

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

PRINTED: 01/14/2016
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 C 12/30/2015
NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336		
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F 281	<p>Continued From page 1</p> <p>Record review revealed the facility admitted Resident #1 on 09/29/15 with diagnoses including Amyotrophic Lateral Sclerosis (ALS), Anxiety, Hypertension, and Gastroesophageal Reflux Disease (GERD).</p> <p>Review of a physician's order dated 12/08/15, revealed orders for Riluzole (a medication for the treatment of ALS) 50 milligrams (mg) twice a day.</p> <p>Review of a physician's order dated 12/10/15 revealed staff was to discontinue the current dose of Riluzole 50 mg twice a day and begin Riluzole 50 mg once a day, and then Riluzole 50 mg every 12 hours. Further review revealed an order to begin Nuedexta - Dextromethorphan/Quinidine (a medication used to treat pseudobulbar affect disorder) 20 mg/10 mg every day for seven days, and then Nuedexta 20 mg/10 mg every 12 hours.</p> <p>Review of a physician's order dated 12/11/15 revealed an order to begin Baclofen (medication used to treat muscle spasms) 20 mg at bedtime for four days, then Baclofen 20 mg twice a day for four days, then Baclofen 20 mg three times a day for four days, and then Baclofen 20 mg four times a day. Further review revealed to start the Baclofen 20 mg one week from other medications.</p> <p>Review of a Medication Administration Record (MAR) dated December 2015 revealed the facility began administering the ordered Baclofen on 12/11/15 and failed to hold the medication for one week as ordered by the physician.</p> <p>Interview with the Unit Manager, Licensed Practical Nurse (LPN) #1, on 12/30/15 at 8:00</p>	F 281	<p>Audit to be completed by 01/31/16. Any issues identified will be corrected immediately with physician notification.</p> <p>3. All new orders will be validated in clinical meeting by the Director of Nursing and/or Unit Managers Monday-Friday to ensure no issues related to transcribing, entering in the electronic medical record and start dates on an ongoing basis with a begin date of 01/6/16. Any issues identified will be corrected with MD notification. A new process will be implemented that all new orders written with medication changes in a shift will be validated by the oncoming nurse in the Electronic Medical Record to ensure correct dates and order is per written request. All licensed staff will be educated by the Education Training Director on this new process by 01/31/16. Licensed staff will be re-educated by Education Training Director on importance of transcribing orders per physician direction, entering the start dates in the electronic medical record correctly and ensuring order follows physician direction by 01/31/16.</p>		

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F 281	Continued From page 2 PM, revealed she was the nurse who transcribed the order into the computer system. LPN #1 stated she forgot to change the start date for the Baclofen from 12/11/15 to 12/18/15 as ordered by the physician. Interview with the Director of Nursing (DON) on 12/30/15 at 6:17 PM, revealed the facility held a Clinical Meeting each morning Monday through Friday to verify the accuracy of the transcription of all new orders. The DON stated the Baclofen order was "just overlooked."	F 281	DON will randomly audit 10 new orders weekly for 4 weeks beginning week of 01/18/16 in addition to clinical review to ensure that process is working correctly and that physician's orders are being entered per the physician direction in the Electronic Medical Record with the correct start dates.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services were provided in accordance with each resident's care plan for one (1) of three (3) sampled residents (Resident #2). Review of the care plan for Resident #2 revealed interventions related to the resident's agitation to administer medication as ordered and to attempt medication administration three (3) times prior to desisting. However, review of the Medication Administration Record (MAR) for December 2015 revealed twenty (20) doses of Xanax (narcotic medication for anxiety) was not administered to Resident #2 with no evidence the resident was offered the medication three (3) times prior to	F 282	4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager will review all audit findings and revise current plan at least monthly beginning January 2016 and ongoing until issue is resolved or satisfactory. 5. Date of Compliance: 02/05/16		

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F 282	<p>Continued From page 3 documenting the medication was refused by the resident.</p> <p>The findings include:</p> <p>Interview with the Administrator on 12/30/15 at 4:30 PM revealed the facility did not have a policy regarding following the care plan. The Administrator stated staff was expected to follow the guidelines for following the care plan per the Resident Assessment Instrument (RAI) Manual.</p> <p>Record review revealed the facility admitted Resident #2 on 02/22/14 with diagnoses that included Severe Intellectual Disabilities, Schizophrenia, Major Depression, and Anxiety.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 12/15/15 revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score "not assessed" indicating Resident #1 was not interviewable.</p> <p>Review of the Comprehensive Care Plan, revised on 12/19/15, revealed Resident #2 had behaviors related to agitation, was combative, and refused medication. Further review revealed interventions that included: administer medications as ordered by the physician and attempt medication administration three times prior to desisting.</p> <p>Review of Resident #2's monthly physician's orders for December 2015 revealed an order for Xanax (narcotic medication for anxiety) 1 milligram (mg) three times a day.</p> <p>Review of the Medication Administration Record</p>	F 282	<p>F282</p> <ol style="list-style-type: none"> 1. Resident #2 care plan was reviewed and updated by IDT Team (consisting of Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager) on 12/31/15 to validate plan of care related to refusal of medication was individualized and met resident goals. MD and Family were aware of resident's refusal of medication prior to survey. Resident #2 had no adverse effects related to alleged deficient practice. 2. Unit Managers were educated by Administrator and Director of Nursing on 01/06/16 on review of care plan, individualizing a care plan and refusal of medication. Unit Managers observed 5 Nurses/KMA giving medication and following plan of care related to refusal of medication and appropriate actions per the care plan to identify if there were any other issues related to not following the plan of care when a resident refuses medication. No issues were identified. Completion date 1/06/16 		

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F 282	<p>Continued From page 4</p> <p>(MAR) from December 2015 revealed the physician ordered Xanax was scheduled for 6:00 AM, 2:00 PM, and 10:00 PM. Further review of the MAR revealed Certified Medication Aide (CMA) #1 documented "N" indicating the medication was not administered on 12/16/15 and on 12/19/15 at 2:00 PM, 12/20/15 at 10:00 PM, and 12/21/15 through 12/27/15 at 2:00 PM. There was no documented evidence Resident #1 was offered the medication three times per the Comprehensive Care Plan before the medication was documented as "not administered."</p> <p>Review of the Medication Administration Notes revealed documentation by the CMA that the physician ordered Xanax was "refused by resident" on 12/16/15 and on 12/19/15 at 2:00 PM, 12/20/15 at 10:00 PM, and 12/21/15 through 12/27/15 at 2:00 PM, for a total of 20 doses of the medication. There was no documented evidence Resident #1 was offered the medication three times per the Comprehensive Care Plan before the medication was documented as "refused."</p> <p>Observations on 12/29/15 at 10:15 AM, 12:47 PM, and 1:30 PM, revealed Resident #1 was in his/her bed. Further observation revealed Resident #1 was yelling and cursing.</p> <p>Interview with CMA #1 on 12/29/15 at 2:43 PM, revealed she was aware of Resident #2's care plan interventions to offer refused medication three times before desisting. CMA #1 stated that Resident #2 refused his/her medication frequently and stated she did not always offer the medication three times per the interventions on the care plan.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 282	<p>3. Licensed staff will be re-educated on following plan of care for residents related to refusal of medication, where on the care plan the interventions are located and when to notify the MD for refusal of medication by Education Training Director by 01/31/16. IDT Team will audit 5 care plans a week for 4 weeks to ensure that care plan for refusal of medication is individualized and that the services provided are in accordance with the resident's written plan of care. Audit to begin week of 01/18/16. Any discrepancies identified will be corrected immediately.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager will review all audit findings and revise current plan at least monthly beginning January 2016 and ongoing until issue is resolved or satisfactory.</p> <p>5. Date of Compliance: 02/05/16</p>		

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F 282	Continued From page 5 12/30/15 at 6:17 PM, revealed she expected the staff to follow the care plan. The DON stated the CMA should have gotten another staff member to attempt to administer the medication.	F 282	F309		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of three (3) sampled residents (Resident #2). Review of the December 2015 Medication Administration Record (MAR) revealed 20 doses of Xanax (narcotic medication for anxiety) were not administered to Resident #2 according to the plan of care. The findings include: Review of the facility policy and procedure titled "Medication Administration," revealed	F 309	1. Resident #2 care plan was reviewed and updated by IDT Team (consisting of Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager) on 12/31/15 to validate plan of care related to refusal of medication was individualized and met resident goals. MD and Family were aware of resident's refusal of medication prior to survey. Resident #2 had no adverse effects related to alleged deficient practice. 2. Unit Managers were educated by Administrator and Director of Nursing on 01/06/16 on review of care plan, individualizing a care plan and refusal of medication. Unit Managers observed 5 Nurses/KMA giving medication and following plan of care related to refusal of medication and appropriate actions per the care plan to identify if there were any other issues related to not following the plan of care when a resident refuses medication. No issues were identified. Completion date 1/06/16 3. Licensed staff will be re-educated on following plan of care for residents related to refusal of medication, where on the care plan the interventions are located and when to notify the MD for refusal of medication by Education Training Director by 01/31/16.		

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F 309	<p>Continued From page 6</p> <p>medications were administered in accordance with written orders of the prescriber. Further review of the policy revealed if a medication was refused by a resident an explanatory note was entered on the reverse side of the record provided for PRN (as needed) documentation.</p> <p>Record review revealed the facility admitted Resident #2 on 02/22/14 with diagnoses that included Severe Intellectual Disabilities, Schizophrenia, Major Depression, and Anxiety.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 12/15/15 revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score "not assessed" indicating Resident #2 was not interviewable.</p> <p>Review of a Comprehensive Care Plan revised on 12/19/15 revealed Resident #2 had behaviors of agitation, was combative, and refused medication. Further review revealed interventions that included: administer medications as ordered by the physician and attempt medication administration three times prior to desisting.</p> <p>Review of Resident #2's monthly physician's orders for December 2015 revealed an order for Xanax (narcotic medication for anxiety) 1 milligram (mg) three times a day.</p> <p>Review of the December 2015 Medication Administration Record (MAR) revealed the physician ordered Xanax was scheduled for 6:00 AM, 2:00 PM, and 10:00 PM. Further review of the MAR revealed Certified Medication Aide (CMA) #1 documented "N" (Not Administered) on</p>	F 309	<p>IDT Team will audit 5 care plans a week for 4 weeks to ensure that care plan for refusal of medication is individualized and that the services provided are in accordance with the resident's written plan of care. Audit to begin week of 01/18/16. Any discrepancies identified will be corrected immediately.</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning January 2016 and ongoing until issue is resolved or satisfactory.</p> <p>Date of Compliance: 02/05/16</p>		

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F 309	<p>Continued From page 7</p> <p>12/16/15 and on 12/19/15 at 2:00 PM, 12/20/15 at 10:00 PM, and 12/21/15 through 12/27/15 at 2:00 PM. There was no documented evidence Resident #2 was offered the medication three times per the Comprehensive Care Plan before the medication was documented as "not administered."</p> <p>Review of the Medication Administration Notes revealed documentation by the CMA that the physician ordered Xanax was "refused by resident" on 12/16/15 and on 12/19/15 at 2:00 PM, 12/20/15 at 10:00 PM, and 12/21/15 through 12/27/15 at 2:00 PM, for a total of 20 doses of the medication. There was no documented evidence Resident #2 was offered the medication three times per the Comprehensive Care Plan before the medication was documented as "refused."</p> <p>Observations on 12/29/15 at 10:15 AM, 12:47 PM, and 1:30 PM, revealed Resident #2 was in his/her bed. Further observation revealed Resident #2 was yelling and cursing.</p> <p>Interview with CMA #1 on 12/29/15 at 2:43 PM, revealed she was aware of Resident #2's care plan interventions to offer refused medication three times before desisting. CMA #1 stated that Resident #2 refused his/her medication frequently and stated she did not always offer the medication three times per the interventions on the care plan.</p> <p>Interview with the Director of Nursing (DON) on 12/30/15 at 6:17 PM revealed she expected the staff to follow the care plan. The DON stated the CMA should have gotten another staff member to attempt to administer the medication.</p>	F 309			

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F 514 F 514 SS=D	Continued From page 8 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy and procedure it was determined the facility failed to ensure clinical records were maintained in accordance with accepted professional standards as complete and accurately documented for one (1) of three (3) sampled residents (Resident #1). Review of the Medication Administration Record for Resident #1 revealed the facility failed to document medication that was administered to the resident on 11/05/15. The findings include: Interview with the Administrator on 12/30/15 at 5.30 PM revealed the facility did not have a policy and procedure that addressed accuracy of	F 514 F 514	F 514 1. RN#1 validated that Resident #1 received Medication as prescribed per physicians orders. Statement of Deficiencies stated this was a CMA, however staff member was RN. Resident #1 had no adverse effects of alleged deficient practice. Medical Director notified by Director of Nursing 12/30/15 with no new orders received. 2. Unit Managers were re-educated on how to validate the Medication Administration record against the telephone order, how to audit the Narcotic Log for signature and quantity by Administrator and the Director of Nursing on 12/30/15 prior to survey exit. Unit Managers and Director of Nursing completed a one time audit of all residents in the facility receiving PRN narcotic medication and PRN anti-anxiety medication to identify if there were any issues with any other resident that did not have a signed Narcotic Log or Medication Administration Record.		

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F 514	<p>Continued From page 9 records.</p> <p>Review of the facility's policy and procedure titled "Medication Administration," dated December 2012, revealed the staff member who administered medication would immediately record the administration on the resident's MAR immediately following the medication administration. Further review revealed in no case should the individual who administered a medication report off duty without first recording the administration of any medication.</p> <p>Record review revealed the facility admitted Resident #1 on 09/29/15 with diagnoses including Amyotrophic Lateral Sclerosis (ALS), Anxiety, Hypertension, and Gastroesophageal Reflux Disease (GERD).</p> <p>Review of a physician's order dated 09/29/15 revealed Resident #1 was ordered Xanax (Narcotic medication for anxiety) 0.5 milligram (mg), three times a day.</p> <p>Review of a physician's order dated 10/07/15 revealed Resident #1 was ordered Xanax 0.5 mg at night as needed for anxiety.</p> <p>Review of a Narcotic Record dated 10/19/15 revealed Resident #1 was administered Xanax 0.5 mg on 11/05/15 at 1:00 AM. Further review revealed there was no signature in the Nurse's Signature area for that dose.</p> <p>Review of a Medication Administration Record (MAR) for November 2015 revealed no documented evidence Resident #1 received an as needed dose of the Xanax on 11/05/15.</p>	F 514	<p>Any discrepancies identified were immediately corrected. Completion date 01/06/16</p> <p>3. Licensed staff will be re-educated to ensure that all narcotics are signed out with quantity and signature as they are dispensed and to ensure that medication administration record is completed to validate that medication was given by the Education Training Director. Completion date 01/06/16. Unit Managers will randomly audit 10 PRN Narcotic/Anti-anxiety medications weekly for 4 weeks to ensure that Narcotic log is correct and Medication Administration record is complete. Audit to begin week of 01/18/16. Any staff member identified of not following process will be re-educated by Unit Managers, Director of Nursing or Education Training Director one on one. Director of Nursing will validate weekly that all Narcotic records and Medication administration records are correct on an ongoing basis.</p>		

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F 514	<p>Continued From page 10</p> <p>Interview with Certified Medication Aide (CMA) #1 revealed she worked the night shift on 11/05/15 and was the staff person who signed out the medication. CMA #1 stated she just forgot to initial the MAR and sign the Narcotic Record. CMA #1 stated she knew that was the facility's policy and stated she just got busy and forgot to sign it.</p> <p>Interview with the Director of Nursing (DON) on 12/30/15 at 6:17 PM revealed it was her expectation for staff to sign all narcotics out per the policy and procedure. Further interview revealed the MAR should have been initialed as well for any medication that was administered by the person who administered the medication. The DON stated she does "spot checks" on the MARs and Narcotic Records to ensure accuracy and completeness and stated she was not sure if the particular Narcotic Record had been reviewed yet.</p>	F 514	<p>3 continued.</p> <p>Unit Managers will validate daily Monday-Friday that all Narcotic records and Medication administration sheets are correct on an ongoing basis. Review of Narcotic records will be discussed ongoing in the Quality Assurance Meeting. Audit to begin week of 01/18/16</p> <p>4. The Quality Assurance Team consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director, Dietary Manager and Maintenance Supervisor will review all audit findings and revise current plan at least monthly beginning January 2016 and ongoing until issue is resolved or satisfactory. Review of Narcotic records will be discussed ongoing in the Quality Assurance Meeting.</p> <p>5. Compliance date 02/05/16</p>		