

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

PRINTED: 07/21/2020
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/21/2020 |
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| NAME OF PROVIDER OR SUPPLIER REGIS WOODS | STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220 |
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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 |
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey investigating Complaint KY#00032017 and a COVID-19 Focused Infection Control Survey was initiated on 07/08/2020 and concluded on 07/21/2020. Complaint KY#00032017 was unsubstantiated. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Census 135.

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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| NAME OF PROVIDER OR SUPPLIER REGIS WOODS | STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220 |
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| E 000 | Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 07/08/2020 and concluded on 07/21/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6). | E 000 | | |
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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.

Office of Inspector General

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100503 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/21/2020 |
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| NAME OF PROVIDER OR SUPPLIER REGIS WOODS | STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE ROAD LOUISVILLE, KY 40220 |
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| N 000 | Initial Comments A Complaint Survey investigating Complaint KY#00032017 and a COVID-19 Focused Infection Control Survey was initiated on 07/08/2020 and concluded on 07/21/2020. Complaint KY#00032017 was unsubstantiated. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Census 135. | N 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE