PRINTED: 06/25/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		DENTI TOATION NOWINGER.	A. BUILDING		COMP				
100503		100503	B. WING		06/2	06/24/2020			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE					
REGIS W	REGIS WOODS 4604 LOWE ROAD								
	P		LE, KY 402	20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
N 000	N 000 Initial Comments		N 000						
	and a COVID-19 Fo Survey was initiated concluded on 06/24 KY#00031870 was deficiencies cited. compliance with 42 regulations and has Medicare & Medical Centers for Disease	substantiated with no The facility was found to be in CFR 483.80 infection control implemented the Centers for d Services (CMS) and c Control and Prevention ed practices to prepare for							

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

TITLE

(X6) DATE

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

PRINTED: 06/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185301	B. WING			C	
NAME OF PROVIDER OR SUPPLIER REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Infection Control Su 06/22/2020 and con Complaint KY#0003 no deficiencies cited in compliance with a control regulations a Centers for Medicar and Centers for Dis (CDC) recommenda COVID-19. Total ce	rvey investigating a COVID-19 Focused brown was initiated on cluded on 06/24/2020. B1870 was substantiated with be facility was found to be accepted to the real many services (CMS) bease Control and Prevention and practices to prepare for		TITLE			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.

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

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185301		185301	B. WING		C		
NAME OF PROVIDER OR SUPPLIER REGIS WOODS				4604 1	ET ADDRESS, CITY, STATE, ZIP CODE LOWE ROAD SVILLE, KY 40220	1 00	5/24/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO		LD BF	(X5) COMPLETION DATE
E 000	Survey was initiated concluded on 06/24	ed Emergency Preparedness d on 06/22/2020 and /2020. The facility was found with 42 CFR 483.73 related	Ε¢	000			
1				0			
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE		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.