

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

PRINTED: 07/15/2013
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 06/28/2013
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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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 Recertification Survey was initiated on 06/26/13 and concluded on 06/28/13. In conjunction with the Standard Survey, an Abbreviated Survey to investigate KY00020381 was conducted. The allegations were unsubstantiated with related deficiency cited. The highest scope and severity cited was a "D". F 281 : 483.20(k)(3)(I) SERVICES PROVIDED MEET SS=D. PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Physician's orders were followed for one (1) of nineteen (19) sampled residents (Resident #1). Resident #1 had an order for bed and chair alarms; however, observation revealed the alarms were in place but were not turned on. The findings include: No policy related to following Physician's Orders was provided. Review of the clinical record revealed Resident #1 was admitted by the facility on 05/07/12 with diagnoses which included Depression, Anxiety, Paranoid Schizophrenia, and Intellect Disability. Review of the Physician Orders, dated 09/23/12,	F 000	To the best of my knowledge and belief, as an agent of Wurland Nursing & Rehabilitation 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. Wurland Nursing & Rehabilitation Center strives to ensure that services provided meet professional standards of quality. The alarm for resident #1 was activated/turned on and checked for proper placement and functioning by LPN #1 on 6/26/2013. An audit was conducted by the Director of Nursing on 6/28/13 of physician orders to ensure that safety devices are activated and functioning properly. All safety devices were activated and functioning properly as ordered. The Director of Nursing will audit all physician orders by 8/8/13 to ensure they are written and followed according to accepted standards of clinical practice.	8/9/2013
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RECEIVED
JUL 25 2013
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Willis</i>	TITLE Administrator	(X6) DATE 7/25/13
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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 in the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281

Continued From page 1
revealed Resident #1 was to have a bed and chair alarm at all times.

Review of the Comprehensive Care Plan, active until 09/25/13, revealed Resident #1 was to have "bed and wheelchair alarms as ordered".

Observation, on 06/26/13 at 11:40 AM, revealed Resident #1 was lying in the bed. Continued observation revealed the resident stood up from the bed, and transferred to the wheelchair independently. No alarm sounded when the resident exited the bed. On further observation, an alarm was noted to be present on the bed and on the wheelchair; however, neither alarm appeared to be turned on.

Telephone interview with Certified Nursing Assistant (CNA) #1, on 06/28/13 at 4:15 PM, revealed she had been assigned to care for Resident #1 on 06/26/13 during the day shift. She stated the alarms must have been off when she started her shift because she didn't turn the alarms off, and did not realize they were off. She further stated Resident #1 got up and down independently throughout the day.

Interview with Licensed Practical Nurse (LPN) #1, on 06/26/13 at 11:50 AM, revealed the alarm on the chair was not attached to the resident, i.e. there was no cord or clip present, and the alarm was turned off. Continued interview revealed the bed alarm was turned off as well. LPN #1 stated the bed alarm should have alerted staff the resident had exited the bed, and the wheelchair also served as an alert if the resident got up without assistance. She stated she did not know why the alarms were turned off.

F 281

All nursing staff will receive education by the Director of Nursing or Staff Development Coordinator by 8/8/2013 on ensuring that services provided or arranged meet professional standards of quality and standards of clinical practice. All nursing staff will receive additional education by the Director of nursing or Staff Development Coordinator by 8/8/13 on ensuring that all safety devices are checked each shift for proper placement and functioning as ordered.

To ensure that professional standards of quality are met and upheld, the Director of Nursing or designee will audit CQI physician orders monthly for 3 months then quarterly thereafter for one year. Results will be forwarded to the monthly CQI Committee Meeting for further recommendations and continued monitoring.

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F 281	Continued From page 2 Interview with the Director of Nursing, on 06/28/13 at 2:20 PM, revealed she was not aware Resident #1's alarms had been turned off. She stated the alarms should have been on as ordered and care planned.	F 281		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 05/30/78</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story Type III (200)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system</p> <p>SPRINKLER SYSTEM: Complete (wet and dry) sprinkler system</p> <p>GENERATOR: One (1) Type II Diesel generator.</p> <p>A standard Life Safety Code survey was conducted on 06/27/13. Wurland Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty-six (126) beds with a census of ninety-five (95) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>To the best of my knowledge and belief, as an agent of Wurland Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.</p> <p>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.</p>	
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RECEIVED
JUL 25 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sarah Welles</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/25/13</i>
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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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K 000

Continued From page 1
Deficiencies were cited with the highest deficiency identified at "E" level.

K 000

K 025
SS-ID

NFPA 101 LIFE SAFETY CODE STANDARD
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025

Wurland Nursing & Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standard and ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating.

8/9/2013

The smoke barrier beside room forty-three was sealed by the Maintenance Director on 6/28/2013.

All smoke barriers will be audited by the Maintenance Director or Maintenance Assistant by 8/8/2013. Any smoke barrier not maintained according to NFPA 101 Life Safety Code Standard will be repaired to ensure a one half hour fire resistance rating in accordance with 8.3.

The Maintenance Director was educated by the Administrator on 7/24/2013 on NFPA 101 Life Safety Code Standards regarding the requirements for smoke barriers.

All smoke barriers will be audited by the Maintenance Director or Maintenance Assistant monthly for three months and quarterly thereafter for one year. Results will be forwarded to the Continuous Quality Improvement Committee for further recommendations and continued monitoring for compliance.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, sixty-four (64) residents, staff and visitors. The facility is licensed for one hundred twenty-six (126) beds and the census was ninety-five (95) on the day of the survey.

The findings include:

Observation, on 06/27/13 at 2:00 PM, revealed the smoke barrier beside room forty-three had penetrations not sealed around sprinkler piping.

Interview, on 06/27/13 at 3:30 PM, with the

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K 025	<p>Continued From page 2</p> <p>Maintenance Director revealed he was unaware of the penetration observed during the survey and stated he checks them monthly.</p> <p>Interview, on 06/27/13 at 3:30 PM, with the Administrator revealed she would monitor the monthly smoke barrier check sheets.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is</p>	K 025		
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K 025	Continued From page 3 designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The findings include: Observation, on 06/27/13 at 1:00 PM, revealed one (1) overhang that was located outside of the	K 056	Wurland Nursing & Rehabilitation Center strives to ensure compliance with NFPA 13 Standards for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. The facility also strives to ensure compliance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Sprinklers were installed on the overhang located outside of the Dry Storage Area by Sentry Fire Protection, Inc., the facilities contractor for fire safety on 7/19/2013. The facility was audited by the Maintenance Director on 7/24/2013 to determine if there were any additional areas in the facility exceeding 4 foot (1.2m) in width that were not sprinklers protected. The audit conducted by the Maintenance Director on 7/24/2013 revealed there were no additional areas that were not sprinkler protected.	8/9/2013

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K 056	<p>Continued From page 4</p> <p>Dry Storage Area extended out from the building five (5) foot that was made of combustible materials and were not sprinkler protected.</p> <p>Interview on 06/27/13 at 3:20 PM, with the Maintenance Director revealed the overhang was made of combustible materials and he was not aware the overhang needed to be sprinkler protected and he thought all the overhangs were identified.</p> <p>Interview on 06/27/13 at 3:20 PM with the Administrator revealed she had only been at this facility for about three months and was still learning the facility's needs. She also stated that this would be corrected.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056	<p>The Maintenance Director was educated on 7/24/13 by the Administrator on NFPA 13 Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building and ensuring the system is properly maintained in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p> <p>The sprinkler system and the facility will be audited by the Maintenance Director or Maintenance Assistant quarterly to determine that automatic sprinkler systems are installed and maintained in accordance with NFPA 13 and NFPA 25 Standards. Results will be forwarded to the CQI Committee for further recommendations and continued monitoring for compliance.</p>	
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p>	K 147	<p>Wurland Nursing & Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standard which ensures that electrical wiring and equipment is in accordance with NFPA 70, National Electrical code 9.1.2.</p>	8/9/2013
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was according to National Fire Protection</p>		<p>The receptacles in rooms 3,4,7,9,17, 19, and 27 were replaced by the Maintenance Director on 7/23/13 with grounds as specified in NFPA 70.</p>	

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K 147	Continued From page 5 Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke Compartments, fifty-nine (59) residents, staff and visitors. The findings include: Observation, on 6/27/13 between 11:00 AM and 3:00 PM revealed when tested with an electrical outlet tester, an electrical receptacle in resident rooms 3,4,7,9,17,19,27 had an open ground. Electrical outlets must be grounded to prevent possible electrical shocks. Interview on 6/27/13 at 3:15 PM with the Maintenance Director revealed he was not aware of the open grounds on the receptacles. Interview on 6/27/13 at 3:15 PM with the Administrator revealed she depends on the Maintenance Director to keep the facility compliant on these type issues and they would get the issue completed in a timely manner. Reference: NFPA 70 (1999) 517-13. Grounding of Receptacles and Fixed Electric Equipment. (a) Patient Care Area. In an area used for patient care, the grounding terminals of all receptacles and all non current carrying conductive surfaces of fixed electric equipment likely to become energized that are subject to personal contact, operating at over 100 volts, shall be grounded by an insulated copper conductor. The grounding conductor shall be sized in accordance with Table 250-122 and installed in metal raceways with the branch-circuit conductors supplying these receptacles or fixed equipment.	K 147	All receptacles in the facility will be inspected and tested by the Maintenance Director by 8/8/2013 to ensure compliance with NFPA 70 regarding Grounding of Receptacles and Fixed Electrical Equipment. Any receptacles found to have failed the inspection will be repaired by the Maintenance Director or Maintenance Assistant by 8/8/2013. The Maintenance Director received education by the Administrator on 7/24/2013 regarding NFPA 70 National Electrical Code 9.1.2 standards. An audit of 15 receptacles will be conducted quarterly for one year and an annual inspection of all receptacles in the facility will be conducted to ensure compliance with NFPA 70, National electrical Code 9.1.2. Results will be forwarded to the monthly CQI Committee Meeting for further recommendations and continued monitoring.		

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K 147	<p>Continued From page 6</p> <p>Exception No. 1: Metal raceways shall not be required where listed Typos MI, MC, or AC cables are used, provided the outer metal armor or sheath of the cable is identified as an acceptable grounding return path.</p> <p>Exception No. 2: Metal faceplates shall be permitted to be grounded by means of a metal mounting screw(s) securing the faceplate to a grounded outlet box or grounded wiring device.</p> <p>Exception No. 3: Light fixtures more than 7 1/2 ft (2.2 m) above the floor and switches located outside of the patient vicinity shall not be required to be grounded by an insulated grounding conductor.</p>	K 147		
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