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

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OMB NO. 0938-0391

RECEIVED
OCT 15 2012
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18833	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/20/2012
NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 214 BERTHA WALLACE DRIVE IRVINE, KY 40336	

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F 000	INITIAL COMMENTS	F 000		
	An abbreviated standard survey (KY19067) was initiated on 09/18/12 and concluded on 09/20/12. The complaint was substantiated with deficient practice identified at 'D' level.			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		
	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).		Physician Notification 1. Resident # 1 Primary care physician was notified of lab result of 09/13/12 by fax and verbally notified 09/17/12. Resident out of facility and no new orders were obtained. 10/16/12 2. All records will be reviewed by DON, SS and Unit Managers for a 30 day look back (09-10-10/9) by 10/15/12 to identify any change in condition that the M.D. and family was not notified. All concerns will be immediately corrected and will be reported to MD and Family.	
	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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Johnson — TITLE: Administrator — (X6) DATE: 10/12/12

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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	185339		C 09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVINE NURSING AND REHABILITATION CENTER	411 BERTHA WALLACE DRIVE IRVINE, KY 40336

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to notify the physician when there was a need to alter to treatment for one of three sampled residents (Resident #1). Interview and record review revealed staff collected a urine specimen from Resident #1 on 09/10/12 to be cultured. On 09/13/12, the culture result was sent to the facility and revealed a result of Pseudomonas Aeruginosa (bacteria). Facility staff failed to notify the physician of the results of the urine culture until 09/17/12, when the physician received the results via fax at his office and as a result there was a delay in treatment of the resident's infection. The findings include: A review of the facility policy, "Notification of Resident Change in Condition," not dated, revealed facility staff was to immediately inform the resident and consult with the physician and, if known, the resident's legal guardian when there was a significant change in the resident's physical, mental, or psychosocial status. According to the policy, if the change in the resident's condition was not crucial or significant, the resident's physician was required to be notified at the earliest convenient time. A review of Resident #1's medical record revealed the facility admitted the resident on 04/13/11 with diagnoses to include Muscle Weakness and Chronic Kidney Disease. A	F 157	3. Re-education was completed for all licensed nurses on change in condition and physician/family notification on 09/30/12 by Administrator and Director of Nursing. An audit will be completed on all labs weekly for 12 weeks by Unit Manager to ensure that all lab results have been communicated to MD and family. A random audit of 20 charts will be reviewed weekly by the Unit Manager/ DON/ ETD x 4 weeks to ensure any change in condition was reported to MD and family. Any issues identified will require one on one re-education with staff.	

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F 157	Continued From page 2 review of a physician's order dated 09/01/12 revealed the resident had an abnormal urinalysis and as a result the physician ordered Diflucan (antifungal antibiotic) 200 milligrams to be given for one day and then 100 milligrams to be given every day for seven days. The physician also requested that an antibiotic (Avelox) ordered on 08/31/12 be continued. A review of a physician's order dated 09/10/12 (nine days after the previous order) revealed facility staff was to obtain a urinalysis from Resident #1 for culture and sensitivity. A review of nurse's notes revealed the urine sample was obtained from Resident #1 on 09/10/12 at 2:00 PM. A review of the lab report revealed the preliminary report dated 09/12/12 for Resident #1's urine culture revealed Pseudomonas Aeruginosa (bacteria) was found in the resident's urine. Facility staff had written on the lab report that the physician and the family were notified of the results. A review of the final lab report dated 09/13/12 confirmed a growth of Pseudomonas Aeruginosa (bacteria) was found in the urine. A review of the lab report for 09/13/12 and nursing notes for 09/13/12 revealed no evidence the physician had been notified of the final urine culture results. Interview with Licensed Practical Nurse (LPN) #2 on 09/19/12 at 2:45 PM, revealed she received the final report for the urine culture for Resident #1 on Thursday, 09/13/12. LPN #2 stated she received the results from the lab at around 10:30 PM, and she faxed the results to the physician's office. LPN #2 stated she was aware Resident #1's physician was not in the office on Friday but she "assumed" someone was at the office on Fridays. LPN #2 acknowledged she was required to notify a resident's physician with abnormal lab	F 157	4. QA meeting consisting of (Administrator, DON, Social Services, Activities Director, Nutritional Services Manager) will review audit finding and make recommendations for follow up weekly x 2 weeks beginning week of 10/15/12, then 2 times monthly for one month or per QA recommendations. QA will be ongoing until compliance is achieved. 5. Compliance Date 10/16/12	10/16/12

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F 157	Continued From page 3 results and stated she did not verbally notify Resident #1's physician of the urine culture report received on 09/13/12. Interview with Resident #1's physician on 09/19/12 at 11:57 AM, revealed he was not notified of Resident #1's abnormal urine culture results on 09/13/12 and would have expected staff to have called him. The physician stated that although Resident #1 was on an antibiotic (Avelox), a different antibiotic was required to treat the bacteria that were identified in the urine culture obtained on 09/10/12. Further interview revealed the physician would have expected facility staff to call him with the abnormal urine results either on 09/13/12 or on 09/14/12, and he would have ordered a change in treatment for Resident #1. Interview with the physician revealed he had previously informed staff that he wanted to be called on Fridays, even though he was not in the office, regarding any changes in a resident's condition or any abnormal lab results. Interview with the Director of Nursing on 09/19/12 at 2:28 PM, revealed staff was required to notify a resident's physician with any change in the resident's condition or any time there was a need to alter treatment. The DON further stated LPN #2 should have called Resident #1's physician with the abnormal urine culture so that proper treatment could have been initiated in a timely manner.	F 157		