

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



PRINTED: 10/30/2014
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 10/16/2014
NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336	
(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 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop a comprehensive care plan with interventions that addressed securing suprapubic catheters for three (3) of fifteen (15) sampled residents (Residents #7, #10, and #12).</p>	F 279	<p>Disclaimer; Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>F279</p> <p>1. Resident #7, #10, # 12 had comprehensive care plan updated with intervention to include size of indwelling catheter and that catheter is anchored and secure to aid in prevention of Injury and irritation 10/17/14 by MDS Coordinator</p>	

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

Lisa R. Johnson

TITLE

Administrator

(X6) DATE

11/6/14

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 279	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility policy for Care Planning, undated, revealed the facility completed an individualized care plan based on the residents' specific needs.</p> <p>1. Observation of Resident #7 on 10/14/14 at 11:05 AM, and on 10/15/14 at 8:20 AM, revealed the resident had an indwelling urinary catheter to a bedside drainage bag. The indwelling catheter was not anchored to the resident and was stretched across the resident's leg and over the side of the bed.</p> <p>Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Hypertension, Diabetes, Peripheral Vascular Disease, and Dementia. The facility completed a quarterly Minimum Data Set (MDS) assessment, dated 09/04/14, which revealed the resident had severely impaired cognition and required extensive assistance with all activities of daily living. The resident had a suprapubic catheter (a catheter that is inserted through the abdomen directly to the bladder) and a colostomy.</p> <p>Review of Resident #7's comprehensive care plan revealed no documentation that addressed anchoring the catheter for prevention of injury.</p> <p>2. Observation of Resident #10 on 10/16/14 at 10.05 AM revealed a suprapubic catheter was in place and unanchored.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident with</p>	F 279	<p>2. A one time audit was completed by MDS Coordinator for residents with indwelling catheters to identify any resident that did not have catheter appropriately documented on comprehensive care plan. Those residents identified had care plan immediately updated. Completed 10/17/14. Education was completed by Education Training Director for licensed staff on newly established indwelling catheter policy to ensure that catheter is secure to aid in prevention of injury and irritation.</p> <p>3. An audit of residents with indwelling catheters will be completed by Unit Managers weekly for 4 weeks beginning week of November 3, 2014 to ensure that care plan is current and up to date with size of catheter, and that catheter is anchored and secure. Care plans will be updated by IDT team during clinical review with changes and new orders on an ongoing basis. Facility established and implemented an Indwelling catheter policy on 10/17/14.</p>		

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F 279	<p>Continued From page 2</p> <p>diagnoses of Obstructive Hydrocephalus and Quadriplegia. A quarterly MDS assessment was completed by the facility on 08/04/14, which revealed the resident had a severely impaired cognition and required extensive assistance with activities of daily living.</p> <p>Review of the comprehensive care plan for Resident #10 revealed no documentation that addressed anchoring the catheter to prevent tugging, which could lead to irritation/trauma.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 10/14/14 at 3:28 PM, revealed the catheters for Resident #7 and Resident #10 were not secured and there was no documentation on the care plan regarding anchoring the catheters. She revealed she had been trained on catheter care but she was responsible for following the care plan. She stated she was supervised by the nurses on the unit.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/15/14 at 9:30 AM, revealed urinary catheters, indwelling and suprapubic, were to be anchored to prevent trauma to the resident. She stated she was responsible for ensuring care for Residents #7 and #10 was provided and did not notice that securing the catheters was not addressed on the care plan.</p> <p>Interview with the Director of Nursing on 10/16/14 at 2:52 PM, revealed the facility did not have a policy to address securing indwelling or suprapubic urinary catheters. She stated the residents' care plans should have included the securing of these catheters.</p> <p>3. Observation of Resident #12 on 10/16/14 at</p>	F 279	<p>Director of Nursing will check care plans for all newly acquired catheters weekly for 8 weeks to ensure compliance beginning November 3, 2014. Any issues identified with compliance, the facility will complete re-education for those individuals. New catheter policy will be reviewed during orientation for all new licensed employees.</p> <p>4. QA committee consisting of Director of Nursing, Administrator, Medical Director, Social Services, Dietary, Act, and MDS) will review finding of indwelling catheter audit monthly in November and December to discuss success and/or revision needed of the plan and to determine if additional education is needed.</p> <p>5. 11/28/14</p>	
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F 279	Continued From page 3 10:10 AM revealed the resident utilized a suprapubic catheter with a bedside drainage bag. The suprapubic catheter was not anchored. Review of the clinical record for Resident #12 revealed the facility admitted the resident with diagnoses that included Senile Dementia and Urinary Retention. The facility completed a quarterly Minimum Data Set (MDS) assessment, dated 09/19/14, which revealed the resident was severely cognitively impaired, required total assistance with all activities of daily living, and utilized a suprapubic catheter. Review of Resident #12's comprehensive care plan last reviewed by the facility on 10/02/14, revealed no documentation that addressed anchoring the resident's catheter to prevent injury to the resident. Interview with Registered Nurse (RN) #4 on 10/16/14 at 10:25 AM revealed the facility did not require suprapubic catheters to be anchored.	F 279		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 1. Resident #7,#10,#12 had indwelling catheter secured to prevent injury and irritation per new established and implemented indwelling catheter care policy on 10/17/14- by Unit Manager	

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F 315	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy on care of indwelling and suprapubic catheters, it was determined the facility failed to ensure three (3) of fifteen (15) sampled residents (Residents #7, #10, and #12) received adequate care to prevent trauma and infection associated with the use of indwelling suprapubic catheters.</p> <p>The findings include:</p> <p>Review of the facility's policy for Indwelling Urinary Catheters, undated, revealed the policy did not address the care of indwelling urinary catheters.</p> <p>Interview with the Director of Nursing on 10/16/14 at 2:52 PM, revealed the facility had no policy for suprapubic catheter care. She stated the facility practice included anchoring suprapubic and other indwelling catheters to prevent injuries and infections from injuries. She indicated the facility used Lippincott as a reference.</p> <p>1. Observation of Resident #7 on 10/14/14 at 11:05 AM, and on 10/15/14 at 8:20 AM, revealed the resident had an indwelling catheter to a bedside drainage bag. The catheter tubing was not anchored to the resident.</p> <p>Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Hypertension, Diabetes, and Dementia. The facility completed a quarterly Minimum Data Set (MDS) assessment dated 09/04/14, which revealed the resident had severely impaired cognition, required extensive</p>	F 315	<p>2. An audit of residents with catheters was checked by Unit Managers to identify if any other resident with catheters that were not anchored and secured per new policy on 10/17/14. Those identified were secured immediately to aid in prevention of injury and irritation 10/17/14</p> <p>3. Indwelling catheter policy established and implemented by Director of Nursing and Administrator on 10/17/14. QA Committee reviewed policy and approved implementation on 10/17/14. Nursing staff in-service completed by Education Training Director to ensure that licensed staff follow new policy regarding catheter care to ensure catheter is anchored and secure to aid in prevention of injury and irritation. Completed 10/17/14</p>	

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F 315	<p>Continued From page 5</p> <p>assistance with all activities of daily living, and had a suprapubic catheter.</p> <p>Review of Resident #7's comprehensive care plan revealed no evidence the facility developed interventions to anchor the catheter to prevent injury and/or infections.</p> <p>2. Observation of Resident #10 on 10/16/14 at 10:05 AM revealed the resident utilized a suprapubic catheter. The catheter tubing was not anchored.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident with diagnoses of Obstructive Hydrocephalus, Neurogenic Bladder, and Quadriplegia. A quarterly MDS assessment completed by the facility on 08/04/14, revealed the resident had severely impaired cognition, required extensive assistance with activities of daily living, and utilized a suprapubic catheter.</p> <p>Review of the comprehensive care plan for Resident #10 revealed no evidence the facility developed interventions to instruct staff on how to secure and anchor the catheter to prevent tugging, which could lead to irritation, trauma, and/or infection.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 10/14/14 at 3:26 PM, revealed the catheters for Resident #7 and Resident #10 were not secured and she was not sure if they should be secured. She stated she had been trained on catheter care, however, she did not remember securing the catheter. She stated she was supervised by the nurses on the unit.</p>	F 315	<p>Unit Managers will audit all indwelling catheters 3 times a week for 4 weeks, then 2 times a week for 3 weeks and then once a week for 2 weeks to ensure compliance that all catheters are safely secured to aid in prevention of injury and irritation. Audit to begin week of 10/27/14. DON to review audit weekly for 9 weeks to ensure compliance beginning week of 11/03/14 and ending week of 12/29/14. Any concerns identified, facility will re-educate those individual employees. All new licensed employees will be educated on new catheter care policy.</p>		

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F 315	<p>Continued From page 6</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/15/14 at 9:30 AM, revealed catheters, indwelling urinary and suprapubic, were to be anchored to prevent trauma to the resident. In addition, she stated trauma could cause irritation, injury, and infection. She stated she was responsible for ensuring care was provided for Residents #7 and #10 and had not noticed the catheters were unsecured.</p> <p>Interview with the Director of Nursing on 10/16/14 at 2:52 PM, revealed the facility did not have a policy to address securing of indwelling urinary or suprapubic catheters. She stated the facility practice was to secure these catheters to prevent injury to the resident. She indicated the failure to secure catheters could lead to injury and infection for residents.</p> <p>3. Observation of Resident #12 on 10/16/14 at 10:10 AM revealed the resident had a suprapubic catheter with a bedside drainage bag; however, the catheter tubing was not anchored to the resident's leg.</p> <p>Review of Resident #12's clinical record revealed the facility admitted the resident with diagnoses that included Senile Dementia and Urinary Retention. A review of a quarterly Minimum Data Set (MDS) assessment, dated 09/19/14, revealed the facility assessed Resident #12 as being severely cognitively impaired, required total assistance with all activities of daily living, and required a suprapubic catheter.</p> <p>Review of Resident #12's comprehensive care plan revealed no evidence the facility developed interventions that addressed securing the resident's catheter tubing to prevent injury.</p>	F 315	<p>4. New Indwelling catheter audit will be reviewed in weekly QA held by IDT team beginning week of November 7, 2014 and continue through week of December 31, 2014 and again in Monthly QA in November, December 2014 and January 2015 consisting of Director of Nursing, Administrator, Medical Director, Social Services, Dietary, Act, and MDS to discuss success and/or revision needed of the plan and to determine if additional education is needed.</p> <p>5. 11/28/14</p>	

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F 315	Continued From page 7	F 315		
F 368 SS=E	<p>Interview with Registered Nurse (RN) #4 on 10/16/14 at 10:25 AM revealed the facility did not require suprapubic catheters to be secured.</p> <p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to offer evening snacks to one (1) of fifteen (15) sampled residents (Resident #2) and eight (8) unsampled residents (Residents A, B, C, D, E, F, G, and H).</p> <p>The findings include: Interview with Residents A, B, C, D, E, F, G, and H during the group meeting on 10/14/14 at 3:04</p>	F 368	<p>368</p> <ol style="list-style-type: none"> All snacks will be distributed per new snack process established and implemented by DON, Nutritional services Manager and Administrator on 10/24/14. Resident council meeting held week of 11/03/14 to identify issues with snacks being offered. New process reviewed with council members. Interviewable residents to be interviewed about snacks being offered week of 11/03/14 by Unit Managers to identify if new process is working and to address snack concerns. Education completed for nursing staff regarding new snack policy consisting of all residents in the center are to be offered snack that is distributed to floor daily prior to bedtime. Dietary staff also Educated by Dietary Manager on 10/24/14 regarding new snack policy and when snacks are to be distributed to floor. HS snack has been added to treatment record for nurse to validate prior to 9pm that HS snacks have been offered and that documentation is complete. 	

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F 368	<p>Continued From page 8</p> <p>PM revealed, "Snacks are not offered, but if you ask, they will give [the residents] something."</p> <p>Individual interview with Resident #2 on 10/14/14 at approximately 2:50 PM revealed the resident was pleased with the food served in the facility, but stated he/she sometimes was hungry in the evening. The resident stated he/she could ask for a snack, but staff did not usually ask the resident if he/she would like a snack before bed.</p> <p>Interview with Cook #6 on 04/15/14 at 2:05 PM revealed he/she was responsible for making sure snacks were made and delivered to each wing prior to the 3:00 PM and 8:00 PM snack times. The cook stated the snacks were provided for specific residents who were not eating well or had issues with their blood sugar. The cook stated he/she did not know how other residents got snacks.</p> <p>Interview with Registered Nurse (RN) #3 on 04/15/14 at 2:20 PM revealed residents without a snack specifically ordered for weight gain or for diabetic reasons could come to the nurses' station and receive a snack at any time. RN #3 stated snacks such as cookies, crackers, candy, and ice cream were kept at the nurses' station and residents just had to ask for a snack.</p> <p>Interview with the Director of Nursing (DON) on 10/16/14 at 2:52 PM revealed staff was required to ask all residents in the facility if they would like a snack every night. The DON stated he/she was unaware that snacks were not being offered to all residents.</p>	F 368	<p>Treatment record will be reviewed by Unit Manager/Designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks and then weekly for 3 weeks to ensure snacks are being offered and documented. Facility established and implemented new snack policy on 10/24/14. All newly hired nursing and dietary employees will be educated on this process upon hire. Ongoing during resident council beginning in December 2014 snacks will be reviewed to ensure continued compliance.</p> <p>4. Snack Audit will be reviewed in weekly QA weight committee meeting beginning week of October 27, 2014 for 9 weeks and during Monthly QA for 3 months beginning in November, December 2014 and January 2015 to review audit findings make recommendations and/or revisions of plan. Resident Council meeting will be held ongoing monthly for success and/or failure of plan and address any needed changes or if additional education is needed.</p> <p>5. 11/28/14</p>	