

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

PRINTED: 11/23/2010
FORM APPROVED
OMB NO. 0938-0391

R E C E I V E D
DEC - 3 2010
11/05/2010

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 11/05/2010
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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336 Division of Health Care Southern Enforcement Branch
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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
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F 000	INITIAL COMMENTS A standard health survey was conducted on November 3-5, 2010. Deficient practice was identified with the highest scope and severity at "E" level.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F157 1. Resident # 2 physician was notified of bowel elimination pattern for prior 60 (sixty) days on 11/05/2010 by the RDCS (Regional Director of Clinical Services) with no new orders. Resident #2 presently has interventions in place to promote bowel elimination and prevent constipation per physician order. 2. A 100% record review will be completed by the DON, Unit Manager(UM), Education Training Director(ETD) and /or the RDCS by 12/10/2010 to identify any change in condition that should be reported to the physician, this will include reviewing bowel elimination records for all residents from period of 10/01/2010 thru 12/01/2010. Any issue identified will be immediately reported to the attending physician by the DON, UM, ETD and /or RDCS. 3. RDCS to reeducate DON, UM and ETD regarding p/p for reporting change in condition to physician and p/p for bowel care and follow up by 12/06/2010. DON/ETD to re educate Licensed Personnel regarding p/p for reporting change in condition to physician and p/p for bowel care and follow up by 12/10/2010. DON, UM and /or ETD to randomly audit ten(10) records each week x six(6) weeks beginning 12/10/2010, then will review five (5) records each week x four(4) weeks to ensure p/p for reporting change in condition to physician was followed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Wilcox TITLE: ADMINISTRATOR (X6) DATE: 12/3/10

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident's physician promptly when a change in the resident's physical status changed for one (1) of seventeen (17) sampled residents. Resident #2 had a diagnosis of constipation and no bowel movement was recorded for four (4) consecutive days and as an-needed medication was administered to the resident on the fifth day. On September 22, 2010, resident #2 complained of rectal pain and the resident required manual removal of large amounts of stool from the rectum. However, there was no evidence the facility notified the resident's attending physician for further interventions to promote bowel elimination after the fecal impaction was removed on September 22, 2010. On September 24, 2010, the resident again complained of rectal discomfort and a large amount of stool was removed manually from the resident's rectum. The findings include: Resident #2 was admitted to the facility on July 10, 2010, with diagnoses of Diabetes Mellitus - Type II, Constipation, Depression, and Status Post Lap Cholecystectomy. A review of resident #2's physician's orders dated September 2010 revealed Enulose 30 milliliters (ml) was ordered to be administered daily and Milk of Magnesia (MOM) 30 ml to be administered daily as needed for constipation. A review of the Care Tracker documentation by the facility Certified Nursing Assistants (CNAs)	F 157	DON/UM to review bowel elimination record for all residents five (5) x week x eight (8) weeks beginning 12/06/2010, then three (3) x week x four (4) weeks to ensure p/p for bowel care and follow up is followed. RDCS to randomly review five (5) records monthly for three (3) months beginning week of 12/10/2010 to ensure p/p for reporting change in condition to physician is followed. RDCS to review bowel elimination records for all residents two (2) x a week x four (4) weeks then one (1) time a week x four (4) weeks beginning week of 12/10/2010 to ensure p/p for bowel care and follow up is followed. 4. Quality Assurance Committee (QA) to review audit results and revise plan as needed weekly x four(4) weeks then bi weekly x four (4) weeks beginning 12/17/2010. 5. Date of Compliance 12/18/2010.		

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F 157	<p>Continued From page 2</p> <p>revealed there was no bowel movement (BM) recorded for resident #2 On September 16, 17, 18, and 19, 2010 (a total of four days). A small bowel movement was recorded on September 20, 2010, at 12:34 a.m. A review of the medication administration record (MAR) revealed MOM 30 ml was not administered to the resident until September 20, 2010, at 8:00 p.m. A medium bowel movement was recorded on the Care Tracker report on September 21, 2010, at 9:55 a.m. On September 21, 2010, MOM 30 ml was again administered to resident #2.</p> <p>A review of the nurse's notes dated September 22, 2010, at 7:00 p.m., revealed resident #2 was crying out with pain in the rectum and was checked for an impaction by the staff nurse. Hard stool was identified in the resident's rectum and the staff nurse administered a Fleets Mineral Enema; however, the resident was unable to pass the stool. The staff nurse further documented that a large amount of hard stool was manually removed from resident #2's rectum. Further review of the nurse's notes revealed resident #2 again complained of rectal discomfort on September 24, 2010, at 11:00 a.m. The nurse assessed the resident to have hard stool present and a large amount of stool was again noted to be removed manually from the resident's rectum. However, there was no evidence the facility had contacted resident #2's attending physician regarding possible further physician's orders to promote bowel elimination after the fecal impaction was removed on September 21, 2010.</p> <p>A review of the facility's policy/procedure related to constipation (dated September 2005) revealed standard bowel care with a physician's order to relieve constipation included MOM 30 ml every</p>	F 157			

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F 157	Continued From page 3 third day without bowel movement, Bisacodyl suppository rectally if no results from the MOM, and fleets Enema rectally if no results from the Bisacodyl suppository. An interview conducted with Registered Nurse (RN #1) on November 4, 2010, at 5:05 p.m., revealed the RN stated he/she checked resident #2 for a fecal impaction on September 22, 2010, and removed a large amount of hard stool from the resident's rectum. The RN stated he/she did not review the bowel elimination record for resident #2 and did not identify that the bowel protocol had not been implemented for resident #2. The RN further stated he/she did not notify resident #2's attending physician since he/she believed the resident was making "progress." An interview conducted with the facility nurse consultant (FNC) on November 4, 2010, at 6:50 p.m., revealed the facility nurses were required to follow the established bowel elimination protocol. The FNC stated the nurses were responsible to contact the resident's attending physician to obtain orders for bowel care. In addition, the FNC stated the physician should be contacted for further intervention when a medication had not been effective to promote bowel elimination for the resident. A review of the facility policy/procedure regarding physician notification (dated January 2005) revealed the resident's physician was required to be notified/updated when a change occurred in the resident's condition.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must		F309 1. Resident #2 and Resident #3 physician was notified of bowel elimination patterns for prior sixty(60) days on 11/05/2010 by the RDCS with no new orders. Resident #2 and Resident #3 presently have interventions in place to monitor bowel elimination and prevent constipation.	

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F 309	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of seventeen (17) sampled residents (residents #2 and #3). Resident #2 had a diagnosis of constipation and no bowel movement was recorded for four (4) consecutive days; however, there was no evidence the facility provided timely intervention as directed by the facility's established bowel management protocol. On September 22 and 24, 2010, the resident required manual removal of large amounts of stool from the rectum. In addition, resident #3 had documentation of ten (10) days without having a bowel movement. There was no documentation in the medical record to substantiate the facility nursing staff intervened as required by the facility's Constipation Management Policy.</p> <p>The findings include:</p> <p>1. Resident #2 was admitted to the facility on July 10, 2010, with diagnoses of Diabetes Mellitus - Type II, Constipation, Depression, and Status Post Lap Cholecystectomy. An admission Minimum Data Set (MDS) assessment completed on July 14, 2010, revealed resident #2 was</p>	F 309	<p>2.DON, UM, ETD and /or RDCS to review bowel elimination reports for all residents for period of 10/01/2010 thru 12/01/2010 to identify any resident who did not have bowel movements per p/p by 12/10/2010. DON, UM,ETD to review all MDS assessments to identify any resident who was coded with no bowel movement for seven(7) days by 12/10/2010. Any issue identified will be reported to physician immediately.</p> <p>3.RDCS to re educate DON, UM and ETD regarding p/p for bowel care and follow up to ensure constipation is prevented by 12/06/2010. DON/ETD to re educate all Licensed personnel regarding p/p for bowel care and follow up to prevent constipation by 12/10/2010. Facility MDS staff to be re educated by RDCS by 12/06/2010 regarding p/p for bowel elimination and follow up and to report any identified issue when reviewing bowel elimination to DON/UM and/or Administrator. DON/UM to review bowel elimination record for all residents five (5) x week x eight (8) weeks then three (3) x a week for four(4) weeks beginning 12/06 2010 to ensure p/p for bowel care is followed. DON/UM to randomly review 5 MDS assessments weekly for four (4) weeks beginning 12/10/2010 to ensure no resident is coded for no bowel movement in seven (7) days.</p>	
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F 309	<p>Continued From page 5</p> <p>assessed to have intact long/short-term memory, independent cognitive skills, and no indicators of disordered thinking. Resident #2 was assessed to be usually continent of bowel and to require extensive assistance of two for toileting needs.</p> <p>A review of the Care Plan for resident #2 dated July 1, 2010, revealed the facility identified a problem related to incontinence and constipation with a goal for the resident to have a bowel movement every three days. Interventions included to encourage the resident to call with the urge to evacuate, to monitor bowel elimination using the Care Tracker, and to provide medication as ordered to aid in elimination.</p> <p>A review of resident #2's physician's orders dated September 2010 revealed Enulose 30 milliliters (ml) was ordered to be administered daily and Milk of Magnesia (MOM) 30 ml to be administered daily as needed for constipation.</p> <p>A review of the Care Tracker documentation by the facility Certified Nursing Assistants (CNAs) revealed there was no bowel elimination for resident #2 on September 16, 17, 18, and 19, 2010 (four days). However, there was no evidence the facility had provided an intervention to address the absence of a bowel movement for resident #2 until September 20, 2010.</p> <p>A review of the Medication Administration Record (MAR) for September 2010 revealed MOM 30 ml was administered to resident #2 on September 20, 2010, at 8:00 p.m. and on September 21, 2010, at 1:00 p.m. Further review of the bowel elimination record for resident #2 revealed a small bowel movement was documented at 12:34 a.m. on September 20, 2010, and a medium</p>	F 309	<p>RDCS to review bowel elimination records for all residents two(2) x a week then one (1)x a week x four(4) weeks beginning week of 12/10/2010.</p> <p>4. QA Committee to review audit findings and revise plan as needed one (1) x week x four (4) weeks then bimonthly x four (4) weeks beginning 12/17/2010.</p> <p>5. Date of Compliance 12/18/2010.</p>	

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F 309	<p>Continued From page 6</p> <p>bowel movement was documented at 9:55 a.m. on September 21, 2010.</p> <p>A review of the nurse's notes dated September 22, 2010, at 7:00 p.m., revealed resident #2 was crying out with pain in the rectum and was checked for an impaction by the staff nurse. Hard stool was identified in the resident's rectum and the staff nurse administered a Fleet's Mineral Enema; however, the resident was unable to pass the stool. The staff nurse further documented that a large amount of hard stool was manually removed from resident #2's rectum. Further review of the nurse's notes dated September 24, 2010, at 11:00 a.m., revealed resident #2 again complained of rectal discomfort and the nurse assessed the resident to have hard stool present. The nurse administered a Fleets Mineral enema; however, the resident was again unable to pass the stool. A large amount of stool was noted to be removed manually from the resident's rectum.</p> <p>A review of the facility's policy/procedure related to constipation (dated September 2005) revealed standard bowel care to relieve constipation included MOM 30 ml every third day without bowel movement (BM), Bisacodyl suppository rectally if no results from the MOM, and Fleets enema rectally if no results from the Bisacodyl suppository.</p> <p>Multiple interviews conducted with CNAs #1 and #2 on November 4, 2010, at 5:05 through 5:10 p.m., revealed the CNAs were aware resident #2 had problems with constipation in the past. The CNAs stated the lack of bowel movement was to be reported to the charge nurse and bowel movements were to be documented in the Care Tracker under resident #2's care record.</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>Interviews with Registered Nurses (RNs) #1 and #2 on November 4, 2010, at 4:45 p.m. and 5:05 p.m., revealed all the staff nurses were responsible to monitor the residents' bowel movements daily. The RNs stated the Unit Supervisor or the Director of Nurses (DON) checked the bowel elimination record daily and provided the staff nurses with a list of residents who had not had a bowel movement in three days. The RNs stated a laxative was required to be administered to the residents on the third day that the resident did not have a documented bowel movement. The RNs also stated the nurses were responsible to check the MAR to evaluate the results of the laxative. RN #1 stated he/she checked resident #2 for a fecal impaction on September 22, 2010, and removed a large amount of hard stool from the resident's rectum. The nurses were unable to explain why the bowel protocol had not been implemented for resident #2.</p> <p>An interview with the facility DON on November 4, 2010, at 2:50 p.m., revealed the DON was responsible to check the bowel elimination record daily and to provide the nurses with a list of all residents who had not had a bowel movement in three days. The DON stated the nurses were responsible to monitor for the effectiveness of the medications/laxatives. The DON was unable to explain why the facility staff had not followed the bowel protocols for resident #2.</p> <p>A review of the daily bowel list provided by the DON revealed resident #2 was identified as having no bowel movement for three days on the list dated September 18, 19, and 20, 2010. However, there was no evidence the facility</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>provided interventions for resident #2 until September 20, 2010, when MOM was administered to the resident.</p> <p>2. A review of the medical record for resident #3 revealed the resident was admitted to the facility on October 19, 2010. The resident had diagnoses to include Congestive heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Dementia, Anxiety, and Depressive Disorder.</p> <p>A review of the Admission Minimum Data Set (MDS) for resident #3 dated October 1, 2010, revealed the resident had been assessed as having no bowel movement for the entire seven days prior to the assessment.</p> <p>A review of the physician's orders for resident #3 revealed the resident had an order dated October 19, 2010, for Miralax 17 grams to be administered daily by mouth as needed for no bowel movement. The resident further had orders dated October 19, 2010, for Dulcolax Rectal Suppository to be administered if the resident had not had a bowel movement after two days and a physician's order dated October 20, 2010, for Coliace 100 milligrams to be administered twice daily.</p> <p>A review of the Resident Bowel and Bladder Record from October 19, 2010 through October 27, 2010, revealed the resident had no bowel movements recorded for this time period.</p> <p>A review of the Medication Administration Record for resident #3 revealed no documentation that the resident received Miralax or Dulcolax until October 27, 2010, when the resident received</p>	F 309			

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F 309	Continued From page 9	F 309			
F 312 SS=D	<p>Miralax 17 grams. A bowel movement was recorded for resident #3 on October 28, 2010.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>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 maintain appropriate grooming and personal hygiene for two (2) of seventeen (17) sampled residents (residents #7 and #12).</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #7 revealed the resident was admitted to the facility on March 5, 2006. The resident had diagnoses to include Debility, Chronic Obstructive Pulmonary Disease, Macular Degeneration, and Cerebral Vascular Accident.</p> <p>A review of the most current quarterly Minimum Data Set (MDS) assessment dated July 21, 2010, revealed the resident was assessed to be independent with cognitive skills for daily decision-making, with the resident's decisions assessed to be consistent and reasonable. The resident had further been assessed to require total assistance of one person to bathe.</p>	F 312 F312	<p>1. Resident #7 and Resident #12 was offered and given a shower on 11/05/2010.</p> <p>2. DON, UM and ETD to review shower report for all residents by 12/06/2010 for period of 10/01/2010 thru 12/05/2010 to identify any resident not receiving two(2) showers a week. Anyone not receiving two(2) showers a week will be offered a shower immediately.</p> <p>3. DON/ETD to re educate all nursing staff regarding p/p for offering and giving showers per residents individualized plan of care by 12/07/2010.</p> <p>DON/UM to review shower report for all residents five(5) times a week beginning 12/06/2010 x eight(8) weeks to ensure showers are being offered and residents are being assisted per their individualized plan of care.</p> <p>RDCS to review shower report for all residents three(3) x a week x four (4) weeks then one(1) x a week x four(4) weeks beginning 12/06/2010 to ensure all residents are being offered showers per their individualized plan of care.</p> <p>Activity Director to interview alert residents in Resident Council one(1) time a month x three(3) months and report findings to Administrator regarding whether residents are being offered showers and assisted per their plan of care.</p>		

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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: 185339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2010
NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH 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 312	<p>Continued From page 10</p> <p>A review of the SRNA assignment sheet revealed resident #7 required the assistance of one person for showers.</p> <p>Observation of resident #7 on November 4, 2010, at 2:05 p.m., revealed the resident was ambulating in the hall with a walker. The resident stated, "I'm going to that meeting with the other residents. I am going to tell them I don't get a shower half the time. All they do is give me a pan of water and I have to wash myself." The resident's nails were observed to be dirty and his/her hair appeared oily.</p> <p>A review of the Bath Detail Report for resident #7 revealed staff documented the resident had received a shower on October 4, 2010, October 7, 2010, October 11, 2010, October 15, 2010, October 18, 2010, October 24, 2010, October 25, 2010, October 28, 2010, November 3, 2010, and November 4, 2010.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #1 on November 4, 2010, at 3:10 p.m., revealed all residents were to receive two showers every week according to the SRNA. The SRNA further stated the nurse should be notified if the resident does not want a shower. The SRNA further stated resident #7 could accurately tell whether he/she had received a shower and did not refuse showers.</p> <p>2. A review of the medical record for resident #12 revealed the resident was admitted to the facility on September 17, 2010, with diagnoses to include Congestive Heart Failure, Hypothyroidism, Atrial Fibrillation, Hypertension, Chronic Obstructive Pulmonary Disease, Osteoporosis, and Convulsions.</p>	F 312	<p>4. QA Committee to review audit findings and revise plan as needed one(1) x a week x four(4) weeks then bi monthly x four (4) weeks beginning 12/17/2010.</p> <p>5. Date of Compliance 12/18/2010.</p>	

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F 312	<p>Continued From page 11</p> <p>A review of the Admission Assessment Minimum Data Set (MDS) dated September 29, 2010, revealed the resident was independent with cognitive skills for daily decision-making, ambulatory with extensive assistance of one person, required extensive assistance of one person with personal hygiene, and required total care for bathing with the assistance of one person.</p> <p>Observation on November 3, 2010, at 1:15 p.m., revealed resident #12 sitting on the side of his/her bed. The resident was very short of breath with talking. The resident's hair appeared oily and his/her fingernails were dirty. The resident stated, "I have only had one shower since I have been here." The resident further revealed the staff of the facility never asked if he/she would prefer a bed bath or a shower. The resident verbalized he/she preferred to receive showers, however, staff had been bringing a pan of water, leaving it on the resident's bedside table, and leaving without assisting the resident.</p> <p>A review of the Bath Detail Report for resident #12 revealed staff documented the resident had received a shower on September 21, 2010, September 28, 2010, October 1, 2010, and October 26, 2010.</p> <p>An interview conducted with SRNA #1 on November 4, 2010, at 3:10 p.m., revealed all residents were to receive two showers every week, and the resident's nurse should be notified if the resident did not want a shower. According to the SRNA, resident #12 does not refuse showers.</p>	F 312		

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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336
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F 312	<p>Continued From page 12</p> <p>An interview conducted with SRNA #2 on November 4, 2010, at 3:20 p.m., revealed at times the facility was short-staffed. According to SRNA #2, when they were short-staffed residents were assisted with bed baths instead of showers.</p> <p>An interview with the Corporate Nurse (CN) for the facility was conducted on November 5, 2010, at 2:20 p.m. The CN revealed all residents were to be showered twice every week. The CN further stated a shower schedule was kept at the nurses' station for every resident and the SRNAs were expected to notify the nurse if a shower is not given. The CN further revealed residents #7 and #12 would accurately be able to say whether they had been receiving showers. The CN stated residents #7 and #12 were alert and oriented and if they said they did not get a bath he/she believed them. The CN further stated the nurse is responsible for monitoring to ensure the residents received a shower.</p> <p>When asked for the facility policy on bathing, the facility provided a page from the Lippincott Manual, Unit #3, page 336, titled Basic Patient and Resident Care. The page stated the method of bathing was determined by many factors including personal choice, and the resident's wishes should be respected.</p>	F 312		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically</p>	F 431	<p>1. The items of Flu vaccine, two bags of 5% Dextrose with 0.2% Sodium Chloride, and two bags 5% Dextrose were immediately discard and replace by pharmacy. No specific resident identified. All residents have the potential to be affected.</p> <p>2. DON, UM and ETD to audit all medication rooms to identify any drug or biological that are not locked per p/p, all drugs and biological are stored per p/p and identify any drugs or biological expired by 12/07/2010.</p>	

Tony Willis Jr Administrator Addendum 12/10/10

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F 431	<p>Continued From page 13 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. The facility had one (1) bottle of Influenza Virus Vaccine opened and available for use with no date on the bottle indicating when the bottle was opened. The facility also had two (2) bags of 5% dextrose with 0.2% Sodium Chloride for intravenous use with an expiration date of</p>	F 431	<p>3.RDCS to re educate DON,UM and ETD regarding p/p for storage of drugs and biological, p/p for ensuring no expired drug or biological is available for resident use and ensuring all scheduled drugs are locked by 12/07/2010.</p> <p>DON/ETD to re educate all Licensed personnel regarding p/p for storage of drugs and biological, ensuring no expired drug or biological is available for use and that all controlled drugs are locked per p/p by 12/12/2010.</p> <p>Pharmacy Representative to audit all medication rooms by 12/17/2010 to ensure no expired drugs or biological are available for use, drugs and biological are stored per p/p and all controlled drugs and biological are locked per p/p.</p> <p>DON/UM and/or ETD to audit medication rooms two (2) x a week x four (4) weeks then one (1) x a week to ensure all drugs and biological are stored per p/p , no expired drug or biological are available for use and all controlled drugs are locked per p/p beginning 12/13/2010.</p> <p>RDCS to audit medication rooms one(1) x a month x two(2) months to ensure no expired drugs or biological are available for use, all drugs and biological are stored per p/p and all controlled drugs are locked per p/p beginning month of December 2010.</p>	

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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336		
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F 431	<p>Continued From page 14</p> <p>October 2010 in a cart and available for use. The facility also had two (2) bags of 5% Dextrose for intravenous use with an expiration date of September 2010 in the cart available for use.</p> <p>The findings include:</p> <p>Observation of the facility's medication room on the West Wing of the facility on November 5, 2010, at 10:00 a.m., revealed a bottle of Influenza Virus Vaccine opened and available for use, however, the bottle did not contain a date indicating when the bottle was opened.</p> <p>An interview conducted with the Director of Nursing (DON) for the facility on November 5, 2010, at 11:15 a.m., revealed the Unit Manager (UM) for the West Wing of the facility was not available due to a family illness. The DON revealed the UM was responsible for checking to assure all opened medications had been labeled indicating the date the medication was opened.</p> <p>A review of the facility policy titled Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles with a revision date of May 10, 2010, revealed staff was required to record the date opened on the medication container.</p> <p>Observation of the facility's medication room on the East Wing of the facility on November 5, 2010, at 10:30 a.m., revealed two 1,000-milliliter bags of 5% Dextrose and 0.2% Sodium Chloride for intravenous use available for use with expiration dates of October 2010. The observation further revealed two 1,000-milliliter bags of 5% Dextrose for intravenous use available for use with expiration dates of September 2010.</p>	F 431	<p>4. QA Committee (consists of Administrator, DON, UM, ETD, Social Services, Activities, Pharmacy Representative and Environmental Services) to review audit findings one (1) x a week x four (4) weeks then bimonthly x one (1) month beginning 12/17/2010.</p> <p>5. Date of Compliance 12/18/2010.</p>		

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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336	
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F 431	Continued From page 15 An interview was conducted with the DON for the facility on November 5, 2010, at 11:15 a.m. The DON revealed the UM was responsible for checking weekly for expired medications and intravenous fluids. A review of the facility policy titled Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles with a revision date of May 10, 2010, revealed staff was required to destroy or return all outdated/expired medications or biologicals in accordance with Pharmacy return/destruction guidelines and other applicable law. The policy further revealed the facility should request that the pharmacy perform a routine nursing unit inspection for each nursing unit in the facility to assist the facility in complying with its obligations pursuant to applicable law relating to the proper storage, labeling, security, and accountability of medications and biologicals, however, there is no evidence this was done.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents of the facility. Rust was found in four (4) bathtubs in the facility, a chipped windowsill was observed in the dining room, and raised tile	F 465	F465 1. The East and West Wings bathrooms in both the men's and women's shower rooms were cleaned and the rust removed from the drain or the drain replaced. The marble windowsill in main dining room had large chip repaired. Loose tile was repaired in rooms 111 and 128. The night stand in room 227 was replaced. The chipped sink countertop was repaired in room 110. The medical equipment in room 115 bathroom has been removed and the wash basin has been covered and stored for the resident's use.	

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F 465	<p>Continued From page 16</p> <p>was present in two (2) resident bedrooms. In addition, chipped countertop was observed in a resident's bedroom, multiple pieces of equipment were being stored in a resident's bathroom, and a resident's nightstand was observed to have rough, chipped edges.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The bathtubs in both the men's and the women's shower rooms on both the East and West Wings of the facility had rust on the drains and were dirty. 2. The marble windowsill in the main dining room of the facility had a large chip in it. 3. Loose raised tile was observed in resident rooms 111 and 128 in front of the bathroom doors. 4. A nightstand with rough, chipped edges was observed in resident room 227. 5. A chipped sink countertop was observed in resident room 110. 6. The bathroom in resident room 115 contained two wheelchairs, three fall mats, four wheelchair foot pedals, and a plastic wash basin hanging over the sink faucet. <p>An interview was conducted with the Housekeeping Supervisor (HS) for the facility and the Maintenance Supervisor (MS) for the facility on November 5, 2010, at 12:30 p.m. The HS revealed he/she and the MS conducted monthly rounds with the Administrative staff of the facility. The HS further revealed the staff reported to</p>	F 465	<ol style="list-style-type: none"> 2. Administrator, Housekeeping Supervisor(HS) and Maintenance Supervisor (MS) completed a resident rooms, dining rooms and shower rooms audit of any rooms that needed to be cleaned, countertops or windowsills with chips, loose tiles, medical equipment stored in resident's areas and for furniture with chipped edges. Any of the above that was found was repaired or replaced. 3. Administrator, MS and HS will do weekly rounds for next 30 days to identify any housekeeping or maintenance Concerns, then bi-weekly for next 30 days and then 1 time a month next month. These rounds will start the week of 12/6/10. Administrator, HS and MS will conduct at a minimum 1 time a month rounds together going forward. 4. The above weekly, bi-monthly rounds results will be brought to QA meeting to validate that areas of concerns are being identified and addressed. 5. Date of compliance 12/18/10. 	

Tony Waller Jr
Administrator

12/3/10

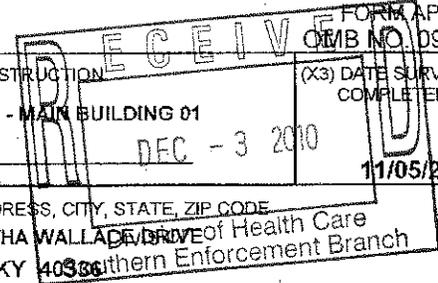
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F 465	Continued From page 17 Housekeeping any areas found and the housekeepers clean the problem area immediately. The MS revealed the staff of the facility was required to complete a maintenance work order and send to Maintenance for repairs to be completed. The interview revealed they were unaware of the items in need of cleaning or repair.	F 465			

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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE of Health Care IRVINE, KY 40336 Southern Enforcement Branch
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K 000	INITIAL COMMENTS	K 000		
K 062 SS=F	<p>A life safety code survey was initiated and concluded on November 5, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on a record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected four (4) of four (4) smoke compartments, staff, and all of the residents. The facility has the capacity for 88 beds with a census of 82 on the day of the survey.</p> <p>The findings include:</p> <p>The Life Safety Code tour on November 5, 2010, at 12:30 p.m., with the Director of Maintenance (DOM) revealed no interior pipe inspection or full flow trip test reports for the facility's sprinkler system. This inspection and test ensures the sprinkler system reacts as intended. An interview with the DOM on November 5, 2010, at 12:30 p.m., revealed the DOM would contact the</p>	K 062	<p>K062</p> <p>The DOM did contact the sprinkler Contractor and they did validate that the test and inspection had been completed, a copy was faxed to the OIG office by the prior Administrator, but we cannot validate it was sent. We have attached a copy of the inspection to this plan of correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Terry Wilkoff</i>	TITLE Administrator	(X9) DATE 12/3/10
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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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NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY, 40336		
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K 062	<p>Continued From page 1</p> <p>sprinkler contractor to see if this inspection and test had been performed. The DOM stated a copy of this test and inspection would be forwarded to this office if they had been performed. This office has not received this information as of November 23, 2010.</p> <p>Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>9-1* General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p>	K 062			

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

PRINTED: 11/23/2010
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2010
NAME OF PROVIDER OR SUPPLIER IRVINE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336		
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K 147	<p>Continued From page 3</p> <p>resident room 214. These types of receptacles help prevent personnel from accidental shock by receptacles located near wet areas. An interview with the DOM on November 5, 2010, at 11:20 a.m., revealed there were 41 resident rooms that did not have GFCI protected receptacles. The DOM stated there used to be GFCI adapters that went to these receptacles but have since been removed.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>210-8. Ground-Fault Circuit-Interrupter Protection for Personnel</p> <p>7. Wet bar sinks. Where the receptacles are installed to serve the countertop surfaces and are located within 6 ft (1.83 m) of the outside edge of the wet bar sink. Receptacle outlets shall not be installed in a face-up position in the work surfaces or countertops.</p> <p>517-20. Wet Locations</p> <p>a. All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated. Exception: Branch circuits supplying only listed, fixed, therapeutic and diagnostic equipment shall be permitted to be supplied from a normal grounded service, single- or 3-phase system, provided that</p> <p>a. Wiring for grounded and isolated circuits does not occupy the same raceway, and</p> <p>b. All conductive surfaces of the equipment are grounded.</p> <p>b. Where an isolated power system is utilized, the equipment shall be listed for the purpose and</p>	K 147			

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K 147	Continued From page 4 installed so that it meets the provisions of and is in accordance with Section 517-160. FPN: For requirements for installation of therapeutic pools and tubs, see Part F of Article 680. 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			