her the plant the resident was care planted to while out of bed. Ac Resident #19 was of out of his/her wheeled bottom when his/her observation on 08/11 #19 stood up from her the planted the revision of th	ent to return the walker to the nt #20 stated the walker mom. Interview with staff at became visibly upset and om, then walked back "at a ver his/her foot causing a eright orbital floor. Resident ed to have an assist of one oom and/or toileting. Ident's care plan was not the resident's "fast pace" when esident care planned for st with ambulation. In #20 had a second fall. On sturning from the beauty shop, and back to his/her unit with a (1) in a group of four (4) and additional staff inbulating off the unit. In the editional staff in the company of the second fall was observed eelchair in his/her room. The form his/her wheelchair, are of the mattress on the floor and his/her head on the back room. The resident was sent eccived a laceration to the eright of the mattress up diditionally, on 05/30/2021, beserved by staff to stand up chair and landed on his/her	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
185301		B. WING		08/24/2021		
	NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	USI	24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	e 74	F 689	9		
	with the resident. Per resident was so fast, supervision.	interviews with staff, the he/she required 1:1				
	have an injury of unking was diagnosed to have of the resident's Minimal related to transfers where resident's plan of care assessed for two (2) a however, the resident (1) assist with transfer 4. On 05/28/2021, Rest to display bruising to limping. Interviews who hospital record revea The resident's care president to wear non-ambulating; however,	as different from the e. The resident was assist with transfers; t was care planned for one rs. esident #22, was observed his/her thigh and was rith staff and review of the led the resident had a fall. lan was up dated for the				
	additional residents w with the assistance of (5) residents. Resident assessed to have a of ambulating off his/her escorted with four (4)	esident #23 and four (4) were escorted off his/her unit of only one (1) staff for all five at #23 however, was ne (person) assist when a unit. The resident was other residents, of whom wel of supervision, increasing				
	additional residents with the assistance of residents. The residents.	esident #24 and four (4) vere escorted off his/her unit f one (1) staff for all five (5) ent; however was assessed assist of one (1) person for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED C		
		185301	B. WING		08/24/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	was escorted with f whom required add of supervision, increase. To no 08/11/2021, F additional residents with the assistance residents. The resisupervision with no locomotion/ambulat 8. On 08/11/2021, F additional residents with the assistance residents. The resisupervision with on with locomotion/off 9. On 08/14/2021, residents sitting in t supervision/oversig observed, Resident among the resident care plans revealed supervision.	cion off the unit. The resident our (4) other residents, of itional and/or the same level easing his/her risk for falls.  Resident #26 and four (4) were escorted off his/her unit of one (1) staff for all five (5) dent was assessed for physical help from staff with cion off the unit.  Resident #27 and four (4) were escorted off his/her unit of one (1) staff for all five (5) dent was assessed to have e (1) person physical assist the unit.  observation of ten (10) he common area without staff ht. Of the ten (10) residents ts #19, #21, and #22 were s. Review of the residents' I the residents required	F 689				
	and was determined areas of 42 CFR 48 Free of Accident Hascope and severity Comprehensive Re F656 Develop/Imple Plan at scope and severity Plan Timing and Reform J"; 42 CFR 483. Administration at scope and severity and severit	y was identified on 08/24/2021 d to exist on 05/10/2021 in the i3.25 Quality of Care, F689 izards/Supervision/Devices at of "J" and 42 CFR 483.21 sident Centered Care Plans, ement Comprehensive Care everity of "J" and F657 Care evision at scope and severity 70 Administration, F835 cope and severity of "J", and idy at scope and severity of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _	B. WING		C <b>08/24/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 4604 LOWE ROAD LOUISVILLE, KY 40220	ZIP CODE	00/24/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 689	"J". Substandard Qu 42 CFR 483.25 Quali Accident Hazards/Su and severity of "J". T Immediate Jeopardy F835 Administration a were previously cited scope and severity of continued non-compl cited at the higher so Additional deficient p CFR 483.12 Freedon Exploitation, F600 Fr at scope and severity previously cited on 05 severity of "K" and as non-compliance, F60 scope and severity of Substandard Quality Freedom from Abuse F600 at a scope and The State Survey Ag with IJ existing on 05 The findings include: Review of the facility w Management System and investigate all ac occurred, or allegedly property. Further rev was defined as any u incident which may re-	ality of Care was identified at ty of Care, F689 Free of pervision/Devices at scope he facility was notified of the on 08/24/2021.  and F837 Governing Body on 05/22/2021, both at facility. As this represents fance F835 and F837 will be ope and severity of "K".  Tractice was identified at 42 in from Abuse, Neglect, and see from Abuse and Neglect of "D". However, F600 was 5/22/2021 at scope and at the higher facility. The facility is resulting in of Care at 42 CFR 483.12, Neglect, and Exploitation, severity of "K".  Pency exited on 08/24/2021 and is ongoing.  See policy titled, prevised 11/28/2016, would use the Risk (RMS) to report, review, cidents/incidents which	F	589		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		, ,	(X3) DATE SURVEY COMPLETED		
185301	B. WING			08/24/2021		
		4604 LOWE ROAD	•	10/24/2021		
SUMMARY STATEMENT OF DEFICIENCIES  X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
build utilize the RMS to report its and assist with completion of ition to determine the root cause. Intered would generate propriate leadership depending well of the event; trigger specific is based on the type of event it expands and federal reporting directed. Continued review of it a follow up investigation would it expends and revent further its had been identified and revent further its had been identified and rether, when conducting an CED (Center's Executive enter's Nurse Executive), or make every effort to ascertain the ident/incident; use the RMS int System) witness interview witness interviews from all staff may have knowledge of the Lastly, the ACED (Assistant Director) or designee would its of the investigations/root and forward to the Quality mance Improvement (QAPI) in the control of the control of the control of the control of the investigations of the investigation of the	F 689					
	185301  185301  RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL	TRENTIFICATION NUMBER:  185301  B. WING  PREFIX TAG  TAG  TAG  TAG  TAG  TAG  TAG  TAG	TRESTORTION NUMBER:  185301  B. WING  STREET ADDRESS, CITY, STATE, ZIP COL 4604 LOWE ROAD LOUISVILLE, KY 40220  PROVIDERS PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  Dage 77  Daild utilize the RMS to report ts and assist with completion of tion to determine the root cause. Intered would generate propriate leadership depending wel of the event; trigger specific s based on the type of event e patient and flow to the reporting forms to assist with ate and federal reporting directed. Continued review of da follow up investigation would be CNE or designee to determine cumentation was completed and revent further ts had been identified and rither, when conducting an CCED (Center's Executive) center's Nurse Executive), or nake every effort to ascertain the dent/incident; use the RMS ant System) witness interview ritness interviews from all staff may have knowledge of the Lastly, the ACED (Assistant Director) or designee would s of the investigations/root not forward to the Quality mance Improvement (QAPI) low-up.  ility's policy titled, "Falls vised on 06/01/2021, revealed e assessed for falls risk as part sessment process. Continued hose determined to be at risk for e appropriate interventions to and minimize injury. Further	STREET ADDRESS, CITY, STATE, ZIP CODE		

NAME OF PROVIDER OR SUPPLIER  REGIS WOODS  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FERRET ADDRESS, CITY, STATE, ZIP CODE  4694 LOWE ROAD  LIGACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FEASURATORY OR LSC IDENTIFYING INFORMATION)  FEASURATORY OR LSC IDENTIFYING INFORMATION)  FEASURATORY OR LSC IDENTIFYING INFORMATION  FEASURATORY OR LSC IDENTIFYING INFORMATION)  FEASURATORY OR LSC IDENTIFYING INFORMATION  FEASURATION  FE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
REGIS WOODS  SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY)  (PAPEL TAG)  FOR CONTINUED FROM THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 78  would receive appropriate care and investigation of the cause. The policy further revealed that the purpose was to reduce the risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall. Continued review revealed the resident's would be identified as a fall risk by reviewing the Electronic Medical Record Systems-Nursing Assessment and Non-electronic Medical Record Systems-Fall Risk Evaluation. Further review revealed the resident's care plan regularly. Continued review revealed that if a resident falls: the incident would be documented as a new event in the Risk Management System (RIMS); the care plan would be updated to reflect new interventions, an interdisciplinary team meeting would be held within seventy-two (72) hours of the fall and the Center Executive Director and Center Nurse Executive Would conduct a post fall review.  Interview with the Clinical Quality Specialist, on 08/24/2021, at 2:00 PM, revealed the facility did not utilize the Non-electronic Medical Record Systems-Fall Risk Evaluation, as per the regulation. She stated staff determined a resident was at risk for falls through completing their "nursing assessments."  1. Review of Resident #20's clinical record			185301	B. WING _			C 08/24/2021	
FREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 78 would receive appropriate care and investigation of the cause. The policy further revealed that the purpose was to reduce the risk for falls and to address injury and provide care for a fall. Continued review revealed the resident would be identified as a fall risk by reviewing the Electronic Medical Record Systems-Nursing Assessment and Non-electronic Medical Record Systems-Nursing Assessment facility would communicate the resident's care plan regularly. Continued review revealed that if a resident falls: the incident would be documented as a new event in the Risk Management System (RMS); the care plan would be updated to reflect new interventions, an interdisciplinary team meeting would be held within seventy-two (72) hours of the fall and the Center Executive Director and Center Nurse Executive would conduct a post fall review.  Interview with the Clinical Quality Specialist, on 08/24/2021, at 2:00 PM, revealed the facility did not utilize the Non-electronic Medical Record Systems-Fall Risk Evaluation, as per the regulation. She stated staff determined a resident was at risk for falls through completing their "nursing assessments."  1. Review of Resident #20's clinical record					4604 LOWE ROAD		00/24/2021	
would receive appropriate care and investigation of the cause. The policy further revealed that the purpose was to reduce the risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall.  Continued review revealed the resident would be identified as a fall risk by reviewing the Electronic Medical Record Systems-Nursing Assessment and Non-electronic Medical Record Systems-Fall Risk Evaluation. Further review revealed the facility would communicate the resident's fall risk to the caregivers, develop individualized plans of care, and review and revise the resident's care plan regularly. Continued review revealed that if a resident falls: the incident would be documented as a new event in the Risk Management System (RMS); the care plan would be updated to reflect new interventions, an interdisciplinary team meeting would be held within seventy-two (72) hours of the fall and the Center Executive Director and Center Nurse Executive would conduct a post fall review.  Interview with the Clinical Quality Specialist, on 08/24/2021, at 2:00 PM, revealed the facility did not utilize the Non-electronic Medical Record Systems-Fall Risk Evaluation, as per the regulation. She stated staff determined a resident was at risk for falls through completing their "nursing assessments."	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
12/17/2019 with diagnoses that included Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, and Reduced Mobility.  Review of the resident's Quarterly Minimum Data	F 689	would receive approf the cause. The purpose was to red minimize the actual address injury and Continued review redentified as a fall	opriate care and investigation oplicy further revealed that the uce the risk for falls and occurrence of falls and to provide care for a fall. evealed the resident would be sk by reviewing the Electronic stems-Nursing Assessment Medical Record Systems-Fall urther review revealed the nunicate the resident's fall risk evelop individualized plans of ad revise the resident's care attinued review revealed that if incident would be ew event in the Risk em (RMS); the care plan would cot new interventions, an am meeting would be held (72) hours of the fall and the director and Center Nurse and Center Nurse and Center Nurse and the post fall review.  Clinical Quality Specialist, on the PM, revealed the facility did electronic Medical Record Evaluation, as per the atted staff determined a for falls through completing essments."  Lent #20's clinical record and the was admitted on agnoses that included attia without Behavioral electronal Reduced	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		C 08/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	was assessed to have Status (BIMS) score of indicative of severe or review revealed the rewas assessed to be sencouragement or cull with locomotion on the assessed to have "accomposed for the unit of the unit o	15/2021, revealed he/she e a Brief Interview for Mental of three (3), which was ognitive impairment. Further esident's functional status upervision (oversight, eing) with set-up (help only), e unit. The resident was tivity did not occur" with t with no physical help.  20's Comprehensive Care les of Daily Living (ADL's), 19/15/2021, revealed the was for the resident to ADL care in bathing, ygiene, dressing, eating, locomotion, tilting related to hin, and impaired cognition, right orbital floor fracture, goal was for the resident to of function in bathing, rgiene, dressing, eating, bed be motion, and toileting. The his was for the resident to hand assistance, initiated hissist with one (1) for bed on one assist for transfers, horovide assist of one (1) for lew revealed no care plan for lid ambulate on or off his/her	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED		
		185301	B. WING			C 08/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220		10/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	station and fell, striki review revealed the laceration to the fore applied to the reside Continued review resystem was notified transferred to the acceparatement. Continuity witnesses were Licer #1 and LPN #2.  Further review of Re Summary, dated 08/measures that were to have the bed agai complete orthostatic observe for changes status, and mental strevealed the root cauresident was walking lost his/her balance are environmental factor corrective actions in corthostatic blood prenursing staff to evaluate footing and the resident was walking lost his/her balance are environmental factor corrective actions in corthostatic blood prenursing staff to evaluate footing and the resident and the common area whallow.  Review of Resident and 8/07/2021, revealed forward striking his/higround. Further revisustained a laceratic during the fall. Recorresident's diagnosis	in the hall near the nursing ng his/her head. Further resident sustained a head. A cold compress was nt's forehead laceration. Wealed Emergency Medical and the resident was ate care Emergency are dreview revealed the nsed Practical Nurse (LPN)  sident #20's RMS Event 07/2021, revealed preventive in place prior to the fall was nst the wall, nursing staff to blood times three (3) days, in medical status, pain ratus. Continued review ase/conclusion was that the in the hallway when he/she and fell. There were no so or hazards noted. The cluded: therapy to evaluate; source for three (3) days; ate for footwear for proper ent was encouraged to be in the nawake as he/she would at the resident tripped and fell er right forehead against the ew revealed the resident in to his/her right eyebrow ard review revealed the at discharge was an "injury of bounter, facial laceration, and	F 68	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			C <b>08/24/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	l	00/24/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	Continued From pag	ge 81	F6	89			
	o8/17/2021 at 6:42 I sitting up in his/her variational Care Ur with 1:1 staff. Reside have the cervical color linterview with Certiff #14, on 08/15/2021 had worked for the fer interview, CNA: day Resident #20 fethe resident was observed entry swalker an walker, the resident walker was his/her rinterview, the resident walker was his/her rinterview, the resident to CNA #14. Contin Resident #20 was a common area while retrieve a towel to wobserved on the kitch when she returned, floor and Licensed Fanother nurse (unidaresident. The CNA the fall and believed for falls. She stated the resident's care promunicate the readditionally, she addresident's behavior, walker that belonged belonged to him/her	nit (TCU), watching television lent #20 was observed to llar to his/her neck.  ded Nursing Assistant (CNA) at 10:00 AM, revealed she acility for over five (5) years. #14 revealed she worked the ll, on 08/07/2021. She stated served to have another d when asked to return the became upset, stating the nother's walker. Per nt forcibly returned the walker ued interview revealed sked to have a sit in the she (CNA #14) went to ipe up liquid that was then floor. CNA #14 stated she saw the resident on the Practical Nurse (LPN) #1 and tentified) were assessing the stated she did not observe the resident was not at risk she was not fully aware of olan, but nursing staff would sident's needs to the CNAs. ded nursing was aware of the which included thinking that a did to another resident					
		een with the facility for over six employed through agency.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185301	B. WING		08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 LOWE ROAD LOUISVILLE, KY 40220	00/24/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 689	and every unit. LPN assessed for falls at often documented to the resident's changstated the resident's changstated the resident's risk for facare plan. Additionary care planned for an toileting, ambulating Activities of Daily Libe at risk for falls.  Continued interview at 7:48 AM, reveale 08/07/2021, when Fhis/her first fall. She PM, around shift chis/her first fall. She PM, around shift chis/her first fall. She pills with LPN #6. Shormally "walks fast anxious. LPN #1 st walked from the cor She stated she thou needed to go to the certain, adding "that normally did, went to the common area revealed that when his/her room, the re "fast" coming back to tripped on his/her of stated the resident lends to the LPN stated, "bl #1 stated that when the landed on to the LPN stated, "bl #1 stated that when the landed on to the landed that when the landed on the landed that when the landed on the landed that when the landed on the landed that when the	ge 82 #1 stated she worked all shifts N #1 stated the residents were fter they had a fall and it was hrough the RMS and within ge in condition. She further were not given a score to ere at high or low risk for falls. If were made aware of a lls by reviewing the resident's ally, when the resident was assist of staff, related to g, dressing, and all other ving (ADL), the resident would  with LPN #1, on 08/18/2021 d she worked the evening of Resident #20 experienced e stated it was around 6:15 ange and she was counting She stated Resident #20 t" when he/she becomes ated the resident got up and mmon area to his/her room. ught Resident #20 might have bathroom, but she was not t was what the resident to the bathroom and returned a." Continued interview Resident #20 came out of sident was observed to walk to the common area and wn foot and fell. LPN #1 hit his/her head. She stated he wooden area" of the unit. ood was on the floor." LPN the resident landed from folled over into the carpet	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 4604 LOWE ROAD LOUISVILLE, KY 40220	TE, ZIP CODE	1 001	24/2U2 I
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORREC' CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page were there, she and I	e 83 _PN #6 were counting pills	F	689			
	and CNA #14. She for recall any other staff resident. LPN #1 revassessed and was im	urther stated she could not who assisted her with the realed the resident was nmediately transported to the gency Medical System					
	revealed she had wo beginning of July. She mployed through ag the Homestead Unit of she was not familiar of stated on the day of F 08/07/2021, she had LPN #1. LPN #6 stat	5, on 08/18/2021 at 9:25 PM, rked at the facility since the ne further stated she was ency and had only worked only twice (2). She stated with the residents. LPN #6 Resident #20's fall, on completed her report with the resident walked from his/her room without					
	assistance. Per intervigrabbed the blood probserved Resident #2 walking at a fast pace seemed as though Rimearful". She stated if the resident was crigood look at the resident.	view, LPN #6 stated she essure cuff when she 20 walking in front of her, e. LPN #6 revealed it esident #20 was "upset" and she could not tell; however; ying, as she did not get a dent's face before he/she fell.					
	nurse's station. She resident's foot "kind of stumbled over his/her #6 stated she believe and she saw the blood right eye brow. Continued resident was sent out Additionally, LPN #6 the incident that happfall, but if the resident walker, it would have	sident fell across from the stated she observed the of dragged" and he/she if foot and went "down". LPN and the resident "hit head first" and coming from the resident's inued interview revealed the it to the hospital immediately, stated she was not aware of bened prior to the resident's it was upset over his/her been important to redirect is/her focus did not remain					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 4604 LOWE ROAD LOUISVILLE, KY 40220	•	0/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	o8/17/2021 at 3:0' employed by the fatwo (2) and a half nurses complete the upon admission. In "documents" that we residents for falls, that when a reside would be assessed vital signs would be the RMS and Characompleted at that revealed Resident 6:22 PM, on 08/07 during the change coming on shift whishift. She stated sonurses' station and happened. LPN # fall. Continued intwas assessed and #3 revealed she did a falls risk, but was percent sure. Furthout aware the resident was assessed and #3 revealed she did a falls risk, but was percent sure. Furthout aware the resident was assessed and #3 revealed she did a falls risk, but was percent sure. Furthout aware the resident sure. Furthout aware the resident sure. Furthout aware the resident sure. Review of Resider Discharge Summa 08/11/2021, revea (3) days during the Continued review.	istered Nurse (RN) #3, on I PM, revealed she was acility and had worked for over (1/2) years. Per interview, the he resident's fall assessment RN #3 was unable to show the were used to assess the Continued interview revealed and experienced a fall, he/she do by the nurse for injury and the taken. She further stated the severity of the injury, the sent to the hospital. She stated ange of Condition would be time. Per interview, RN #3 #20's incident occurred around (1/2021. She stated it was of shift and LPN #1, was nile LPN #6 was coming off the was on the phone at the drushed to find out what 1 stated she did not witness the terview revealed the resident I sent out to the hospital. RN id not believe the resident was so not one-hundred (100) ther interview revealed she was dent was upset over "not other's walker, but the concern	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pag	je 85	F 6	689		
		havioral disturbance, difficulty /here classified, and muscle				
	Discharge Summary for the resident was two-hundred (200) for device with supervision within the facility. For 08/08/2021, the resist seventy-five (75) feed one or two hands on provides no other as	et with Contact Guard (having the resident's body, but esistance to perform the esist with steadying the				
	documented evidend to reflect the resident ambulating on or off after the resident's s Phone interview with 08/20/2021 at 8:29 A	n Physical Therapist, on M, revealed Resident #20				
	stated the resident s needed assistance f assessment. The P had not worked with he/she fell the secor revealed the nursing	after his/her fall on erview, the Physical Therapist howed some decline and or ambulation, per his hysical Therapist revealed he the resident long before and time. Further interview staff were responsible for nended intervention would be				
	System (RMS) Even	#20's Risk Management It Summary Report, dated by Registered Nurse (RN) #3,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 689	with the activity aide a from the beauty shop revealed, the resident head, sustained head bruise on the inner let and pressure applied resident was taken to per EMS. Continued I were the Activity Assistance of	d, "Describe the event and immediate ed the resident was walking and several other residents in-house. Further review the fell and struck his/her laceration, and a large fit wrist. A cold compress to the resident's head. The the Emergency Room (ER) review revealed witnesses stant and Resident #26.  Resident #20's RMS Event 1/2021, revealed preventive in place prior to the fall was list the wall, nursing staff to blood for three (3) days sing staff to encourage common area while awake w, nursing to evaluate ing, observe for changes in status, and mental status indicated. Toileting offered ation evaluation, place call the in bed or close proximity in clutter-free environment to evaluate. Continued esident's care plan was	F	689			

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NAME OF P	ROVIDER OR SUPPLIER	1	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1604 LOWE ROAD LOUISVILLE, KY 40220		0/2-1/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	08/13/2021, revealed the emergency room resident had significated bruising. He/She was pain. There was no had a small right from without any mass-eff Continued review resolution resident was adsolution follow-up CT (composed follow-up CT (composed following day showed hemorrhage with mill midline shift 3 mm (prevealed the cervical minimally displaced was stable alignment recommended.  Interview with Resid witness in the facility 08/17/2021 at 4:05 Frecall the incident resident was "really that on the day of Reconstruction of the part of the	#20's hospital record, dated d the resident was brought to a for an evaluation. The ant right forehead and facial as complaining of left wrist wrist fracture. The resident and subdural hematoma fect or midline shift. We aled the resident had a se of the right orbital floor and contide fracture nondisplaced. mitted for observation. A suted tomography scan was a shinique) scan of the head the d a mild increase in subdural d mass-effect and leftward millimeter). Further review I spine CT confirm the C2 base odontoid fracture which	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	165301	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO	•	8/24/2021	
TO WILL OF TH	TO VIDER OR GOLF EIER			4604 LOWE ROAD	352		
REGIS WO	OODS			LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	stated the resident CNA #15 stated shresidents that wen located off the resiresidents required the beauty shop. The beauty shop of the beauty shop of the so was unaware he the residents off the located state of the loca	own". Per interview, the CNA stated "ok" and slowed down. He could not recall all the to the beauty shop, which was dent's unit, but recalled the assistance with ambulation to The CNA revealed she was on sidents returned from the wall stated this was her first residents to the beauty shop, ow many staff it took to escort	F	589			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185301	B. WING			C 08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	4604 L	T ADDRESS, CITY, STATE, ZIP CODE OWE ROAD SVILLE, KY 40220	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	by the Activity Assist he turned to reach for had fallen on the floor resident was on the body was on the woor responded to the fall the Activity Assistant time, he and another residents back to the residents were stron independently. Furth revealed he was not level of assistance in he was not as familia Further, he stated that to have all aspects or residents' needs courimportant to keep up residents.  Interview with the Ass (ADON), on 08/19/20 witnessed the Activita (unidentified) escorti beauty shop. Per instruggled to keep up not notice any gait or revealed the Activity the residents without She further revealed fall, he/she should he beauty shop in a who staff with him. The Aresidents were asset	rview, the resident was told ant to "slow down" and when or the resident, the resident or. He revealed half of the carpet and half of his/her od floor. He stated LPN #1. Continued interview with revealed that most of the CNA would escort the equit. He further stated, the grand walk mer, the Activity Assistant aware of Resident #20's eeded for ambulation, adding ar with their care plans. The care plans were important ompleted because the lid change and it was with the needs of the sistant Director of Nursing 021 at 3:16 PM, revealed she by Assistant and CNA or Resident #20 to the derview, the resident with the group, but she did concerns. Continued interview Assistant normally escorted at the assistance of other staff. It that with Resident #20's first ave been escorted to the electoric or had additional ADON revealed if the seed to be an assist of one have an additional staff with	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		185301	B. WING _			C 08/24/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 4604 LOWE ROAD LOUISVILLE, KY 4022			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 689	(CNE), on 08/23/202 communicated with the related to Resident # was not informed the "unsteady" gait. Add the resident required ambulating on and/or been made aware.  2. Review of the facil Patient Supervision: 06/01/2021, revealed being of the residents supervision; however temporary period of corder to maintain his/others. Further revier requiring enhanced swere not limited to, thinjury/neurological propending transfers, sumental distress such sexually aggressive to revealed continuous provided per nursing recommended by a provider (APP).  Review of Resident # revealed the resident 07/24/2020 with diag Unspecified Demention Disturbance, Psychological propending transfers, sumported the resident 07/24/2020 with diag Unspecified Demention Disturbance, Psychological propending transfers, and Unspecified Demention Disturbance, Psychological propending transfers, sumported to the propending transfers, sumported to the propending transfers and transfers are propending transfers.	the Center Nurse Executive 1 at 12:49 PM, revealed she herapy (date unknown) 20's first fall. She stated she resident displayed an itionally, she was not aware additional assistance when r off the unit, but should have  ity's policy titled, "Enhanced Continuous 1:1, revised I the whereabouts and well s was part of routine nursing r, a resident may require a enhanced supervision in ther safety and the safety of w revealed the residents upervision may include, but hose with: head oblems, violent behaviors bstance abuse/withdrawal, as acute delirium, and behaviors. Further review 1:1 supervision would be judgement or when whysician/advanced practice  1:19's Medical Record a was admitted on noses that included a with Behavioral tic Disorder with Delusions logical Condition, Muscle pecified Fall, Subsequent	F	689			
	Review of Resident #	19's Quarterly Minimum					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 4604 LOWE ROAD LOUISVILLE, KY 40220	<b>I</b>	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	resident's assessmed Mental Status (BIMS) the BIMS' score for score of three (3) ar resident was severe Further review revestatus, revealed the limited assistance wassist.  Review of Resident Care Plan, last review revealed the focus or resident had a histor cognition, lack of sabed without staff assifloor, muscle weakn of falls. The goal was falls with major injury of the interventions position, fall mat to mattress to the right to the resident craw when in bed. Additing planned to have an with ambulation and wheelchair, and the the common area to decrease fall risk.  Review of Resident 05/10/2021, revealed System (RMS) Even Registered Nurse (Foursing Assistant (Coresident stand up from the score of the resident stand up from the score of the second of the seco	ted 07/27/2021, revealed the ent for a Brief Interview for S) was incomplete. Review of 04/26/2021 revealed a BIMS and the facility determined the ely cognitively impaired. Called Section G, Functional eresident was assessed to be with one (1) person physical eresident was assessed to be with one (1) person physical eresident was the ere plan was the ery of falls related to impaired fety awareness, would exit esistance and crawl on the ess as evidenced by a history as for the resident not to have by thru the next review. Some included: bed in lowest right side of bed for safety, as side of the bed for safety due ling out of bed every shift onally, the resident was care extensive assist of one (1)	F	589		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			C 08/24/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		0012-112021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	decided to send the Room for sutures to Continued review remeasures that were included the fall mareview revealed the resident's gait was action was that the supervision to preveassistance.  Review of Resident 05/10/2021, signed resident fell in his/h injury. The resident Attending Physiciar the resident be sen wound.  Review of Resident visit, admitted on 05 resident was treated of the record reveal was attempting to a got his/her feet caucausing him/her to head. Further revies ustain a small lace region of the scalp. repaired with one (100 Observation of Res 1:45 PM, revealed to common area, with fall safety. Resident	assessed the resident and resident to the Emergency of the scalp laceration. Evealed preventative in place prior to the fall tress at the bedside. Further root cause was that the unsteady. The corrective resident "may" need 1:1 ent attempts to walk without was assessed by the and the Physician requested to the ER for suture(s) of the din the ER for a fall. Review ed the resident stated he/she mbulate to his/her bed and ght up on a piece of foam fall hitting the back of his/her ew revealed the resident station to the left parietal Further, the laceration was	F 6	89			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		STRUCTION	(X3) DATE COMP	SURVEY LETED
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		185301	B. WING				24/2021
NAME OF F	ROVIDER OR SUPPLIER		-	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00//	
DECIC W	0000			4604 L	OWE ROAD		
REGIS W	פעטט			LOUIS	SVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	AM, revealed she was per interview, Reside to 1:1 supervision in resident would often bad days. CNA #16 try to stand from his She further stated it remained on 1:1 supresident, adding she "believed" he/she considered to his/her rower to she worked the day 05/10/2021. She staresident to his/her rower to his/her rower to his/her rower to his/her rower to his/her matth his/her room, to get his/her head on the resident had his/her the fall made the hewas bleeding and the to send the resident interview with CNA soften believed he/she Continued interview room was changed #25 could watch the room. She further supervision.  Interview with Regis 08/21/2021 at 12:04 the day of Resident Per interview, RN #3	#16, on 08/20/2021 at 7:10 as employed by the facility. ent #19 was care planned to a the past. She stated the a have his/her good days and revealed the resident would //her wheelchair "all the time". would be nice if the resident pervision for the safety of the a believed the resident buld walk. CNA #16 stated	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		33/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	obtained. RN #3 statche resident with the could not recall the would have caused interview revealed to information possible not recall the witness the mattress, adding documented." She a "safety" risk would linterview with the At 08/23/2021 at 11:21 Resident #19 had a in which the resident hospital. Per interviresident's room to a stated she recalled his/her helmet on which the reviresident's helmet was fall. She further reviresident's mattress bed. The Attending up sending the resident with CNA AM, revealed she were sident with the country in the country	om CNA #16 was not atted she recalled assessing attending Physician, but environmental factors which the resident to fall. Further that she would obtain all the from the witness, but could as mentioning anything about g, "I just see what was further stated the mattress as	F6	· · · · · · · · · · · · · · · · · · ·		
	revealed she normal was familiar with the one stated to her she Resident #19, but she would keep an stated if Resident # would ensure Resident #	25. Per interview, the CNA ally did not work the unit, but the resident. CNA #17 stated no be would have to watch ince he/she was in the room, eye on the resident. She 19 needed anything, she ent #25 was safe and if so, the to the resident if needed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/2-4/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	She further stated to Resident #25, she would light. Continued #19 was care plann he/she liked to roll of where the resident interview revealed to be placed on the flowas in it's lowest powhen the resident womattress would be mattress would be ma	hat if she was busy with would put on Resident #19's dinterview revealed Resident ed for the mattress because out of bed and had episodes crawled out of bed. Continued he resident's mattress would for, while the resident's bed osition. She further stated that was out of his/her bed, the moved. CNA #17 stated the removed for safety reasons.  The Center Nurse Executive 1 at 11:03 AM, revealed staff dent #19's mattress was up en up and out of bed. She are plan should be followed.  If Resident #19's Medical eresident fell again on the t#19's Progress Notes, dated by Licensed Practical Nurse the resident was constantly liking around without used review revealed the gin and out of bed. The cted by putting the resident elchair, taken out of his/her nack. Redirection was	F 6	89		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C 9/24/2024
NAME OF PI	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220		8/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pag	e 96	F 68	39		
	wheelchair out of roo been known to transf wheelchair by himsel Review of Resident # Report, dated 05/30/ under the section, titl	f/herself. #19's RMS Event Summary 2021, and signed by LPN #1, ed, "Describe the				
	circumstances of the event and immediate actions taken", revealed the resident was sitting in his/her wheelchair during activities. Continued review revealed the resident stood and fell.  According to the report, the Activities staff					
	and Range of Motion the upper and lower review revealed a sk	he resident was assessed (ROM) was performed to extremities. Continued in assessment was njuries noted. The resident				
	did not hit his/her hea witness was the Activincluded preventative place prior to the fall	ad. Per the report, the vity Assistant. The report e measures that were in were the fall mat to the right				
	head, when restless, propel, redirect resid	r, non-skid socks, helmet on get up and allow to self ent when attempting to get				
	resident when he/she self propel or lay dow	fall included redirecting the e was restless and allow to on when restless if resident				
	root cause was that t related to cognition.	ntinued review revealed the he resident had poor safety Further review revealed the to lay the resident down rest periods.				
	08/14/2021 at 6:01 P	#19's Progress Note, dated 'M, signed by LPN #7, t was trying to stand and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			C <b>08/24/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 97	F 6	89			
	resident with a pho	f/herself. Staff redirected the ne and magazines. Continued further behaviors were noted as in reach.					
	Unit, on 08/14/2021 resident was up and Continued observat moved forward and	ident #19 on the Homestead at 10:30 AM, revealed the d seated in his/her wheelchair. ion revealed the resident attempted to stand. The cy (SSA) Surveyor called for					
	staff to come to ass	ist the resident.					
	recall seeing the re	ctivity Assistant, on PM, revealed he could not sident standing and falling to the resident's fall on					
	revealed she could of Resident #19's so recalled the resident area with the Activit Activity Assistant woother residents and interview, she state stand up out of his/few steps, and then stated she was not saw the fall, but it h room. She stated sand the resident fel stated the resident	#1, on 08/20/2021 at 7:55 AM, not recall the complete details econd fall, on 05/30/2021, but it was seated in the common y Assistant. She stated the as doing activities with the she was on the cart. Per d she observed the resident her wheelchair, he/she took a landed on the floor. She certain if the Activity Assistant appened while he was in the he called out for the resident, I on his/her bottom. She did not injure his/her head.					
	AM, revealed she h facility for over two	#7, on 08/14/2021 at 10:56 ad been employed by the (2) months. Per interview, ie had worked with Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>08/24/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b>_</b>	00/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	his/her wheelchair, you saw earlier." S get up and walk. C #7 revealed she wo the resident; howev "quick" the resident #7 revealed this wo the resident's falls.  Interview with the A (ADON), on 08/19/2 staff should not hav his/her wheelchair v further stated the releft alone in the hall known risk of falls. have brought the restation, to provide the Phone interview wit (CNE), on 08/23/20 was not aware Resimattress and stated of the Risk Manage investigation. The Continued interview have been removed bed. Further, the C say for certain that had the SSA made it would be her experound at least every	e resident would get up out of unassisted, adding, "which he stated the resident liked to ontinued interview with LPN uld try to keep a closer eye on er, because the resident was needed 1:1 supervision. LPN uld be beneficial because of ssistant Director of Nursing 2021 at 3:16 PM, revealed e left Resident #19 up and in without staff supervision. She sident should not have been way due to the resident's She revealed the staff should sident closer to the nurses he supervision.  The Center Nurse Executive 21 at 12:49 PM, revealed she dent #19 tripped over his/her I that information was not part ment System (RMS)  CNE stated it was important to tion related to the residents' are planning for interventions. It revealed the mattress should the when the resident was out of NE revealed she could not staff would have intervened them aware. She stated that ectation that staff would make it two (2) hours.	F6	889		
	revealed the reside	ent #21's Medical Record nt was admitted on gnoses that included Vascular				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED		
		185301	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	ı	08/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Depressive Disorde without current Path Weakness.  Review of Resident Data Set (MDS), da resident was assess for Mental Status (Bindicating the reside impaired. Review of Status, revealed the an extensive assist transfers. Additional assessed to have limperson for ambulation Review of Resident Plan, reviewed by the revealed the resident extensive assist of the rolling walker. He the resident to be an persons assist with Review of Resident Progress Report, da 05/21/2021 to 05/27 goal was to complet with verbal cues in a functional performance resident was assess Continued review refrom transfer ability Assistance (having resident's body, but to perform the funct steadying the resident	wivior Disturbance, Major r, Age-Related Osteoporosis cological Fracture, and Muscle  #21's Quarterly Minimum ted 06/03/2021, revealed the sed to have a Brief Interview sIMS) score of three (3), ent was severely cognitively of Section G, Functional resident was assessed to be with two (2) persons, with silly, the resident was mited assistance with one (1) on.  #21's Comprehensive Care the facility on 06/11/2021, that was care planned for one (1) staff for transfers with owever, the MDS assessed the extensive assist with two (2) transfers.  #21's Physical Therapy (PT) tates of service from of 1/2021, revealed the resident's te transfers with contact guard order to facilitate improved the contact guard order to facilitate improved	F 68			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			, ,	OMPLETED		
		185301	B. WING _			C 08/24/2021
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	<b> </b>	00/2-4/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	to moderate assist (two (2) staff). Further resident exhibited poincreased retropulsion Review of Resident 07/29/2021, signed revealed a follow-up complaints of pain to Further review reveas showed no fracture. revealed the Venous extremity was negat Thrombosis (DVT), a was ordered Tylenol lower extremity.  Review of Resident Report, dated 08/05, revealed under the "of the event and immore ported the resident increased edema to complaints of increare vealed the resident calf area on palpation noted on exam. Per Physician sent the rexamination.  Review of Resident 08/05/2021, revealed by EMS for painful less wollen. Per review trauma but were unstrauma. Further reviagnosed with close	teps away to prevent a fall), the assistance of one (1) to be review revealed the por motor planning and had on when attempting to stand.  #21's Progress Note, dated by the Attending Physician, note related to the resident's phis/her lower extremity. The file of the note of the note of the note of the left lower in the left lower extremity and in the left lower in the lower in the lower in the lower in the left lower the Attending	F 6	89		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C <b>08/24/202</b>	,
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES 4604 LOWE ROA LOUISVILLE, I		00/24/202	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D 43	ETION
F 689	Orthopedic Surgeon, would be from a fall.  Observation of Resid 1:35 PM, revealed the table, in his/her whee immobilized. The rescould not provide any related to what happed Interview with Certifies #15, on 08/13/2021 at Resident #21 could be getting him/her out of CNA #15 stated sheed a handful of times. So a leg brace and did finand out of bed. CNA ago, when she first sisten was told by staff one (1). CNA #15 stated one (1). CNA #15 stated the resident out of bed, the weight, and was total notified her nurse, where the resident to it hurts." RN #2 state resident, but there was Continued interview rordered. RN #2 state everything came back.	ent #21, on 08/13/2021 at eresident was sitting at the elchair with knee sident stated he/she fell, but additional information en to his/her leg.  ed Nursing Assistant (CNA) at 2:43 PM, revealed ecome "tearful" when the bed. Per interview, only worked with the resident wore ne when getting him/her in #15 stated about a month earted working for the facility, the resident was an assist of ated that morning, on eattempted to get the ne resident was "dead" assist. She stated she no contacted the MD.  on 08/18/2021 at 8:18 PM, day shift and was with exercise Resident #21. She lid her, "do not touch my leg, and she assessed the as no bruising identified. Everaled an x-ray was ad that at that time, k negative. RN #2 stated to the resident fractured	F	889			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER.  A. BUILDING	(X3) DATE SURVEY COMPLETED	
185301 B. WING	C 08/24/2021	
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS  STREET ADDRESS, CITY, STATE, ZIP CODE  4604 LOWE ROAD  LOUISVILLE, KY 40220	30,24,2021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Interview with Certified Nursing Assistant (CNA) #18, on 08/13/2021 at 3:34 PM, revealed she had worked for the facility a couple for months and was employed through an agency. Per interview, CNA #18 revealed she did not work the Homestead Unit all of the time. However, she was familiar with Resident #21. Per interview, CNA #18 revealed that when she had gotten to work, the day of 08/05/2021, she reached to get the resident up and noticed a bruise on his/her leg. Continued interview revealed the resident's leg was dark, from the back of his/her legs. CNA #18 stated the resident would "scream" when she would go to touch him/her, adding the resident stated, "I don't want to fall." CNA #18 stated she went and got the nurse to assess the resident. Further, she revealed the resident was sent to the hospital. Prior to the incident, CNA #18 revealed the resident was an assist of one (1) with transfers.  Interview with Registered Nurse (RN) #4, on 08/15/2021 at 8:50 AM, revealed she had worked for the facility for three (3) months and worked part-time every other weekend. RN #4 revealed she recalled the day CNA #18 called her into Resident #21's room to assess the resident. She stated the resident had a bruise on the back of his/her leg. RN #4 stated the resident was fine when she assessed her, but would say, "don't touch me, it hurts." She stated this incident occurred on 08/05/2021. RN #4 further stated she called the MD as she was made aware by LPN #7 that the resident expressed some concerns about a week prior. RN #4 stated be called the Attending Physician and requested to have the resident sight resident did not repress any concerns or call out		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  4604 LOWE ROAD  LOUISVILLE, KY 40220			00.2 11.202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	independently. She "drag (his/her) leg" of pushed in the whee would; however, put foot rest while escor chair. She stated,"I resident would atter from being pushed. Interview with CNA AM, revealed Resid his/her walker, prior stated that when ca resident would ofter "it made it difficult domornings. Per inter doing this for the parevealed the level of transfer the resident to the resident's kneresident may become because he/she had revealed that for othe an assist of two (2), assisting the resident would "lock his/her leg. CNA #1 uncertain with the rewould ask the nurse plan. She stated the not followed or revisite resident, injury them with injuries.  Telephone Interview (DOT), on 08/23/202 Resident #21 requirestant.	ever seen the resident walk e stated the resident would on the floor when being lchair. RN #4 stated she t the resident's foot in his/her rting the resident in his/her f you did not do that, the mpt to stop the wheelchair	F	689			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
		185301	B. WING _			C 08/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  4604 LOWE ROAD  LOUISVILLE, KY 40220			0.2.1.202.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	with transfers. Conresident required suambulate two-hundh his/her discharge from She further stated the rolling walker, as we his/her ambulation is "his/her functional le resident's level of far Interview with the O 08/25/2021 at 2:00 Resident #21 once, interview, the resident way it was crack only way that could "weight" put on all a would have had to he such an injury to occinjury such as Residigust by the resident 4. Review of Resident record revealed the 06/27/2018 with dia Alzheimer's Disease Review of Resident was assess "Cognitive Skills for a three (3), indicating "cognitively" impaired Review of Section Of the resident required person assist.	and required functional assist tinued interview revealed the upervision and could only red (200) feet at the time of the om therapy, on 05/27/2021. The resident was issued a rell as, a wheelchair when became unsafe, adding evel depended upon the	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY LETED				
		185301	B. WING _				24/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 4604 LOWE ROAD LOUISVILLE, KY 40220	TE, ZIP CODE	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTION CROSS-REFERENCE CROSS-REFER	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	resident's focus was for falls related to impafety awareness, and fracture. The goal winjury. Review of the included provide verification of the included provide verification of the included provide verification. Review of Resident of 05/26/2021 at 3:23 Fronted to constantly wandered into other resident was constant to his/her room and the activities. Continued was distracted for a siduring meals and activities. Continued was distracted for a siduring meals and activities and activities. Review of Resident System (RMS) Event 05/28/2021, signed by "Describe the circum immediate actions tanoted to the resident mobility, inability to be lower extremity. The on the Homestead Uplaced to bare feet unwas sent to the Emelevaluatuation. An X-completed on 05/29/received and no fractication in the Homestead uplated on 05/29/received and no fractication.	wed 06/17/2021, revealed the that the resident was at risk paired cognition, lack of and history of falls with as to have no falls with resident's interventions bal cues for safety and eded and for non skid socks.  #22's Progress Notes, dated M, revealed the resident was vander the halls and resident's rooms. The antly redirected and reoriented to the dinning room area for review revealed the resident short time from wandering tivities, but would begin to	F	689			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		COMPLETED	
		185301	B. WING _			C 08/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	I	08/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	the Emergency Dep of possible right hip the nursing home refurther review reverse were negative for according to the nursing home refurther review reverse negative for according to the province of the nursing and the other sock of the number of the number of the number of the number of the nursing the nursing the nursing was important to have of the nursing was off of the reside locked unit. These	d the resident presented to partment (ED) with complaints fracture. The resident from exported the resident fell. alled the x-rays of the right hip cute fracture.  dent #22, on 08/12/2021 at the resident was wandering assisted, with one (1) sock on off.  #1, on 08/18/2021 at 7:48 AM, for Resident #22. Per tated she thought the resident he resident was observed to the stated the resident would would touch his/her side as if the ted the resident was sent to the en the x-rays came back, they fracture. LPN #1 revealed termined how the resident	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C <b>8/24/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4604 LOWE ROAD LOUISVILLE, KY 40220	•	0/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 689	ambulating on and/orisk to the residents  5. Record review retesident #23 on 09, included Alzheimer's Impulsiveness, Musimental Straus.  Review of Resident Data Set (MDS), daresident was assess for Mental Status (Bwas indicative of set Review of Section Of the resident was assperson assist with long Review of Resident Plan, last reviewed Activities of Daily Lindocumented eviden planned for Locomounit.  6. Review of Resident Plan, last reviewed Planned for Locomounit.  6. Review of Resident Plan Plan Plan Plan Plan Plan Plan Plan	el of assistance when or off the unit, creating a falls wealed the facility admitted (08/2016, with diagnoses that is Disease, Dementia, cle Weakness, and Altered (18/23's Quarterly Minimum ted 05/25/2021, revealed the sed to have a Brief Interview (18/18) score of five (5), which were cognitive impairment. Gr., Functional Status, revealed sessed to have one (1) comotion off the unit. (19/23's Comprehensive Care (19/2021, related to 19/2021, revealed no ce the resident was care tion/Ambulation when off the unit (19/24's medical record at was admitted on gnoses that included (19/2021), unspecified Dementia with noce, Psychotic Disorder with now Physiological (19/24's Quarterly MDS, dated d the facility assessed the IMS score of two (2), which	F 68	39		
	Condition, Muscle W Disorder. Review of Resident 06/24/2021, reveale resident to have a B indicated the residen	#24's Quarterly MDS, dated d the facility assessed the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		185301	B. WING _			C 08/24/2021
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS				STREET ADDRESS, CITY, STATE, ZIP COD 4604 LOWE ROAD LOUISVILLE, KY 40220	•	00/2-4/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		(X5) COMPLETION DATE
F 689	need extensive assis locomotion/ambulation review of Resident # Plan, last reviewed of documented evidence planned for Locomotiunit  7. Review of Resident revealed the facility a 03/18/2021 with diagounspecified Demention Disturbance, and Estable Review of Resident 06/24/2021, revealed to have a BIMS scorresident was severel Review of Section Gother resident was asson physical help from locomotion/ambulation review of Resident # Plan, last reviewed of the re	resident was assessed to stance of one (1) person for on off the unit. However; 24's Comprehensive Care on 06/29/2021, revealed no see the resident was care ion/Ambulation when off the ont #26's medical record admitted the resident on inoses that included it with Behavioral sential Hypertension.  #26's Quarterly MDS, dated the resident was assessed to of five (5), indicating the y cognitively impaired.  Functional Status, revealed essed for Supervision with	F 6	89		
	unit.  8. Review of Resider revealed the residen 08/28/2018 with diag Alzheimer's Disease Muscle Weakness, a without Behavioral D  Review of Resident assessment, dated 0	noses that included , Unspecified Psychosis, and Unspecified Dementia isturbance.				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS				STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220		00/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	cognitively intact. R Functional Status, re assessed to have su physical assist with I unit. Review of Res Care Plan, last revier revealed the resider standard cushion, dy leg rest for locomotic documented evidence planned for the level locomotion/ambulati  Interview with the Ac 08/12/2021 at 12:08 escorting the resider 08/11/2021, he obse "wobble" on the way the resident did not revealed the resident independently, but F walker. Further, he the residents level or ambulating, but it sh provide the resident assistance required.  Interview with Regis 08/17/2021 at 3:01 F residents' were asse (1) staff, that meant assist the resident we interview revealed or not escort five (5) re assessed to be an a #3 revealed she wor the day of 08/11/202	A), indicating the resident was eview of Section G, evealed the resident was apervision with one (1) person locomotion/ambulation off the sident #27's Comprehensive ewed on 05/05/2021, at required a wheelchair with every under cushion and left for; however, there was no be the resident was care to fassistance needed for on when off the unit.  Activity Assistant, on PM, revealed that while extend from the beauty shop, on every Resident #23 to a back to the unit. He stated fall. Continued interview that were capable of walking Resident #23 required a stated he was not aware of a fassistance required when ould be care planned to so with the needed of	F 6	39			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS				STREET ADDRESS, CITY, STATE, ZIP CODI 4604 LOWE ROAD LOUISVILLE, KY 40220	•	00/24/2021	
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F 689	escorted the reside notified her so that guidance on the rewhen ambulating. A residents' level of a planned.  9. On 08/13/2021, residents sitting in supervision/oversigobserved, Resident among the resident care plans revealed supervision.  Observation of the 08/13/2021 at 1:32 (10) residents seat listening to music. (3) of which include and Resident #22.  Observation of Res PM, revealed the rewith his/her walker Resident #19 state his/her head.  Observation of Res PM, revealed the recommon area, in he/she was wearing Observation of Res PM, revealed the recommon area, in he/she was wearing Observation of Res PM, revealed the recommon area, in he/she was wearing on non skid sock of the recommon skid sock of the r	der, she stated the staff who ents off the unit should have she could have provided sidents' level of assistance Additionally, she stated the assistance should be care  observation revealed ten (10) the common area without staff that. Of the ten (10) residents ts #19, #21, and #22 were ts. Review of the residents' did the residents required  facility's common area on PM to 1:48 PM, revealed ten the common area. The ten (10) residents, three and Resident #19, Resident #21, sident #19, 08/13/2021 at 1:45 tesident was seated in a chair, close by with a straw hat on. did the helmet was "squishing"  sident #21, 08/13/2021 at 1:33 tesident was seated in the is/her wheelchair at a table. It is the wheelchair at a table of the sident #22, 08/13/2021 at 1:35 tesident wandering the unit with	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED C	
		185301	B. WING			/24/2021	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689	at 1:30 PM and staff the residents while he revealed the resident linterview with RN #2 revealed staff were at floor/common area was Activity Assistant did that he was leaving added the residents there safety.  Telephone interview (MDS) Coordinator, revealed that though working as MDS Coordinator, revealed to a seistance of one (1 Additionally, she star assess for two (2) statements of the MDS Coordinator, when care planned to assi Lastly, the MDS Coordinator, when care should have supervisionally in the Assi (ADON) on 08/19/20 residents should be common area, to enteresidents. Additional	PM, revealed he left the unit were to provide ADL care to be was gone. He further its should be supervised.  P., on 08/19/2021 at 5:42 PM, available to watch the within the unit; however, the not communicate with staff the unit. Additionally, she should be supervised for  with the Minimum Data Set on 08/232021 at 10:40 AM, or today was her first day ordinator at the facility, she S for over four (4) years. For revealed the MDS the Care Plans for the view, the residents who were assist of one (1) required the control of the staff to assist with care. The today is the care of the view of the control of the staff to assist a resident was aff to assist a resident with the staff that the explanned for supervision,	F 68	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP C 4604 LOWE ROAD LOUISVILLE, KY 40220	ODE	00/24/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Phone interview with (CNE), on 08/23/202 nursing staff had not RMS. She stated sh the RMS to gain add and the incident. Pe was just an informati assess the residents appropriate intervent.  Continued interview at 12:49 PM, revealed the Minimum Data S believed the care pla MDS. The CNE revishould be reflectived would not be her expsupervise the resider adding it would be 1: the CNE revealed it staffing would compl. She stated the stand hours, though it was supervised more often Phone interview with 08/23/2021 at 5:18 Feen his expectation situation differently, Interview with the Vicion Operations (VPRO), revealed it would haven the nursing star would supervise the	the Center Nurse Executive 21 at 12:49 PM, revealed the been trained to complete the e or the ADON would review itional information from staff r interview, the CNE stated it onal tool for the facility to 'falls and to have tions in place.  with the CNE, on 08/23/2021 at she was not aware of how et (MDS) worked, but ans were generated from the ewed the resident's care plan of the resident's care that it bectation that the staff would ents in the common area, if if she had. Additionally, would be her expectation that ete rounding of the residents. Itard would be every two (2) her belief the staff en.  If the Administrator, on PM, revealed it would have a that staff would look at each related to supervision.  The President of Regional on 08/24/2021 at 2:20 PM, we been his expectation that eff were on the unit, they residents. Additionally, he ents' care plans should be	F	389			