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

PRINTED: 07/16/2020 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	B. WING		06/15/2020	
NAME OF PROVIDER OR SUPPLIER REGIS WOODS				STREET ADDRESS, CITY, STATE, ZIP 4604 LOWE ROAD LOUISVILLE, KY 40220	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	and a COVID-19 Foc Survey was initiated of concluded on 06/15/2 was substantiated with facility was found to be CFR 483.80 infection implemented the Cen Medicaid Services (C Disease Control and recommended practic COVID-19. Total cens	ey investigating KY#31787 used Infection Control on 06/09/2020 and 2020. Complaint KY#31787 th deficiencies cited. The oe in compliance with 42 control regulations and has sters for Medicare & eMS) and Centers for Prevention (CDC) the second control of the cont		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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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
E 000	Initial Comments		E	000	20.			
	Survey was initiated concluded on 06/15	sed Emergency Preparedness d on 06/09/2020 and 5/2020. The facility was found with 42 CFR 483.73 related					,	
		Δ.						
10 to								
:								
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE	

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
100503			B. WING		06/	06/15/2020	
NAME OF PROVIDER OR SUPPL	IER		DRESS, CITY, STA	TE, ZIP CODE			
REGIS WOODS			E ROAD .E, KY 40220				
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
A COVID-19 F was initiated 0 06/15/2020. E Focused Infect Survey was continuous of the Division of the pursuits of the Division of the Divisio	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments A COVID-19 Focused Infection Control Survey was initiated 06/05/2020 and concluded on 06/15/2020. During the course of the COVID-19 Focused Infection Control Survey a Complaint Survey was conducted to investigate KY 31787. The Division of Health Care identified deficient practice pursuant to 42 CFR 483.10 - 483.95 and substantiated the allegation with deficiencies		N 000				

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

TITLE (X6) DATE