STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	C 07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CENTER	1550 RAYDALE DRIVE LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY #31906 and a COVID-19 Focused Infection Control Survey were initiated on 06/29/2020 and concluded on 07/10/2020. Complaint KY#00031906 was substantiated with deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 79.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

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

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

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement a comprehensive person- centered care plan for one (1) of three (3) sampled residents. Resident #1's care plan was not followed in regards to 1. Wound Interventions, and 2. Nutritional Risk/Weights. The findings include: 1. The facility admitted Resident #1 on 05/07/2020 with the following diagnoses: Hypertension, Insomnia, Nausea, Tracheotomy Status, Other Non-Traumatic Intracerebral Hemorrhage, and Presence of Neuro-Stimulator. The resident was transferred to the hospital on	F 656		

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F 656	Continued From page 2 05/18/2020, and did not return to the facility. Review of the policy titled, "OPS416 Person Centered Care Plan," revised on 07/01/19, stated the purpose of a Person Centered Care Plan was to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. Closed record review of the Comprehensive Minimum Data Set (MDS), signed and dated on 05/20/2020, revealed a Brief Interview for Mental Status Score of four (4). The MDS revealed Resident #1 had one (1) Stage II pressure ulcer, and two (2) unstagable pressure ulcers that were present upon admission. Review of the Person Centered Care Plan revealed Focus- Resident #1 was admitted with suspected deep tissue injury to right medial foot, left lateral foot, and a Stage II pressure ulcer to the right lateral foot (05/09/2020). Interventions- Treatment to wounds per order (05/19/2020), observe skin for signs and symptoms of skin breakdown, for example- redness, cracking, blistering, decrease in sensation, and skin that does not blanche easily (05/09/2020), and observe skin daily with activity of living care and report abnormalities (05/09/2020). Review of the acute care facility "Transfer Report," dated 05/06/2020, revealed Resident #1 had pressure wounds on bilateral heels, left foot first metatarsal head 0.4 centimeters (CM) by 0.4 CM by 0.1 CM, left foot fifth metatarsal head healed, right foot fifth metatarsal head 0.7 CM by 0.5 CM, and right foot first metatarsal head	F 656		

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F 656	Continued From page 3 healed. Review of the closed record revealed a "Skin Check" assessment was not documented upon admission to the facility. Closed record review revealed no documentation of staff observations/assessments of Resident #1's pre-existing pressure ulcers from the resident's admission on 05/07/2020 through 05/11/2020. 2. Review of the Person Centered Care Plan revealed- Focus Resident #1 is at nutritional risk (05/13/2020). Interventions- Weigh and alert dietitian and physician dietician and physician to any significant loss or gain (05/13/2020). Closed record review of Resident #1's care plan, dated 05/13/2020, revealed, Focus- Resident is at nutritional risk: Altered chewing/swallowing related to Subarachnoid Hemorrhage (SAH), and Interventions- Weigh and alert dietician and physician to any significant loss or gain, and monitor for changes in nutritional status ...unplanned weight loss/gain. Closed record review of the May 2020 "Medication Administration Record" (MAR), dated 05/11/2020, revealed an order to weigh Resident #1 every dayshift on every Monday for four (4) weeks. Closed record review of the "Weights and Vitals Summary Log" revealed Resident #1 weighed one-hundred and sixty seven point six (167.6) pounds on 05/07/2020, and one-hundred and seventy point eight (170.8) pounds on 06/03/2020. Continued review revealed the	F 656		

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F 656	Continued From page 4 resident did not have a documented weight for 05/11/2020, 05/18/2020, 05/25/2020, or 06/01/2020. Telephonic interview with Licensed Practical Nurse #3 on 07/08/2020 revealed each resident's care plan was resident-centered and specific to the resident's needs. She stated the care plan should be followed by the staff. Telephonic interview with the Director of Nursing, on 07/08/2020 at 2:27 PM, revealed the care plan was very specific to each resident's needs, and used as a tool to guide staff in resident care, and should be followed. Telephonic interview with the Administrator, on 07/10/2020 at 1:00 PM, revealed the purpose of the individualized care plan was to provide the best possible care to each resident in accordance with their needs. She revealed the care plan should be followed, and also should be revised with any new resident information.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		

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F 686	Continued From page 5 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to provide necessary treatment and services to promote healing of existing pressure ulcers for one (1) out of three (3) sampled residents. Resident #1 was admitted to the facility on 05/07/2020 with pre-existing pressure ulcers, however, the facility was unable to provide documentation the pressure ulcers were assessed or documented by staff from 05/07/2020 through 05/11/2020. The finding include: Review of the policy titled, "Skin Integrity Management," revised on 01/31/2020, stated the implementation of an individual patient's skin integrity management occurs within the care delivery process. The purpose of the policy is to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Staff were to perform daily monitoring of wounds or dressings for presence of complications, or declines, and document. The facility admitted Resident #1 on 05/07/2020 with the following diagnoses: Hypertension, Insomnia, Nausea, Tracheotomy Status, Other Non-Traumatic Intracerebral Hemorrhage, and Presence of Neuro-Stimulator. The resident was transferred to the hospital on 05/18/2020, and did	F 686		

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F 686	Continued From page 6 not return to the facility. Record review of the residents Discharge Summary from the transferring facility, dated 05/06/2020, revealed skin status on discharge left first metatarsal head 0.4 centimeters (CM) by 0.4 CM by 0.1 CM, left fifth metatarsal head healed, right fifth metatarsal head 0.7 CM by 0.5 CM, and right first metatarsal head healed, and pressure ulcers bilateral heels. Review of the Individualized Plan of Care for Resident #1 created on 05/09/2020 revealed, Focus- Resident #1 was admitted with suspected deep tissue injury to right medial foot and left lateral foot, and a stage II ulcer to the right lateral foot. Goal, created on 05/19/2020 - Wounds will show signs of improvement without signs and symptoms of infection through next review, and Interventions- apply barrier cream with each cleansing, dated 05/09/2020, observe skin for signs and symptoms of skin breakdown such as redness, cracking, blistering, decreased sensation, and skin that does not blanche easily, dated 05/09/2020. Closed record review of the Comprehensive Minimum Data Set (MDS), signed and dated on 05/20/20, revealed a Brief Interview for Mental Status Score of four (4) and the resident was not interviewable. Continued review of the MDS revealed Resident #1 was at risk to develop pressure ulcers/injuries. The MDS stated the resident had one (1) Stage II pressure ulcer, and two (2) unstagable pressure ulcers that were present upon admission. Review of the Braden Scale for Predicting Pressure Sore Risk, and signed by Licensed	F 686		

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Practical Nurse #1 on 05/08/2020, revealed the resident scored ten (10) and indicated Resident #1 was at high risk for developing pressure ulcers.

Review of the closed record revealed a "Skin Check" was not documented upon admission to the facility.

Review of the progress notes, dated 05/07/2020 at 6:00 PM, and signed by LPN #1 stated- Integumentary System reviewed, resident is not experiencing foot pain. Heels appear free from redness, maceration, or breakdown. Bony prominences appear free from redness, maceration or breakdown.

Telephonic interview with Licensed Practical Nurse #1 on 07/06/2020 at 2:05 PM stated she had been Resident #1's admitting nurse. She stated she had not had a chance to complete the resident's "Skin Check," and must have documented the resident did not have skin breakdown in error, possibly on the wrong resident's chart. She stated she had reported to the oncoming nurse LPN #2 that the "Skin Check" had not been completed on Resident #1. She stated she had received report from the transferring facility, however, could not recall if the facility had informed her of the existing pressure ulcers, or not.

Telephonic interview with LPN #2 on 07/10/2020 at 8:00 AM revealed she did not recall LPN #1 reporting to her that Resident #1's "Skin Check" had not been completed. She revealed most nurses tend to stay over their shift if they have too in order to complete the "Skin Check." She stated the provider should have been notified for

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treatment orders anytime pressure ulcers are present so the ulcers do not get worse and can heal.

Review of the History and Physical, dated 05/08/2020, and signed by the Physician, stated, "Physical examination conducted by nurse at bedside and guided by me with Telemedicine." Continued review of the Exam revealed; Skin- no rashes or ulcers, warm and dry.

Telephonic interview with the physician on 07/09/2020 at 12:00 PM revealed Resident #1 had been assessed by her, and a nurse through a telemedicine call on 05/08/2020. She stated the nurse did not inform her of any skin breakdown. She stated if Resident #1 presented upon admission with existing pressure ulcers, the physician, or the Advanced Nurse Practitioner should have been notified at the time of admission so treatment orders could have been started. She revealed she had not been notified upon admission that Resident #1 had pre-existing pressure ulcers.

Review of the Progress Note, signed and dated on 05/12/2020 at 12:41 PM by the Advanced Registered Nurse Practitioner (ARNP) with date of service (DOS) on 05/11/2020 revealed- Skin: Horseshoe incision to left scalp, pink, healing. Plan- float heels while in bed.

Continued review of the Progress Note, signed and dated by the ARNP on 05/12/2020 at 2:02 PM revealed Resident #1 had scabbing to the left lateral foot- suspected Deep Tissue Injury (DTI), red, dry, scaly and approximately 2.6 centimeters (CM) length by 1.9 CM width. Right lateral foot Stage II pressure sore with wound bed dry, skin

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surrounding dry and scaly. Wound measured approximately 1.4 CM length by 1 CM width, and medial right foot, suspected deep tissue injury, red, and approximately 3 CM length by 1.8 CM width. Order- Apply Optifoam to bilateral medial and lateral feet daily and as needed (PRN). Float heels while in bed, "I communicated plan and orders with the nurse."

Telephonic interview with the ARNP on 07/09/2020 at 10:41 AM revealed she had not received notification from the nursing staff regarding the presence of pre-existing pressure ulcers on Resident #1 upon the resident's admission. She stated it was her expectation staff notify the Provider for treatment orders when pressure ulcers are present. She revealed the admitting nurse should have completed a Skin Check upon admission, as well as taken photos of any existing wounds. She stated she did not find out about the existing pressure ulcerations until 05/12/2020 during skin care rounds.

Telephonic interview with the Director of Nursing (DON) on 07/08/2020 at 2:27 PM revealed it was the responsibility of the admitting nurse to complete a "Skin Check" on all newly admitted residents. She stated Resident #1 was a later admission therefore the oncoming nurse should have completed the assessment if the off going nurse did not have time to complete it prior to her shift ending. She stated it was an expectation of the facility all newly admitted residents have a "Skin Check" assessment completed upon admission. She revealed all pre-existing wounds present upon transfer from another facility should be assessed and documented in the clinical record, and the provider should have been notified by the nurse in regards to pre-existing

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F 686	Continued From page 10 wounds so that treatment orders could be obtained to promote healing. Telephonic interview with the Administrator on 07/10/2020 at 1:00 PM revealed Resident #1's skin assessment should have been completed by a nurse within twenty-four hours of admission, and documented in the clinical record. She revealed the nurse should have taken a photograph and made a progress note to indicate the resident had the wounds upon admission. She stated the practitioner should have been made aware of pre-existing ulcers so treatment can be started. She revealed the Quality Assurance Performance Improvement (QAPI) met monthly and as needed and included all Department Heads, as well as the physician. She stated the facility currently was in the auditing process for pressure ulcer prevention,	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		

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F 692	Continued From page 11 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, and policy review, it was determined the facility failed to monitor one (1) of three (3) sampled residents body weight. Resident #1 weekly weights were not documented, as ordered. The findings include: Review of the policy and procedure titled, "Nutrition/Hydration Management", and revised on 01/31/2020, revealed the implementation of an individual resident's nutrition/hydration management occurred within the care delivery process, and staff should consistently observe and monitor residents for changes ...Practice Standards- 8. Monitor resident's weight as ordered. The facility admitted Resident #1 on 05/07/2020 with the following diagnoses: Hypertension, Insomnia, Nausea, Tracheotomy Status, Other Non-Traumatic Intracerebral Hemorrhage, and Presence of Neuro-Stimulator. The resident was transferred to the hospital on 05/18/2020, and did not return to the facility. Closed record review of the "Comprehensive Minimum Data Set" (MDS) signed and dated on 05/20/20, revealed a Brief Interview for Mental	F 692		

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F 692	Continued From page 12 Status Score of four (4) and the resident was not interviewable. Continued review of the "Care Area Assessment," (CAA) summary revealed Resident #1 triggered for nutritional status. Closed record review of Resident #1's care plan, dated 05/13/2020, revealed, Focus- Resident is at nutritional risk: Altered chewing/swallowing related to Subarachnoid Hemorrhage (SAH), and Interventions- Weigh and alert dietician and physician to any significant loss or gain, and monitor for changes in nutritional status ...unplanned weight loss/gain. Closed record review of the May 2020 "Medication Administration Record" (MAR), dated 05/11/2020, revealed an order to weigh Resident #1 every dayshift on every Monday for four (4) weeks. Closed record review of the "Weights and Vitals Summary Log" revealed Resident #1 weighed one-hundred and sixty seven point six (167.6) pounds on 05/07/2020, and one-hundred and seventy point eight (170.8) pounds on 06/03/2020. Continued review revealed the resident did not have a documented weight for 05/11/2020, 05/18/2020, 05/25/2020, or 06/01/2020. Telephonic interview with the Dietician on 07/06/2020 at 1:50 PM revealed residents who are nutritionally at risk (NAR) are discussed every morning in the facility's daily clinical meeting. She stated she was unaware Resident #1 had not been weighed as ordered, and the resident's weight should have been documented as ordered so any weight changes could be assessed.	F 692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 13 Telephonic interview with the Minimum Data Set (MDS) Nurse on 07/07/2020 at 10:02 AM revealed residents should be weighed upon admission, and then most residents are then weighed weekly for four weeks, unless the resident was on comfort care. She stated staff should monitor and complete weights as ordered to ensure a resident was not losing weight, or gaining weight, and significant weight changes should be reported to the physician. She revealed the dietician should also review the weights as well for any changes. Telephonic interview with the Assistant Director of Nursing on 07/07/2020 11:00 AM revealed per facility nursing standards, residents should be weighed upon admission, and then weekly for four (4) weeks. She revealed weekly weight orders were placed on the resident's Medication Administration Record (MAR), and it was the ultimate responsibility of the nurse to ensure each resident was weighed as ordered, and that the weight was documented on the MAR. She revealed any significant weight changes should be immediately reported to the physician. Telephonic interview with Certified Nursing Assistant #1 on 07/08/2020 at 9:50 AM revealed the nurse would inform her if any resident weights should be obtained. She stated the weights were directly reported to the nurse as completed. Telephonic interview with the Director of Nursing on 07/08/2020 at 2:27 PM revealed that with this "covid thing," and strict lockdown, a lot of our weights were hampered. She stated on 05/22/2020, the facility was directed not to use the same equipment on the Quarantine Unit and the non-quarantine units, therefore there were no	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. BUILDING _____ B. WING _____	C 07/10/2020

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F 692	Continued From page 14 scales available that could be used on the Quarantine Unit. The DON continued to state she was not completely sure why Resident #1 had not been weighed. Telephonic interview on 07/10/2020 at 10:37 AM with Licensed Practical Nurse # 4 (LPN) revealed she had cared for Resident #1 on 05/11/2020, 05/18/2020, 05/25/2020. The LPN revealed Resident #1's weights on 05/11/2020, 05/18/2020, and 05/25/2020 had been performed. The LPN stated she could not honestly say why the weights were not documented in the Medication Administration Record (MAR). She continued to state Resident #1 was on the Quarantine Unit, and staff had access to lifts and scales in order to weigh the resident's on the Quarantine Unit, as ordered. She stated the lift pads were sent to laundry every day, and the machine was sanitized after each resident use. Telephonic interview with the Administrator on 07/10/2020 at 1:00 PM revealed the Dietician was pretty good about communicating when resident weights had not been completed as ordered. She revealed she had not been made aware Resident #1 had not been weighed per orders, and her expectation was that weights be completed as ordered, and any weight changes be immediately reported to the physician. She continued to state the Quality Assurance Performance Improvement (QAPI) was comprised of all the Department Heads, and the Physician and met on a monthly basis and as needed. She stated the goal of QAPI, was to identify any quality assurance concerns, and to develop quality plans as identified. She stated the facility had recently discussed resident weights and resident nutrition, especially during COVID19.	F 692		

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	185290	A. BUILDING _____ B. WING _____	C 07/10/2020

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	185290	A. BUILDING _____ B. WING _____	C 07/10/2020

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/29/2020 and concluded on 07/10/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6). Total census 79.	E 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100559	A. BUILDING: _____ B. WING _____	07/10/2020

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N 000	Initial Comments A Complaint Survey was initiated on 06/29/2020 and concluded on 07/10/2020 to investigate Complaint #KY00031906. The Division of Health Care substantiated the allegations with deficiencies cited pursuant to 42 CFR 483.10 - 483.95. In addition, a Focused Infection Control Survey was conducted and found the facility to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 79.	N 000		

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