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

PRINTED: 07/21/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
185301			B. WING		C 07/24/2020		
NAME OF PROVIDER OR SUPPLIER REGIS WOODS			:	STREET ADDRESS, CITY, STATE, ZIP 4604 LOWE ROAD LOUISVILLE, KY 40220	CODE	07/21/2020	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 000	KY#00032017 and a Infection Control Su 07/08/2020 and cor Complaint KY#0003 was determined the CMS and Centers for Prevention (CDC) results for the control of the control	rvey investigating Complaint a COVID-19 Focused rvey was initiated on acluded on 07/21/2020. 32017 was unsubstantiated. It facility had implemented the or Disease Control and ecommended practices to 19. Total Census 135.	F O	00			
BODATON		R/SUPPLIER REPRESENTATIVE'S SIGN/		TITLE			

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185301		185301	B. WING			07/21/2020	
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 PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
E 000	Survey was initiated concluded on 07/21	ed Emergency Preparedness I on 07/08/2020 and /2020. It was determined erns with 42 CFR §483.73 e)(6).	E	000			
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURF	TITL	F		(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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(X6) DATE

If continuation sheet 1 of 1

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C 100503 B. WING 07/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4604 LOWE ROAD REGIS WOODS** LOUISVILLE, KY 40220 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 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.

TITLE

LYBV11

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

STATE FORM