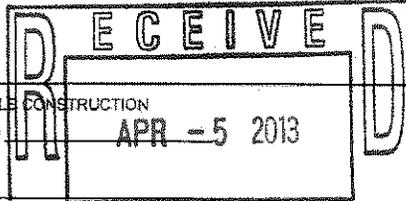


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/14/2013
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NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER	STREET ADDRESS 411 BERTHA WALLACE DRIVE IRVINE, KY 40336
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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
F 000	INITIAL COMMENTS	F 000		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined the facility failed to provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. Observations during the environmental tour on 03/12/13, 03/13/13, and 03/14/13 revealed the vinyl covering on the armrests of the wheelchairs utilized by Resident #7 and Resident B were cracked and in need of repair. The men's and women's shower stalls on the West Wing had a black "mold-like" substance in the tile grout on the walls and around the baseboards, and the emergency "crash cart" (a locked cart that contains medications/equipment used in medical emergencies) on the West Wing had a layer of dust/dirt under the cover on all of the equipment that was available for use in the event of an emergency.</p> <p>The findings include:</p> <p>1. A review of the weekly cleaning schedule for the "crash cart" located on the West Wing revealed the carts were to be cleaned daily and a</p>	F 253	<p>F253</p> <p>1. Resident #1 and Resident B vinyl arm rests were replaced on 03/17/13 by Maintenance Supervisor and Therapy supervisor. Crash cart located on west wing was cleaned by Housekeeping Supervisor on 03/17/13. West Wing shower rooms were deep cleaned on 03/16/13 and 03/17/13 to ensure no "mold-like" substance was present on the grout of the wall tiles and baseboards of the shower stalls.</p>	

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

Lisa K. Johnson

TITLE

Adm.

(X6) DATE

4/5/13

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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F 253	<p>Continued From page 1</p> <p>Unit Manager was to check the emergency cart weekly for cleanliness and supplies.</p> <p>Interview with the Director of Nursing (DON) on 03/14/13 at 3:30 PM revealed it was the responsibility of the day or night shift Charge Nurse or the Unit Managers to monitor the emergency drug carts on a weekly basis.</p> <p>Observation on 03/14/13 at 3:15 PM of the emergency cart on the West Wing revealed a layer of dust/dirt on the emergency equipment that was available for resident use in the event of an emergency.</p> <p>Interview with Registered Nurse (RN) #1 on 03/14/13 at 3:45 PM revealed the emergency "crash cart" was to be cleaned daily as part of the duties of the nurses; however, RN #1 stated she had just been checking that the equipment was in place and not lifting the cover to clean.</p> <p>Interview with the West Wing Unit Manager on 03/14/13 at 3:45 PM revealed the day shift RN was to check the emergency carts. The Unit Manager said she did not routinely check the "crash cart" on her weekly monitoring rounds to ensure the cleaning had been completed.</p> <p>2. According to a signed statement on 03/14/13 by the Administrator, there was no written policy related to cleaning of the shower room; however, the Administrator noted there was a calendar located in the housekeeping office that had a note written on it to remind housekeeping staff to clean the shower rooms weekly.</p> <p>Observation on 03/13/13 at 8:45 AM of the West</p>	F 253	<p>2. All wheelchairs in the facility were checked by Administrator and Maintenance Supervisor on 03/17/13 to identify if any other areas of concerns were present with any equipment in need of repair. Any issues identified were immediately corrected. Crash carts on East and West unit was checked by Administrator on 03/17/13 and again on 04/05/13 to identify if any cleaning issues were identified with the cart and/or equipment. Any issues were immediately corrected.</p>		

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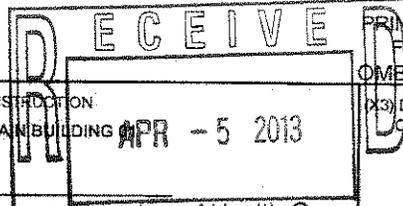
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F 253	<p>Continued From page 2.</p> <p>Wing men's and women's shower rooms revealed a black "mold-like" substance on the grout of the wall tiles and baseboards of the shower stalls.</p> <p>Interview with Housekeeper #1 on 03/14/13 at 9:45 AM revealed she cleaned the outside of resident rooms and the front lobby; however, she was not assigned to clean the bathrooms or showers.</p> <p>Interview with Housekeeper #2 on 03/14/13 at 9:55 AM revealed she cleaned the resident rooms, shower rooms, and shower stalls on a daily basis. Housekeeper #2 said she had cleaned the shower stalls on the West Wing, and had noticed the black "mold-like" substance in the tile grout, but had not attempted to clean the grout.</p> <p>Interview with the Housekeeping/Laundry Supervisor on 03/14/13 at 10:05 AM revealed she monitored the shower rooms for cleanliness on a weekly basis on Fridays. The Housekeeping Supervisor stated she had noticed the black "mold-like" substance on the West Wing shower stalls on Friday (03/08/13) and stated the housekeepers cleaned the shower rooms daily with Virex. However, according to interview, the Housekeeping Supervisor had not monitored the shower rooms to ensure staff had cleaned the black "mold-like" substance from the grout.</p> <p>3. Interview with the Maintenance Supervisor on 03/14/13 at 10:00 AM revealed although there was not a specific policy related to the maintenance and repair of wheelchair armrests, facility staff was to notify the Maintenance</p>	F 253	<p>3. In-service was completed for all Housekeeping staff by Housekeeping supervisor on cleaning schedule of the shower rooms and crash cart on 03/26/13. An in-service will be completed by In-service Training Director and/or Maintenance Supervisor for all staff on work orders to educate to complete work order for any repairs needed through-out center by 04/15/13 to include wheelchairs.</p> <p>4. An audit of all resident equipment in the center will be completed 2 times a week for 6 weeks, and then monthly for 3 months by Administrator to ensure work orders are completed and no equipment including wheelchairs are in need of repair.</p>		

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F 253	<p>Continued From page 3</p> <p>Department of needed repairs by completing a work order and placing the work order in a "bin" located across from each nursing station. In addition, according to the Maintenance Supervisor, wheelchairs were to be checked by the Maintenance Department weekly when making rounds.</p> <p>Observation during the initial tour on 03/12/13 at 10:30 AM revealed the vinyl covering of the armrests on the wheelchairs utilized by Resident #7 and Resident B was cracked and in need of repair.</p> <p>The Maintenance Supervisor stated on 03/14/13 at 10:00 AM he had not received any work orders for the cracked wheelchair armrests for Resident #7 or Resident B and had not observed the covering of the wheelchair armrests to be cracked when weekly rounds were conducted.</p>	F 253	<p>Environmental rounds are to be completed 2 times a week for 12 weeks then monthly ongoing by Administrator/Housekeeping supervisor to ensure environment is clean, safe and sanitary. Crash carts will be audited by Unit Managers weekly for 12 weeks, then twice monthly ongoing to ensure they are clean and have all equipment. Charge nurse on 1st shift is to audit crash cart daily to ensure cart is clean and equipment is available and sign off on sheet located at nurses station validating they have been checked.</p> <p>4. Results of audit will be reviewed in QA meeting (consisting of DON, ADMIN, SS, HK, Maintenance, ACT, DM) to identify needed changes to the plan and validate success of audits.</p>	04/20/13	

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NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS 411 BERTHA WALLACE DRIVE IRVINE, KY 40336		
Division of Health Care Southern Enforcement Branch					
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two story, Type 111 (211) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Diesel generator A life safety code survey was initiated and concluded on 03/13/13, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The census on the day of the survey was 85. The facility is licensed for 88 beds. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000			
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018			

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

Lisa R. Johnson

TITLE

Adm.

(X6) DATE

4/5/13

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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K 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor room doors would resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, eight residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 03/13/13 at 11:00 AM, revealed the corridor doors to resident rooms 201, 203, 205, and 210 had a gap larger than one-half inch. The findings were confirmed with the</p>	K 018	<p>K 018</p> <ol style="list-style-type: none"> 1. RESIDENT ROOMS 201, 203, 205 AND 210 CITED FOR GAP WHEN DOOR IS CLOSED LARGER THAN ONE-HALF INCH. DOORS WILL BE ADJUSTED BY MAINTENANCE DIRECTOR TO ENSURE THAT THE REQUIREMENT OF LESS THAN ONE-HALF INCH GAP IS EVIDENT BY 04/20/13 2. RE-EDUCATION WILL BE COMPLETED BY ADMINISTRATOR FOR MAINTENANCE STAFF THAT ALL DOORS MUST MEET GAP REQUIREMENT AS EVIDENCED BY NFPA 80 BY 04/15/13 3. AN AUDIT OF ALL DOORS IN THE CENTER WILL BE COMPLETED BY MAINTENANCE DIRECTOR WEEKLY FOR 6 WEEKS TO BEGIN ON 04/08/13, THEN MONTHLY TO ENSURE BUILDING HAS NOT SETTLED AND GAP IN DOORS IS NOT GREATER THEN REQUIREMENT. 4. RESULTS OF AUDIT FINDINGS WILL BE REVIEWED IN MONTHLY QUALITY IMPROVEMENT MEETING FOR ADDITIONS AND/OR CHANGES TO THE PLAN. 5. COMPLIANCE DATE 04/20/13. 	4/20/13

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K 018	Continued From page 2 Maintenance Director. Interview on 03/13/13 at 11:00 AM, with the Maintenance Director, revealed the building is settling due to age and the doors had gaps possibly due to the settling of the building. Reference: NFPA 101 (2000 Edition). 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. Survey and Certification letter from Centers for Medicare & Medicaid Services: 07-18	K 018			
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029			

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K 029 SS=D	<p>Continued From page 3</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two smoke compartments, eight residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 03/13/13 at 11:50 AM, revealed the Mechanical Room (containing fuel-fired water heaters) on the Ground Level Floor contained an unsealed penetration around a piece of conduit. Further observation revealed the Mechanical Room (containing fuel-fired water heaters) located on the Lower Level Floor contained four unsealed penetrations from conduit. Penetrations located around conduit must be sealed to resist the passage of smoke. The observations were confirmed with the Maintenance Director.</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> 1. UNSEALED PENETRATION AROUND A PIECE OF CONDUIT IN THE MECHANICAL ROOM WAS REPAIRED BY OUTSIDE CONTRACTOR ON 04/03/13 2. AN AUDIT OF FACILITY WILL BE CONDUCTED BY MAINTENANCE SUPERVISOR BY 04/20/13 TO IDENTIFY IF ANY OTHER AREAS AROUND CONDUIT VIOLATE THE PENETRATION OF SMOKE BARRIERS IN ACCORDANCE WITH 8.3.6. ANY ISSUES IDENTIFIED WILL BE CORRECTED IMMEDIATELY. 3. AN AUDIT WILL BE COMPLETED MONTHLY ONGOING TO ENSURE THAT ANY WORK COMPLETED OR REQUIRED AROUND SMOKE BARRIERS ARE SECURE PER REGULATION. 4. RESULTS OF AUDIT WILL BE REVIEWED IN THE MONTHLY QUALITY IMPROVEMENT COMMITTEE FOR 2 MONTHS TO ENSURE NO REVISIONS ARE NEEDED TO THE PLAN. 5. COMPLIANCE DATE 04/20/13 	4/20/13

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K 029	Continued From page 4	K 029			
K 104 SS=F	<p>Interview on 03/13/13 at 11:50 AM, with the Maintenance Director revealed he had never noticed the penetrations around the conduit located in the Mechanical Rooms.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure documentation showing fusible links located in the HVAC system were changed, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four smoke compartments, eighty-eight residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 03/13/13 at 3:00 PM revealed the facility had a total of four fire dampers located in the HVAC system. The observation was confirmed with the Maintenance Director.</p> <p>Interview and record review of the HVAC maintenance records with the Maintenance Director on 03/13/13 at 3:05 PM revealed the facility had an outside contractor to service the HVAC system. The documentation did not show if the fusible links for the fire dampers had been changed. Further interview revealed the outside</p>	K 104			

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K 104	<p>Continued From page 5</p> <p>contractor had not changed the fusible links for the HVAC system.</p> <p>Reference: NFPA 90A (1999 Edition).</p> <p>3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p>	K 104	<p>K104</p> <ol style="list-style-type: none"> 1. FOUR FIRE DAMPERS LOCATED IN THE HVAC SYSTEM FUSIBLE LINKS HAD NOT BEEN CHANGED TO MEET THE 4 YEAR REQUIREMENT. THESE DAMPERS WERE CHANGED BY TOTAL COMFORT , OUTSIDE CONTRACTOR ON MARCH 2902013 2. FACILITY AUDIT WAS COMPLETED BY MAINTENANCE DIRECTOR TO IDENTIFY IF ALL FUSIBLE LINKS IN HVAC SYSTEM HAD BEEN CHANGED PER REGULATION WITHIN 4 YEARS. ANY AREAS IDENTIFIED WAS CORRECTED DURING CONTRACTOR VISIT ON 03/29/13. 3. AN AUDIT WILL BE COMPLETED YEARLY BY OUTSIDE CONTRACTOR TO ENSURE THAT LINKS HAVE BEEN REMOVED, DAMPERS FULLY CLOSE, THE LATCH CHECKED AND MOVING PARTS LUBRICATED AS REQUIRED TO MEET THE 4 YEAR REQUIREMENT. 4. RESULTS OF AUDIT FINDINGS WILL BE REVIEWED IN QUALITY IMPROVEMENT COMMITTEE TO VALIDATE THE LINKS ARE CHANGED EVERY 4 YEARS. 5. COMPLIANCE DATE 04/20/13 	4/20/13
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