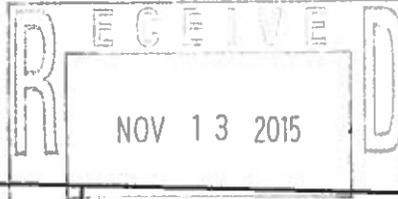


From:

11/13/2015 19:35

#974 P.002/027



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185339	(X2) MULTIPLE CONSTRUCTION: A. BUILDING <u>Government Branch</u> B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2015
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NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338
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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 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide ongoing activities to meet the residents' interests and psychosocial well-being for two (2) of seventeen (17) sampled residents (Resident #4 and Resident #11). The facility, after assessing Resident #5 as enjoying multiple different indoor and outdoor activities, failed to afford the resident the opportunity to enjoy indoor and outdoor activities. The facility assessed Resident #11 to enjoy music; however, the facility failed to provide a radio that had been requested by the resident.  The findings include:  A review of the facility policy for activities titled "Individual Activities and Room Visit Program," undated, revealed the activities program provided individual activities consistent with overall goals of an effective activities program and activities offered were reflective of the resident's individual	F 248	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 the federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.  F248 1. Resident # 4 was taken outside by family and not by activities staff. Resident #4 will be taken outside by facility staff per resident choice and documented by Activities staff Resident # 11 was provided a radio prior to survey exit 10/21/15 by Social Service Director. All activities attended and refused will be documented by Activities Director/staff  2. A one time audit was completed by Activities director for all residents in the center to identify if any other residents had activity preferences that were not being met. Anyone identified had care plan updated with activity preferences and all activities provided and/or refused will be documented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Lisa R. Johnson* TITLE Administrator DATE 11/13/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 248	<p>Continued From page 1 activity interest.</p> <p>1. Review of Resident #4's medical record revealed the facility admitted the resident on 02/10/15 with diagnoses of Type 2 Diabetes Mellitus, Major Depressive Disorder, Hypertension, Atrial Fibrillation, Aphasia, Dysphagia, Hemiplegia, Acute Upper Respiratory Infection, and Pneumonitis. Review of the Admission Minimum Data Set (MDS) assessment dated 02/10/15, revealed the resident's daily decision-making capabilities were moderately impaired which indicated Resident #4 was not able to be interviewed. Review of the Admission MDS assessment dated 02/10/15 revealed Resident #4's activity preferences were as follows: doing things with groups of people, going outside, music, news, reading, animals, and participating in religious services or practices. Review of the resident's plan of care, revised on 09/28/15, revealed the following interventions for activities: State Registered Nurse Aides (SRNAs) and Activities staff would assist Resident #4 to engage in group activities, offer activity programs directed toward specific interests of the resident, provide transportation to and assistance for engagement in activities as needed, continue to familiarize the resident with nursing home environment and activity programs on a regular basis, and arrange for the activity aide to visit and encourage the resident to observe specific or designated activities (religious oriented). The care plan further stated that Resident #4 enjoyed watching TV, reading, and listening to music.</p> <p>Review of the activity individual participation records from January to October 2015 for Resident #4 revealed the resident was only provided some type of activity program 31 times</p>	F 248	<p>3. Re-education was provided to Activities Director and Activities Staff by Administrator on one on one program, Activities as defined by F248, activities process and documenting one on one as well as refusals of activities. Completed 11/03/15. Hospice provider will be met with by Social Services Director and plan put in place that with each visit with resident that all issues and needs will be communicated to facility staff prior to hospice leaving the facility. Completion date 11/20/15. All direct care staff will be re-educated by Education Training Director on activity program, offering resident activities and ensuring that Activities Director is aware of refusals by 11/11/2015</p> <p>4. An audit will be completed by Administrator once a week for 4 weeks on all residents identified to meet the one on one program and reviewing the out of room activity log attendance sheet to ensure that Activities staff is documenting activities and refusals to begin week of 11/16/15. An audit of 5 care plans a week for 4 weeks will be completed by Activities Director to ensure that activity care plan is accurate and preferences are being met with documentation to validate that their activity preferences are being met. Audit to begin week of 11/16/15</p> <p>5. Audits will be reviewed monthly in Quality Assurance meeting (consisting of Social Service, Dietary Manager, Director of Nursing, Administrator, Maintenance Director, Activities Director) for 3 months in November, December 2015 and January 2016 to evaluate effectiveness of plan and make revisions and changes as necessary</p>	11/30/15	

Corrected #  
3

Received 12-1-15

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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 248	<p>Continued From page 2</p> <p>for the period reviewed. The following activities were documented: music three (3) times (08/21/15, 09/02/15, and 10/07/15), read to fourteen (14) times (04/14/15, 05/06/15, 06/01/15, 08/10/15, 08/15/15, 08/24/15, 07/07/15, 07/15/15, 08/26/15, 09/16/15, 09/23/15, 09/30/15, 10/09/15, and 10/12/15), one-on-one visits ten (10) times (04/14/15, 04/20/15, 04/22/15, 05/19/15, 05/26/15, 08/20/15, 09/09/15, 10/05/15, 10/16/15, and 10/19/15), group activity two (2) times (08/21/15 and 10/15/15), and news one (1) time (09/16/15). There was no documented evidence that the staff did any outside activities with Resident #4.</p> <p>Observation of Resident #4 on 10/20/15 at 2:53 PM revealed the resident was lying in bed in his/her room. The resident did not have a television or radio turned on, on his/her side of the room. Further observations conducted on 10/20/15 at 3:59 and 5:18 PM revealed that the resident was still in his/her room in bed, with no television or radio turned on in the room. According to the activity calendar, there was gospel singing at 4:00 PM on 10/20/15.</p> <p>Observation on 10/21/15 at 10:29 AM revealed that the resident was in his/her room in bed. Further observations on 10/21/15 at 11:00 AM revealed the resident was in his/her room in bed with the television on and his/her eyes closed. On 10/21/15 at 3:00 PM, Resident #4 was observed in his/her room in bed. On 10/21/15 at 4:03 PM Resident #4 was observed in his/her room in bed with his/her eyes open. According to the activity calendar, there was a religious activity in the Activity Room at 4:00 PM on 10/21/15.</p> <p>Observation on 10/22/15 at 10:19 AM revealed the resident was in bed with his/her eyes open. The television was on and according to the</p>	F 248			

From:

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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 248	<p>Continued From page 3</p> <p>activity calendar, there was a group activity in the Activity Room at 10:00 AM on 10/22/15.</p> <p>Interview with SRNA #9 on 10/22/15 at 4:47 PM revealed that she was one of the regular SRNAs for the resident. The SRNA stated it was the responsibility of nursing staff to get residents up and take them to some activities, but she had not seen Activities staff provide activities in residents' rooms much. SRNA #9 stated that "someone tells us" if residents need to be up for activities and they get them up. SRNA #9 further stated that Resident #4's family visits often.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 10/22/15 at 4:17 PM revealed that she had seen Activities staff read to Resident #4, but could not remember the resident going outside or to group activities. LPN #5 stated the facility has many religious activities, but could not remember if she had seen Resident #4 go out to any of the religious activities.</p> <p>Interview with Resident #4's Family Member on 10/22/15 at 1:01 PM revealed that he/she visited every day and had not seen staff provide any activities in Resident #4's room. The Family Member further stated that Resident #4 enjoyed gardening, being outside, religious activities, and church singing.</p> <p>Interview with the Director of Nursing on 10/08/15 at 8:15 PM revealed that she would expect staff to provide activities to the residents that they were assessed to enjoy.</p> <p>Interview with the Activities Director on 10/22/15 at 3:04 PM revealed that she does activities with Resident #4 but had not documented all the</p>	F 248			

From:

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NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338		
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F 248	<p>Continued From page 4</p> <p>activities that had been done.</p> <p>2. Review of a quarterly MDS assessment dated 07/31/15 conducted for Resident #11 revealed the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. According to the most recent comprehensive MDS, dated 04/30/15, Resident #11 was assessed for the activity of being able to listen to music as very important to the resident. Review of the activities participation records for Resident #11 from January to October 2015 revealed no documented evidence that the facility provided any music activities for Resident #11.</p> <p>Interview with Resident #11 on 10/22/15 at 2:00 PM, revealed the resident liked music and did not get to listen to music because it was hard for her to physically go to music activities. Resident #11 stated "someone" at the facility was going to get a radio so the resident could listen to music in his/her room, but the resident could not remember the date.</p> <p>A review of a hospice note from a visit dated 10/14/15 revealed a desire that was most important to the resident now was to have a radio to be able to listen to music.</p> <p>An interview conducted with the hospice Social Worker on 10/22/15 at 3:20 PM revealed when she had visited the resident on 10/14/15, the resident had requested a radio, and according to the Social Worker, she was trying to find one for the resident. The hospice Social Worker stated she had not considered coordinating the request with the facility or with the Activities Director.</p> <p>An interview with the facility Social Worker on</p>	F 248			

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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 248	Continued From page 5 10/22/15 at 2:15 PM revealed she was not aware of the resident's request for a radio or to listen to music in the resident's room. The facility Social Worker stated that hospice did not communicate concerns from every hospice visit with the facility.  An interview conducted with the facility Activities Director on 10/22/15 at 2:25 PM revealed she had music players residents could use in their rooms, but was not aware that Resident #11 had requested a radio to listen to music in the resident's room. According to the Activities Director music activities were offered by the facility in the dining room, but the resident refused to attend group activities.	F 248		
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, record review, and facility policy review, it was determined the facility failed to provide services in accordance with the plan of care to maintain grooming and personal hygiene for three (3) of seventeen (17) sampled residents (Residents #2, #8, and #9). Review of the plan of care for Residents #2, #8, and #9 revealed each resident had interventions to assure toenails were groomed. Observations on 10/20/15 and during skin assessments on 10/22/15 revealed residents had long untrimmed toenails.	F 282	1. Resident #2, #8 and #9 was seen by in-house podiatry Prime-Source service on 10/23/15 per facility established list compiled by Director of Nursing and Social Services Director on 10/14/15 Resident # 2, # 8, # 9 toenails were cut and trimmed and documented in the resident medical record.  2. A one time skin audit will be conducted by wound nurse on all residents in the facility to identify if any residents need nail care by 11/20/2015. Prime-source Podiatry service has evaluated all residents in the facility with permission to be treated as of 11/5/15. Any residents identified on skin audit by Wound nurse to need nail care will have nail care provided by qualified persons.	

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F 282	<p>Continued From page 8</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) and Administrator on 10/22/15 at 6:20 PM revealed the facility did not have a policy regarding following a resident's care plan.</p> <p>Review of the facility's policy, Oral Care Policy/Grooming/Nail Care, undated, revealed that residents were to have nails checked with morning and evening care to ensure grooming dignity. The policy further stated that the nurse was to check toenails during weekly skin assessments.</p> <p>1. Review of Resident #8's medical record revealed the facility admitted the resident on 04/12/13 with diagnoses that included Acute Pancreatitis, Tremor, Hypothyroidism, Dementia without behavioral disturbance, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 08/25/15, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was interviewable and required the total assistance of two persons for personal hygiene. Review of Resident #8's plan of care dated 09/17/15 revealed staff was to get assistance when trimming the resident's nails related to hand tremors.</p> <p>Observation of Resident #8 on 10/20/15 at 3:00 PM and interview at the time of the observation revealed the resident had long toenails in need of trimming and was requesting to have them trimmed.</p>	F 282	<p>3. All nursing staff will be reeducated by Education training director on when to perform nail care, reporting to nurse when a resident needs nail care and when to schedule podiatry in house. Completion date 11/05/15. Wound care nurse will be re-educated by Education Training Director one on one in addition to all nursing staff in-service on providing nail care and identifying when a resident needs nail care when providing weekly skin assessments by 11/15/15.</p> <p>4. Unit Managers/ Designee will complete 5 random skin audits weekly for 4 weeks to ensure that nails are being trimmed and cut if needed. Audit to begin week of November 16, 2015. Director of nursing will randomly observe 2 residents a day Monday-Friday for 4 weeks to ensure that auditing is effective at identifying resident need of nail care. Audit to begin week of 11/23/15. Prime-source documentation will be reviewed after every visit by the Unit Manager on an ongoing basis to ensure that patients are seen and needs have been met. To begin week of 11/16/15</p>		

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NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338
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F 282	Continued From page 7  Observation of a skin assessment for Resident #8 on 10/22/15 at 9:52 AM with Licensed Practical Nurse (LPN) #3 revealed the resident's toenails were long and in need of trimming.  Interview conducted with LPN #3 on 10/22/15 at 9:52 AM revealed that Resident #8 goes to Podiatry to have his/her toenails trimmed and was unsure when the resident last saw the podiatrist.  Interview with State Registered Nurse Aide (SRNA) #8 revealed that the Podiatrist cuts the resident's toenails and if the Podiatrist was not available the SRNA was to assess the nails during shower day and report to the nurse on duty and the nurse was to trim the nails.  2. Review of Resident #9's medical record revealed the facility admitted Resident #9 on 04/28/15 with diagnoses that included Thoracic, Thoracolumbar, and Lumbosacral Inverted Disc Disorder, Type 2 Diabetes Mellitus with diabetic neuropathy, Pain, Vitamin D Deficiency, Gastroesophageal Reflux Disease, Hypertension, Anemia, and Dementia without behavioral disturbance.  Review of a Quarterly MDS assessment dated 08/08/15 revealed Resident #9 had a BIMS score of 14 indicating the resident was interviewable and required the assistance of one person for personal hygiene. Review of Resident #9's plan of care revealed that a Podiatry consultation and treatment would be provided as indicated.  Observation of and interview with Resident #9 on 10/21/15 at 8:55 AM revealed the resident had	F 282	5. Audits will be reviewed monthly in Quality Assurance meeting (consisting of Social Service, Dietary Manager, Director of Nursing, Administrator, Maintenance Director, Activities Director) for 3 months in November, December 2015 and January 2016 to evaluate effectiveness of plan and make revisions and changes as necessary. Prime-source treatment list will be reviewed in QA monthly on an ongoing basis.	11/30/15

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F 282	<p>Continued From page 8</p> <p>long toenails in need of trimming and was requesting to have them trimmed.</p> <p>Observation of a skin assessment for Resident #9 on 10/22/15 at 9:35 AM with LPN #3 revealed the resident's toenails were long and in need of trimming.</p> <p>Interview conducted with SRNA #6 on 10/21/15 at 8:55 AM revealed the Podiatrist normally cuts Resident #9's toenails. SRNA #6 further stated that SRNAs assessed the nails during showers/baths and reported to the nurse if toenails were long and needed to be trimmed.</p> <p>Interview conducted with LPN #3 on 10/22/15 at 9:35 AM revealed the SRNAs were to assess nails during showers/baths and report to the nurses if any care was needed. LPN #3 stated if a resident was diabetic then only a nurse could trim the resident's nails.</p> <p>Interview conducted with the DON and Administrator on 10/22/15 at 6:20 PM revealed that nail care should be provided on shower days and completed with skin assessments. The DON and Administrator stated staff should not wait on Podiatry if toenails need to be trimmed.</p> <p>3. Observation on 10/21/15 at 9:05 AM revealed Resident #2 had long toenails on both feet. A complete observation was not conducted at that time because the resident had heel protectors on and all of the toenails could not be seen. However, at 11:20 AM, observation during perineal/catheter care and a skin assessment with Registered Nurse (RN) #1, SRNA #1, and SRNA #2, revealed four dark yellow toenails, two on each foot, that curled over the resident's toes.</p>	F 282			

From:

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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  10/22/2015
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 282	Continued From page 9  Review of the record for Resident #2 revealed the facility admitted the resident on 07/09/13 with diagnoses that included Multiple Sclerosis (MS), Dysphagia, Paralysis of Sciatic Nerve, Chronic Leg Pain, Neurogenic Bladder, Recurrent Urinary Tract Infections, Dementia, Behavioral Disturbances, Legally Blind, and Depression. Review of the Minimum Data Set (MDS) dated 07/11/15 revealed Resident #2 required extensive assistance with personal hygiene. Review of the Comprehensive Care Plan revealed Resident #2 had a self-care deficit due to the diagnosis of MS. The goal was for Resident #2 to "be neat, clean, and well groomed daily" and the approach was for "setup, cue, and assist as needed" with Activities of Daily Living (ADL); however, the care plan did not specifically address nail care.  Interview with SRNA #3 on 10/22/15 at 10:47 AM revealed nail care was to be provided to residents on shower/bath days. SRNA #3 further stated she provided Resident #2's shower on the evening of 10/17/15. SRNA #3 stated that when she provided a shower for the resident, Resident #2 received shampoo, bath, and toenails cut unless Resident #2 was agitated. SRNA #3 stated when Resident #2 was agitated SRNA #3 made the nurse aware that Resident #2's toenails needed to be cut. SRNA #3 did not remember if a nurse was made aware that Resident #2's toenails needed to be cut on 10/17/15.  Interview with RN #2 (telephone interview) on 10/22/15 at 10:30 AM revealed she completed the skin assessment for Resident #2 on 10/15/15 and all wounds had healed. RN #2 stated she could not recall if there was a problem with Resident #2's toenails. She stated if the toenails	F 282			



From:

11/13/2015 19:59

#974 P.013/027

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

PRINTED: 11/05/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2015
NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338	

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F 312 Continued From page 11

1. Review of Resident #8's medical record revealed the facility admitted the resident on 04/12/13 with diagnoses that included Acute Pancreatitis, Tremor, Hypothyroidism, Dementia without behavioral disturbance, Anxiety Disorder, and Major Depressive Disorder.

Review of a Quarterly Minimum Data Set (MDS) assessment dated 08/25/15, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was interviewable and required the total assistance of two persons for personal hygiene. Review of Resident #8's plan of care dated 08/17/15 revealed staff was to get assistance when trimming the resident's nails related to hand tremors.

Observation of and interview with Resident #8 on 10/20/15 at 3:00 PM revealed the resident had long toenails in need of trimming and was requesting to have them trimmed.

Observation of a skin assessment for Resident #8 on 10/22/15 at 9:52 AM with Licensed Practical Nurse (LPN) #3 revealed the resident's toenails were long and in need of trimming.

Interview conducted with LPN #3 on 10/22/15 at 9:52 AM revealed that Resident #8 goes to Podiatry to have his/her toenails trimmed and was unsure when the resident last saw the podiatrist. LPN #3 stated the facility did not have a podiatrist at this time and had recently hired one, but was not sure when he would be coming.

Interview with SRNA #8 revealed that the Podiatrist normally cuts the nails but if he/she is not here then the SRNA assessed the nails

F 312

4. Unit Managers will complete 5 random skin audits weekly for 4 weeks to ensure that nail care is being provided. Audit to begin week of November 16, 2015. Director of nursing will randomly observe 2 residents a day Monday-Friday for 4 weeks to ensure that auditing is effective at identifying resident need of nail care. Audit to begin week of 11/23/15

5. Audits will be reviewed monthly in Quality Assurance meeting (consisting of Social Service, Dietary Manager, Director of Nursing, Administrator, Maintenance Director, Activities Director) for 3 months in November, December 2015 and January 2016 to evaluate effectiveness of plan and make revisions and changes as necessary

11/30/15

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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 312 Continued From page 12  
during showers and reported to the nurse and they are responsible to trim nails.

2. Review of Resident #9's medical record revealed the facility admitted Resident #9 on 04/28/15 with diagnoses that included Thoracic, Thoracolumbar, and Lumbosacral Inverted Disc Disorder, Type 2 Diabetes Mellitus with diabetic neuropathy, Pain, Vitamin D Deficiency, Gastroesophageal Reflux Disease, Hypertension, Anemia, and Dementia without behavioral disturbance.

Review of a Quarterly MDS assessment dated 08/08/15 revealed Resident #9 had a BIMS score of 14 indicating the resident was interviewable and required the assistance of one person for personal hygiene. Review of Resident #9's plan of care revealed that a Podiatry consultation and treatment would be provided as indicated.

Observation of Resident #9 on 10/21/15 at 8:55 AM revealed the resident had long toenails in need of trimming and was requesting to have them trimmed.

Observation of a skin assessment for Resident #9 on 10/22/15 at 9:35 AM with LPN #3 revealed the resident's toenails were long and in need of trimming.

Interview conducted with State Registered Nurse Aide (SRNA) #8 on 10/21/15 at 8:55 AM revealed the Podiatrist normally cuts Resident #9's toenails. SRNA #8 further stated that SRNAs assessed the nails during showers/baths and reported to the nurse if toenails were long and needed to be trimmed.

F 312

From:

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F 312	<p>Continued From page 13</p> <p>Interview conducted with LPN #3 on 10/22/15 at 9:35 AM revealed the SRNAs were to assess nails during showers/baths and report to the nurses if any care was needed. LPN #3 stated if a resident was diabetic then only a nurse could trim the resident's nails.</p> <p>Interview conducted with the DON and Administrator on 10/22/15 at 6:20 PM revealed that nail care should be provided on shower days and completed with skin assessments. The DON and Administrator stated staff should not wait on Podiatry if toenails needed to be trimmed.</p> <p>3. Review of the record for Resident #2 revealed the facility admitted the resident on 07/09/13 with diagnoses that included Multiple Sclerosis (MS), Dysphagia, Paralysis of Sciatic Nerve, Chronic Leg Pain, Neurogenic Bladder, Recurrent Urinary Tract Infections, Dementia, Behavioral Disturbances, Legally Blind, and Depression. Review of the Minimum Data Set (MDS) dated 07/11/15 revealed Resident #2 required extensive assistance with personal hygiene. Review of the Comprehensive Care Plan revealed Resident #2 had a self-care deficit due to the diagnosis of MS with decreased mobility. The goal was for Resident #2 to "be neat, clean and well groomed daily" and the approach was for "setup, cue, and assist as needed" with Activities of Daily Living (ADL) and to "complete weekly skin assessment and document in skin inspection." Further review of the record revealed no documented evidence of Resident #2's long toenails.</p> <p>Observation on 10/21/15 at 9:05 AM revealed Resident #2 had long toenails on both feet. A complete observation was not conducted at that time because the resident had heel protectors on</p>	F 312			

From:

11/13/2015 20:00

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F 312	Continued From page 14 and all of the toenails could not be seen. However, at 11:20 AM, observation during perineal/catheter care and a skin assessment with Registered Nurse (RN) #1, SRNA #1, and SRNA #2, revealed four dark yellow toenails, two on each foot, that curled over the resident's toes.  Interview on 10/22/15 at 9:53 AM with LPN #1 (Unit Manager) revealed nurses monitor nail care through skin assessments that are done weekly. She further stated that staff documented by exception and unless there was a problem there would be no documentation other than the assessment being completed.  Interview with RN #2 (telephone interview) on 10/22/15 at 10:30 AM revealed she completed the skin assessment for Resident #2 on 10/15/15 and all wounds had healed. RN #2 stated she could not recall if there was a problem with Resident #2's toenails. She stated if the toenails had been long, they would have been cut at that time or RN #1 would have been made aware to clip the toenails.  Interview with SRNA #3 on 10/22/15 at 10:47 AM revealed that Resident #2 had received a shower on the evening of 10/17/15 provided by SRNA #3. SRNA #3 further stated that when SRNA #3 provided a shower, Resident #2 received shampoo, bath, and toenails cut unless Resident #2 was agitated. SRNA #3 stated when Resident #2 was agitated, SRNA #3 made the nurse aware that Resident #2's toenails needed to be cut. SRNA #3 did not remember if a nurse was made aware that Resident #2's toenails needed to be cut on 10/17/15.	F 312			
F 371	483.35(l) FOOD PROCURE,	F 371			

From:

11/13/2015 20:00

#974 P.017/027

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

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F 371 S6=E	Continued From page 15 STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of facility policies, and review of manufacturer's guidelines it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observations on 10/20/15 revealed the facility Kitchen staff failed to calibrate thermometers to ensure food was served at an appropriate temperature, and failed to follow the manufacturer's guidelines for testing the three-compartment sink to ensure proper sanitation of dishes.  The findings include:  Review of the facility's policy, "Three Compartment Sink," no date, revealed the following procedure was to be followed for the sanitation of dishes washed in the three-compartment sink: 1) fill sink 1 with water with the water temperature to at least 110 degrees Fahrenheit; 2) fill sink 2 with rinse water or leave the sink empty if you spray-rinse items;	F 371	1. Employees in the kitchen including the new dietary manager were immediately re-educated by a tenured Dietary Manager from another facility on how to properly use the three compartment sink and proper immersion time and temperature requirements for sanitizing dishes in the 3 compartment sink and how to calibrate a thermometer with return demonstration. Documentation was also provided by Regional Dietician for additional reference. Re-education was completed prior to survey exit on 10/21/15. New updated three compartment sink chemical dispenser was installed 10/22/15 and all employees in the kitchen were educated on proper use by the Ecolab representative, Christopher Hatfield prior to survey exit. Surveyor was present and had staff demonstrate use of 3 compartment sink.  2. Dietary employees will be given a validation checklist by the Dietician and/or Dietary Manager with return demonstration with all sanitary equipment in the kitchen to ensure proper usage and understanding as well as proper sanitation that all foods must be stored, prepared, distributed, and served under sanitary conditions and all cooking utensils and dishware sanitized to meet requirements by November 16, 2015 to identify any additional education and training needed for the dietary staff.		

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F 371	Continued From page 16 3) fill sink 3 with hot water to a temperature of 171 to 180 degrees Fahrenheit or use sanitizer at least 200 parts per million (ppm) prepared with warm water; 4) Allow dishes to air dry, do not hand dry. The policy did not address how often or when to check the sanitizer.  Review of the facility's policy, "Calibrating a Thermometer," dated June 2009 revealed instructions to calibrate a thermometer. The following instructions were given to calibrate a thermometer using the ice water method: fill a large glass with finely crushed ice; add clean tap water to the top of the ice and stir well; immerse the food thermometer stem a minimum of two (2) inches into the mixture, touching neither the sides nor the bottom of the glass; wait a minimum of 30 seconds before adjusting (for ease in handling, the stem of the food thermometer can be placed through the clip section of the stem sheath and, holding the sheath horizontally, lowered into the water); without removing the stem from the ice, hold the adjusting nut under the head of the thermometer with a suitable tool and turn the head so the pointer reads 32 degrees Fahrenheit. The following instructions were given to calibrate a thermometer using the boiling water method: bring a pot of clean tap water to a full rolling boil; immerse the stem of a food thermometer in boiling water a minimum of two (2) inches and wait at least 30 seconds (for ease in handling, the stem of the food thermometer can be placed through the clip section of the stem sheath and, holding the sheath horizontally, lowered into the boiling water); without removing the stem from the pan, hold the adjusting nut under the head of the food thermometer with a suitable tool and turn the head so the thermometer reads 212 degrees Fahrenheit.	F 371	3 All Dietary staff will be re-educated on equipment usage, sanitary requirements for cooking utensils, dishware and that all foods must be stored, prepared, distributed and served under sanitary conditions by the Dietician/and or Dietary Manager by November 16, 2015  4. A sanitation audit will be completed by the dietary manager and forwarded to the Administrator and Regional Dietician weekly for review to ensure that sanitation requirements are being met and that any identified issues are resolved. Audit to begin week of November 9 2015 to be completed ongoing with no end date. Dietary Manager will observe kitchen staff calibrating a thermometer 2 x a week for 4 weeks beginning week of November 30, 2015 to validate that staff are calibrating thermometers and are doing so properly. Ongoing a log will be completed weekly validating that thermometers are calibrated and reviewed weekly by Dietary Manager Administrator will also complete a sanitation audit weekly for 4 weeks to ensure that sanitation and food preparation is being followed. Audit to begin the week of November 16, 2015	

Corrected  
# 4

From:

11/13/2015 20:01

#974 P.019/027

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338
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F 371

Continued From page 17

F 371

Review of the facility training handout, "Everything you Always Wanted to Know about Bimetallic Stemmed Thermometers... But Were Afraid to Ask," Section D revealed, "Thermometers should be calibrated regularly to ensure accuracy. a. At the start of each shift. b. Any time that they are dropped. c. Any time that they are exposed to extreme changes in temperature."

Review of the directions for use of the sanitizer revealed that the "required water temperature should be from 65 degrees to 75 degrees (room temperature)" and there should be from 150 ppm to 400 ppm of sanitizer present in the water.

Review of the three-compartment sink Sanitizer Log dated October 2015 revealed that the morning and noon sanitizer level had only been checked one time on 10/04/15. The log further revealed the night level had been checked every day and had a reading of 300 ppm each time except for one reading on 10/08/15 and it was 200 ppm.

Observation on 10/20/15 at 11:40 PM revealed Cook #2 was taking food temperatures on the serving line in the kitchen. Cook #2 was asked how often the thermometer was calibrated and Cook #2 replied that she did not know. Further observation revealed Cook #2 then went to the sink and placed four thermometers in a cup of hot tap water from the sink.

Interview with Cook #1 at 11:45 AM revealed that to calibrate thermometers, staff was to place the thermometers in hot water and when they reached the same temperature, they were calibrated.

5. Audits will be reviewed monthly in Quality Assurance meeting (consisting of Social Service, Dietary Manager, Director of Nursing, Administrator, Maintenance Director, Activities Director) for 3 months in November, December 2015 and January 2016 to evaluate effectiveness of plan and make revisions and changes as necessary

11/30/15

From:

11/13/2015 20:01

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F 371	Continued From page 18  Interview on 10/20/15 at 3:39 PM with Cook #2 revealed she had worked in the kitchen for three years and she had never calibrated a thermometer.  Observation on 10/20/15 at 12:35 PM revealed Dietary Aide #2 set up the three-compartment sink. Dietary Aide #2 then took a sanitizer reading that indicated the sanitizer was well below the minimum of 200 ppm required for adequate sanitation.  Interview with Dietary Aide #2 on 10/20/15 at 12:40 PM revealed that she was told to fill the sink up to the line and push the button one time to add the sanitizer. The Dietary Aide stated that no one was assigned to check the sanitizer level.  Interview with the Dietary Manager (DM) on 10/22/15 at 4:45 PM revealed that when new staff starts they are put with tenured staff and they do on the job training. The DM stated all staff should know how to calibrate thermometers and all staff should follow the manufacturer's guidelines for the sanitizer and know how to properly test the sanitizer solution.  Interview with the Technician on 10/22/15 at 12:55 PM revealed even though the sanitizer dispenser said to push the button one time he had to push it three times to get the correct sanitizer concentration; he said the current dispenser was very old and it was not putting out enough sanitizer in the water.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

From:

11/13/2015 20:02

#974 P.021/027

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 441	<p>Continued From page 19</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>1. Certified Nursing Assistant that was identified during survey as not following appropriate hand-washing was in-serviced one on one on proper hand-washing and infection control practices by Education and Training Director on 10/22/2015 prior to survey exit.</p> <p>2. A random review of 8 employees were observed on hand-washing practices and overall infection control practices by the Unit Manager to identify if there are other employees that are not following proper hand-washing and infection control practices. Those employees identified were immediately educated. Completion date 11/06/15.</p> <p>3. All staff was re-educated on proper hand-washing and infection control practices by Education Training Director- Completion date 10/29/15</p>		

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NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338		
(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 441	Continued From page 20  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 maintain an effective Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Observations during meal service on 10/20/15 revealed State Registered Nurse Aide (SRNA) #7 touched a resident and continued to pass meal trays without sanitizing her hands.  The findings include:  Review of the facility's policy, "General Infection Control Policy," no date, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment to help prevent and manage transmission of diseases and infections.  Observation on 10/20/15 at 6:44 PM revealed SRNA #7 was observed passing food trays to residents in their rooms. SRNA #7 was observed coming out of a resident's room when she stopped in the hall and hugged a resident touching the resident on the back. SRNA #7 proceeded to the food cart, got a tray, and took it into another resident's room and set up the tray. SRNA #7 was then observed to go to the food cart, get another tray, and serve it to a resident without washing or sanitizing her hands.  Interview with SRNA #7 on 10/20/15 at 6:48 PM revealed that SRNA #7 said she had not noticed that she had not washed or sanitized her hands.	F 441	4. An audit will be completed by Unit Managers and/or Education Training Director observing 8 employees a week for 4 weeks varying all three shifts combination of nurses and certified nursing assistants to validate that staff are following appropriate hand-washing and adhering to adequate infection control practices. Audit to begin week of 11/9/2015. Director of Nursing will validate audits weekly for 4 weeks to ensure compliance.  5. Audits will be reviewed monthly in Quality Assurance meeting (consisting of Social Service, Dietary Manager, Director of Nursing, Administrator, Maintenance Director, Activities Director) for 3 months in November, December 2015 and January 2016 to evaluate effectiveness of plan and make revisions and changes as necessary	11/30/15	

Corrected  
#4

From:

11/13/2015 20:03

#974 P.023/027

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

PRINTED: 11/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2015
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 441	Continued From page 21  Interview with Licensed Practical Nurse (LPN) #2 on 10/22/15 at 4:17 PM revealed that SRNA #7 should have sanitized her hands after touching the resident and that the facility policy was to sanitize their hands after every third tray served.  Interview with the Director of Nursing (DON) on 10/22/15 at 6:00PM revealed that SRNA #7 should have washed her hands after touching the resident, and should have been sanitizing her hands between each tray and washing her hands every third tray when passing trays in resident rooms.	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure that equipment necessary to sanitize dishes in the kitchen was in safe operating condition. Observation on 10/20/15 revealed that the three-compartment sink sanitizer dispenser was not dispensing enough sanitizer solution to provide adequate sanitation.  The findings include:  Interview with the Maintenance Director on 10/22/15 8:00 PM revealed that there was not a	F 456  F456	1. The three compartment Quat Sanitizer dispenser above the three compartment sink was an older version and operated slowly requiring multiple pushes of button to release multiple units of sanitizer. The unit was in working order per Ecolab representative however was old. A new updated sanitizer was ordered and installed prior to survey exit on 10/22/15.  2. An audit of all equipment in the kitchen was completed by Administrator and Dietary manager to identify if any other equipment was not working properly or old and functioned slowly. Audit completed 11/12/15. Any equipment identified will be replaced by 11/30/15. Unit Manager/Designee will complete a one time review all equipment in facility to identify any need for equipment that is not functioning or working slowly by 11/20/15. Any equipment identified will be replaced by 11/30/15.		

From:

11/13/2015 20:03

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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 458	<p>Continued From page 22</p> <p>policy that covered equipment that was not working properly.</p> <p>Review of the facility's policy, "Three Compartment Sink," no date, revealed sanitizer was to be added to sink 3 to an amount of at least 200 parts per million (ppm) of sanitizer.</p> <p>Review of the three-compartment sink Sanitizer Log for October 2015 revealed that from 10/01/15 to 10/20/15 the morning and noon sanitizer level had only been checked one time on 10/04/15 and all readings were within the acceptable range (200 ppm to 300 ppm).</p> <p>Observation of the sanitizer dispenser on 10/20/15 at 12:35 PM revealed that there was a sticker above the dispenser button that said "Push One Time."</p> <p>Observation on 10/20/15 at 12:35 PM revealed Dietary Aide #2 set up the three-compartment sink pushing the sanitizer dispenser button one time, and took a sanitizer reading after the water was up to the fill line. Observations revealed the sanitizer was well below the minimum 200 parts per million required for adequate sanitation.</p> <p>Interview with Dietary Aide #2 on 10/20/15 at 12:40 PM revealed that she was told to fill the sink up to the line and push the button one time in order to get the appropriate amount of sanitizer.</p> <p>Interview with Cook #2 on 10/20/15 at 3:39 PM revealed that she was told to fill the sink up to the line and push the sanitizer dispenser one time in order to get the appropriate amount of sanitizer.</p> <p>Interview with the Technician on 10/22/15 at</p>	F 458	<p>3. Re-education was provided for all dietary staff by Dietary manager on proper use of all kitchen equipment and in addition how to use the three compartment sink Quat Sanitizer and calibrate a thermometer with return demonstration on 11/03/2015 Re-education was provided by dietary Manager for dietary staff on how to report to maintenance if there is broken equipment, how to complete a work order and notifying Administrator and Dietary Manager immediately. Completion date 11/16/2015</p> <p>4. Observation of 2 employees a day Monday-Friday will be completed by Dietary manager to ensure that equipment is being used properly. Audit to begin week of November 16, 2015. Audit of equipment in kitchen will be completed weekly for 4 weeks by Dietary Manager to ensure that all equipment is functioning properly and in working order. Administrator will complete a walk through of kitchen weekly for 6 weeks to ensure compliance with equipment, documentation of temp logs and overall sanitation to ensure compliance of above plan. Audit to begin week of November 16, 2015</p> <p>5. Audits will be reviewed monthly in Quality Assurance meeting beginning in November 2015, December 2015 and January 2016. Team will review and determine success and or if revisions of the plan is necessary.</p>	11/30/15	

From:

11/13/2015 20:04

#974 P.025/027

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/22/2015
NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338		
(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 456	Continued From page 23 12:55 revealed even though the sanitizer dispenser said to push the button one time, he had to push it three times to get the correct sanitizer concentration. The Technician stated the current dispenser was very old and it was not putting out enough sanitizer in the water with just one push of the button.  Interview with the Maintenance Director on 10/22/15 at 6:00 PM revealed that he would not work on the Ecolab equipment, that the kitchen staff would either send a work order or call him directly and let him know what the problem was, and he would make sure that Ecolab had been notified. He was not aware of any problems with the sanitizer dispenser.  Interview with the Housekeeping/Dietary Manager on 10/21/15 at 3:55 PM revealed that the instructions for the three-compartment sink were to fill the sink with water to the line on the sink with the water temperature between 100 and 120 degrees Fahrenheit. Staff was to push the button on the sanitizer dispenser one time to deliver enough sanitizer to have the sanitizer at 200 ppm or more. The Housekeeping/Dietary Manager stated she was not aware that the dispenser was not working correctly.	F 456			
F 489 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 489			

From:

11/13/2015 20:04

#974 P.026/027

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

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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 469	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of facility policy it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Observations from 10/20/15 to 10/22/15 revealed roaches in the Kitchen area.</p> <p>The findings include:</p> <p>Review of the facility's policy dated 01/01/15, titled "Pest Control Program," revealed that the facility would maintain an effective pest control program that eradicated and contained common household pests.</p> <p>Review of the current pest control contract revealed the facility was contracted with a pest control agency and the contract went into effect on 08/16/15. Review of the service report for 08/28/15 revealed that German Roaches had been identified in the facility. Further review of the service reports for 07/20/15, 08/17/15, and 09/20/15 revealed that German Roaches and Oriental Roaches had been detected in the facility and had been treated.</p> <p>Observation on 10/20/15 at 3:30 PM revealed two roaches in the dish room crawling up the wall under the dish machine. Further investigation revealed twelve additional live roaches in the dish room on the walls, floor, and ceiling. Observation on 10/20/15 at 3:56 PM revealed a live roach on the counter of the tray serving line and a Dietary Aide removed it.</p> <p>Observation on 10/21/15 at 3:49 PM revealed a live roach crawling above the three-compartment</p>	F 469	<ol style="list-style-type: none"> <li>The facility currently has a pest control program through Orkin. The facility was on an active treatment plan with additional plans established and "bombing" to be completed prior to survey entrance. Orkin Representative came in center and treated 10/23/15 with little activity noted. At 7pm. Bombing occurred at 10pm on 10/23/15 as previously scheduled. Upon exit, Orkin Representative documented no visible pests.</li> <li>Orkin Representative was contacted and an additional onsite visit was completed to identify if there were any pests issues in the facility and/or kitchen. No visible pests were noted by Orkin. Completion date 10/23/15</li> <li>Re-education will be completed for all staff by Education Training Director on work orders, when to notify maintenance of a needed issues of equipment and/or pests by 11/20/15. Pest Control binder has been put in place to document any areas of visible pests and upon Orkin entrance the Tech will easily be able to identify area of additional treatment needed. Completion date 10/23/15. Service reports are completed with every treatment and indicates if there is any live activity present.</li> </ol>		

From:

11/13/2015 20:04

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2015
NAME OF PROVIDER OR SUPPLIER  IRVINE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40338	

(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 469	Continued From page 25 sink and the Dietary Manager removed it.  Observation on 10/22/15 at 12:49 PM revealed a live roach crawling up the wall in the dish room.  Interview with Dietary Aide #1 on 10/20/15 at 3:30 PM revealed that roaches had been a problem for several months and that they had been "really bad" at times.  Interview with Cook #2 on 10/20/15 at 3:39 PM revealed that there had been a roach problem for several months.  Interview with the Dietary Manager on 10/22/15 at 4:45 PM revealed that every time she saw roaches she notified the Front Desk and they notified the pest control company. The Dietary Manager estimated that the pest control company had to be notified six or seven times since April 2015. The Dietary Manager stated the kitchen staff made sure food was covered or wrapped so roaches could not get into the food. She further stated that roaches had been a problem for several months.	F 469	4. An audit will be completed weekly of Dietary Manager to review for any live pests in the kitchen area. Audit to be ongoing weekly. Any identified area will be documented in the Orkin Binder with Administrator notified. Audits to begin week of November 16, 2015. Department managers will complete room rounds daily to identify if any live pests are present beginning week of 11/16/15 and continue for 4 weeks.  5. Audits will be reviewed monthly in Quality Assurance meeting beginning in November 2015, December 2015 and January 2016. Team will review and determine success and or if revisions of the plan is necessary	11/30/15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185339</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>IRVINE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>411 BERTHA WALLACE DRIVE IRVINE, KY 40336</b>		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 111 (211)</p> <p>SMOKE COMPARTMENTS: Five</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET and DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II propane generator</p> <p>A life safety code survey was initiated and concluded on 10/21/15, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.