

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

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

*Acceptable
PoC
1/30/14*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) STATE SURVEY COMPLETED 12/19/2013
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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
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F 000 INITIAL COMMENTS

A standard health survey was initiated on 12/17/13 and concluded on 12/19/13 and a Life Safety Code survey was conducted on 12/19/13 with deficiencies cited at the highest scope and severity of an "F" with the facility having opportunity to correct the deficiencies before remedies would be recommended for imposition.

Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation."

F 323 483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=E

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. Resident # 4 wheelchair foot cradle in need of repair was replaced on 12/19/13 prior to survey exit. Toilet bolt covers will be placed on all toilet bowls in the facility by Maintenance Director. Completion date 01/24/14
2. A one time audit to be completed by Administrator and/or Environmental Manager on all equipment to identify if any other equipment is in need of repair. Any equipment identified will be repaired and/or replaced. Completion date 01/16/14

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the resident environment and equipment remained as free of accident hazards as was possible. The facility failed to ensure toilet bolt covers were in place on facility toilets in resident bathrooms and shower rooms. In addition, Resident #4's wheelchair foot cradle was worn with jagged edges, and created a potential for skin injury.

- The findings include:
1. Interview with the facility Administrator, on 12/19/13 at 4:54 PM, revealed the facility did not have a policy related to environmental hazards to prevent injury. The Administrator stated her

JAN 4 8 2014

02/01/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sam Johnson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/27/14</i>
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Any deficiency statement ending with an asterisk (*) indicates 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 323 Continued From page 1
expectation was the facility would provide the residents with a clean, homelike environment which was free from accidents.

Observations during a tour of resident bathrooms and shower rooms, on 12/19/13 starting at 1:53 PM, revealed the toilet bolts were not covered in the following resident bathrooms: 104, 108, 109, 114, 115, 118, 119, 123, 125, 130, 201, 202, 206, 207, 209, 210, 213, 214, 218, 223, and 227. Many of the bathrooms were shared by adjoining resident rooms. In addition, observation of the common shower rooms revealed the toilets had bolts which were not covered. The uncovered bolts exposed a sharp object which presented a potential for injury to the residents.

Observation of the exposed toilet bolts and interview with the Maintenance Director, on 12/19/13 at 4:00 PM, revealed when he repaired toilets in the resident bathrooms he replaced the original toilet bolts with heavy duty bolts, to prevent them from breaking off. He stated the cap covers did not fit over the replaced bolts. He further stated the exposed bolts could be harmful to a resident if they were to fall or slip in the bathroom.

Interview with the Administrator, on 12/19/13 at 4:20 PM, revealed she knew there was a problem with exposed bolts at the facility a few years ago. She stated the bolts were too tall and had to be cut down. She further stated the current problem would be fixed and monitoring of the issue could be added to the environmental rounds.

2. Observation of Resident #4 on 12/17/13 at 3:20 PM, 12/18/13 at 8:35 AM and 9:50 AM, and on 12/19/13 at 4:10 PM, revealed the foot cradle

F 323 4. An audit will be completed by Environmental Manager 2 x a week for 4 weeks on all equipment used by residents to ensure equipment is free of hazards. To begin week of 01/13/14. Unit Managers to establish a check off list to be completed when wheelchairs/Geri-chairs are cleaned per schedule to ensure that any hazards are identified and corrected. To begin week of 01/13/14 ongoing. Administrator to complete walking environmental rounds 2 x a week for 4 weeks to begin week of 01/13/14 to ensure that environment is clean, sanitary and free of hazards, then monthly ongoing.

5. The audits will be reviewed once a month for the following months February 2014, March, 2014, April 2014 during Quality assurance meetings consisting of the following (Social Services, Activities Director, Environmental Manager, Director of Nursing, Administrator, Education Training Director and Medical Director quarterly) determine success of the plan and make recommendations to continue and/or revise plan.

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F 323 Continued From page 2
on the resident's wheel chair was torn with jagged edges, which produced a potential for skin injury.

F 323

Interview with the Director of Nursing (DON), on 12/19/13 at 4:10 PM, revealed Resident #4's foot cradle was in dire need of repair. The DON stated any staff member should report equipment in need of repair or replacement. She further stated the resident did have frail skin and could receive an injury from the jagged edges. Continued interview revealed the facility did not have a policy related to the issue.

F514

F 514 483.75(l)(1) RES
SS=F RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure each resident's clinical record was accurately documented, for seventeen (17) of seventeen (17) sampled residents. A review of Physician Orders and Progress Notes revealed all did not

1. Timing of physicians orders were immediately implemented prior to survey exit on 12/19/13.
2. An audit of all orders were completed to identify any issues and/or care concerns related to any non timed physicians orders by Unit Managers on 12/20/13 and immediately corrected for any issues identified.
3. Education was completed for all licensed staff by Education Training Director that all telephone physicians orders and progress notes are to be timed with the time and date the order was received. Completed by 12/20/13
4. An audit of 10 physician telephone orders will be reviewed by Unit Managers 3 x a week for 4 weeks, then 2 times a week for 3 weeks to ensure that physicians telephone orders and progress visits are timed when order is received. Director of Nursing will audit physicians telephone orders on 5 residents randomly weekly for 3 weeks to ensure compliance.

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F 514 Continued From page 3
include the time they were received or written.

The findings include:

Review of the medical records for the seventeen (17) sampled residents revealed multiple Physician telephone orders did not indicate the time the order was received. In addition, Physician Progress Notes did not include the time the Physician saw the resident.

Interview with the Director of Nursing (DON), on 12/19/13 at 3:55 PM, revealed she had not considered the timing of Physician orders to be a standard of practice; however, she agreed all Physician Orders and Progress Notes should be timed.

Interview with the Administrator, on 12/19/13 at 4:25 PM, revealed the facility had not trained staff to time Physician orders. She stated she saw the importance of timing Physician Orders and Progress Notes and would begin training staff regarding the practice immediately.

F 514

5. The audits will be reviewed once a month beginning February 2014, March 2014 and April 2014 during Quality assurance meetings consisting of the following (Social Services, Activities Director, Environmental Manager, Director of Nursing, Administrator, Education Training Director and Medical Director quarterly) to determine success of the plan and make recommendations to continue and/or revise

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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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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR §483.70 (a)
BUILDING: 01
PLAN APPROVAL: 1985
SURVEY UNDER: 2000 Existing
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: Two story, Type 111 (211)
SMOKE COMPARTMENTS: Five
COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM
FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)
EMERGENCY POWER: Type II Diesel generator

Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation

A life safety code survey was initiated and concluded on 12/19/13, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The census on the day of the survey was eighty seven (87). The facility is licensed for eighty nine (89) beds.

Deficiencies were cited with the highest deficiency identified at "D" level.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 147

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

TITLE

(X6) DATE

Lisa Johnson Administrator 1/14/14

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

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K 147	Continued From page 1 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure multi-plug power strips were only used according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, eight (8) of eighty seven (87) residents, staff and visitors. The findings include: Observation on 12/19/2013 at 11:47 AM, with the Maintenance Director, revealed a multi-plug power strip with flexible wiring was attached to the wall in Resident Room 203. Multi-plug power strips cannot be attached to the wall due to increased risk of fire. Further observations revealed the same for Resident Rooms 201, 207 and 217. All the observations were confirmed with the Maintenance Director. Interview on 12/19/2013 at 11:47 AM, with the Maintenance Director, revealed he was told by a previous inspector that the multi-plug power strips had to be attached to the wall to prevent spilled liquids from coming in contact with the multi-plug power strips. Interview on 12/19/2013 at 4:38 PM, with the Administrator, revealed the Maintenance Director was responsible for insuring the Life Safety Code	K 147	K147 1. Multi- Plug power strip in resident room 203, 207, 217 that was attached to wall was removed. 2. A one time audit will be completed by 01/16/14 to identify if any other rooms have power strips located in an area that violates the electrical wiring and equipment code. Any issues identified will be corrected immediately. 3. Education will be completed by Administrator for Maintenance Supervisor regarding electrical wiring and equipment code regarding power strips and they can only be used according to National Fire Protection Association that multi plug power strips cannot be attached to the wall due to increased risk of fire by 01/31/14 4. Administrator will randomly audit 10 rooms per week during environmental rounds for 4 weeks and then monthly to ensure that multi plug power strips are used according to Fire Protection Association Standards and not attached to the wall. 5. Audits completed will be discussed monthly for 3 months in Quality Improvement meetings (consisting of the following: Director of Nursing, Administrator, Social Services, Medical Director, Environmental Services, Activities Director, Activities Director) to discuss results of audits and make recommendations and/or revision of plan.	

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K 147	Continued From page 2 was met. Further interview revealed the facility did not have a policy for the use of multi-plug power strips. Reference: NFPA 70 (1999 edition) 400-8:(Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	