

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

PRINTED: 06/01/2011
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 05/17/2011
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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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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey and an Abbreviated Survey Investigating ARO#KY00016390, ARO#KY00016393, ARO#KY00016394, ARO#KY00016281, ARO#KY00016331, ARO#KY00016225, ARO#KY00016391, ARO#KY00016392, ARO#KY00016224, ARO#KY00016389, ARO#KY00016442, and ARO#KY00016223 was initiated on 05/10/11 and concluded on 05/17/11. Deficiencies were cited at the highest Scope & Severity of an "F". ARO#KY00016390, ARO#KY00016394, ARO#KY00016225, and ARO#KY00016223 were substantiated with no deficiencies. ARO#KY00016393, ARO#KY00016281, ARO#KY00016331, ARO#KY00016391, ARO#KY00016224, and ARO#KY00016442 were unsubstantiated with no deficiencies. ARO#KY00016392 was substantiated with an unrelated deficiency cited. ARO#KY00016389 was unsubstantiated with an unrelated deficiency cited. A Life Safety Code Survey was conducted 05/11/11 with deficiencies cited.</p>	F 000	<p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.</p>	
F 164 SS=D	<p>489.10(e), 489.76(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this</p>	F 164	<p>F164</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>The Social Services Director interviewed unsampled resident B regarding resident rights and dignity on 6/9/11. Unsampled</p>	6/22/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 6/24/11
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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 patient. (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 184	<p>Continued From page 1</p> <p>section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to protect the resident's rights to personal privacy during the provision of care for one (1) unsampled resident (Resident B). Unsampled Resident B's bed was located next to an outside window. Observation revealed the window curtains were left open while Unsampled Resident B was utilizing a bedpan.</p> <p>The findings include:</p> <p>Observation on 05/10/11 at 11:05 AM revealed the curtains to an outside window next to Resident B's bed were open while the resident was unclothed and on the bedpan.</p> <p>Interview on 05/10/11 at 11:06 AM with State Registered Nurse Aide (SRNA) #2 revealed it was a "privacy issue" to leave Resident B "exposed".</p>	F 184	<p>Resident B voiced no issues or concerns.</p> <p>A resident council meeting was conducted by the Activities Director on 6/7/11 to ensure that residents were informed of these rights and determine if any other resident was affected by this practice. There were no issues which resulted from this meeting. SRNA #2 received one-on-one education by the Staff Development Coordinator (SDC) on 5/16/11 regarding the importance of ensuring that resident personal privacy and confidentiality of clinical records is observed.</p> <p>All staff received education by the SDC by 6/22/11 regarding the importance of maintaining resident personal privacy and confidentiality of personal and clinical records.</p> <p>Random visual audits will be conducted by the DON/designee on all three shifts at least three times per week for four weeks to ensure that privacy and confidentiality is maintained. Additionally, the Activity</p>	

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F 164 F 225 SS=D	<p>Continued From page 2</p> <p>Further interview revealed she had placed the resident on the bedpan and pulled the window curtains shut to protect the resident's privacy and did not know why or how they got opened.</p> <p>483.13(c)(1)(II)-(III); (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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</p>	F 164 F 225	<p>Director will address privacy and confidentiality in resident council meetings for the next three months.</p> <p>The results of the audits and council meetings will be forwarded to the monthly CQI Meeting for three months for further monitoring and continued compliance. The CQI Committee is composed of the Administrator, DON, ADON, RN Supervisor, Social Services, MDS Coordinators, Medical Records, Activity Director, Rehab Manager, Dietary Manager, SDC, Housekeeping/Laundry Director, Accounts Payable/Payroll Manager, AR Manager, Maintenance Director and HR Manager.</p> <p>F225 It is the policy of Wurland Nursing and Rehabilitation Center to 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</p>	C/22/11

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F 225	Continued From page 3 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 record review, it was determined the facility failed to ensure employees were not guilty of abusing, neglecting, mistreating residents or misappropriating resident property for four (4) of fourteen (14) employee files reviewed. The findings include: Review of fourteen (14) employee files revealed four (4) of the employee files failed to have documented evidence State Nurse Aide Registry checks were made prior to employment. Two (2) employees had State Nurse Aide Registry checks completed three (3) days after hire, one (1) employee had State Nurse Aide Registry check completed twenty (20) days after hire, and one (1) employee file showed a hire date of 11/15/10 and did not have a State Nurse Aide Registry check on file. Interview with the Human Resources Director (HRD) on 05/13/11 at 10:25 AM revealed she was a new employee (employed approximately six (6) months) who did not know to keep documentation from background checks done prior to employment, or to keep background checks from employees once terminated.	F 225	concerning abuse, neglect, mistreatment of residents or misappropriation of their property. The missing State Nurse Aide Registry checks for the employees were obtained on 5/13/11 and provided to the state surveyors. There were no issues noted on the State Nurse Aide Registry Check regarding the employees. An audit of all employee files was conducted by the Human Resources Director (HR) will be completed by 6/22/11 to ensure that all current employees had a criminal background check as well as a current State Nurse Aide Registry check on file. One on one education was provided to the Human Resources Director by 6/22/11 by the Administrator to ensure that she understands the importance of obtaining/retaining the criminal background check as well as the State Nurse Aide Registry checks, even after employment ceases. The Administrator/designee will audit at least five employee files per week for four weeks to ensure		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241			

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F 241	Continued From page 4 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 and interview, it was determined the facility failed to promote care for residents in a manner and environment that maintains each resident's dignity and respect in full recognition of his/her individuality for one (1) Unsampled resident, (Resident A). The findings include: Observation of the breakfast meal on 05/10/11 revealed State Registered Nurse Aide (SRNA) #13 was feeding Unsampled Resident A without trying to engage Resident A in any socialization activity during the meal. SRNA #13 was observed talking to a Restorative Aide and the Speech Language Pathologist about personal life while feeding Resident A. Interview with the Director of Nursing on 05/13/11 at 2:30 PM revealed training was provided upon hire and staff was specifically instructed to talk to the residents during meal times. Further interview revealed if staff members were observed not socializing with the resident, they would be re-educated. Interview with Staff Development Director on 05/13/11 at 2:45 PM revealed specific training regarding staff to resident socialization was covered during orientation. Further interview revealed SRNA #13	F 241	that the State Nurse Aide Registry checks are on file. The results of these audits will be forwarded to the monthly CQI Committee meeting for the next three months for further monitoring and continued compliance. F241 It is the policy of Wurland Nursing and Rehabilitation Center to 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. The Social Services Director interviewed unsampled resident A on 6/9/11 to ensure that she feels as though her dignity, respect and individuality is upheld by the facility staff. Unsampled Resident A voiced no concerns during the interview. A resident council meeting was conducted by the Activities Director on 6/7/11 to determine if any other resident had been	6/22/11

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F 241	Continued From page 5 had received specific training involving socialization during SRNA classes provided by the facility.	F 241	affected by this practice. No issues were noted .	
F 253 SS=E	489.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a comfortable and home-like environment as evidenced by the heavily stained and discolored carpet in the common area near the entrance into the Lighthouse Unit. The findings include: Observation on 05/10/11 at 9:35 AM revealed the carpet located in the common area near the entrance into the Lighthouse Unit had multiple areas of discoloration of red and dark stains. Interview on 05/11/11 at 2:00 PM with the Housekeeping Supervisor revealed several different cleaning agents had been tried to remove the stains from the carpet. Further interview revealed that someone had again tried on 05/09/11 to see if repeated use of the agents could minimize the stains and had been unsuccessful and administration was aware of the damaged carpet.	F 253	SRNA #13 received one on one education by the DON on 5/16/11 regarding the importance of promoting care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality. All staff received additional education by the SDC by 6/22/11 regarding the importance of promoting care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality. Random visual audits will be conducted by the DON/designee on all three shifts at least three times per week for four weeks to ensure that staff provides care for residents in a manner and environment that maintains dignity and respect. The results of these audits will be forwarded to the CQI Committee for three months for further	

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F 253	Continued From page 6	F 253	monitoring and continued compliance.	
F 279 SS=D	<p>403.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to develop a comprehensive care plan to meet medical, nursing, and mental and psychosocial needs for two (2) of twenty-seven (27) sampled residents, (Residents #17 and #7). Resident #17 exhibited</p>	F 279	<p>F253</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. New flooring for the Lighthouse Unit was ordered on 6/9/11 and will be installed when the flooring arrives from the distributor. The Administrator, Housekeeping Supervisor, and the Maintenance Director conducted a Housekeeping audit on 5/13/11 to ensure that all areas of the facility is maintained in a sanitary, orderly, and comfortable manner. Any identified issues were corrected or placed on a plan of correction. The Housekeeping Supervisor and Maintenance Director received additional education by the Administrator by 6/22/11 regarding the importance of conducting</p>	6/22/11

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F 279	<p>Continued From page 7</p> <p>behaviors which were not identified on the Care Plan. Resident #7 had a permanent pacemaker for which no care plan was developed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Comprehensive Plan of Care, dated 12/01/10, revealed the Care Plan "must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being".</p> <p>1. Record review revealed the facility admitted Resident #17 on 06/11/09 with diagnoses which included Alzheimer's Disease, Depressive Disorder, Psychosis, Vascular Dementia with behaviors and Diabetes Mellitus.</p> <p>Review of the Nursing Notes for Resident #17 revealed on 04/29/11 the resident came up behind another resident who was talking on the phone and slapped him/her in the back of the head.</p> <p>Further review of Nurse's Notes revealed on 04/28/11 the resident was exiting the dining room using his/her walker and there was another resident in the hallway in their wheelchair and Resident #17 stopped behind him/her and yelled move. The Nurses Notes continued to say the resident was redirected to go around the resident who was in their wheelchair and Resident #17 cursed as he/she went around the resident.</p> <p>Review of the Comprehensive Plan of Care revealed the problem/need of Resident #17 exhibiting socially inappropriate behaviors: he/she</p>	F 279	<p>Housekeeping audits as per facility protocols.</p> <p>The Housekeeping Supervisor and Maintenance Supervisor will conduct 2 audits weekly for four weeks to ensure that the facility is maintained in a sanitary, orderly, and comfortable manner.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p> <p>F279</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care so that services are provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The IDCPT is composed of the MDSC, Social Services, Dietary Manager, Activities Director and a Nursing Designee.</p>	6/22/11

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F 279	<p>Continued From page 8</p> <p>wandors/paces, is obsessed with drinking soda and throws whatever is in his/her hands when he/she becomes angry. The Care Plan continued to state the resident is verbally abusive with staff at times and becomes easily agitated. The problem onset date was noted to be 05/07/11 and the goal was to decrease episodes of disruptive behaviors by fifty (50) percent by the target date of 08/10/11. There was no evidence the facility had addressed the resident's behavior towards others or interactions with other residents.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 05/13/11 at 3:40 PM revealed the Social Services Director was responsible for developing the behavior portion of the Comprehensive Plan of Care.</p> <p>Interview with the Social Services Director on 05/13/11 at 4:00 PM revealed she did not include the incident on the residents Comprehensive Plan of Care secondary to it was an isolated incident. She further indicated the resident was combative with staff at times, however, had never hit or been combative with another residents.</p> <p>2. Review of the Clinical Record revealed the facility admitted Resident #7 on 02/05/04 with diagnoses which included a Permanent Pacemaker, placed in 2002. Continued review revealed the resident had several hospitalizations with the most recent readmission being 11/20/10.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 05/12/11 at 6:45 PM revealed she had never been involved with a pacemaker check. She stated she did not know what the policy was and had received no training related to pacemakers.</p>	F 279	<p>The IDCPT updated the care plans on 6/9/11 for resident #17 and #7.</p> <p>The IDCPT reviewed the plan of care for each resident in the facility by 6/22/11 to determine that the assessment was utilized to develop, review and revise the comprehensive plan of care so that services can be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. Any care plan identified to need revision was corrected at the time of the audit.</p> <p>The DON/designee provided additional education to the IDCPT by 6/22/11 regarding the importance of using the assessment to develop, review and revise the plan of care so that services are provided to attain or maintain the resident's highest practicable well being. The DON/designee provided education to nursing staff regarding their roles in developing, reviewing and revising care plans by 6/22/11.</p>		

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F 279	<p>Continued From page 9</p> <p>She further stated she would expect to see interventions for a pacemaker on the Care Plan.</p> <p>Interview with the Staff Development Coordinator on 05/12/11 at 6:48 PM revealed the physician should be notified on admission to schedule the first pacemaker check. She stated the appointment should be noted on the Medication Administration Record. Continued interview revealed she did not know how often the checks should be done.</p> <p>Interview with Registered Nurse #2 on 05/12/11 at 6:52 PM revealed the pacemaker checks were usually scheduled by the cardiologist. She stated the doctor would call the facility to schedule the checks. Continued interview revealed the nurse, on admission, should initiate the first contact with the cardiologist. And develop a care plan for the pacemaker.</p> <p>Interview with LPN #3 on 05/12/11 at 6:56 PM revealed she did not know anything about pacemakers. She stated she did not know of any residents on the back hall, where Resident #7 resided, who had a pacemaker.</p> <p>Review of the Comprehensive Care Plan revealed no evidence the facility addressed the pacemaker and no interventions related to the pacemaker, including no instructions for periodic checks of the function of the device.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator (Interviewee #13) on 05/13/11 at 11:45 AM revealed the nurse was responsible for developing the Initial Care Plan upon the resident's admission. From that point, the MDS</p>	F 279	<p>The DON/designee will audit five care plans per week for four weeks to determine that the IDCPT is utilizing the assessment to develop, review and revise the plan of care and that interventions are current and meet the individual needs of each resident. The results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/17/2011
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F 279	Continued From page 10 Coordinator reviewed the chart and revised the plan as indicated. Interview with the MDS Coordinator (Interviewee #8), for the back hall and the Lighthouse (locked) Unit, on 5/13/11 at 2:15 PM revealed she updated the Care Plans daily, based on Physician's Orders. She stated, for issues or diagnoses that were not reflected by an order, she depended on the nurses or aides to tell her so she could update it as needed. She further stated the nurses don't make any revisions on the Comprehensive Care Plan. Continued interview revealed the purpose of the Care Plan was to ensure care was appropriate, what the residents wanted and needed. She stated the nurses were supposed to look at them.	F 279		
F 280 SS=D	Interview with LPN #6 on 05/13/11 at 4:15 PM revealed licensed staff should use the Care Plan to know what was going on with the resident. 403.20(d)(3), 403.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F280 It is the policy of Wurland Nursing and Rehabilitation Center to develop a plan of care within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team; and to the extent possible, the participation of the resident and/or the responsible party. The plan of care will be reviewed and revised as necessary. The plan of care for resident #2 and #27 were revised as needed by the MDSC. Resident #2 had been discharged on 5/27/11. Resident #27's care plan was updated on 6/9/11 to reflect toileting behaviors. The IDCPT is composed of the MDSC, Social Services, Dietary Manager, Activities Director and a Nursing Designee. The IDCPT reviewed and revised the plan of care for each active resident in the facility	6/22/11

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F 280	<p>Continued From page 11</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Care Plan was revised for two (2) of twenty-seven (27) sampled residents, (Residents #2 and #27). Resident #2's care plan was not revised to reflect the recent downward trend of his/her medical condition. Resident #27 exhibited behaviors which were not addressed on the Care Plan.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Comprehensive Plan of Care, dated 12/01/10, revealed it was the responsibility of all interdisciplinary team members involved in a resident's care to provide input into the Care Plan. Continued review revealed the interdisciplinary team included the nurse responsible for the resident's nursing care.</p> <p>1. Observation of Resident #2 on 05/10/11 revealed Tube Feeding (TF) infusing via pump, eyes closed, and a Foley catheter (FC), (a urinary drainage device) was present and patent.</p> <p>Review of the Clinical Record revealed the facility admitted Resident #2 on 01/25/11 with diagnoses</p>	F 280	<p>no later than 6/22/11 to ensure that each care plan reflected the current individualized needs of the resident and that revisions had occurred as necessary. Any care plans identified to need revisions were corrected at that time. The DON/designee provided education to nursing staff regarding their roles in developing, reviewing and revising care plans by 6/22/11. The DON/designee provided additional education to the IDCPT by 6/22/11 regarding the importance of revising the plan of care for each resident as changes occur so that the care plan addresses the current individual needs of each resident. The DON/designee will review at least five plans of care per week for four weeks to ensure that the care plan has been reviewed and revised as changes occur and that the individual needs of the resident are addressed. The results of these audits will be forwarded to the monthly CQI Committee meeting for further</p>	

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F 280	<p>Continued From page 12 which included Chronic Renal Failure, Acute Respiratory Failure, Alzheimer's and Transient Ischemic Attack (mini stroke).</p> <p>Review of the Significant Change Minimum Data Set (MDS) Assessment dated 05/10/11 revealed Resident #2's cognitive status had decreased from 3 (three) to 2 (two) since the Admission MDS Assessment of January 2011. Care Plan approaches included ask about daily preferences and provide verbal cues for memory issues.</p> <p>Review of the Clinical Record revealed a overall decline in Resident #2's medical condition since admission. He/she was to receive nothing by mouth (NPO) and on continuous tube feeding infusion for total nutrition. However, in the weight loss section of the Comprehensive Care Plan dated 12/01/10, interventions for Resident #2 included; food like/dislikes are to be listed, between meal snacks are to be provided, and verbal encouragement and cueing is to be provided.</p> <p>Interview with the House Supervisor (2 PM-10 PM) on 05/13/11 at 4:10 PM revealed Care Plans are used to guide staff in providing care and services to residents and she expected staff to make use of them. She further stated the Care Plan should have been revised. Interview with LPN #5 on 05/13/11 at 4:15 PM revealed licensed staff are to use the Care Plans to know what's going on with the residents and the SRNA's also have a resident care plan to assist in caring for the residents.</p> <p>2. Review of the Clinical Record revealed the facility admitted Resident #27 on 08/02/09 with</p>	F 280	monitoring and continued compliance.	

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F 280	<p>Continued From page 13</p> <p>diagnoses which included Dementia, Psychosis, and Anxiety.</p> <p>Review of the Nurses Notes revealed frequent, almost daily, references to Resident #27's tendency to self-toilet in inappropriate places, including trash cans, closets, and common areas of the the unit. In addition, the resident was noted to have occasional Incontinence. Review of the note dated 02/06/11 revealed the resident voided on the carpet in the TV room. Continued review of the note dated 04/10/11, revealed Resident #27 had a bowel movement in the floor and down the wall of the dining room.</p> <p>Review of the Comprehensive Care Plan revealed the resident had behavioral disturbances. However, interventions were general, not individualized for the resident. There was no reference to the resident's inappropriate toileting or incontinence. Continued review revealed no interventions related to managing the specific behaviors as documented in the Nurses Notes.</p> <p>Interview with the MDS Coordinator #13 on 05/13/11 at 11:45 AM revealed Care Plans were updated daily based on physician orders or anything she knew that was going on with the residents. She stated the nurse would occasionally add something to the Care Plan, but usually brought it to the MDS coordinator to update. She further stated it was not common practice for nurses to update the Care Plan.</p> <p>Interview with Licensed Practical Nurse #4 on 05/13/11 at 12:20 PM revealed the Minimum Data Set (MDS) Coordinators updated the Care Plans</p>	F 280		
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F 280	<p>Continued From page 14</p> <p>daily, based on any new Physician's Orders. For any concerns that were not reflected by an order, the nurse told the MDS Coordinator and she would update the Care Plan accordingly. She stated she had never updated the Care Plan herself, and did not really ever look at it.</p> <p>Interview with the MDS Coordinator for the back hall and the Lighthouse (locked) Unit on 05/13/11 at 2:15 PM revealed she updated the Care Plans daily, based on Physician's Orders. She stated, for issues that were not reflected by an order, she depended on the nurses or aides to tell her. She further stated the nurses don't do anything on the Comprehensive Care Plan. Continued interview revealed the purpose of the Care Plan was to ensure care was appropriate, what the residents wanted and needed. She stated the nurses were supposed to look at them.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure professional standards of quality were met for all residents when emergency suctioning and resuscitation equipment was not readily available. Observations revealed both facility crash carts were soiled and disorganized, and essential equipment was missing. In addition, physician orders were not followed for two (2) of twenty-seven (27) sampled residents (Residents</p>	F 280	<p>F 281</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center that the facility provide or arrange services in a manner that meets professional standards of quality. Each emergency cart was cleaned and re-assembled by the Administrator, DON, and Central Supply Clerk on 5/12/11. As evidenced by the Statement of Deficiencies, emergency supplies were available for use on the unit. As noted in the SOD, the surveyor brought both carts to the conference room for inspection "after ensuring emergency supplies were available for use on the units." Though the carts were disorganized, the facility had alternate emergency supplies available for use on the units at all times. No resident was negatively affected by this practice.</p>	6/22/11
F 281 SS=PF		F 281		

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F 281	<p>Continued From page 15</p> <p>#11 and #9). Resident #11 did not have a sensor alarm to the bed, as ordered by the physician. Resident #9 did not have a soft hand roll, as ordered by the physician.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of the crash cart on the front hall, on 05/12/11 at 11:15 AM, revealed it was heavily soiled and disorganized. Observation of the crash cart on the back hall, on 05/12/11 at 11:25 AM revealed it to be heavily soiled and disorganized. After ensuring emergency supplies were available for use on the units, both carts were brought to the conference room for inspection. The following observations were made: expired IV catheters, some since 2009, were stored on the unlocked carts; one cart held an Ambu bag (for administering artificial respirations) in an opened plastic bag containing black debris and cobwebs; non-sterile gloves in a dilapidated box, dated 2004, were discolored and stuck together; and a used nasal cannula with a dried yellow-green substance on the inside of the tube on top of one cart. Both carts held a portable suction machine. However, neither cart had suction tubing available, rendering the machines useless in an emergency. Additionally, oxygen tanks on both carts were empty and clean supplies (tubing and masks) for administering oxygen were not available. <p>Review of the Crash Cart Checklist for the back hall revealed the following items should be "on the cart and operable": oxygen tank with gauge, oxygen mask, nasal oxygen tubing, sharps container, suction machine with tubing, gloves, Micro-shield mouth barrier, and Ambu bag (for</p>	F 281	<p>The DON/designee reviewed Resident #11 care plan and physician order for the sensor pad on 6/10/11. The review revealed that the sensor alarm can be discontinued at this time. The facility obtained a telephone order on 6/10/11 to discontinue the alarm. The physician order is implemented at this time for the removal of the sensor pad alarm. The DON/designee reviewed Resident #9 care plan and physician order for the soft roll with no changes noted on 6/10/11. The physician order is implemented at this time. All physician orders were reviewed by the Medical Records Nurse no later than 6/22/11 to ensure that physician orders have been noted and received as written by the MD for the past 60 days.</p> <p>The Administrator and DON created a policy for the Emergency Carts on 5/13/11. See Attachment A for Facility Policy. All nursing staff received education regarding the</p>	
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F 281	<p>Continued From page 16</p> <p>administering artificial respirations). Continued review revealed the checklist for the day shift was last initiated on 02/24/11. The checklist for the evening shift was last initiated on 04/09/11. The checklist for the night shift was signed as recently as the night before the carts were discovered as they were.</p> <p>Review of the Crash Cart Checks form for the front hall revealed the following items were "present and functional" when the form was initiated: oxygen, a key for operating the oxygen gauge, a suction machine with necessary supplies, an Ambu bag, a cardiac board, and gloves. Continued review revealed the checklist had been initiated on every shift from the beginning of January through May 9, 2011.</p> <p>Interview with Licensed Practical Nurse (LPN) #9 on 05/12/11 at 11:45 AM revealed she was unable to assemble oxygen for administration or suction apparatus with the available equipment. She stated there was no oxygen, and no suction or oxygen tubing. She further stated the carts were to be checked each shift and initials on the checklist indicating the items listed were present and ready for use. Continued interview revealed if she had a code situation and found the cart in this condition she would call for the other cart. When LPN #9 inspected the second cart, she confirmed it was not in usable condition either. When asked what she would do next, she stated she would have to pull equipment from the supply room.</p> <p>Interview with LPN #10 on 05/12/11 at 4:30 PM revealed the crash carts should be checked every shift but "it wasn't happening". She stated there</p>	F 281	<p>Emergency Cart Policy by the SDC no later than 5/16/11.</p> <p>All nursing staff received additional education regarding the importance of providing or arranging services in a manner that meets professional standards of quality by the SDC no later than 6/22/11.</p> <p>The DON/designee will visually audit the Emergency Carts at least three times per week for four weeks to ensure that the carts are maintained in a professional manner and that essential equipment is available and ready for immediate use.</p> <p>The DON/designee will review at least ten physician orders per week for four weeks to ensure that the order has been received, noted and implemented as directed by the physician.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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F 281	<p>Continued From page 17</p> <p>should be a full oxygen tank, a sealed Ambu bag, suction machine and tubing, and oxygen tubing on each cart. Continued Interview revealed if an oxygen tank was used, it should never be put back on the cart, but replaced with a new, full tank.</p> <p>Interview with LPN #8 on 05/13/11 at 2:20 PM revealed the crash carts must be checked every shift. She stated the carts "looked a wreck", and noted there was no suction tubing and the oxygen tanks were empty.</p> <p>Interview with LPN #6 on 05/13/11 at 4:14 PM revealed she would have to call for help if she needed suction equipment and there was none on the crash cart. She stated she did not know where extra equipment was located.</p> <p>Interview with Registered Nurse (RN) #3 on 05/13/11 at 4:20 PM revealed she knew how to set up and use suction equipment but did not know where it was located. She stated she would have to call a supervisor for help.</p> <p>Interview with LPN #3 on 05/13/11 at 4:35 PM revealed she was able to locate suction tubing in the locked unit and was able to assemble the equipment for use. However, she stated, only long tubing was available and short tubing would have been preferable for connecting the suction machine to the collection chamber.</p> <p>Interview with the Director of Nursing (DON) on 05/13/11 at 4:45 PM revealed if supplies were not available on the carts in an emergency situation, someone would have to obtain them from the locked supply room in side the locked unit at the</p>	F 281		

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F 281	<p>Continued From page 18</p> <p>end of the back hall. She stated only the nurses knew the code to enter the supply room. She further stated the crash carts should be check by nursing staff every shift.</p> <p>Interview with LPN #5 on 05/13/11 at 5:10 PM revealed if she had a "code" (cardiopulmonary arrest) and there was no oxygen on the cart, she would send someone for another tank, located in the medication room on the back hall. She stated the back hall nurse had the only key to the room on the night shift. She further stated she did not know where extra Ambu bags were located but assumed they would be in the storage room on the back hall. She stated if she had no Ambu bag or mouth shield, she would have to do mouth-to-mouth breathing for the resident.</p> <p>Interview with the Asistant Director of Nursing on 05/13/11 at 5:15 PM revealed the nurse supervisors should be ensuring that all nursing duties were completed, including the crash cart checks every shift. She stated upon seeing the condition of the carts, it was clear checks were not being done.</p> <p>Interview with the Administrator on 05/13/11 at 6:00 PM revealed he had not considered the condition of the crash carts prior to the survey. He stated nursing had ultimate reaponsibility for crash cart integrity and he would expect some sort of monitoring was occurring. He further stated, based on his observation of the carts during survey, someone should have identified the problem.</p> <p>2. Review of the Clinical Record revealed the</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>facility admitted Resident #11 on 11/02/07 with diagnoses which included Dementia and Depression. Review of the Physician's Order dated 08/20/10 revealed the resident was to have a bed alarm. Review of the current Comprehensive Care Plan revealed Resident #11 was at risk for falls due to debility, confusion, and poor balance. Interventions included a sensor alarm to the bed, to be observed every shift and checked for function every week.</p> <p>Observation of Resident #11 on 05/11/11 at 9:20 AM, 10:30 AM, 11:30 AM, and 1:40 PM revealed the resident was lying in bed with no bed alarm in place. On 05/11/11 at 2:00 PM, LPN #9 confirmed there was no bed alarm, as ordered. Interview with LPN #9 at that time revealed she did not know the resident well and did not know why there was no alarm on the bed.</p> <p>3. Review of the Clinical Record revealed the facility admitted Resident #9 on 10/10/09 with diagnoses which included Chronic Airway Obstruction, Hypertension, Diabetes, Depression, Anxiety, Debility, Dysphagia. Review of the Physician's Orders for May 2011 revealed an ongoing order dated 08/19/10 for the resident to have a left resting hand splint. Review of a verbal order dated 07/24/10 at 4:30 PM revealed Resident #9 was discharged from Occupational Therapy on 07/23/10 due to maximum rehabilitation potential had been reached. At that time, an order had been received for the resident to utilize a soft roll, in place of the splint, to the left hand as tolerated. The soft roll was to be removed for bathing and hygiene. Review of the Comprehensive Care Plan and the Resident Care Flow Sheet (both undated) revealed entries for</p>	F 281		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/17/2011
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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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F 281	<p>Continued From page 20</p> <p>Resident #9 to utilize a soft roll to left hand and to remove for bathing and hygiene.</p> <p>Observation of Resident #9 on 05/10/11 at 11:15 AM and 12:00 PM and on 05/11/11 at 10:30 AM and 12:30 PM revealed Resident #9 was not utilizing a soft roll hand splint.</p> <p>Interview on 05/11/11 at 12:00 PM with State Registered Nurse Aide (SRNA) #18 revealed she received resident report from off going SRNAs and oncoming nurses. Further interview revealed she used a care plan to know special areas of concern. Review of the SRNA care plan revealed instructions for the soft hand roll was included. However, the SRNA stated she was unaware of the order for the soft roll for left hand.</p> <p>Interview with LPN #1 on 05/11/11 at 12:20 PM revealed she was unaware of the order for the hand splint. She further stated she did not use the care plans and was unaware she could make revisions to the care plans.</p>	F 281	<p>F282</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center to provide or arrange services in accordance with each resident's written plan of care.</p> <p>The DON/designee reviewed Resident #11 care plan and physician order for the sensor pad 6/10/11. The review warranted the removal of the sensor alarm. The facility obtained a telephone order for the discontinuation of the sensor pad alarm. The physician order is implemented at this time for the removal of the sensor pad.</p> <p>The DON/designee reviewed Resident #9 care plan and physician order for the soft roll with no changes noted on 6/10/11. The physician order is implemented at this time.</p>	6/22/11
F 282 89=D	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the comprehensive care plan was followed for two (2) of twenty-seven (27) sampled</p>	F 282		

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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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F 282	<p>Continued From page 21</p> <p>residents (Residents #11 and #9). Resident #11 did not have a sensor alarm to the bed, as indicated on the care plan and Resident #9 did not have a soft hand roll as per the care plan.</p> <p>The findings include:</p> <p>1. Review of the Clinical Record revealed the facility admitted Resident #11 on 11/02/07 with diagnoses which included Dementia and Depression. Review of the Physician's Order dated 08/20/10 revealed the resident was to have a bed alarm. Review of the current Comprehensive Care Plan revealed Resident #9 was at risk for falls due to debility, confusion, and poor balance. Interventions included a sensor alarm to the bed, to be observed every shift and checked for function every week.</p> <p>Observation of Resident #11 on 05/11/11 at 9:20 AM, 10:30 AM, 11:30 AM, and 1:40 PM revealed the resident was lying in bed with no bed sensor alarm in place. Observation, with Licensed Practical Nurse (LPN) #9 on 05/11/11 at 2:00 PM, confirmed no sensor alarm was in place.</p> <p>Interview with LPN #9 on 05/11/11 at 2:00 PM revealed she did not know why there was no alarm on the bed.</p> <p>2. Review of the Clinical Record revealed the facility admitted Resident #9 on 10/10/09 with diagnoses which included Chronic Airway Obstruction, Hypertension, Diabetes, Depression, Anxiety, Debility, Dysphagia. Review of the Physician's Orders for May 2011 revealed an ongoing order dated 08/19/10 for the resident to</p>	F 282	<p>The IDCPT reviewed the plan of care for each resident no later than 6/22/11 and visually ensured that interventions were implemented via walking care plan rounds. Any care plans identified to need revisions were corrected at that time.</p> <p>The DON/designee provided additional education to the IDCPT by 6/22/11 regarding the importance of ensuring that each individual intervention is implemented as written and the importance of utilizing walking care plan rounds.</p> <p>The DON/Designee provided education to nursing staff regarding their role in developing, reviewing and revising care plans by 6/22/11.</p> <p>The DON/designee will accompany the IDCPT on walking care plan rounds weekly for four weeks to ensure that interventions are implemented as written.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further</p>	

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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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F 282	<p>Continued From page 22</p> <p>have a left resting hand splint. Review of a verbal order dated 07/24/10 at 4:30 PM revealed that Resident #9 was discharged from Occupational Therapy on 07/29/10 due to maximum rehabilitation potential had been reached. At that time, an order had been received for the resident to utilize a soft roll, in place of the splint, to the left hand as tolerated. The soft roll was to be removed for bathing and hygiene.</p> <p>Review of the Comprehensive Care Plan and the Resident Care Flow Sheet (both undated) revealed entries for Resident #9 to utilize a soft roll to left hand and to remove for bathing and hygiene.</p> <p>Observation of Resident #9 on 05/10/11 at 11:15 AM and 12:00 PM and on 05/11/11 at 10:30 AM and 12:30 PM revealed Resident #9 was not utilizing a soft roll hand splint.</p> <p>Interview on 05/11/11 at 12:00 PM with State Registered Nurse Aide (SRNA) #18 revealed she received resident report from off going SRNAs and oncoming nurses. Further interview revealed she used a care plan to know special areas of concern. Review of the SRNA care plan revealed instructions for the soft hand roll was included. However, the SRNA stated she was unaware of the order for the soft roll for left hand.</p> <p>Interview with LPN #1 on 05/11/11 at 12:20 PM revealed she was unaware of the order for the hand splint. She further stated she did not use the care plans and was unaware she could make revisions to the care plans.</p>	F 282	<p>monitoring and continuing compliance.</p> <p>F283 It is the policy of Wurland Nursing and Rehabilitation Center that when a discharge is anticipated, a resident will have a discharge summary that includes a recapitulation of the resident's stay. Resident #24 had a discharge summary completed by the Medical Records Nurse on 5/22/11 which included the information sent to the transferring facility. The Medical Records Director reviewed the discharges for the last 60 days by 6/24/11 to ensure that a discharge summary had been completed. The Medical Records Director received education by the Administrator by 6/22/11 regarding the importance of</p>	6/24/11
F 283 SS=0	483.20(1)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/17/2011
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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F 283	<p>Continued From page 23</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay, and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a discharge summary was completed for one (1) of twenty-seven (27) sampled residents (Resident #24).</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #24 on 02/23/10 with diagnoses which included Alzheimer's disease, Diabetes Mellitus, and Glaucoma.</p> <p>Record review revealed Resident #24 was transferred to another facility per the resident's family's request on 04/15/11.</p> <p>Review of the medical record revealed no evidence a discharge summary had been completed.</p> <p>Interview on 05/12/11 at 6:39 PM with Licensed Practical Nurse (LPN) #7 revealed she likes to wait until all of the Physician's orders are signed before writing the discharge summary, which the</p>	F 283	<p>maintaining discharged summaries as dictated by facility protocols.</p> <p>The DON/designee will audit all anticipated discharges for the next four weeks to ensure that discharge summaries are completed as directed by facility protocols.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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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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F 283	Continued From page 24	F 283		
F 309 SS=D	<p>doctor reads and then signs.</p> <p>403.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the highest practicable physical, mental, and psychosocial well-being was maintained in accordance with the comprehensive assessment and plan of care, for one (1) of twenty-seven (27) sampled residents (Resident #10). Resident #10's pain was not evaluated and documented per facility policy and current practice standards.</p> <p>The findings include: Record review revealed the facility admitted Resident #10 on 12/14/10 with diagnoses which included Seizure Disorder, Cerebral Palsy, Depression and Anxiety. Review of the Annual Minimum Data Set (MDS) Assessment, dated 12/31/10, and the Quarterly MDS Assessment of 03/23/11 revealed the resident was coded a "3", indicating the resident had indications of pain or possible pain occurring daily. Review of the Physician Orders dated 01/26/11 revealed the following medications were to be given for pain:</p>	F 309	<p>F309</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center to provide each resident the care and services needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Resident #10 was discharged to the hospital on 5/10/11.</p> <p>All medical records were reviewed by Medical Records Nurse/designee by 6/22/11 to ensure that Pain Medication Records were present in each chart as directed by Facility practice in order that pain indicators, dosages, administration and effectiveness can be documented and monitored for each resident if indicated. Any Pain Medication Records noted to</p>	6/22/11

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F 309	<p>Continued From page 25</p> <p>Tylenol, 500 milligrams (mg.) every six (6) hours as needed; or Percocet, 5 mg. every six (6) hours as needed. Review of the Comprehensive Care Plan, active through 06/30/11, revealed the Intervention to evaluate complaints of other indications of pain.</p> <p>Review of the Nurses Notes for the month of March 2011 revealed Resident #10 experienced pain on the 4th, 5th, 6th, 16th, 21st, 23rd, 24th, 25th, and 27th of the month. Continued review revealed the resident was given unspecified pain medicine on those dates. There was no indication of the severity of the pain and no consistent description of the location of the pain. For example, on March 4th, 5th, 6th, 25th, and 27th, no pain location was noted. On no occasion was the severity of pain documented.</p> <p>Review of the Medication Administration Record (MAR) for March 2011 revealed Percocet was given for pain on the 19th, 21st and 23rd of the month. Tylenol was not given, per documentation, in the month of March. Continued review of the MAR revealed no indication of the location or severity of the pain, or the resident's response to the medication.</p> <p>Review of the policy titled Pain Management and Assessment revealed monitoring and documentation of pain level and evaluation of interventions was to be documented on the Pain Management Record (PMR). Continued review of the Clinical Record for Resident #10 revealed no PMR had been initiated.</p> <p>Review of the Clinical Record with Licensed Practical Nurse (L.P.N) #9 confirmed Resident #10</p>	F 309	<p>need revision/correction were updated at that time.</p> <p>All nursing staff received additional education by the SDC no later than 6/22/11 regarding the importance of ensuring the Pain Medication Records were enclosed in each resident chart if indicated and the importance of utilization of the PMR. They were also educated regarding the facility process to document medication administration requirements on the MAR no later than 6/22/11.</p> <p>The DON will audit five charts per week for four weeks to ensure that Pain Medication Records are present if indicated and utilized per facility protocols.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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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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F 309	<p>Continued From page 26</p> <p>did not have a PMR on the chart. Interview with LPN #9 on 05/12/11 at 1:30 PM revealed the PMR would have included an evaluation of the resident's pain by use of a pain scale, either by a number on a scale of one to ten, or a nonverbal facial expression tool. She further stated the administration of any PRN (as needed) pain medication should be documented on the MAR. The nurse should also document the dose, the location of the pain, and the results of the medication administration in the appropriate area on the back of the MAR.</p> <p>Interview with the Director of Nursing on 05/13/11 at 3:30 PM revealed pain medication administration should be documented on the back of the MAR. She stated documentation should include the location of the pain and whether or not the medication was effective. She further stated the PMR, had it been present, would have included an area for documentation of pain severity, based on a facial expression or number scale.</p> <p>Resident #10 was out to the hospital and not available for observation or interview.</p>	F 309		
F 323 SS#E	<p>489.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323	<p>F323</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The Maintenance Director adjusted the mixing valves on 5/10/11 and the water temperatures were maintained at an acceptable level within regulatory guidelines.</p> <p>The head rest for Resident C was replaced on 5/11/11 by the therapy department. It had previously been identified to need replacement by the facility and ordered prior to the survey.</p>	6/22/11

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F 323	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure the resident environment was free from hazards as evidenced by the water temperature in the shower room sink was above the maximum safe water temperature recommendation. In addition, the facility failed to ensure assistive devices were maintained in good repair and/or replaced as necessary for one (1) unsampled resident (Resident C).</p> <p>Observation on 05/10/11 at 10:45 AM revealed the water temperature from the shower room sink on the front hall was one-hundred and eighteen (118) degrees Fahrenheit. Observation on 05/11/11 at 2:10 PM revealed the cushioned headrest on Resident C's high back wheelchair was split and worn with exposed threads and cushioning visible.</p> <p>The findings include:</p> <p>A review of the facility policy, undated, titled, Nursing Home Division Position Description for Certified Nursing Technicians stated that job requirements include utilization of equipment that is safe to minimize risk of accidents.</p> <p>A review of the facility policy, dated 01/01/95, titled Repair Requisitions revealed repair needs are reported to the Charge Nurse or other supervisory person who fills out the requisition so that repairs can be evaluated, prioritized and scheduled.</p> <p>1. Observation on 05/10/11 at 10:45 AM revealed</p>	F 323	<p>The Administrator/designee conducted an Environmental/Accident Hazards audit on 6/13/11 to identify any further areas of concern. All identified issues were corrected or placed on a corrective action plan. The Maintenance Director received additional education by 6/22/11 by the Administrator regarding the importance of maintaining the hot water temperatures within the acceptable range. All staff received additional education by the SDC regarding the importance of maintaining an environment that remains as free of accident hazards as is possible and the importance of each resident receiving adequate supervision and assistive devices to prevent accidents by 6/22/11. Staff were also re-educated by the SDC regarding the procedure for completing the Maintenance Repair Requisition forms by 6/22/11. The Maintenance Director will audit hot water temps at least three times per week for four</p>	
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F 323	<p>Continued From page 28</p> <p>the water temperature from the sink located in the shower room on the front hall across from resident room twenty-one (21) was one-hundred and eighteen (118) degrees Fahrenheit.</p> <p>Interview with the Maintenance Supervisor on 05/10/11 at 10:55 AM revealed he was unaware of the temperature being above the safe water temperature recommendation and knew the water should be between one-hundred (100) and one-hundred and ten (110) degrees Fahrenheit. Further interview revealed the pipe had been replaced in the shower room and random temperature checks and monitoring had revealed no concerns.</p> <p>Observation on 05/10/11 at 11:15 AM revealed the water temperature consistently remained above one-hundred and seventeen (117) degrees and mechanical plumbing adjustments were made.</p> <p>2. Observation in the dining room on 05/11/11 at 2:10 PM revealed the cushioned headrest on Unsampled Resident C's high back wheelchair was split and worn with exposed threads and cushioning visible.</p> <p>Interview with Resident C on 05/11/11 at 2:15 PM indicated the he/she would like to have the padded headrest cushion replaced.</p> <p>Interview on 05/12/11 at 9:00 AM with the Director of Nursing and Administrator revealed nursing aides were responsible for checking residents' equipment daily and communicate any repair needs to charge personnel. Further interview revealed residents were assigned a member of</p>	F 323	<p>weeks at different times of the day.</p> <p>The Administrator/designee will complete an Environmental/Accident Hazards audit weekly for four weeks to identify any areas noted to need improvement.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further review and continued compliance.</p>	
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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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F 323	Continued From page 29 management staff that served as a "Guardian Angels" whose duties would also include reporting equipment that needed repaired. Interview on 05/13/11 at 10:45 AM with State Registered Nurse Aide (SRNA) #3 revealed she thought Physical Therapy routinely examined wheelchair equipment and replaced and repaired equipment if needed. Further interview revealed she was unaware Resident C's headrest was in such bad shape.	F 323		
F 364 SS-E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined the facility failed to ensure food was served at the proper temperature. The eggs and sausage were served at the improper temperature. The findings include: Review of the facility's policy titled "Minimum Temperature at Point of Service to Resident", not dated, revealed meat, portioned for service should be at least between 115-125 degrees Fahrenheit. A test tray was ordered in the dining room	F 364	F364 It is the policy of Wurland Nursing and Rehabilitation Center that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. The Dietary Manager changed the distribution pattern of trays on 5/11/11. The Dietary Manager reduced the number of trays placed on the dining room carts at each time interval on 6/6/11 in order to ensure appropriate temperatures are maintained at point of service. All staff received education by the SDC regarding the new system for the delivery of the dining room carts by 6/22/11. All dietary staff received education from the	6/22/11

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F 364	Continued From page 30 because it was the last area residents would receive food on 05/10/11. The test tray temperatures were tested by the Dietary Manager at 8:40 AM and revealed the eggs had a point of service temperature of one-hundred and eighteen (118) degrees Fahrenheit and sausage eighty-two (82) degrees.	F 364	Regional Dietary Manager and/or the Dietary Manager regarding the appropriate food temperatures that must be maintained at point of service no later than 6/22/11. The Dietary Manager will audit food temps at least five times per week (during various meals) for four weeks to ensure that food temperatures are maintained at an acceptable level.	
F 371 SS=E	409.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store and serve food under sanitary conditions as evidenced by outdated food items stored in the refrigerator, pans stored wet and improper hand washing and glove changing practices. Also outdated food items were noted to be stored in the residents' snack refrigerator on the units. The findings include:	F 371	The audits will be forwarded to the weekly Focus Committee meeting (a sub-committee of the CQI Committee) for further monitoring and continued compliance. The committee is composed of the Administrator, DON, ADON, Nursing Designee, Dietary, Social Services, MDSC, Medical Records, Activities and Rehab. F371 It is the policy of Wurland Nursing and Rehabilitation Center to procure food from approved sources; and to store, prepare, distribute and serve food under sanitary conditions.	6/22/11

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F 371	<p>Continued From page 31</p> <p>During the initial tour on 05/10/11 at 5:50 AM observation revealed mashed potatoes (powder mix) in a 6.31 pound container covered with aluminum foil which was not dated.</p> <p>Further observation on 05/10/11 at 5:50 AM revealed two (2) quarter size hotel pans stored wet and a deep hotel pan stored wet.</p> <p>Interview on 05/10/11 with Cook #22 should not be stored wet because bacteria can grow.</p> <p>Observation on 05/10/11 at 6:00 AM in the dry storage revealed one (1) 115 ounce can of ketchup, which was dented on the top seam, stored with the other canned items. Further observation revealed one (1) 111 ounce can of kidney beans, which was dented on the top seam, was stored with the other canned items.</p> <p>Observation in the walk-in refrigerator on 05/10/11 at 6:10 AM revealed a pitcher of tomato juice which was dated 04/28/11. Further observation in the walk-in refrigerator revealed one (1) five (5) pound container of cottage cheese with an expiration date of 05/00/11 and four (4) five (5) pound containers of sour cream with an expiration date of 05/07/11.</p> <p>Observation on 05/10/11 at 6:20 AM revealed a plastic Ziploc bag with a twenty-four (24) ounce bag of biscuit mix which had been opened and a fourteen (14) ounce bag of chicken gravy mix. The chicken gravy mix was dated 04/11 and the biscuit mix was dated 05/11, however, there was no date on the Ziploc bag to indicate when items were opened and stored in the bag.</p>	F 371	<p>All outdated and undated foods were discarded by the dietary staff and/or Dietary Manager on 5/10/11. All dented cans were discarded by the Dietary Manager on 5/11/11. All wet dishes were rewashed by the dietary staff on 5/10/11 and allowed to air dry. The resident refrigerators in the medication rooms were cleaned and organized by the dietary staff on 5/13/11. Any unlabeled or outdated item was discarded. The infection control log for the past six months was reviewed by the RN Supervisor on 5/16/11 and 6/9/11 to ensure that no food borne illnesses had been recorded. All dietary staff received additional education on 5/20/11 by the Dietary Manager regarding the appropriate storage, preparation, distribution, and serving of food items utilizing sanitary conditions. This included appropriate hand washing protocols. The dietary staff received education by the Dietary Manager regarding the appropriate methods for storing and rotating stock in</p>		

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F 371	Continued From page 32 Observation on 05/10/11 at 6:20 AM revealed a five (5) pound bag of taco seasoning mix in a Ziploc bag which was not dated. Observation on 05/10/11 at 6:25 AM revealed a ten (10) ounce container of parsley flakes which was not dated when opened. Further observation revealed a twenty-four (24) ounce container of taco seasoning which was not dated. Observation on 05/10/11 at 7:20 AM revealed Cook #22 opened a drawer to obtain a spatula and did not wash hands or change gloves. Observation on 05/10/11 at 7:25 AM revealed Dietary Aide #23 used the telephone to announce trays were ready to be passed to residents on the units. Further observation revealed she did not wash her hands or change her gloves and continues to place drinks on trays handling the rim of the glasses and placing lids on them. Observation on 05/10/11 at 7:26 AM revealed Dietary Aide #24 pushed a cart out of the kitchen, she changed her glove but did not wash her hands prior to returning to tray line to place lids on plates and check trays for accuracy. Observation on 05/10/11 at 7:34 AM revealed Dietary Aide #23 adjusted her glasses with her left hand and did not change her gloves and wash her hands. Further observations revealed Dietary Aide #23 adjusted her glasses without changing her gloves and washing her hands at 7:35 AM and again at 7:37 AM. Observation on 05/10/11 at 7:55 AM revealed	F 371	the resident refrigerators and discarding items outdated or undated by 6/22/11. The facility began using stickers in order to identify the appropriate open/used by dates for all opened food items on 5/20/11. The Housekeeping Supervisor received education by the Administrator by 6/22/11 regarding the facility protocols for cleaning the resident refrigerators. Licensed nurse staff received additional education by the SDC no later than 6/22/11 regarding the importance of monitoring the resident refrigerators, discarding items as appropriate and notifying the appropriate departments if any issues are noted. The Dietary Manager will conduct sanitation audits at least five times per week for 8 weeks. These audits will occur randomly and will cover all three meals served in the facility. Additionally, the Registered Dietician will conduct a monthly sanitation audit during one of her routinely scheduled visits.	

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F 371	<p>Continued From page 33</p> <p>Dietary Aide #23 took a glass containing a food thickening agent from an aide in the dining room and did not change her gloves and wash her hands prior to returning to tray line.</p> <p>Observation on 05/10/11 at 8:10 AM revealed Dietary Aide #23 used the telephone to announce trays were ready for a unit and did not change her gloves and wash her hands prior to returning to resident tray line.</p> <p>Observation on 05/10/11 at 8:18 AM revealed Dietary Aide #23 answered the telephone and did not change her gloves and washes her hands prior to returning to resident tray line.</p> <p>Observation on 05/10/11 at 8:22 AM revealed Dietary Aide #23 used the telephone to announce trays were ready, changed the glove on her right hand however did not wash hands prior to returning to resident tray line.</p> <p>Interview with the Dietary Manager on 05/10/11 at 9:05 AM revealed she did not know how long spices could be stored, stated the Health Department said there was no specific amount of time. She further indicated all food items should be dated when opened. She stated the chicken mix, biscuit and taco mix should be dated when opened. Further interview revealed the cottage cheese and sour cream should be discarded and the dented cans should be stored separately. She further stated the tomato juice should only be kept for three (3) days after being removed from its original container.</p> <p>Interview with Dietary Aide #24 on 05/10/11 at 9:10 AM revealed hands should be washed and</p>	F 371	<p>The DON/designee will audit the resident refrigerators three times per week for four weeks to ensure that the refrigerators are clean and organized and that food items are dated when opened. Any undated or outdated items will be discarded.</p> <p>The results of these audits will be forwarded to the weekly Focus Committee meeting for further monitoring and continued compliance.</p>	

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F 371	<p>Continued From page 34</p> <p>gloves changed prior to returning to tray line after performing tasks away from the tray line such as handling the carts used to deliver trays to residents on the units.</p> <p>Interview with Dietary Aide #23 on 05/10/11 at 9:12 AM revealed hands should be washed after performing tasks away from tray line. She further indicated it was not practical to wash her hands each time after using the phone before returning to tray line.</p> <p>Interview with Cook #22 on 05/10/11 at 9:14 AM revealed hands should be washed and gloves changed after performing other tasks, before returning to resident tray line.</p> <p>Observation on 05/12/11 at 10:30 AM revealed procedure signage posted on the facility designated residents' refrigerator freezers located in the medication rooms which stated the refrigerator is for resident items only and all items must be dated and labeled with resident name. Review of the facility policy and procedure, undated, revealed Daily, Housekeeping Department will clean the refrigerator and throw away all items unsealed, undated, and more than 3 days old. Daily, Dietary Department will stock and rotate items. The procedure also stated nursing will monitor and report problems to the supervisor.</p> <p>Observation on 05/12/11 at 10:30 AM revealed spilled liquids of various colors inside and outside of the residents' refrigerators. Observation also revealed scattered solids with the appearance of "goldfish crackers/crumbs" in the freezer. The slide storage pockets/shelves and seals to the</p>	F 371		
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F 371	<p>Continued From page 35</p> <p>refrigerator freezers were coated with dark colored crustations.</p> <p>Observation on 05/12/11 at 10:45 AM of the resident refrigerators revealed crumpled aluminum foil and dried crumbs on the shelves. Observation also revealed two (2) partially thawed individual frozen dinner entrees and a bottled soft drink that were not identified as belonging to residents. The refrigerator contained a sixty-four (64) ounce bottle of juice noted to be about half full, dated 04/02/11 and a container of chip dip labeled with a resident's name with the expiration date of 11/24/10. Observations of the refrigerator's content also revealed individual single-serving size milk cartons which were not stocked by dates and two (2) cartons were noted to have a "sale by date" of 05/08/11.</p> <p>Observation on 05/12/11 at 3:45 PM of the resident storage refrigerator freezer revealed a three (3) gallon container of orange sherbet, dated 12/10/10 with a lid that was not completely closed. Further observation revealed ice like crystals covering the remaining contents. In addition the freezer contained two (2) packages of glycerin swabsticks (medical supplies) with one (1) package torn open with no date or resident identifier noted.</p> <p>Interview with the Housekeeping Supervisor on 05/12/11 at 10:50 AM revealed she was unaware it was Housekeeping's responsibility to clean the refrigerator freezers.</p> <p>Observation and interview with Licensed Practical Nurse (LPN) #13 on 05/12/11 at 1:30 PM revealed the milk with a sale by date of 05/08/11</p>	F 371		

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F 371	<p>Continued From page 36</p> <p>would be considered outdated and not served to a resident and she discarded the milk. Further interview revealed that it was Dietary Departments responsibility to rotate stock and discard outdated items.</p> <p>Interview on 05/12/11 at 4:30 PM with the Dietary Manager revealed the dietary aides should have removed the outdated milk and rotated the stock.</p> <p>Interview on 05/13/11 at 11:00 AM with Dietary Aide #17 revealed it would be the Dietary Aide's responsibility to check and remove outdated and rotate nourishments daily when stocking the facility designated resident refrigerators.</p>	F 371		
F 386 SS=D	<p>483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the monthly Physician Orders were signed and dated for one (1) of twenty-seven (27) sampled residents (Resident #24).</p> <p>The findings include:</p>	F 386	<p>F386</p> <p>It is the policy of Wurland Nursing and Rehabilitation Center that the physician review the resident's total program of care, including medications and treatments, at each visit; and sign and date progress notes at each visit; and sign and date orders at each visit.</p> <p>Resident #24 had the physician order signed on 5/18/11 by the attending physician.</p> <p>The Medical Records Nurse/designee reviewed the record for each active resident for the last 90 days to ensure that the physician had signed and dated all orders by 6/22/11. Any omission was addressed by the physician.</p> <p>All licensed nursing staff and the Medical Records Director received education no later than</p>	6/22/11

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F 386	<p>Continued From page 37</p> <p>Review of the facility's policy titled "Physician Orders-Monthly", dated 12/01/10, revealed "... including all orders for medication, treatments, and services needed, as dictated by the Attending Physician, and verified monthly by his/her signature".</p> <p>The facility admitted Resident #24 on 02/23/10 with diagnoses which included Alzheimer's Disease, Diabetes Mellitus, and Glaucoma.</p> <p>Review of the residents monthly Physician's Orders revealed the Physician's Orders for the month of 03/11 had not been signed.</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 05/12/11 at 6:39 PM revealed she leaves the charts on the floor after residents have been discharged for the Physician to sign when he enters the facility. She noted the orders had not been signed for the month of March 2011.</p>	F 386	<p>6/22/11 by the DON regarding the importance of obtaining signatures in a timely manner on verbal and monthly renewal orders during each physician visit. The DON/designee will audit ten charts per week for four weeks to ensure that physician signatures are obtained in a timely manner during physician visits. The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>	F 425	<p>F425 It is the policy of Wurland Nursing and Rehabilitation Center to provide pharmaceutical services to meet the needs of each resident and implement procedures to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological.</p> <p>All outdated medications were removed from the refrigerator on 5/12/11 by the Nursing Supervisor. The saline was discarded on 5/12/11 by the</p>	6/22/11

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F 425	<p>Continued From page 38</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of drugs and biologicals. Observations revealed expired pharmaceuticals that were stored in the medication refrigerator/room and not removed from stock; medications stored for residents that were no longer in the facility; and pharmaceuticals from residents' personal supply and outside pharmacy in a medication room cabinet, not properly labeled or identified.</p> <p>The findings include:</p> <p>Review of the facility policy, Medication Storage/Disposal When Resident is Transferred, dated 12/01/10, stated when a resident is transferred to another facility/home or expires, all medications are transferred or destroyed according to each state/facility regulations/guidelines.</p> <p>Review of the facility policy, ID1:Storage of Medications, undated, stated outdated medications are removed immediately from</p>	F 425	<p>Nursing Supervisor. The medications for discharged residents were returned to the pharmacy by the Nursing Supervisor on 5/12/11. The home medications were sent home with the resident's family by the Nursing Supervisor on 5/13/11. All licensed nursing staff received additional education by the SDC no later than 6/22/11 regarding facility policies related to providing pharmaceutical services to meet the needs of each resident. The appropriate storage of medications and medication return policy were included. Additionally, the pharmacy was reminded to check refrigerator for expired medications and medications that should be returned to pharmacy after resident discharge on 6/3/11. The DON/designee will audit the medication room at least four times per week for four weeks to ensure that expired medications are discarded, discharged resident medications are returned and that home medications are not stored</p>	

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F 425	<p>Continued From page 39</p> <p>stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. It further stated medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.</p> <p>1. Observation on 05/11/11 at 2:30 PM of the medication refrigerators revealed medications that the facility had failed to identify as expired. The medication expiration dates included, Eight (8) Phenergan Suppositories, dated 4/2011; three (3) Phenergan Suppositories, dated 08/26/10; Acetaminophen Suppository, dated 01/2011; and three (3) Bisacodyl Suppositories, dated 01/11.</p> <p>Observation on 05/12/11 at 4:30 PM of the intravenous storage bin in the medication room revealed a 1000 milliliter bag of 5% Dextrose, undated, that no longer had the outside packaging intact. Observation further revealed a multi-dose vial of Dextrose, expiration date January 2011.</p> <p>Interview on 05/12/11 at 4:30 PM with the Director of Nursing (DON) revealed although pharmacy checked for outdated pharmaceuticals, nursing was also responsible for checking for expired medications.</p> <p>Interview on 05/13/11 at 11:40 AM with the facility pharmacist revealed the pharmacy is responsible for checking for outdated medications monthly. Further interview revealed the pharmacy had failed to identify outdated medications because their procedure probably included only checking the dates on the "baggy" the suppositories are sent to the facility in and not each individual</p>	F 425	<p>in the medication room, but are returned to family members.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	
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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 05/17/2011
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)	(X6) COMPLETION DATE
F 425	<p>Continued From page 40 suppository for expiration date.</p> <p>2. Observation on 05/12/11 at 3:30 PM of the medication refrigerators revealed medications that were designated for five (5) residents that no longer resided at the facility. Those medications included Pneumovax Injectable, six (6) Acetaminophen Suppositories, four (4) Prochlorperazine Suppositories, five (5) Phenergan Suppositories and eleven (11) Acetaminophen Suppositories.</p> <p>Interview on 05/12/11 at 4:30 PM with the DON revealed nursing failed to properly dispose of the medications when the residents left the facility.</p> <p>Interview on 05/13/11 at 11:40 AM with the Pharmacy Director revealed the facility was responsible for ensuring medications were returned or disposed of when residents left the facility. Interview further revealed when a resident leaves the facility nursing is responsible for disposition of medications and supplies charged to that resident.</p> <p>3. Observation on 05/12/11 at 10:00 AM revealed several brown colored non-facility retail pharmacy containers of pharmaceuticals from three (3) residents' personal supply in a medication room cabinet not properly identified/labeled.</p> <p>Interview on 05/12/11 at 10:00 AM with the DON revealed the medications looked like the medicine bottles were brought in by family and should never have been kept at the facility.</p> <p>Interview on 05/12/11 at 2:30 PM with Registered</p>	F 425		

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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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F 425	Continued From page 41 Nurse (RN) #12 revealed that she thought the brown bottles were from residents personal medications from home and did not know why those bottles would be in the cabinet in the medication room. Interview on 05/13/11 at 2:40 PM with Licensed Practical Nurse (LPN) #13 revealed any medications a resident or family member brings into the facility should be properly identified, labeled and stored if intended to be used or returned to the responsible party for removal from the facility.	F 425		
F 465 88=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT 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 sanitary environment for residents. Observations revealed the medication rooms were not organized in a sanitary manner. Examples include ice buildup in the front hall medication freezer and pooled water in a tray containing medication vials. In addition food items were in drawers with medical supplies, equipment stored with cleaning supplies and laboratory tubes with expired dates in the "blood draw tray". The findings include:	F 465	F465 It is the policy of Wurland Nursing and Rehabilitation Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The refrigerators in the medication rooms were cleaned and organized by the Housekeeping Supervisor on 5/12/11. Any outdated or undated items were discarded at that time. All medication room cabinets and drawers were cleared of clutter and organized appropriately with items stored separately as indicated by facility policy. All licensed nursing staff received additional education regarding facility protocols related to maintaining the medication rooms in a safe, functional, and sanitary environment by the SDC no later than 6/22/11.	6/22/11

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F 465	<p>Continued From page 42</p> <p>Review of the facility policy, ID1: Storage of Medications, undated, stated medication storage areas are kept clean, well lit and free of clutter. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock. Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.</p> <p>Observation on 05/12/11 at 10:30 AM revealed procedure signage posted on the facility designated residents' refrigerator freezers located in the medication rooms which stated the refrigerator is for resident items only and all items must be dated and labeled with resident name. Further review of the facility policy and procedure, undated, revealed Daily, Housekeeping Department will clean the refrigerator and throw away all items unsealed, undated, and more than 3 days old. Daily, Dietary Department will stock and rotate items. The procedure also stated nursing will monitor and report problems to the supervisor.</p> <p>Observation on 05/12/11 at 10:30 AM revealed spilled liquids of various colors inside and outside of the resident storage refrigerators. Observation also revealed scattered solids with the appearance of "goldfish crackers /crumbs" in the freezer. The side storage pockets/shelves and seats to the refrigerator freezers were coated with dark colored crustations.</p> <p>Interview with the Housekeeping Supervisor on 05/12/11 at 10:50 AM revealed she was unaware that it was Housekeeping's responsibility to clean</p>	F 465	<p>The DON/designee will monitor the medication rooms at least four times per week for four weeks to ensure that the medication room is clean, sanitary and orderly. This will include a review of the medication refrigerators, drawers, cabinets, counter areas and floors. The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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F 465	<p>Continued From page 43</p> <p>the refrigerator freezers used for resident nourishments.</p> <p>Observation on 05/12/11 at 3:46 PM of the resident nourishment refrigerator freezer contained two (2) packages of glycerin swabsticks (medical supplies) with one (1) package torn open with no date or resident identifier noted.</p> <p>Observation on 05/12/11 at 4:30 PM of the medication room revealed food items/condiments including salt, pepper and ketchup packets in drawers with medical supplies such as syringes and tape. Equipment including suction cannisters, tubing and a pill crusher were stored with cleaning supplies. Laboratory tubes with expired dates were observed in the "blood draw tray" located on the counter in the medication room. The counter top was noted to have streaks of dried sticky substance in various locations. There was also a build-up of dust like particles noted in the medical supply drawers and cabinets and Intravenous (IV) storage bins.</p> <p>Observation on 06/13/11 at 10:15 AM revealed ice build-up that limited complete door closure of the freezer of the medication refrigerator located in the front hall medication room. Further observation revealed pooled water in the container holding the vials of resident medication such as Insulin.</p> <p>Interview on 05/12/11 at 1:30 PM with Licensed Practical Nurse (LPN) #1 revealed she was uncertain who was responsible for cleaning the medication refrigerator, counter, and shelf area in the medication room but Central Supply cleaned</p>	F 465		

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F 465	Continued From page 44 and stocked the drawers and cabinets. Interview with Central Supply Supervisor on 05/12/11 at 2:20 PM revealed she only replenished the stock in the cabinets and drawers of the medication rooms but did not routinely clean, rotate stock or check for outdates. Interview with the DON on 05/13/11 at 10:15 AM revealed the nursing department is responsible to ensure the medication room is clean including checking the medication refrigerator and freezer.	F 465			
F 514 86=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the Clinical Record was complete and accurately documented for one (1) of twenty-seven (27) sampled residents, (Resident #10). Resident #10 received pain medications that were not	F 514	F514 It is the policy of Wurland Nursing and Rehabilitation Center to maintain clinical records on each resident in accordance with accepted professional standards and practice that are complete; accurately documented; readily accessible; and systematically organized. Resident #10 was discharged from the facility on 5/10/11. The Medical Records Nurse will review the clinical record for each active resident for the last 90 days by 6/22/11 to ensure that records are maintained in accordance with accepted professional standards and practices. Any area identified as a concern will be corrected if appropriate.	6/22/11	

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F 514	<p>Continued From page 45 documented on the Medication Administration Record (MAR).</p> <p>The findings include:</p> <p>Review of the facility's policy dated 12/01/10, titled Pain Management and Assessment, revealed monitoring and documentation of pain level and evaluation of interventions is to be documented on the Pain Management Record.</p> <p>Resident #10 was admitted on 12/14/10 with diagnoses which included Seizure Disorder, Cerebral Palsy, Depression and Anxiety. Review of the Physician Orders dated 01/26/11 revealed the following medications were to be given for pain: Tylenol 500 milligrams (mg.) every six (6) hours as needed; or Percocet 5 mg. every six (6) hours as needed.</p> <p>Review of the Nurses Notes for the month of March 2011 revealed Resident #10 experienced pain on the 4th, 5th, 6th, 16th, 21st, 23rd, 24th, 26th, and 27th of the month. Continued review revealed the resident was given unspecified pain medicine on those dates. There was no indication of the severity of the pain and no consistent description of the location of the pain.</p> <p>Review of the Medication Administration Record (MAR) for March 2011 revealed Percocet was given for pain on the 19th, 21st and 23rd of the month. Tylenol was not given, per documentation, in the month of March. Continued review of the MAR revealed no indication of the location or severity of the pain, or the resident's response to the medication.</p>	F 514	<p>All licensed nursing staff and the Medical Records Director received additional education by SDC no later than 6/22/11 regarding the importance of maintaining resident records in accordance with accepted professional standards and practice that are complete, accurately documented, readily accessible and systematically organized.</p> <p>The DON/designee will audit five charts per week for four weeks to ensure that records are maintained in accordance with accepted professional standards and practice.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>		
			F518		

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F 514	<p>Continued From page 48</p> <p>Review of the Clinical Record with Licensed Practical Nurse (LPN) #9 confirmed Resident #10 did not have a Pain Management Record (PMR) on the chart. During interview on 05/12/11 at 1:30 PM, LPN #9 revealed the PMR included an evaluation of the resident's pain by use of a pain scale, either by a number on a scale of one to ten, or a nonverbal facial expression tool. She further stated the administration of any PRN (as needed) pain medication should be documented on the MAR. The nurse should also document the dose, the location of the pain, and the results of the medication administration in the appropriate area on the back of the MAR.</p> <p>Interview with the Director of Nursing on 05/13/11 at 3:30 PM revealed pain medication administration should be documented on the MAR. She stated documentation should include the location of the pain and whether or not the medication was effective. She further stated the PMR, if used, included an area for documentation of pain severity, based on facial expression or number scale.</p>	F 514	<p>It is the policy of Wurland Nursing and Rehabilitation Center to train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using these procedures. SRNA #15, SRNA #16 and the Dietary Manager received one on one education by the SDC by 5/13/11 regarding their delegated roles during a tornado warning and a tornado watch. The facility disaster manual was reviewed by the Administrator and Maintenance Director on 5/18/11. No changes were made to the manual.</p>	6/22/11
F 518 88-F	<p>103.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all</p>	F 518	<p>All facility staff received additional education by the SDC/designee no later than 6/22/11 regarding individual responsibilities/role during emergency situations. The Administrator/designee will verbally quiz staff members on various shifts at least four times per week for four weeks to ensure that all staff are aware of their</p>	

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F 518	<p>Continued From page 47</p> <p>employees were trained in disaster and emergency preparedness procedures. Staff did not know their role in the event of a weather related disaster or tornado warning. Interview revealed State Registered Nurse Aide (SRNA) #15, SRNA #16, and the Dietary Manager did not know their role in the event of a a tornado warning.</p> <p>The findings include:</p> <p>Review of the facility's policy "Tornado Procedures", undated, revealed it is imperative that residents are located in the North Hallway.</p> <p>Review of the facility's policy "Tornado Warning", undated, revealed televisions should be disconnected. Further review revealed all residents, including bedfast residents, should be moved into the hallway, against the walls. Residents should be covered with a blanket and the over the bed table placed over their heads.</p> <p>Review of the facility's policy "Tornado Watch", undated, revealed dietary will gather up containers to be filled with water immediately if the watch turns to a warning.</p> <p>Interview on 05/10/11 at 8:10 AM with SRNA #15 revealed she could not verbalize staff procedures in the event of a tornado warning at the facility.</p> <p>Interview on 05/10/11 at 8:40 AM with SRNA #16 revealed she could not verbalize her role in the event of a tornado warning at the facility.</p> <p>Interview with the Staff Development Coordinator on 05/10/11 at 9:00 AM revealed emergency</p>	F 518	<p>role and responsibilities during facility emergency situations. The results of these verbal quizzes will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	

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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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F 518	<p>Continued From page 48</p> <p>disaster procedures were covered during orientation for all new employees.</p> <p>Interview on 05/13/11 at 10:00 AM with the Dietary Manager revealed the facility had drills regarding staff roles in the event of weather disasters. However, further interview revealed the Dietary Manager was unable to verbalize specific dietary duties outlined in the policy and procedures for dietary such as "gathering and filling water containers".</p>	F 518		
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 05/11/2011. 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 "D".	K 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.	
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency affected one (1) smoke compartment, thirty (30) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 05/11/2011 at 12:30 PM, with the Administrator and the Director of Maintenance, revealed the Dry Storage Room had a gap along</p>	K 029	<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> <p>Wurland Nursing & Rehabilitation Center ensures that hazardous areas are maintained according to NFPA standards pertaining to smoke compartments.</p> <p>The Director of Maintenance installed rock wool in the gap along the top of the wall in the dry storage room on 6/2/11.</p> <p>The Director of Maintenance will be educated by 6/22/11 by the Administrator in regards to smoke compartments.</p> <p>The Director of Maintenance will audit smoke barriers to ensure compliance by 6/10/11.</p> <p>The Director of Maintenance will audit smoke barriers weekly for 4 weeks. The results of the audits will be discussed during monthly CQI and Safety meetings.</p>	06/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 6/10/11
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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.

RECEIVED
JUN 15 2011
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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)	(X6) COMPLETION DATE
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K 029	<p>Continued From page 1</p> <p>the top of the wall, where the block met with the corrugated roof. The gap was approximately one (1) inch in height. This must be sealed to prevent smoke from entering the corridor.</p> <p>Interview on 05/11/2011 at 12:30 PM, with the Director of Maintenance, revealed the corporate office was discussing fixing the area during a future renovation.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 	K 029		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
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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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K 029	Continued From page 2 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 104 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire walls/smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency affected two (2) smoke barriers, twenty eight (28) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 05/11/2011 at 9:30 AM, with the</p>	K 104	<p>Wurland Nursing & Rehabilitation Center ensures that the fire walls/smoke barriers are maintained according to NFPA standards.</p> <p>The Director of Maintenance's designee repaired the smoke/fire barrier by filling the hole with a material that is capable of maintaining the smoke resistance of the smoke barrier on 5/11/11.</p> <p>The Director of Maintenance will be educated by 6/22/11 by the Administrator in regards to ensuring penetrations in the smoke/fire barrier are filled with a suitable material.</p> <p>The Director of Maintenance will audit smoke/fire barriers to ensure compliance by</p>	06/22/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
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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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K 104	<p>Continued From page 3</p> <p>Director of Maintenance, revealed the fire barrier/smoke barrier located next to the dining room was penetrated by HVAC duct work. The area around the HVAC duct work was filled with polyurethane foam insulation. Polyurethane foam cannot be used to seal holes located in fire/smoke barriers due to its flammability.</p> <p>Interview on 05/11/2011 at 9:30 AM, with the Director of Maintenance, revealed the facility periodically checks the fire/smoke barriers and had not noticed the polyurethane foam being used as a seal.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke</p>	K 104	<p>6/10/11.</p> <p>The Director of Maintenance will audit smoke/fire barriers weekly for 4 weeks. The results of the audits will be discussed during monthly CQI and Safety meetings.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185281	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
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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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K 104	Continued From page 4 barrier, 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 maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.	K 104		
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