

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

PRINTED: 04/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2013
NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144	
(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

An Abbreviated Survey investigating KY00019939 was initiated on 03/25/13 and concluded on 03/26/13. KY00019939 was substantiated with deficiencies cited, with the highest scope and severity of a "D".

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This STANDARD is not met as evidenced by:
Based on interview, record review and review of the facility's policy it was determined the facility failed to ensure resident's rights to refuse treatment as evidenced by administering a Tuberculosis (TB) Skin Test after the resident refused for one (1) out of five (5) sampled

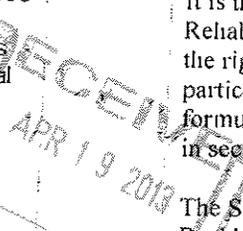
F 000 To the best of my knowledge and belief, as an agent of Wurland Nursing & Rehab Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.

F 155 Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.

It is the policy of Wurland Nursing and Rehabilitation Center that all residents have the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in section (8) of section 483.10(b)(4).

The Social Services Director will meet with Resident #1 weekly for four weeks beginning 4/11/13 to ensure that he has exercised his rights free of interference, coercion, discrimination, or reprisal based upon interview of the resident. The plan of care for Resident #1 was updated on 4/11/13 by the Interdisciplinary Care Plan Team with an additional intervention indicating that if Resident #1 became abusive toward others to notify the Interdisciplinary Care Plan Team to determine an appropriate intervention if all other attempts are unsuccessful.

5/1/2013



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

Sarah Willis

TITLE

Administrator

(X6) DATE

4-19-2013

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 155 Continued From page 1 residents. (Resident #1)

The findings include:

Review of the facility's policy "Resident's Rights and Quality of Life", dated 05/01/12, revealed residents have the right to exercise his/her rights as a resident of the facility and a citizen or resident of the United States and be free of interference, coercion, discrimination, or reprisal by Advocate or its employees for the exercise of such rights. Additionally, residents have the right to refuse treatment.

Review of the medical record revealed Resident #1 was readmitted to the facility, on 04/05/10, with diagnoses which included Hypotension, Seizures, Renal Failure, Cerebral Vascular Accident, Psychosis, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Depression, Anxiety, and Dementia. Review of a Quarterly Minimum Data Set (MDS), dated 02/11/13, revealed the facility assessed Resident #1 to be cognitively impaired. Further review of the MDS revealed the facility assessed Resident #1 to require limited assistance of one (1) person for transfers and extensive assistance of two (2) people for dressing. Additional review of the MDS revealed Resident #1 had verbal behaviors directed towards others to include threatening, screaming and cursing.

Review of Resident #1 Care Plan for Mood/Behavior, dated 02/18/13, revealed if Resident #1 became abusive towards other to remove him/her from situation to decrease stimulation and to approach the resident at a later time.

F 155 additional intervention indicating that if Resident #1 became abusive toward others to notify the Interdisciplinary Care Plan Team to determine an appropriate intervention if all other attempts are unsuccessful.

All residents Care Plans will be audited by 4/19/13 by the Interdisciplinary Care Plan Team to identify any other resident(s) that refuse treatment and update their care plans as needed to ensure that they are consistent with the resident's values, preferences, or goals. The Social Service Director will then interview all interviewable residents by 4/25/13 to ensure that each resident had opportunity to exercise his/her rights free of interference, coercion, discrimination, or reprisal. Additionally, the Social Service Director will interview all interviewable residents by 4/25/13 to ensure each resident's right to refuse treatment was honored.

The Administrator educated the Staff Development Coordinator, a registered nurse, on March 27th regarding resident rights and the proper procedure to be followed in the event of rejection of care by a resident. All staff (this includes all disciplines, departments, and shifts) will receive education by the Staff Development Coordinator (a registered nurse) by 4/30/13

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Interview with Registered Nurse (RN) #1, on 03/26/13 at 10:38 AM, revealed Resident #1 had refused previous attempts to administer TB skin test, as required by state regulations, as well as requests for a chest X-ray to determine exposure to TB. Further interview revealed on the morning of 03/21/13, RN #1 approached Resident #1 and asked for consent to administer the TB skin test. RN #1 indicated Resident #1 refused, became agitated, stood up out of wheelchair, at which time other staff members assisted Resident #1 to his/her room due to being a fall risk. Further interview revealed as staff was assisting Resident #1, RN #1 administered the TB skin test without obtaining permission from the resident and without approaching the resident at a later time.

Interview with Licensed Practical Nurse (LPN) #2, on 03/26/13 at 11:03 AM, revealed she assisted with Resident #1, who attempted to strike out at staff, while RN #1 administered the TB skin test without obtaining permission.

Interview with Certified Medication Technician (CMT), on 03/26/13 at 11:16 AM, revealed Resident #1 was told he/she must have the TB skin test. At that time, Resident #1 became agitation and was striking out at staff. Staff assisted Resident #1 to his/her room and RN #1 administered the TB skin test.

Interview with the Social Services Director (SSD), on 03/26/13 at 12:40 PM, revealed when Resident #1 was approached regarding the administration of TB skin test he/she refused and attempted to get up out of wheelchair. The SSD indicated when staff approached Resident #1

F 155 regarding resident rights. The education will include: residents have the right to exercise his/her rights as a resident of the facility and a citizen or resident of the United States and be free of interference, coercion, discrimination, or reprisal. Additionally, the education will include that residents have the right to refuse treatment and that observance of the patients individualized care plan is required.

The Social Services Director will interview 5 residents per month whose Minimum Data Set and Plan of Care reflect a refusal of treatment to ensure that the residents have exercised his/her rights free of interference, coercion, discrimination, or reprisal based upon interview of the resident. The Social Service Director will continue these audits for 6 months. In addition, the MDS Coordinator (a registered nurse) will audit 5 residents care plan per month whose Minimum Data Set reflect a "rejection of care" in Section E to ensure the care plan strategies are determined to be consistent with the resident's values, preferences or goals.

The results of all above audits will be forwarded to the monthly Continuous Quality Improvement Committee for review. The members of this team include the Administrator, DON (a registered nurse),

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F 155 Continued From page 3
he/she became combative and started kicking and swinging at staff. The SSD stated staff assisted Resident #1 to his/her room and then RN #1 administered the TB skin test at that time; however, RN #1 should have waited and approached Resident #1 at a later time.

F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL BEING

Each resident must receive and the facility must 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.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to provide the necessary care and services in accordance with the comprehensive assessment and plan of care for one (1) of five (5) sampled residents. Resident #1 was assessed by the facility to have behaviors which included being abusive towards others with care plan interventions to remove resident from the situation and approach the resident at a later time. On 03/21/13, Resident #1 became agitated when Registered Nurse #1 attempted to administer a TB test to the resident. The facility failed to implement the care plan based on the comprehensive assessment related to approaching Resident #1 at a later time when

F 155 ADON (a registered nurse), MDS Coordinators (2 registered nurses and a licensed practical nurse), Staff Development Coordinator (a registered nurse), Medical Records Director, Activity Director and Social Services Director, the Housekeeping/Laundry Supervisor, and

F 309 Maintenance Supervisor, Business Office Manager, and Dietary Manager. The Medical Director and Pharmacist also attend the CQI meeting quarterly, at a minimum. The members CQI Committee will make recommendations regarding further monitoring and continued compliance.
TAG F 309 ON NEXT PAGE.

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F 155 Continued From page 3
he/she became combative and started kicking and swinging at staff. The SSD stated staff assisted Resident #1 to his/her room and then RN #1 administered the TB skin test at that time; however, RN #1 should have waited and approached Resident #1 at a later time.

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Each resident must receive and the facility must 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.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to provide the necessary care and services in accordance with the comprehensive assessment and plan of care for one (1) of five (5) sampled residents. Resident #1 was assessed by the facility to have behaviors which included being abusive towards others with care plan interventions to remove resident from the situation and approach the resident at a later time. On 03/21/13, Resident #1 became agitated when Registered Nurse #1 attempted to administer a TB test to the resident. The facility failed to implement the care plan based on the comprehensive assessment related to approaching Resident #1 at a later time when

F 155
F 309 To the best of my knowledge and belief, as an agent of Wurland Nursing & Rehab Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.

Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.

It is the policy of Wurland Nursing and Rehabilitation Center that each resident must receive and the facility must 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 as specified in 483.25.

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F 309 Continued From page 4
RN #1 administered the TB test, even though Resident #1 was refusing, and failed to wait and approach resident #1 at a later time.

The findings include:

Review of the medical record revealed Resident #1 was readmitted to the facility, on 04/05/10, with diagnoses which included Hypotension, Seizures, Renal Failure, Cerebral Vascular Accident, Psychosis, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Depression, Anxiety, and Dementia.

Review of a Quarterly Minimum Data Set (MDS), dated 02/11/13, revealed the facility assessed Resident #1 to be cognitively impaired. Further review of the MDS revealed the facility assessed Resident #1 to require limited assistance of one (1) person for transfers and extensive assistance of two (2) people for dressing. Additional review of the MDS revealed Resident #1 had verbal behaviors directed towards others to include threatening, screaming and cursing.

Review of Resident #1 Care Plan for Mood/Behavior, dated 02/18/13, revealed if Resident #1 became abusive towards other to remove him/her from situation to decrease stimulation and to approach the resident at a later time.

Interview with Registered Nurse (RN) #1, on 03/26/13 at 10:38 AM, revealed Resident #1 had refused previous attempts to administer TB skin test, as required by state regulations, as well as requests for a chest X-ray to determine exposure to TB. Further interview revealed on the morning

F 309 The Social Services Director will meet with Resident #1 weekly for four weeks beginning 4/11/13 to determine that services provided attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The plan of care for Resident #1 was revised on 4/11/13 by the Interdisciplinary Care Plan Team to include an intervention to notify the Interdisciplinary Care Plan Team to determine an appropriate intervention if all other attempts are unsuccessful.

The Social Service Director will interview all interviewable residents by 4/25/13 to ensure that each resident had opportunity to exercise his/her rights free of interference, coercion, discrimination, or reprisal. Additionally, the Social Service Director will interview all interviewable residents by 4/25/13 to ensure each resident's right to refuse treatment was honored and that each resident is receiving 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.

The Administrator educated the Staff Development Coordinator, a registered nurse,

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F 309	Continued From page 5 of 03/21/13, RN #1 approached Resident #1 and asked for consent to administer the TB skin test. RN #1 indicated Resident #1 refused, became agitated, stood up out of wheelchair, at which time other staff members assisted Resident #1 to his/her room due to being a fall risk. Further interview revealed as staff was assisting Resident #1, RN #1 administered the TB skin test without obtaining permission from the resident and without approaching the resident at a later time. Interview with Licensed Practical Nurse (LPN) #2, on 03/26/13 at 11:03 AM, revealed she assisted with Resident #1, who attempted to strike out at staff, while RN #1 administered the TB skin test without obtaining permission. Interview with Certified Medication Technician (CMT), on 03/26/13 at 11:16 AM, revealed Resident #1 was told he/she must have the TB skin test. At that time, Resident #1 became agitation and was striking out at staff. Staff assisted Resident #1 to his/her room and RN #1 administered the TB skin test. Interview with the Social Services Director (SSD), on 03/26/13 at 12:40 PM, revealed when Resident #1 was approached regarding the administration of TB skin test he/she refused and attempted to get up out of wheelchair. The SSD indicated when staff approached Resident #1 he/she became combative and started kicking and swinging at staff. The SSD stated staff assisted Resident #1 to his/her room and then RN #1 administered the TB skin test at that time; however, RN #1 should have waited and approached Resident #1 at a later time as per the comprehensive plan of care.	F 309	on March 27th regarding resident rights and procedures for refusal. All staff (this includes all disciplines, departments, and shifts) will receive education by the Staff Development Coordinator by 4/30/13 on providing 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. Additionally, the education will include that residents have the right to refuse treatment and that observance of the patients individualized care plan is required. The Social Service Director will interview 5 interviewable residents per month for 6 months to ensure that the residents continue to be able to exercised his/her rights free of interference, coercion, discrimination, or reprisal based upon interview of the resident. In addition, the MDS Coordinator (a registered nurse) will audit 5 residents care plan per month whose Minimum Data Set reflect a "rejection of care" in Section E to ensure the care plan strategies are determined to be consistent with the resident's values, preferences or goals. The results of the above mentioned audits will be forwarded to the monthly Continuous Quality Improvement Committee for review.		

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The members of this team include the Administrator, DON (a registered nurse), ADON (a registered nurse), MDS Coordinators (2 registered nurses and a licensed practical nurse), Staff Development Coordinator (a registered nurse), Medical Records Director, Activity Director and Social Services Director, the Housekeeping/Laundry Supervisor, and Maintenance Supervisor, Business Office Manager, and Dietary Manager. The Medical Director and Pharmacist also attend the CQI meeting quarterly, at a minimum. The members CQI Committee will make recommendations regarding further monitoring and continued compliance.