PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER: WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WURTLAND AVENUE, WURTLAND, 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 A Recertification Survey was conducted on 05/25-27/10 with deficiencies cited at the highest scope/severity of an "F". A Life Safety Code survey was also conducted which resulted in deficiencies with the highest scope/severity of an "F". In addition, a complaint investigation (ARO KY00014820) was investigated which was determined to be substantiated with a deficiency cited.	F 000	To the best of my knowledge and belief, as an agent of Wurtland 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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	It is the policy of Wurtland Nursing and Rehabilitation Center to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility administrator reported the theft of narcotics for dates 4/8/10 and 4/26/10 to the Kentucky State Police on 6/16/10. RECEIVED JUN 25 2010 BY:	06/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 06/25/10

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.

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

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

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 05/27/2010
NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURTLAND AVENUE WURTLAND, 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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and observation, it was determined the facility failed to ensure that all alleged violations of misappropriation of residents' property were reported to all appropriate officials. Incidents related to misappropriation of residents' property were discovered on 04/08/10 and 07/26/10 involving controlled substances. However, the facility failed to report both incidents to local law enforcement agencies. The findings include: Prior to the standard survey conducted on 05/25-27/10, the facility had reported to the State Agency a series of thefts of controlled substances belonging to residents at the facility. On 03/22/10, the facility discovered Resident #13 was missing a card of thirty (30) tablets of Percocet, a narcotic analgesic used for control of pain. On that occasion, the facility reported the loss to the State Agency and to the State Police, then initiated its internal investigation, but was unable to recover the medication or to identify a perpetrator. The State Police responded, but also failed to resolve the issue.	F 225	The facility administrator and DON will receive additional education regarding the appropriate reporting of information to local law enforcement by the Continuous Quality Improvement Director by 6/25/10. The facility administrator reviewed the investigative reports for the last 3 months by 6/25/10 to ensure that proper reporting of any misappropriation had occurred in accordance with state law. The facility administrator will review all alleged violations for the next six weeks to ensure that appropriate investigation, follow-up and appropriate reporting to all officials in accordance with State law are completed. The results of these reviews will be forwarded to the monthly Continuous Quality Improvement Committee (CQI) for further review and continued compliance.	

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

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

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 05/27/2010
NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURTLAND AVENUE WURTLAND, 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 225	Continued From page 2 On 04/08/10, the facility discovered a second theft of controlled substances when it was determined that Resident #14 was missing a card of thirty (30) Lortab 5/500, a narcotic analgesic used for control of pain. Again, the facility notified the State Agency and initiated its internal investigation of the incident. However, on that occasion, the facility failed to notify local law enforcement (i.e., the police) or the State's Drug Enforcement Agency. Again, the medication was never recovered, and no perpetrator was positively identified. On 04/26/10, the facility discovered a third theft of controlled substances when it was determined that Resident #1 was missing a card of thirty (30) OxyContin 5 milligram tablets, a narcotic analgesic used for control of pain. The facility again responded by notifying the State Agency and initiated its internal investigation. However, on that occasion, the facility again failed to notify either the law enforcement or the State's Drug Enforcement Agency. That medication was also never recovered, and no perpetrator was ever identified. During in interview with the facility's Director of Nursing on 05/26/10, she explained that, following all three thefts, pertinent nursing staff were made to submit to drug testing. However, none of the staff tested positive for the presence of opiates (narcotics). In addition, the medication carts were audited which resulted in no discovery of additional losses. Numerous residents were re-assessed for pain, and it was determined that the three affected residents (Resident #'s 1, 13, and 14) were never denied doses of their medications as a result of the thefts. The facility also put into place more rigid measures for	F 225		

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

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

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 05/27/2010
NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURTLAND AVENUE WURTLAND, 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 225	Continued From page 3 accounting for its controlled substances following the third loss. During further interview with the Director of Nursing on 05/26/10, she explained that the State Police did visit the facility following the initial theft involving Resident #13's Percocet. She explained that although the police filed a report of the incident, they did not appear to be too concerned with the incident. She went on to explain that, as a result of that, the facility declined to notify the police following the second and third thefts. When asked why the facility declined to notify the State's Drug Enforcement Agency, she explained that, following an earlier incident of drug theft, the facility did notify Drug Enforcement, but was told by the Agency that they were more involved in "drug trafficking" and not involved with "drug theft".	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services were provided in a manner which enhanced each resident's dignity for two (2) unsampled residents during meal service. One (1) resident was fed by a Certified Nursing Assistant (CNA) who stood over the resident. Another resident had to wait approximately forty (40) minutes to be served while other residents at	F 241	It is the policy of Wurtland Nursing and Rehabilitation Center to promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The SRNA #5 was provided with a chair to sit in during the evening meal service on 5/25/10 by the ADON. SRNA #5 will receive one-on-one education by the Staff Development Coordinator by 6/25/10 . regarding the importance of sitting at eye level with residents while assisting with feeding. The DON will review the current dining room seating chart make changes as required based on resident preference and	06/26/10

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

PRINTED: 06/24/2010
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 05/27/2010
NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURTLAND AVENUE WURTLAND, 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 241	Continued From page 4 the table were eating. The findings include: Observation of the evening meal on 05/25/10 at 5:15 PM revealed CNA #5 was standing over an unsampled resident while feeding the resident. At 5:40 PM, after intervention by the Assistant Director of Nursing (ADON), the CNA sat down and finished feeding the resident the meal. During interview on 05/25/10 at 6:00 PM, CNA #5 revealed she did not remember being trained to sit down while feeding residents. She stated the ADON brought her a chair, and she "kinda figured it out." Interview with the ADON on 05/27/10 at 8:10 AM revealed the aides were trained to sit down while feeding in Nurse Aide training. She stated the facility reinforced "person-centered care" in dining. She could not say why CNA #5 was standing to feed the resident but acknowledged the staff get nervous when they know they are being watched. Continued observation of the evening meal revealed an unsampled resident sitting at a table with three (3) other residents. When the table was first observed at 5:20 PM, two (2) residents had been served and were eating. At 5:40 PM, the third resident was served. At 5:54 PM the fourth resident was served. During the wait, the resident sat with his/her head down and no interaction with staff or other residents was observed. When questioned, the fourth resident responded, "I'm a patient person." Interview with the Administrator and Nursing	F 241	and habit, notify the Dietary Manager regarding changes and update the dining room process by 6/25/10. The staff will receive additional education by the Staff Development Coordinator by 6/25/10 regarding the importance of providing care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Special emphasis was placed on the dining experience. The DON and/or designee will monitor meal service at least five (5) times per week for six weeks in order to ensure that the dining experience is provided in a manner that enhances each individual's dignity and respect in regards to his/her individuality. The results of these audits will be forwarded to the monthly CQI meeting for further monitoring and continued compliance.	

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

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER: WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WURTLAND AVENUE, WURTLAND, 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 241	Continued From page 5 Management on 05/27/10 at 4:30 PM revealed the facility knew they had some problems related to efficient meal service. Continued interview revealed they tried to promote meal service table by table at each sitting, but it was sometimes difficult. Continued interview revealed the facility was working on "revamping" dining room procedures. Observation of the lunch meal on 05/27/10 at 12:00 PM revealed Resident #18 was sitting at a table in the restorative dining room with two (2) unsampled residents who were being assisted with their meals. Resident #18's tray did not arrive until 12:16 PM, at which time LPN #3 began assisting Resident #18 with the meal.	F 241		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the resident environment remained free of accident hazards. The findings include: On 05/25/10 at 9:00 AM, observation revealed the	F 323	It is the policy of Wurtland Nursing and Rehabilitation Center to 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. The facility has purchased keypad locks for the central supply closet, biohazard closet and soiled utility closet. These locks were installed by the Maintenance Director on 6/11/10. There were no adverse effects on any resident due to this practice. The Administrator, Maintenance Director and Housekeeping Director will conduct an environmental audit by 6/25/10 to ensure that the resident environment remains as free of accident hazards as possible. Any identified issues will be	06/26/10

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

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER
WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
100 WURTLAND AVENUE
WURTLAND, 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 323	Continued From page 6 keys to the Central Supply room, the biohazard rooms, and the dirty utility rooms were accessible to residents. The keys to these rooms were suspended from strings on the door frames of these rooms and were within reach of anyone. Residents were constantly observed ambulating or propelling wheelchairs by these rooms. Observation of the contents of the Central Supply Room revealed toxic substances that were dangerous if ingested: bottles of iodine, liquid soap, and bottles of peroxide. Observation of the contents of the biohazard room revealed contaminated trash and linen, exposing a resident to sources of infection. Interview with the Assistant Director of Nurses on 05/27/10 at 10:15 AM revealed she was not aware of any problem with unauthorized individuals gaining access to these rooms. Further interview with the ADON revealed alternative safety measures to prevent access to these rooms by residents had not been considered by the facility. Interview with the Director of Nurses (DON) on 05/27/10 at 11:25 AM revealed she did not want to consider other preventative safety measures to prevent residents from gaining access to these rooms. Further interview with the DON revealed she did not think it was necessary to consider any other preventative safety measures. Interview with the facility Administrator on 05/7/10 at 11:30 AM revealed he did not think it was necessary to install keypads to these rooms "since there has been no problem" with unauthorized access.	F 323	addressed and/or corrected during the environmental audit. The Administrator and/or designee will conduct weekly environmental audits for the next six weeks to ensure that the environment remains as free of accident hazards as is possible. The results of these audits will be forwarded to the monthly CQI committee meeting for further monitoring and continued compliance.	

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

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER
WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
100 WURTLAND AVENUE
WURTLAND, 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 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to have an effective Infection Control Program to prevent the transmission of infection for one (1) unsampled resident. During the evening meal, a staff member was observed handling the resident's sandwich with bare hands. The findings include: During the evening meal on 05/25/10 at 5:00 PM, a Certified Medication Aide (CMA) was observed removing a resident's sandwich from the paper wrapper with bare hands. At 5:10 PM, the CMA paused from feeding a second resident at the same table, picked the sandwich up with bare hands, and handed it to the first resident. During interview on 05/25/10 at 5:52 PM, the CMA revealed she had been trained "a long time ago" not to handle residents' food with bare hands. She further stated sometimes it was hard not to touch the food and she just forgot. Interview with the Assistant Director of Nursing on 05/27/10 at 8:10 AM revealed the staff were trained not to handle residents' food with bare hands. She could not say why the CMA picked	F 444	It is the policy of Wurtland Nursing and Rehabilitation Center to require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. The CMA observed to be touching the food with bare hands will receive one-on-one education regarding handwashing by the Staff Development Coordinator by 6/25/10. The Director of Nursing or designee will review the infection control reports for the last 3 months by 6/25/2010. There were no trends identified during this review. The staff will receive additional education by the Staff Development Coordinator by 6/25/10 regarding the facility's infection control practices and protocols. Special emphasis was placed on handwashing practices. The DON and/or designee will monitor infection control protocols and handwashing practices at least three times a week for the next six weeks in order to ensure that proper infection control techniques and appropriate handwashing practices are observed by staff. The results of these audits will be forwarded to the monthly CQI committee for further monitoring and continued compliance.	06/26/10

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

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER
WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
100 WURTLAND AVENUE
WURTLAND, 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 444	Continued From page 8 up the sandwich with bare hands but acknowledged staff were nervous when they were being watched.	F 444		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a safe environment for the residents. Products used for the direct care of residents were found stored under inappropriate conditions. Those conditions could lead to the deterioration of the products, making their use with residents potentially dangerous. The findings include: On 05/27/10 at 3:38 PM, observation of the outdoor Central Supply Storage (CSS) shed revealed the presence of no thermometer inside the shed. Further observation revealed the shed to be built out of metallic material. Further observation revealed three holes in the shed door, which measured approximately four (4) inches in diameter. On 05/27/10 at 3:38 PM, with the door open, the temperature inside the shed was registered at 93 degrees Farenheit and 92 degrees Farenheit.	F 465	It is the policy of Wurtland Nursing and Rehabilitation Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The supplies in the outside building will be relocated to an area inside of the facility by 6/15/10. Supplies were visually inspected to ensure that no damage from excessive heat or cold had occurred by the Administrator and Central Supply Coordinator by 6/25/2010. There were no adverse effects on any resident due to this practice. The Administrator will provide additional education to the Central Supply Coordinator by 6/21/10 regarding the importance of storing supplies in an appropriate area. The Administrator and/or designee will monitor the storage of supplies weekly for six weeks to ensure that proper storage guidelines are followed. The results of these audits will be forwarded to the monthly CQI committee meeting for further monitoring and continued compliance.	06/26/10

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

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	185261		C 05/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, 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 465	Continued From page 9 Interview with the Manager of Central Supply Stores on 05/26/10 at 2:40 PM revealed the majority of CSS items were stored in the shed, as the Central Supply Room inside the facility "is quite small and also serves as my office." Further interview with the CSS Manager revealed he started his employment at the facility on 05/05/10 and was told the temperatures were excessively cold in winter, just as the shed was "very hot right now". No fan or any other form of temperature control was seen in shed at that time. Review of the manufacturer's instructions on the labels on the following items stored in the shed revealed the following recommended storage temperatures: For peroxide, mouthwash, suction catheter tubing, oxygen masks, oxygen tubing, and zinc oxide, room temperature was recommended. For facial moisturizer and indwelling catheters, storage instructions were to protect the items from excessive cold or heat. Disposable gloves were not to have direct contact with the sun and were to be stored in a cool dry place. Glucose Control Test Strips and Iodoform Packing were not to be refrigerated or frozen. Also observed was the storage of sphygmomanometers, which contained mercury and which were not be stored at excessively high or low temperatures.	F 465		

PRINTED: 06/11/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185261		05/26/2010

NAME OF PROVIDER OR SUPPLIER: WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WURTLAND AVENUE, WURTLAND, 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
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 05/26/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F".	K 000	To the best of my knowledge and belief, as an agent of Wurtland Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the outside canopy had an automatic sprinkler system, according to NFPA standards. The findings include: Observation on 05/26/10 at 9:37 AM, revealed an approximate twenty (20) by ten (10) foot combustible (wood) overhang at the smoking area of the facility. The Maintenance Supervisor was present during the observation. An interview with the Maintenance Supervisor on 05/26/10 at 9:37 AM revealed the Maintenance Supervisor was not aware the canopy should be sprinkler protected. Reference: NFPA 13 1999 edition 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.	K 012	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 practice of Wurtland Nursing and Rehabilitation Center to promote the safety of all residents in a manner and in an environment that maintains each resident's safety. The Director of Maintenance contacted Sentry Fire in regards to the canopy's needing to be sprinkled on 5/26/2010. Sentry Fire visited the facility on 6/14/2010 to estimate sprinkling the canopies. Sentry Fire will install the sprinklers by 6/25/10. There were no adverse effects on any resident due to the canopies not being sprinkled.	06/26/10

RECEIVED
JUN 21 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 06/21/10

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.

PRINTED: 06/11/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, 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
K 012	Continued From page 1 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	The Director of Maintenance will monitor and note any issues and report them during the monthly CQI meetings.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The findings include: Observation on 05/26/10 at 9:03 AM revealed seven (7) dirty sprinkler heads which were located in the kitchen area. The Maintenance Supervisor and the Administrator were present during the observation. An interview with the Maintenance Supervisor on 05/26/10 at 9:03 AM revealed he was unaware of the dirty sprinkler heads. The Maintenance Supervisor stated the sprinkler heads were cleaned as needed by housekeeping, but they would change the policy so the sprinkler heads would be cleaned more often. Further observation on 05/26/10 at 9:08 AM revealed a valve for the sprinkler system accelerator was in the closed position. An interview with the Maintenance Supervisor on	K 062	It is the practice of Wurtland Nursing and Rehabilitation Center to promote the safety of all residents in a manner and in an environment that maintains each resident's safety. The Director of Maintenance contacted Sentry Fire in regards to the Accelerator issue noted on 5/26/2010. Sentry Fire repaired the Accelerator on 6/14/2010. The Director of Maintenance cleaned the 7 sprinkler heads in the kitchen area on 5/27/2010. There were no adverse effects on any resident due to the Accelerator not working appropriately and 7 dirty sprinkler heads. The Director of Maintenance will audit the Accelerator and sprinkler heads weekly for 6 weeks to ensure proper working condition of Accelerator and cleanliness of sprinkler heads. The Director of Maintenance will monitor and note any issues and report them during the monthly CQI meetings.	06/26/10

PRINTED: 08/11/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, 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
K 062	Continued From page 2 05/26/10 at 9:08 AM revealed he was unaware of the closed accelerator valve. The maintenance Supervisor called Sentry Fire,who performs inspections of the system to ask about the valve. Sentry Fire told the Maintenance Supervisor that the valve needed to be open, and to open the valve. Sentry Fire also directed the Maintenance Supervisor to close the valve if air was heard escaping from the valve. Air was noted to be heard escaping from the valve. The valve was closed and Sentry Fire was noticed. Sentry Fire told the Maintenance Supervisor that they would get someone there to work on the valve. Reference: NFPA 25 (1999 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. NFPA 13 (1999 edition) 12-1 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066	It is the practice of Wurtland Nursing and Rehabilitation Center to promote the safety of all residents in a manner and in an environment that maintains each resident's safety. The facility ordered new metal self closing ashtrays on 6/2/2010.	06/26/10

PRINTED: 06/11/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, 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)	(X6) COMPLETION DATE
K 066	Continued From page 3 area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain a smoking policy, according to NFPA standards. The findings include: During the Life Safety Code survey on 05/26/10 at 9:40 AM, observation at that time revealed there were no metal containers with self-closing cover devices, located in the smoking area, into which ashtrays could be emptied. The smoking area was located at the side of the building near the kitchen. The Maintenance Supervisor was present during the observation. An interview with the Maintenance Director on 05/26/10 at 9:40 AM revealed he was unaware of the requirements for the metal containers with	K 066	The facility replaced existing ashtrays with new self closing ashtrays on 6/4/2010. There were no adverse effects on any resident due to the type of ashtrays which the facility had previously used. The Director of Housekeeping will audit 10% of smoking areas weekly for 6 weeks to ensure proper ashtrays are in use. The Director of Housekeeping will monitor and note any issues and report them during the monthly CQI meetings.	

PRINTED: 06/11/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. BUILDING 01 - MAIN BUILDING 01 B. WING [redacted]	[redacted] 05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, 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
K 066	Continued From page 4 self-closing devices. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		