STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185339	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irvine Nursing and Rehabilitation Center	411 Bertha Wallace Drive Irvine, KY 40336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the security and confidentiality of medical records for one of twenty-nine (29) sampled residents, Resident 4 (R4). Medical information including the patient's name and medical symptoms were given to a family member of R4's physician. The findings include: Observation, on 02/12/2025 at 11:55 PM, revealed Registered Nurse (RN) 1 call Physician 1's home phone number to report R4's complaint of chest pain. Review of the facility's policy, Change of Condition Standard of Practice, dated 07/2020, revealed the policy purpose was to ensure all interested parties were informed of the resident's change in health status so a treatment plan could be developed which was in the best interest of the resident. Further review revealed the facility would immediately (as soon as possible/no longer than twenty-four (24) hours) consult the resident's physician, nurse practitioner, or physician assistant when there was a significant change in the resident's physical status (a deterioration in health status in either life-threatening conditions or clinical complications). Review of Resident 4's (R4) admission Face Sheet revealed the facility admitted R4 on 10/24/2023 with diagnoses which included cerebral infarction, transient cerebral ischemic attack, and atrial fibrillation (an irregular heartbeat). During an interview, on 02/13/2025 at 12:10 AM, RN1 stated she had called Physician 1's home phone number and spoke with Physician 1's daughter to give report on R4. During further interview, RN1 stated Physician 1's daughter was not a medical professional (nurse, nurse practitioner, physician assistant, or physician), but was a smart sweet girl who was knowledgeable and helped Physician 1. During continued interview, RN1 stated she normally did not give report to a physician's family member, but Physician 1's daughter stated she would take report and relay it to Physician 1. Additionally, RN1 stated she should not have given report to Physician 1's daughter as she was not a trained medical profession because she may have given incorrect information regarding R4 to Physician 1 regarding the patient's condition. During an interview, on 02/13/2025 at 3:45 PM, the Director of Nursing (DON) stated only a physician, physician assistant, or nurse practitioner should be notified of a change in a resident's condition because information might not be relayed to the medical provider correctly, and it would be a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to give information regarding a resident to someone other than the medical provider. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/13/2025 at 4:35 PM, the Administrator stated staff should never relay a resident's medical information to a physician's family member because information could be relayed incorrectly to the physician. During an interview, on 02/13/2025 at 5:13 PM, Physician 1 stated RN1 did relay R4's medical information to his daughter on 02/12/2025 around 11:55 PM, and his daughter relayed the information to him and he called RN4 back a short time later with an order to send R4 to the emergency room (ER) for complaints of chest pain. He further stated his daughter had worked for him when he had a medical practice a few years ago, but was not a trained medical professional and did not work for him currently.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, record review, and review of the facility's policy, the facility failed to provide food served at a safe and appetizing temperature to ensure resident satisfaction and safety for 5 out of 17 residents who attended the Resident Group Meeting held on 02/12/2025 at 1:20 PM. Five interviewable residents (Resident (R)4, R7, R38, R69, and R291) selected by the facility in a resident group meeting all expressed concerns about the facility's food, which included hot food being served cold. Observation of a test tray with the Dietary Manager (DM) revealed hot food temperatures were below 135 degrees Fahrenheit (F)and cold foods were above 41 degrees F. An interview with the DM revealed the hot foods on the test tray should be served at 135 degrees F, at a minimum, and the cold foods/beverages should have been below 41 degrees F. The findings include: A review of the facility's policy titled Food: Preparation, revision dated 02/2023, revealed that All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding. A review of the facility's policy titled Meal Distribution, revision dated 02/2023, revealed that Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and delivers in a timely and accurate manner. A review of the facility's policy titled Food: Quality and Palatability revised 02/2023, revealed that Foods will be palatable, attractive, and served at a safe and appetizing temperature. During the resident group meeting held on 02/12/2024 at 01:20 PM, with interviewable residents selected by the facility, all five residents (R4, R7, R38, R69, and R291) expressed concerns about the facility's food. The interviews were as follows: -R38 stated food was the big issue at the facility, adding that the facility always serves her food cold. -R291 stated, Food is always cold by the time I get it. -R7 and R69 stated sometimes food items are cold. -R4 stated, I have to eat snacks that my family brings because the food is too cold from the kitchen. The facility provided the Resident Council Minutes from 09/09/2024 through 02/04/2025. The minutes revealed that residents expressed concerns about the food during the resident council meeting on 02/04/2025. Residents further stated, [NAME] top Hall trays are cold when they are passed out to them. On 02/13/2024 at 12:30 PM, a State Survey Agent (SSA) performed an observation of a lunch tray pass conducted on the [NAME] Hall unit. After the staff served the last resident tray, the Dietary Manager (DM), alongside the District Dietary Manager (DDM), obtained the food temperature on the test tray. Per observation, the floor staff completed the tray pass in 18 minutes. Continued observation revealed the temperature results of the test tray food were as follows: cheese pizza was 112.9 degrees (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F, verified by the DM; the fruit cocktail was 45 degrees F, verified by the DM; the salad was 62.5 degrees F, verified by the DM. During an interview with the DDM at the time of observation, he stated meals needed to be served at an appropriate temperature for food palatability, resident satisfaction, and resident safety to prevent foodborne illness, scalding, and burns. The DDM further stated the nursing staff did not deliver meals to the residents promptly. During an interview on 02/13/2025 at 3:00 PM, the Administrator stated she was aware of residents' food complaints. Although, the Administrator stated she had educated staff on meal service, the facility had failed to monitor to ensure food temperatures were within the required ranges and foods were palatable.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of twenty-nine (29) sampled residents, Resident 4 (R4). The findings include: Observation, on 02/12/2025 at 11:30 PM, revealed Registered Nurse (RN) 1 obtained vital signs and a glucometer (blood sugar) check for R4 without washing her hands before or after obtaining vital signs and the glucometer check. Further observation revealed RN1 exited R4's room into the hallway while wearing gloves and unlocked and reached into a drawer of the treatment cart while wearing the soiled gloves, then reentered R4's room wearing the same soiled gloves. Continued observation revealed RN1 placed a bottle of glucometer strips on R4's bed while obtaining R4's glucometer check, then picked up the bottle of glucometer strips and placed it in her pocket. Review of the facility's policy, Infection Control, undated, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Continued review of the policy revealed the objectives of the infection control policies and procedures were to prevent infections in the facility. Review of Resident 4's (R4) admission Face Sheet revealed the facility admitted R4 on 10/24/2023 with diagnoses which included cerebral infarction, transient cerebral ischemic attack, and atrial fibrillation (an irregular heartbeat). During an interview, on 02/13/2025 at 12:10 AM, RN1 stated she had received Infection Control Training in the facility which was provided at least annually, and she thought the last in-service on Infection Control was about 2 weeks ago. She further stated she should have washed her hands before checking vital signs, between checking the vital signs and the glucometer check, and after finishing the glucometer check. She continued to state she should not have left the room wearing gloves. Additionally, she stated it was important to use proper handwashing technique and the proper use of gloves to prevent the spread of any germs or infections from one resident to another resident. During an interview, on 02/13/2025 at 3:45 PM, the Director of Nursing (DON) stated she expected all staff to perform proper handwashing technique and the proper use of personal protective equipment (PPE), including gloves, to prevent the spread of infection between residents. During an interview, on 02/13/2025 at 4:35 PM, the Administrator stated staff should follow the facility's policies and procedures, including the Infection Control Policy, for the safety of the residents.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on interviews, record review, and review of the facility's policy, the facility failed to allow residents to call for staff assistance through a communication system that relays the call directly to a staff member from each resident's bedside. During observations on the 2/12/2025 night shift, call lights for Resident (R) 23, R26, and R67 were found lying under the bed, behind a chair on the floor, and clipped to the privacy curtain, and all were out of reach for the residents to call for assistance. The findings include: The facility resident council meeting was held on 02/12/2025 at 1:20 PM, with 4 out of seventeen residents who attended voicing the following concerns about call lights: R291 revealed, We can't get any help during the night. The workers sit at their desks or stand in the hallway talking on their cell phones all night. R69 revealed, They hide our call lights at night, so we can't reach them. R7 revealed, They tell us not to ring our call bells and To go back to bed if we get up. Observation of R26 on 02/12/2025 at 11:04 PM revealed that staff had left the call light cord loosely draped around the bedrail, with the call light device dangling just above the floor. When the SSA entered the room for observation, resident 26 called out for help. An interview with R26 during the observation revealed that R26 was calling out for help because R26 said he was thirsty, hungry, and wanted a snack. Observation of R67 on 02/12/2025 at 11:15 PM revealed that the call light device was attached and wrapped in the center privacy curtain that divides the room, out of reach of R67, while she was lying in her bed. Observation of R23 on 02/12/2025 at 11:20 PM revealed that R23 was lying awake in the bed while the call light device was under the bedside chair on the floor out of R23's reach. An interview with State Registered Nursing Assistant (SRNA) #14, on 02/12/2025 at 11:14 PM, revealed that the call light cord should be within reach of the residents and the call light not being accessible to the resident increases the risk of them getting hurt trying to take care of their needs alone. An interview with SRNA #12 on 02/12/2020 at 11:18 PM revealed that staff had moved the call light during R26's care and forgotten to place it back within the resident's reach. Further interviews revealed that SRNA # 12 stated that the residents use the call light system to communicate their needs to us. If the resident can't reach the call light, it increases the risk of them getting hurt trying to get things alone. An interview with the facility Educator on 02/11/25 at 2:50 PM revealed the call light issue has been an ongoing problem that the residents have been voicing for a while. A review of R26's Plan of care revealed that the resident has a history of falls, and having his (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light in reach is listed as an intervention. A review of Resident Council minutes for the time range of 09/09/2024 through 02/04/2025 revealed the following: On 11/5/2024 at 2 PM, Residents were concerned about call lights, and the Social Worker informed them that audits and education were in place. On 01/07/25 at 2 PM, a Resident voiced that staff was not answering the call lights promptly. The social worker told the council the staff was being educated again on answering call lights promptly. On 02/04/2025 at 2 PM, Residents voiced they were still having issues with the night shift not answering call lights promptly. A review of the facility's Grievance / Concern Form revealed a grievance was filed on the following dates by residents or a family member for the time range of 09/01/2024 through 02/10/2025 concerning call bells not being answered timely:12/02/2024,12/27/2024,01/24/2025, and 02/04/2025 A review of a grievance form dated 12/02/2025 revealed that R61 had called her family and stated that she needed assistance to go to the bathroom. She had rung the call light for over an hour, but the staff had not responded. R61's family drove to the facility to inform staff that the resident required assistance. The resident was found soiled with feces, and the call light remained activated with no staff response. The resident did not receive staff assistance until prompted by the family member. Although the Administrator stated in an interview on 02/13/2025 at 3 PM that she was aware of the problem and educated staff regarding staff answering call lights promptly, the facility continued to receive resident complaints and grievances regarding staff's failure to answer call lights promptly on 1/07/25, 01/24/2025, and 02/04/2025.