Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING _____ B. WING _____	R-C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
{P 000}	Initial Comments Based on the On-Site Revisit Survey initiated on 10/28/2025 and concluded on 10/30/2025, it was determined the facility had corrected the deficiencies as of 10/30/2025.	{P 000}		

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

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	100264	A. BUILDING: _____ B. WING _____	C 05/08/2023

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P 000	Initial Comments A Complaint Survey Investigating complaint KY00039378 and KY00038922 was initiated on 05/02/2023 and concluded on 05/08/2023. KY00039378 and KY00038922 were both substantiated with deficient practice identified.	P 000		
P 005	902 KAR 20:036 2(1)(a-d) Section 2. Scope of Operations and Services (1) A resident in a PCH or SPCH shall: (a) Be admitted in accordance with KRS 216.765; (b) Be ambulatory or mobile nonambulatory; (c) Be able to manage most of the activities of daily living; and (d) Have care needs that do not exceed the capability of the PCH or SPCH. This requirement is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the facility's "Corrective Action Plan", dated 02/28/2023, it was determined the facility failed to establish a system to ensure residents' care needs were not above the level of care the facility was able to provide for six (6) of six (6) sampled residents, Resident #31, #26, #27, #25, #9, and #10. The findings include:	P 005	Until 10.31.23, the manager will ensure that the paperwork noted below is reviewed with a manager of a sister facility or upper management. Documentation needed for an admission is: pre-admission assessment, medical history, H&P and diagnosis list. If there is a discharge summary or H&P that includes the aforementioned and has been done within 14 days of admission, that will suffice. Upon completion of the admission, the manager will share the elopement risk assessment form with either a manager of a sister facility or upper management.	

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

Heather Hobbs 6-28-23

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P 005	Continued From page 1 Review of the facility's policy titled, "Admission Policy", no date, revealed fourteen (14) days prior to admission, a pre-admission assessment would be performed to assure care needs of the potential resident were understood, and the facility could provide a safe home. Continued review revealed, prior to admission, a medical exam including a medical history, History & Physical (H&P) would be obtained within fourteen (14) days of admission. Additional review revealed a copy of the resident's discharge summary and H&P from another facility, if done within fourteen (14) days of admission, would suffice for the medical exam. Further review revealed upon admission an Elopement Risk Assessment would be completed to assure the resident was not at risk for elopement due to confusion. Review of the facility's policy titled, "Elopement Risk Assessment Form Policy", revision date 01/26/2023, revealed upon admission an Elopement Risk Assessment Form would be completed. Review of the document Position Description for Facility Manager, Department of Administration revealed job functions and tasks for this position included to develop and update the resident selection plan in accordance with regulatory requirements and to ensure compliance with policies, procedures, practices, and standards. 1. Review of Resident #31's medical record revealed the facility admitted the resident on 03/20/2023, and his/her Pre-Admission Assessment was dated 03/20/2023. Further review revealed medical exams were performed per Emergency Room (ER) visits, dated	P 005		

Heather Hobbs
6-28-23

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P 005	Continued From page 2 01/28/2020, 02/06/2021, and 01/02/2023 (seventy-seven(77) days before admission). In addition, the Elopement Risk Assessment (ERA) form was dated 03/25/2023. 2. Review of Resident #26's medical record revealed the facility admitted the resident on 03/16/2023, and his/her Pre-Admission Assessment was dated 03/16/2023. Further review revealed a yearly H&P was done on 02/21/2023, twenty-three (23) days before admission. 3. Review of Resident #25's medical record revealed the facility admitted the resident on 04/11/2023, and his/her Admission Assessment was dated 04/13/2023. A Physical Examination/Assessment was performed on 03/22/2023 twenty (20) days before admission. Further review of the ERA form revealed it was dated 04/13/2023. 4. Review of Resident #9's medical record revealed the facility admitted the resident on 04/24/2023, and his/her Pre-Admission Assessment was dated 04/2412023. Further review of the ERA form revealed it was dated 04/26/2023. 5. Review of Resident #27's medical record revealed the facility admitted the resident on 02/02/2023, and his/her Pre-Admission Assessment was dated 02/02/2023. Further review of the ERA form revealed it was dated 02/03/2023. 6. Review of Resident #10's medical record revealed the facility admitted the resident on 04/27/2023, and his/her Pre-Admission Assessment was dated 04/27/2023. Further	P 005		

6-28-23
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Office of Inspector Genera

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P 005	Continued From page 3 review of the ERA form revealed it was dated 04/28/2023. In an interview with Manager #1 (in training), on 05/03/2023 at 10:10 AM, she stated she had performed the Pre-admission Assessment with resident/s prior to admission but had not taken the form with her. She stated the pre-admission process was performed verbally, and she took no paper documents with her at the time of the interview. She stated she felt the process made residents safer by performing the assessment before they entered the building to help prevent inappropriate admissions. She stated she knew the form was to be completed prior to residents entering the building to help assure their safety but thought the admission date was to be entered on the document. She stated the dates on the ERA forms were correct and should have been performed upon admission, but no concerns had been identified. She stated medical exams within fourteen (14) days of admission for Residents # 31, #25, and #26 could not be located. In an interview with Manager #2 (from sister facility), on 05/03/2023 at 11:05 AM, she stated the Pre-admission Assessment was performed on all new admissions by either herself or Manager #1 prior to admission. She stated no concerns for elopement had been identified, but she was unsure of dates for the ERAs. She stated medical exams given for new admissions were all the facility could locate. In an interview with the Chief Operating Officer (COO), on 05/04/2023 at 2:20 PM, she stated she had performed random compliance reviews of ERA forms and the admission process, with the last being about three (3) weeks ago. She stated she had found no concerns and felt the process	P 005		

Heather Hobbs
6-28-23

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P005	Continued From page 4 had increased the safety of residents.	P 005		
P 040	902 KAR 20:036 3(3)(c)Section 3. Administration and Operation (3) Admission. (c) Prior to admission, each resident shall have a complete medical examination in accordance with KRS 216.765. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, and review of "Corrective Action Plan", dated 02/28/2023 it was determined the facility failed to establish a system to ensure residents had a complete medical examination within fourteen (14) days of admission for three (3) of six (6) sampled residents, Resident #31, #26, and #25. The findings include: Review of the facility's policy titled, "Admission Policy", no date or revision date, revealed prior to admission, a medical exam including a medical history and History & Physical (H&P) would be obtained within fourteen (14) days of admission. Additional review revealed a copy of the resident's discharge summary and H&P from another facility, if done within fourteen (14) days of admission, would suffice for the medical exam. Review of the document Position Description for Facility Manager, Department of Administration, revealed job functions and tasks for this position	P 040	Until 10.31.23, the manager will ensure that the medical exam received is reviewed with the manager of a sister facility or upper management.	

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6-28-23

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F'040	Continued From page 5 included to develop and update the resident selection plan in accordance with regulatory requirements and to ensure compliance with policies, procedures, practices, and standards. 1. Review of Resident #31's medical record revealed the facility admitted the resident on 03/20/2023. Further review revealed medical exams were performed per Emergency Room (ER) visits, dated 01/28/2020, 02/06/ 2021, and 01/02/2023. Therefore, the last medical exam was done seventy-seven (77) days before admission. 2. Review of Resident #26's medical record revealed the facility admitted the resident on 03/16/2023. Further review revealed a yearly H&P was done on 02/21/2023, twenty-three (23) days before admission. 3. Review of Resident #25's medical record revealed the facility admitted the resident on 04/11/2023. Further review revealed the medical exam was performed 03/22/2023, which was twenty (20) days prior to admission. Interview with Manager #1 (in training), on 05/03/2023 at 10:10 AM, was conducted. She stated medical exams within fourteen (14) days of admission for Residents # 31, #25, and #26 could not be located. Interview with Manager #2 (from sister facility), on 05/03/2023 at 11:05 AM, was conducted. She stated medical exams given for new admissions were all the facility could locate. Interview with the Chief Operating Officer (COO), on 05/04/2023 at 2:20 PM was conducted. She stated she had performed random compliance	P 040		

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6-28-23

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P 040	Continued From page 6 reviews of the admission process, with the last being about three (3) weeks ago. She stated she had found no concerns and felt the process had increased the safety of residents.	P 040		
P 225	902 KAR 20:036 4(1)(i)1-2 Section 4. Provision of Services (1) Basic health and health related services. (i)1. All medicines kept by the PCH or SPCH shall be kept in a locked place. 2. The administrator or staff person designated by the administrator shall: a. Be responsible for administering or supervising the self-administration of medication; b. Ensure that all medications requiring refrigeration are kept in a separate locked box in the refrigerator in the medication area; and c. Ensure that drugs for external use are stored separately from those administered by mouth and injection. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have a process in place to ensure a prescription, sent with a resident from the Emergency Department (ED) for medication, was filled and the medication given for one (1) of twenty-three (23) sampled residents and failed to ensure documentation of medications being administered for one (1) of twenty-three (23) sampled residents, Resident #13.	P 225	Upon receipt of the signed medication orders from the Emergency Department, the orders will be sent to the pharmacy for processing. Upon receiving the medication from the pharmacy, the medications will be reviewed to ensure that they match the signed order. If the orders match, the order will be entered onto the MAR and the medication will be placed on the cart. If there is an issue with a medication received, it will be brought to the pharmacy's attention. The manager will conduct random audits of the med techs to ensure that medications administered are being properly documented. When needed, staff will be educated.	

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6-28-23

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P 225	Continued From page 7 Review of Resident #13's Medication Administration Record (MAR) for the month of March 2023 revealed it did not contain an order for Cortef (hydrocortisone, a steroid) twenty-five (25) milligrams (mg) every twelve (12) hours as prescribed, dated 03/13/2023. Further review of Resident #13's MAR for the month of March 2023 revealed nineteen (19) various medications that had missing documentation they had been given. The findings include: Review of the facility's policy titled, "Med Techs", no date, revealed medication administered must be signed (initialed) on the MAR out after its administration to show it was given. Review of the facility's policy titled, "Regency Manor Admission Agreement", no date, revealed medications were to be administered under the order of the resident's physician, and the facility would maintain storage and control of all medications at the nurses' station. Further, the policy stated medications could not be administered unless ordered by a physician or ordering personnel. Review of Resident #13's medical record revealed the facility admitted the resident, on 11/22/2022, with diagnoses to include Depression, Addison's Disease, Bi-Polar Disorder, and Essential Hypertension. Review of Resident #13's medical record revealed a copy of a prescription, dated 03/13/2023, from the local ED for Hydrocortisone (Cortef) ten (10) mg tablet, take 2.5 tablets by mouth every twelve (12) hours for thirty (30) days,	P 225		

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6-28-23

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P 225	Continued From page 8 one-hundred fifty (150) tablets with no refills. However, review of Resident #13's March 2023 MAR, from 05/02/2023 to 05/04/2023, revealed no entry for Cortef 10 mg tablets, 2.5 tablets by mouth every twelve (12) hours for thirty (30) days, dated 03113/2023. The resident was discharged on 04/03/2023. Therefore, Resident #13 missed forty-two (42) doses of this prescribed medication. Review of the document Med-Admin Summary for March 2023 revealed no entries for Cortef 10 milligram tablets. In addition, further review of Resident #13's March 2023 MAR, from 05/0212023 to 05/04/2023, revealed missing documentation on dates administered for other medications. These other medications were 1) Dicyclomine Capsule (an antispasmodic) 10 milligrams (mg) -give one (1) capsule by mouth four (4) times a day, ended 03/13/2023-8:00 PM- no initials for 03/01/2023 through 03/11/2023, nor 5:00 PM dose for 03/01/2023 through 03/11/2023, no initial for 12:00 PM dose or 8:00 AM dose on 03/01/2023 through 03/13/2023; 2) Triamcinolone Cream (a corticosteriod) 0.025% daily at bedtime, apply to left ear, no initials as given for 03/01/2023 through 03/29/2023, "H" for hold on 03/30/2023, and no initial for 03/31/2023; 3) Prazosin HCL Capsule (an antihypertensive) give one (1) tab by mouth once daily at bedtime, no initials 03/01 through 03/29/2023, "H" for hold on 03/30/2023, and no initial for 03/31/2023; 4) Pravastatin Tab (a statin to treat high cholesterol and triglycerides) 20 mg, give one (1) tablet by mouth at bedtime (started 03/13/2023 at 12:12 AM)-no initials as given 03/13 through 03/29/2023, "H" for hold on 03/30/2023, and no initial for 03/31/2023; 5)	P 225		

Heather Hobbs
6-28-23

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P 225	Continued From page 9 Oxcarbazepine Tab (anti-seizure medication) 600 mg, give one (1) tablet by mouth twice daily, no initial for bedtime dose 03/01 through 03/29/2023, "H" for hold on 03/30/2023, no initials for 03/31/2023, no initials for AM dose on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/27/2023, "H" for hold on 03/31/2023, declined on 03/14, 03/17, 03/30/2023; 6) Ondansetron HCL 4 mg tabs (an antiemetic), give one (1) tab by mouth three (3) times daily-no initials for bedtime dose for 03/01 through 03/2e/2o23, "H" for hold on 03/30/2023, and no initials on 03/31/2023, no initials noted for midday dose from 03/01 through 03/06/2023, 03/08 through 03/14/2023, 03/17 through 3/21/2023, 03/23 through 03/24, and 03/30 through 03/3112023, no initials for AM dose on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, 03/28/2023, "H" for hold on 03/31/2023, declined on 03/14 and 03/17/2023; 7) Omeprazole (a proton pump inhibitor) 20 mg, one (1) tablet twice per day, for bedtime dose, no initial on 03/01 through 03/2e/2o23, "H" for hold on 03/30/2023, and no initials for 03/31/2023, for AM dose, no initials on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03131/2023, and declined on 03/14, 03/17, 03/30/2023; 8) Mirtazapine Tab (anti-depressant) 15 mg tablet at bedtime-no initials for 03/01 through 03/29/2023, "H" for hold on 03/30/2023, and no initial for 03/31/2023; 9) Hydrocort Tab 5 mg, take three tablets (15) mg by mouth every night at bedtime, started 03/07-no initials for 03/07/2023 through 03/29/2023, "H" for hold on 03/30/2023, and no initials for 03/31/2023; 10) Cephalexin (an antibiotic) 500 mg capsule, take one (1) capsule by mouth twice daily for seven (7) days, started 03/02/2023-no initials for 03/02 through 03/09/2023 for bedtime dose; 11) Metoprolol	P 225		

Heather Habbs
6-28-23

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P 225	Continued From page 10 Tartrate (a beta blocker for high blood pressure) 25 mg twice daily-no initials for 03/01 through 03/29/2023 for PM dose, "H" for hold on 03/30/2023, no initials for AM doses on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/31, and declined on 03/14, 03/17, and 03/30/2023; 12) Metformin (a hypoglycemic) 500 mg, give one (1) tab by mouth twice daily-for PM dose no initials on 03/01 through 03/29 and 03/31/2023, and "H" for hold on 03/30/2023, for AM dose no initials on 03/02, 03/04, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/31, and declined on 03/14, 03/17, and 03130/2023; 13) Nystatin Cream 100,000 units/gram, apply a small amount to affected area twice a day beneath breasts and abdominal folds-for PM dose, no initials for 03/01 through 03/2e and 03/31/2023, "H" for hold on 03/30/2023, and for AM dose no initials for 03/02, 03/04, 03/05, 03/09, 03/09, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/31/2023, and declined on 03/14, 03/17, 03/30/2023; 14) Vitamin D3 Capsule 50 micrograms (mcg) once a day-no initials on 03/04, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/31/2023, and refused on 03/14, 03/17, and 03/30/2023; 15) Sertraline (an anti-depressant) 50 mg, take three (3) tablets once daily-no initials for 03/02, 03/04, 03/0s, 03/oe, o3/10, 03/12, 03/18, 03/19, 03/20, 03/21, and 03128/2023, "H" for hold on 03/31/2023, and declined on 03/14, 03/17, and 03/30/2023; 16) Multivitamin one (1) tablet daily-no initials on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/30/2023, and declined on 03/14 and 03/17/2023; 17) Oxybutynin Chloride ER (for overactive bladder) 15 mg daily-no initials for 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and	P 225		

Heather Hobbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100284	A. BUILDING _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 225	Continued From page 11 03/28/2023, "H" for hold on 03/31, and declined on 03/14, 03/17, and 03/30/2023; 18) Furosemide (a diuretic) 20 mg daily in AM-no initials on 03/02, 03/04, 03/05, 03/09, 03/10, 03/12, 03/18 through 03/21, and 03/28/2023, "H" for hold on 03/31/2023, declined on 03/14, 03/17, and 03/30/2023; and 19) Fluconazole (an anti-fungal) 200 mg tablets, take two (2) once daily for ten (10) days- no initials for 03/09, 03/10, and 03/12/2023, and declined on 03/14 and 03/17/2023. MedTech/Aide #6, in an interview on 05/04/2023 at 8:35 AM, stated when giving medications, residents usually came to the nurses' station to get them. She stated if the resident did not come to the nurses' station, she went to the resident's room to administer medications. She stated once medications were given, she signed off (initialed) the MAR to show they had been given. Also, she stated Resident #13 sometimes refused to take medications. MedTech/Aide #7, in an interview on 05/02/2023 at 1:50 PM, stated she administered medications to residents, and there had been no issues with the supply of medications. She stated she had received training on the process of administering medications. She stated Resident #13 would sometimes refuse medications. Manager #2, in an interview on 05/03/2023 at 2:50 PM, stated when residents went to outside appointments, the facility where the resident had the appointment would send a prescription to this facility's pharmacy. She stated when this happened, medications were shipped to this facility, and the MAR was changed or updated automatically per pharmacy. She stated staff at this facility did not make any changes to the MAR;	P 225		

Heather Hobbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 225	Continued From page 12 and, the only one who had that authority would be the Manager. She stated the facility had recently changed pharmacies, but was unable to state the exact date. The Nurse Practitioner (NP), in an interview on 05/05/2023 at 1:59 PM, revealed she was unaware of an order for Hydrocortisone (Cortef) 10 mg tablet, 2.5 tablets every twelve (12) hours for thirty (30) days from the ED visit on 03/13/2023. She stated the Cortef dosing was determined by symptoms, and Resident #13's condition was very hard to manage. She stated the only way she had of keeping up with prescriptions given from other appointments, either at the ED or the physician's office, was to have her medical assistant scan and place them in the resident's chart. She stated other providers usually did not communicate with her. She stated Resident #13 frequently called e11 for transfers to the hospital, and this was what happened with the ED visit on 03/13/2023. The Administrator, in an interview on 05/04/2023 at 8:46 AM, stated the staff members had been trained to always document on medication given/refused on the MAR, but they did not always do this. She stated when she found an omission on the MAR, she retrained staff in the process of documenting when the medication was given. She stated she thought if initials were missing on the MAR, staff had simply forgotten to initial. She stated sometimes when residents returned from appointments or ED visits, the facility did not always get any correspondence of their treatment.	P 225		
P 310	902 KAR 20:036 4(3)(b)4a-d Section 4. Provision of Services	P 310		

Heather Hobbs
6-29-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 13 (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 4. Maintenance. The premises shall be well kept and in good repair as established in clauses a. through d. of this subparagraph. a. The facility shall insure that the grounds are well kept and the exterior of the building, including the sidewalk, steps, porches, ramps, and fences are in good repair. b. The interior of the building, including walls, ceilings, floors, windows, window coverings, doors, plumbing, and electrical fixtures, shall be in good repair. Windows and doors shall be screened. c. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned regularly. d. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable insecticides and rodenticides. The compounds shall be stored under lock if stored by the facility.	P 310		

Heather Hobbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING. _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P310	Continued From page 14 This requirement is not met as evidenced by: Based on observation, interview, review of the facility's documents, review of the label for usage of Crossfire bed bug spray, and review of the facility's policy, it was determined the facility failed to ensure a pest control program was in operation in the facility to prevent bed bug infestation. This affected all fifty-four (54) residents in the facility. The findings include: Review of the facility's policy titled, "Bed Bug Policy", dated 08/16/2009, revealed any resident admitted to the facility would have all belongings taken to a quarantined area, and all items would be treated for bed bugs. Further review revealed any items that could be would be laundered before they were brought to the resident's room, and any furniture would only be accepted at the Administrator's discretion. Continued review revealed no process for treatment of the facility for bed bugs seen or reported, and no pest control policy was given. Review of Commercial Services Agreement from Orkin, dated 05/20/2022, revealed service performed to control roaches, common ants, rats and mice, pharaoh ants, and common spiders. Further review revealed service exclusions included bed bugs among other pests, which indicated no treatment for those pests was performed.	P 310	Through 7.31.23. maintenance personnel will spray each resident room on a weekly basis for bed bugs, and more if necessary. After 7.31.23, all rooms will be sprayed on an as needed basis.	

Heather Hobbs
6-29-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100204	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 15 Review of a Maintenance staff record revealed treatment of bed bugs on 04/25/2023 for Rooms 00, 0, 2, 4, 5, 9, and 17, and treatment on 05/02/2023 for Room 13. Review of label for the usage of Crossfire, the bed bug spray used at the facility, revealed surfaces should be vacuumed prior to treatment. Continued review revealed areas where bed bugs could harbor that should be sprayed were baseboards, floorboards, millwork, bedframes, headboards, wall hangings, furniture, door and window frames, walls, closets, window treatments, beneath floor coverings, as well as non-washable items such as luggage, shoes, and backpacks. Further review of Crossfire product revealed key signs of infestation included fecal deposits and live bugs, and re-inspection should occur every one (1) to two (2) weeks. It also stated adjacent areas of sightings should be treated. Observation of room where surveyor was housed during first day of survey, 05/02/2023, revealed large amounts of clutter on the floor consisting of tied garbage bags, clothes, lamps, plastic containers, chairs, a card table, and wheelchairs. Observation, on 05/03/2023 at 9:20 AM, of Rooms 00, 0, 2, 4, 5, and 9 revealed no active bedbugs. However these rooms did have mattresses, mattress covers, and room divider curtains with rust colored spots/blotches. Additional observation, at that time, of Resident #14's upper and lower arms, revealed small reddened open skin areas. Interview with an Orkin employee at National Headquarters, no name given, on 05/05/2023 at 9:55 AM, was conducted. The Orkin employee	P 310		

Heather Hobbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 16 stated Crossfire was "kinda" effective, and the entire area should be evaluated before throwing anything away. Also, the Orkin employee stated there was a high likelihood there were more bedbugs in more places if they were spotted on mattresses. Interview with Certified Nursing Assistant (CNA) #2 was conducted on 05/02/2023 at 11:46 AM. She stated she knew the facility had bed bugs but rooms were being treated, and to her knowledge, no resident had any decline or skin issues. Interview with Dietary/Aide #4 was conducted on 05/02/2023 at 12:00 PM. She stated the facility did have bed bugs, and rooms were being treated. She stated she had not noted any bug bites to residents, except for Resident #14, who had bed bug bites on the arms. Additional interview with Dietary/Aide #4 was conducted on 05/04/2023 at 12:00 PM. She stated she found a bed bug on her coat today, which was hanging on the back of a chair at the nurses' station, and had killed it. She stated the chairs to her knowledge had never been treated for bed bugs. Interview with Laundry/Housekeeping Staff #1 was conducted on 05/02/2023 at 12:20 PM. She stated there were bed bugs in the facility, and the rooms were being treated. She stated, when a sighting of a bed bug was reported, all linens were washed and dried at the highest temperature the dryer had, not saying what that temperature was. She stated she believed the bed bug problem had improved. Interview with Dietary/Aide #2 was conducted on 05/02/2023 at 12:35 PM. She stated there had	P 310		

Heather Hobbs
6-28-23

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 17 been no complaints from residents about bed bugs, and she had not seen any. She stated she thought someone had reported bed bug sightings, about three (3) weeks ago, and the rooms were being treated. Interview with Maintenance #1 was conducted on 05/02/2023 at 12:45 PM. He stated when a sighting of a bed bug was reported, the room was treated with a solution of Crossfire. He added the bed was stripped, and all the bed, including the frame, was sprayed. He stated he had training by maintenance staff from the sister facility on the process of spraying for bed bugs when he first started at the facility in September 2022. He stated he believed the bed bugs were decreasing since he was not spraying additional rooms. He stated he could not saying if the process included inspections ongoing throughout the building, he was just spraying where the sightings were reported. He stated he did a visual inspection of furniture in the affected rooms by opening drawers, and none of the furniture was treated or removed from the room. He added Crossfire was stored in the basement and mixed per the instructions on the label. Interview with Aide/Med Tech #7 was conducted on 05/02/2023 at 1:50 PM. She stated she had worked at the facility since January 2023. She stated she knew the facility had bed bugs and had seen some last week but not this week. She stated she knew the rooms were being treated. Interview with Aide/Med Tech #6 was conducted on 05/02/2023 at 3:50 PM. She stated bed bugs were in the facility, but treatment was in place. She also stated no residents had any skin issues with the exception of Resident #14, who had spots on the arms. She stated the facility had	P 310		

Heather Hobbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 18 been infested with bed bugs for several months. Interview with Nurse Practitioner (NP) #1 was conducted on 05/04/2023 at 9:55 AM. She stated she was aware the facility had bedbugs. She stated no resident she knew of had any declines due to bug bites, with the exception or Resident #14. She stated Resident #14 had spots on the arms, but she was not convinced the spots were bug bites since he/she had a history of picking at the skin. Interview with the Administrator was conducted on 05/02/2023 at 10:45 AM. She stated the facility did have bed bugs, which were discovered two (2) to three (3) weeks ago, after a report from an employee who stated he/she had seen a bedbug in Room 00. The interview continued at 11:43, when the Administrator stated Room 00 was treated. However, she stated, after that treatment, there had been bed bug sightings in four (4) other rooms. She stated the facility was in the process of treating those areas per maintenance staff, not professionally. Additional interview with the Administrator was conducted on 05/04/2023 at 8:46 AM. She stated she was unsure of the location of the quarantine area for resident belongings. She stated she was unsure if the clutter in the conference room where the State Survey Agency (SSA) Surveyor was housed on 05/02/2023 was quarantined or inspected for bedbugs. Interview with Manager #2 (from sister facility) was conducted on 05/03/2023 at approximately 9:00 AM. She stated the clutter in the conference room probably had not been inspected for bed bugs, and those items should have been taken to the basement.	P 310		

Heather Habbs
6-28-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE
P 310	Continued From page 19 Interview with the Chief Operating Officer (COO) was conducted on 05/04/2023 at 2:20 PM. She stated she knew the facility had bed bugs. She stated bed bug treatment had not been done professionally since maintenance staff had always treated bed bugs in the past, and the treatment worked.	P 310		

Heather Hobbs
6-28-23

Office of Inspector

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100264	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(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) COMPLETE DATE

Heather Hobbs
7-24-23

	Initial Comments A Complaint Survey investigating complaint KY00039378 and KY00038922 was initiated on 05/02/2023 and concluded on 05/08/2023. KY00039378 and KY00038922 were both substantiated with deficient practice identified. 902 KAR 20:036 2(1)(a-d) Section 2. Scope of Operations and Services (1) A resident in a PCH or SPCH shall: (a) Be admitted in accordance with KRS 216.765; (b) Be ambulatory or mobile nonambulatory; (c) Be able to manage most of the activities of daily living; and (d) Have care needs that do not exceed the capability of the PCH or SPCH. This requirement is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the facility's "Corrective Action Plan", dated 02/28/2023, it was determined the facility failed to establish a system to ensure residents' care needs were not above the level of care the facility was able to provide for six (6) of six (6) sampled residents, Resident #31, #26, #27, #25, #9, and #10. The findings include:	P 000 P 005	As of 6.28.23, through 10.31.23, the manager will ensure that the paperwork noted below is reviewed with a manager of a sister facility or upper management. Documentation needed for an admission is: pre-admission assessment, medical history, H&P and diagnosis list. If there is a discharge summary or H&P that includes the aforementioned and has been done within 14 days of admission, that will suffice. Upon completion of the admission, the manager will share the elopement risk assessment form with either a manager of a sister facility or upper management.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Heather Hobbs TITLE manager (X6) DATE 7-24-23

Office of Inspector

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLET
	100264	A. BUILDING: _____ B. WING _____	C 05/081 023

NAME OF PROVIDER ORSUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
REGENCY MANOR	11725 MADISON PIKE INDEPENDENCE, KY 41051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC ENCY 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) COMPLETE DATE

Heather Hobbs
7 24 23

	Continued From page 1 Review of the facility's policy titled, "Admission Policy", no date, revealed fourteen (14) days prior to admission, a pre-admission assessment would be performed to assure care needs of the potential resident were understood, and the facility could provide a safe home. Continued review revealed, prior to admission, a medical exam including a medical history, History & Physical (H&P) would be obtained within fourteen (14) days of admission. Additional review revealed a copy of the resident's discharge summary and H&P from another facility, if done within fourteen (14) days of admission, would suffice for the medical exam. Further review revealed upon admission an Elopement Risk Assessment would be completed to assure the resident was not at risk for elopement due to confusion. Review of the facility's policy titled, "Elopement Risk Assessment Form Policy", revision date 01/26/2023, revealed upon admission an Elopement Risk Assessment Form would be completed. Review of the document Position Description for Facility Manager, Department of Administration, revealed job functions and tasks for this position included to develop and update the resident selection plan in accordance with regulatory requirements and to ensure compliance with policies, procedures, practices, and standards. 1. Review of Resident #31's medical record revealed the facility admitted the resident on 03/20/2023, and his/her Pre-Admission Assessment was dated 03/20/2023. Further review revealed medical exams were performed per Emergency Room (ER) visits, dated	P 005		

Heather Hobbs
7-24-23