

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

PRINTED: 06/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/16/2012
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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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F 000	INITIAL COMMENTS  A Recertification and Abbreviated Survey investigating KY#00018628 and KY#00018508 was initiated 06/12/12 and concluded on 06/15/12. KY#00018528 was substantiated with no deficiencies cited and KY#00018508 was unsubstantiated with no deficiencies cited. Deficiencies were cited on the survey with the highest scope and severity of an "F". 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, Wurland Nursing and Rehabilitation Center (WNRC) has taken or will take the following action.	
F 248 SS-E	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's Activity Calendar Policy, (Effective 04/01/12) and the facility's Statement of Provision of Activity Services (Effective 04/01/12), it was determined the facility failed to develop and implement an Activity Program designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. The group interview, with fifteen (15) residents in attendance, revealed activity staff members were not arriving to scheduled activities, which were posted on the monthly Activity Calendars and the facility did not provide outings that the residents wanted to participate in.  The findings include:	F 248	It is the practice of WNRC to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.  The activities calendar was reviewed on 7/5/12 by the Administrator, DON and Activities Director. Changes to the calendar were made including the times and frequency of activities provided. All residents will be re-evaluated by the Activity Director regarding their activity interests by 7/22/12.  The Administrator and Activities Director reviewed the Activity Calendar Policy and Procedure on 7/5/12 with no changes being made.  The Activities Director was educated by the Administrator on 7/5/12 regarding the importance of providing activities designed to meet, in accordance with the	7/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X5) DATE 7/15/12
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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 60 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 248	<p>Continued From page 1</p> <p>Review of the facility's Statement of Provision of Activity Services (Effective 04/01/12) revealed the goal of activities was to enhance the resident's sense of well-being through activities that promoted self-esteem, pleasure, and independence and the facility believed in promoting activities that created a positive self image and independence. Review of the facility's Activity Calendar Policy (Effective 04/01/12) revealed a variety of activities would be included each month such as: activities to promote independence (community involvement) and activities to provide pleasure.</p> <p>Record review of the facility's March 2012 Activity Calendar revealed three (3) activities were scheduled every morning in March and one (1) activity was scheduled every afternoon with the exception of two (2) activities scheduled on six (6) days and three (3) activities scheduled on one (1) day. Further review revealed no activity programs were offered after 2:00-3:00 PM, with the exception of five (5) days, one (1) day an activity was scheduled from 3:00-4:00 PM and four (4) days an activity was scheduled at 6:00 PM.</p> <p>Record review of the facility's April 2012 Activity Calendar revealed three (3) activities were scheduled every morning with the exception of five (5) days (one (1) of those days a fishing outing was scheduled and one (1) of those days a community Easter Egg hunt was scheduled); however, the outings never occurred. Further review revealed one (1) activity was scheduled every afternoon, no later than 2:00-3:00 PM with the exception of one (1) day in which two (2) activities were scheduled and four (4) days an activity was scheduled at 6:00 PM.</p>	F 248	<p>comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>The Activities Director will also be educated by the Regional Activity Mentor by 7/22/12 regarding the importance of providing activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>The Activities Director and Administrator will request permission to attend 2 months of future Resident Council meetings during the 7/9/12 meeting in order to discuss the facility's activity program. If residents are not agreeable to the Administrator and Activity Director attending the Resident Council meeting, a separate meeting will be held to discuss the process of the improvement of the Activity Program. Further attendance at resident council will be dependent upon the satisfaction of the residents with the activity program after the initial 2 month period.</p> <p>The Activities Director will initiate a monthly meeting by 7/22/12 with interested residents to occur each month, for a minimum of 3 months, prior to the finalization of the Activity Calendar in order to receive input from interested residents regarding the activities that they wish to have placed on the calendar.</p>	

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F 248	<p>Continued From page 2</p> <p>Review of the facility's May 2012 Activity Calendar revealed three (3) activities were scheduled every morning with the exception of two (2) activities scheduled one (1) day and four (4) activities scheduled one (1) day. Further review revealed one (1) activity was scheduled every afternoon, no later than 2:00-3:00 PM, with the exception of five (5) days in which two (2) activities were scheduled and two (2) days an activity was scheduled at 6:00 PM.</p> <p>Interview, on 06/12/12 at 3:00 PM, with fifteen (15) unsampled residents revealed activities were not provided according to the monthly Activity Calendars, which usually happened on days the Activity Assistant was not working and the only activity on Sundays was when a church came. The residents stated the Activity Director would not provide the activities. Further Interview revealed the residents wanted to take trips outside of the facility and outings were scheduled; however, the facility did not provide the outings. The residents further stated the facility explained there was not enough staff to supervise outings. The last outing the facility provided was in December 2011, to see the Christmas lights in the park.</p> <p>Interview, on 06/15/12 at 5:00 PM, with the Activities Director (AD) revealed the Activity Assistant (AA) was off on Sundays and Mondays and the Director was off on Saturdays and Sundays. She further stated Church was the only activity on Sundays and if the church cancelled the residents would not have an activity that day. She stated Mondays (the AA's day off) were hard for her to provide activities to the residents</p>	F 248	<p>The Administrator will monitor that activities occur as scheduled, at least 3 times per week (M-F) for 8 weeks in order to ensure that the scheduled activities are occurring as recorded on the monthly Activity Calendar.</p> <p>The Social Services Director will audit 5 activities provided each week for 4 weeks to ensure that they were completed timely and designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>The results of the audits will be discussed during the monthly CQI (Continuous Quality Improvement) Meetings to determine if additional interventions are required in order to meet the satisfaction of the residents regarding the Activity Program. 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 and Maintenance Director.</p>	

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F 248	Continued From page 3 because she had other duties in the morning to take care of such as arranging the Lighthouse activities, taking residents out to smoke, paper work to complete, errands to run for residents and Minimum Data Sets (MDS) Assessment to complete. She stated those duties had to be completed in the mornings in order for her to provide activities in the afternoons. She stated the facility was responsible for providing activities for the residents and should provide the staff to fill in when she couldn't be there. Further interview revealed outings were scheduled; however, the residents were unable to go the last couple of months because the facility did not have enough staff/volunteers to supervise the residents. She stated the last outing the residents had was in December, to see the lights in the park.  Interview, on 06/15/12 at 7:45 PM, with the Administrator revealed the facility provided activities every day, activities were available at any given time, activity carts were available in the activities room/restorative dining room and if a resident wanted the cart brought to his/her room all they had to do was ask a staff member. He further stated families could take a resident out of the facility at any time. Further interview revealed the facility provided activities outside when it was warmer and didn't put an undue hardship on the facility. He stated it took a lot of planning and manpower to do that. He further stated the facility didn't take residents out in cold weather and the last outing was in December to see the lights.	F 248		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides	F 364	It is the practice of WNRC to provide food that is that is prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	7/23/12

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F 364	<p>Continued From page 4</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</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 each resident with a palatable diet for two (2) of twenty-three (23) sampled residents (Residents #4 and #5) and eleven (11) of fifteen (15) residents interviewed in group. Interview with Residents #4 revealed the food did not taste good, the meats were generally not very tender and usually overcooked. Interview with Resident #5 revealed the foods were not seasoned enough. During the Group Interview, eleven (11) of the fifteen (15) residents who attended complained about the taste of the food and the toughness of the meat served. A test tray, requested on 06/12/12, had items which included pepper steak and mashed potatoes. Upon observation, the pepper steak appeared to be dry. A taste test of the food items revealed the pepper steak was tough, hard to chew and lacked flavor, the vegetable soup was salty and tasted canned, and the mashed potatoes had no flavor and had a film like taste.</p> <p>The findings include:</p> <p>A Group Interview was conducted, on 06/12/12 at 3:00 PM, with fifteen (15) residents in attendance. When asked about the food at the facility eleven (11) of the fifteen (15) residents had complaints about the food which included comments about</p>	F 364	<p>On 7/4/12, residents #4 and #5 were interviewed by the Dietary Manager, updated their dietary preferences and were educated to inform the Dietary Manager any time they do not like their meal.</p> <p>The Dietary Manager will update all resident tray cards related to preferences by 7/22/12.</p> <p>On 6/12/12, the Registered Dietician tasted the pepper steak, mashed potatoes and vegetable soup with no issues noted to the palatability, taste, flavor or appearance of the food.</p> <p>Though the temperature of the carrots was not recorded on the tray line, the test tray containing the carrots had the temperature recorded at the point of service. The test tray temperatures, including the carrots, were within the acceptable temperature range for hot foods at the point of service.</p> <p>The Dietary Manager and dietary staff will be educated by the Registered Dietician by 7/22/12 regarding the importance of providing food that is that is prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>The Dietary Manager will request permission to attend 2 months of future Resident Council meetings during the 7/9/12 meeting in order to discuss the</p>	

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F 364	<p>Continued From page 5</p> <p>taste and the meats being tough. Some comments included the cooked green beans were raw tasting, the vegetable soup did not have enough vegetables, and the mashed potatoes had no taste</p> <p>Review of the medical record revealed Resident #4 was admitted by the facility, on 02/04/12, with diagnoses which included Acute Kidney Failure, Diabetes, and Renal Dialysis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/01/12, revealed the Brief Interview Mental Status (BIMS) was fifteen (15), which indicated the resident was cognitively intact.</p> <p>Individual interview, on 06/14/12 at 10:30 AM, with Resident #4 revealed the food combinations were not presentable. The food did not taste good and the meats were overcooked and generally not tender. Further interview revealed Resident #4 had discussed his/her food concerns with staff.</p> <p>Review of the medical record revealed Resident #5 was admitted by the facility, on 11/29/11, with diagnoses which included Diabetes, Peripheral Vascular Disease, and Congestive Heart Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/16/12, revealed the Brief Interview Mental Status (BIMS) was fifteen (15), which indicated the resident was cognitively intact.</p> <p>Individual interview, on 06/15/12 at 8:45 AM, revealed Resident #5 reported the food did not have enough seasoning. He/She did like salt and pepper on his/her food, but revealed foods like pizza should have had other seasonings for taste.</p>	F 364	<p>facility's dietary services. If residents are not agreeable to the Dietary Manager attending the Resident Council meeting, a separate meeting will be held to discuss the process of the improvement of the dietary services. Further attendance at resident council will be dependent upon the satisfaction of the residents with the dietary services after the initial 2 month period.</p> <p>The Dietary Manager will audit 5 test trays per week for 4 weeks to ensure that the food which was prepared conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>The Dietary Manager will interview 5 residents at least 3 times per week for 4 weeks after different meals (breakfast, lunch and dinner) to assess the resident's acceptance of the current meal. The Dietary Manager will interview at least 5 residents in different areas of the facility during these interviews. Resident input will be considered for future meals unless it is contraindicated for the well-being of other resident diets. However, plates will be individualized as requested.</p> <p>The Administrator, Dietary Manager or the cook will sample at least 1 meal per day for 4 weeks to determine that the food taste is acceptable and that the texture and appearance are suitable for resident service.</p>	
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F 364	<p>Continued From page 6</p> <p>Observation and taste, on 06/12/12 at 6:55 PM, of a test tray of food items served for dinner revealed the pepper steak appeared to be dry and when tasted was tough and hard to chew. The mashed potatoes were bland and had a film like taste. The vegetable soup tasted salty and canned.</p> <p>Interview with the Dietary Manager (DM), on 06/12/12 at 7:30 PM, regarding food palatability revealed she would go to the Resident Council Meetings when invited and ask about the food including taste. She last attended a meeting about a month ago. The DM also stated she would make rounds during dining service and ask residents about the food. If a resident did not like the food, they would apply it to that residents meal ticket under dislikes. Further interview revealed, the pepper steak did appear dry and they probably should have cooked it with a gravy to keep it moist and add flavor.</p> <p>Interview with the Dietitian, on 06/15/12 at 3:45 PM, revealed they sometimes received complaints about the food taste and texture. To help maintain their nutritional status, residents should get food per their preference, which tasted good, and the residents should be able to chew the meat.</p>	F 364	<p>The Registered Dietician will also sample trays during her routine visits to determine palatability of food and tray presentation.</p> <p>The results of the audits will be discussed during the monthly CQI (Continuous Quality Improvement) Meetings. 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 and Maintenance Director.</p>	
F 371 SS=F	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p>	F 371	<p>It is the practice of WNRC to procure food from sources approved or considered satisfactory by Federal, State or Local authorities; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>WNRC staff was not informed of the sanitation concerns nor had the temperature</p>	7/23/12

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F 371	<p>Continued From page 7 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy and procedures, it was determined the facility failed to prepare and distribute food in a sanitary manner. In addition, the facility failed to ensure food was held at the appropriate temperature. Dietary staff failed to wash hands and change gloves when changing tasks. In addition, when a tray of cooked carrots was replaced on the service line, staff failed to take the temperature of the replacement tray to determine if the carrots had reached the appropriate temperature to prevent food borne illness.</p> <p>The findings include:</p> <p>1. Review of the facility's policy entitled "Hand Washing Procedures", undated, revealed it was the policy of this facility to prevent the transmission of bacteria. Hands were to be frequently and thoroughly washed.</p> <p>Interview, on 06/12/12 at 7:15 PM, with the Dietary Manager (DM) revealed her expectation was that staff on the food service line would wash their hands; if they performed another task, to avoid cross contamination before returning to serve food.</p> <p>Observations of the tray line, on 06/12/12 from</p>	F 371	<p>concern voiced by the surveyor until after the meal had been served.</p> <p>The Dietary Manager educated staff including Cook #1 and Aide #2 once notified by the surveyor on 6/12/12 regarding the importance of appropriate hand washing practices while preparing and serving foods.</p> <p>The DON will review the infection control log to determine that no resident had experienced negative outcomes which would be directly correlated to improper food handling by 7/22/12.</p> <p>The Administrator reviewed the contract for WNRC's food distributor to ensure that they are considered satisfactory by Federal, State and Local authorities on 7/5/12 with no issues noted.</p> <p>The Dietary Manager and dietary staff will be educated by the Regional Dietician by 7/22/12 regarding sanitation practices and the recording of food temperatures.</p> <p>The Administrator and Dietary Manager reviewed the Hand Washing and Tray Line and Meal Service Temperatures Policies on 7/5/12 with no changes being made.</p> <p>The Dietary Manager will request permission to attend 2 months of future Resident Council meetings during the 7/9/12 meeting in order to discuss the</p>	
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F 371	<p>Continued From page 8</p> <p>4:30 PM to 6:40 PM, revealed Server #1 got a slotted ladle from a drawer and returned to the service line without washing her hands and re-gloving. Further observation of Server #1 revealed she went through the meal tickets and returned to the service line without washing her hands and re-gloving. In addition, Dietary Aide #2 was observed going into a refrigerator at two different times to get a carton of lactose intolerant milk and a sandwich. The aide did not wash their hands before returning to the service line.</p> <p>Interview, on 08/12/12 at 7:15 PM, with Server #1 revealed she should have washed her hands before returning to the tray line. It was important to wash your hands because of concerns related to bacteria after she touched the drawer and meal tickets.</p> <p>Continued interview, on 08/12/12 at 7:15 PM, with the DM revealed Server #1 should have washed her hands after touching the drawer and meal tickets before returning to the food line. She further stated after touching the refrigerator, Dietary Aide #2 should have washed his hands before returning to the food line. The concern would be cross contamination after touching those items and then returning to the food line without washing hands.</p> <p>2. Review of the facility's policy entitled "Tray Line and Meal Service Temperatures", undated, revealed it was the policy of this facility to serve food to the residents at the appropriate temperatures. All hot food must be held at temperatures above 135 (140 was crossed out) degrees Fahrenheit. Food temperatures would be taken prior to the start of every meal at the</p>	F 371	<p>facility's dietary services. If residents are not agreeable to the Dietary Manager attending the Resident Council meeting, a separate meeting will be held to discuss the process of the improvement of the dietary services. Further attendance at resident council will be dependent upon the satisfaction of the residents with the dietary services after the initial 2 month period.</p> <p>The Dietary Manager will audit 5 meals per week for 4 weeks regarding the preparation, sanitation practices and recording of food temperatures.</p> <p>The Dietary Manager will audit the food storage areas 5 times per week for 4 weeks to ensure that the storage area is maintained in a sanitary manner.</p> <p>The Director of Nursing will audit the distribution of meal trays 5 times per week for 4 weeks to ensure that the meals are distributed in a sanitary manner.</p> <p>The results of the audits will be discussed during the monthly CQI (Continuous Quality Improvement) Meetings. 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 and Maintenance Director.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/15/2012
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NAME OF PROVIDER OR SUPPLIER  WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 9</p> <p>service line. All food items that did not register a minimum of 140 degrees Fahrenheit would be returned to the stove and heated until they exceed 140 degrees Fahrenheit. The policy did not address taking the temperature of replacement trays to ensure they met the hot food temperature requirement identified under the policy.</p> <p>Observations of the tray line, on 06/12/12 from 4:30 PM to 6:40 PM, revealed at 6:10 PM the tray of cooked baby carrots was replaced with another tray of cooked carrots. No temperature was taken of the replacement tray of cooked baby carrots when it was placed on the service line.</p> <p>Continued interview, on 06/12/12 at 7:15 PM, with the DM revealed they should have taken the temperature of the cooked baby carrots to ensure they were at the proper temperature prior to serving.</p>	F 371		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective</p>	F 441	<p>It is the practice of WNRC to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The RN Supervisor applied a new urinary catheter drainage bag/tubing and privacy bag to residents 3 and 16 on 6/15/12.</p> <p>The RN Supervisor replaced resident 5's nebulizer mask and covering on 6/15/12.</p> <p>The RN Supervisor audited all residents with urinary catheters on 6/15/12 to ensure</p>	7/23/12

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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 441	<p>Continued From page 10 actions related to Infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Catheter-Urinary-Insertion/Re-insertion Policy (Effective December 01, 2010), it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure infection control practices as evidenced by catheter bags were observed lying on the floor for two (2) of twenty-three (23)</p>	F 441	<p>all had a cover and that the bag/tubing were noted to be off of the floor.</p> <p>The RN Supervisor audited all residents with nebulizer treatments on 6/15/12 to ensure all were stored appropriately. The RN Supervisor made rounds in the facility to determine if any other infection control issues were identified on 6/15/12 with no further issues noted.</p> <p>The DON will review the infection control log for the last 90 days to ensure that no trends were identified by 7/22/12. The SDC will in-service certified and licensed clinical staff regarding infection control practices including the storage of nebulizer masks and urinary catheter bag/tubing care/maintenance by 7/22/12.</p> <p>The DON will audit facility infection control practices including but not limited to urinary collection bags and nebulizer masks daily (M-F) for 4 weeks.</p> <p>The DON will review the infection control log weekly for 4 weeks to ensure that no trends are identified.</p> <p>The results of the audits will be discussed during the monthly CQI (Continuous Quality Improvement) Meetings. The CQI Committee is composed of the Administrator, DON, ADON, RN Supervisor, Social Services, MDS Coordinators, Medical Records, Activity Director, Rehab Manager, Dietary Manager,</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 441	<p>Continued From page 11</p> <p>sampled residents (Resident #3 and Resident #16). In addition the facility failed to ensure a resident's nebulizer mask was stored appropriately as evidenced by observation of the mask lying on a nightstand, uncovered, throughout the survey for one (1) of twenty-three (23) sampled residents (Resident #5).</p> <p>The findings include:</p> <p>Review of the facility's Catheter- Urinary- Insertion/Re-insertion Policy (Effective December 01, 2010) revealed catheter drainage bags were to be placed in a catheter drainage privacy bag cover when attached to a wheelchair, geri-chair, recliner or whenever resident is out of bed. Catheter drainage bags and tubing must remain off the floor at all times.</p> <p>1. Record review revealed the facility admitted Resident #3 on 08/17/11 with diagnoses which included Stage IV Pressure Ulcer, Colostomy, Urinary Tract Infection (UTI), and Diabetes.</p> <p>Observations, on 06/12/12 at 6:40 PM, 06/13/12 at 8:40 AM, 11:55 AM, 2:25 PM and 5:45 PM and on 06/14/12 at 9:00 AM, revealed the resident lying in bed with his/her catheter bag lying on the floor. Continued observation, on 06/14/12 at 10:25 AM, revealed the resident was sitting in a wheelchair with his/her catheter bag lying on the floor.</p> <p>2. Record review revealed the facility readmitted Resident #16 on 05/30/12 with diagnoses which included Aspiration Pneumonia, Debility, Cerebellar Ataxia, and Dysphagia.</p>	F 441	SDC, Housekeeping/Laundry Director, Accounts Payable/Payroll Manager, AR Manager and Maintenance Director.	
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F 441	<p>Continued From page 12</p> <p>Observation, on 06/13/12 from 11:18 AM until 12:15 PM, revealed Resident #16 was sitting in a geri-chair in the facility's lobby and the resident's catheter bag was lying on the floor. Further observation revealed eight (8) staff members walked by the resident while the catheter bag was on the floor. At 11:33 AM, two (2) staff members repositioned the resident and the catheter bag continued to lie on the floor until 12:15 PM, at which time a Licensed Practical Nurse (LPN) spoke with an aide and the aide placed the catheter bag into a privacy bag.</p> <p>Interview, on 06/14/12 at 10:25 AM, with Licensed Practical Nurse (LPN) #1 revealed the catheter bag should be in a privacy bag. She stated aides were responsible for putting catheter bags in the privacy bags and nurses were responsible for ensuring that it was done. She further stated nurses did walking rounds at shift change, however they do not go into the residents' rooms unless the off-going nurse wanted the on-coming nurse to look at something. She stated the nurses were responsible for ensuring catheter bags were in privacy bags at meals.</p> <p>Interview, on 06/15/12 at 10:50 AM, with Registered Nurse (RN)/Supervisor #4 revealed, to prevent the spread of infections, catheter bags were to be off the floor at all times and were to be in privacy bags when the resident was out of bed. She stated aides, nurses, herself, the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) were responsible for ensuring infection control guidelines were followed.</p> <p>Interview, on 06/15/12 at 6:02 PM, with the DON revealed catheter bags were to be off the floor at</p>	F 441		
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F 441	<p>Continued From page 13</p> <p>all times and in a privacy bag when residents were out of bed. She further stated the catheter bag, that was lying on the floor, should have been changed prior to being put in the privacy bag. She stated ensuring the infection control guidelines were followed was the responsibility of the aides, nurses, supervisors, ADON and DON.</p> <p>3. Record review revealed Resident #5 was admitted by the facility, on 11/29/11, with diagnoses which included Pleural Effusion, Pulmonary Embolism, and Diabetes. Review of the Physician's Orders, for June 2012, revealed Resident #5 was on oxygen at two (2) liters per nasal cannula and had an order for Duoneb 0.5 milligrams (MG)/3 millimeters (ML) solution take 3 ML by nebulization every six (6) hours as needed for wheezing.</p> <p>Observation, on 06/13/12 at 8:40 PM and 4:00 PM and on 06/14/12 at 11:25 AM, revealed a nebulizer machine on the bedside table and nebulizer mask which was uncovered and lying on the bedside table.</p> <p>Interview with RN #2 regarding Resident #4's nebulizer mask uncovered on the bedside table, on 06/15/12 at 4:20 PM, revealed the nebulizer mask should have been in a plastic bag. It is an infection control issue because there was the concern about cross contamination.</p> <p>Interview with the DON, on 06/15/12 at 7:30 PM, revealed when nebulizer masks were not in use they should be bagged. The reason was for cleanliness and infection purposes.</p>	F 441		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 05/30/78</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story Type III (200)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system</p> <p>SPRINKLER SYSTEM: Complete (wet and dry) sprinkler system</p> <p>GENERATOR: One (1) Type II Diesel generator.</p> <p>A standard Life Safety Code survey was conducted on 06/12/12. Wurland Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty-six (126) beds with a census of one hundred and sixteen (116) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, Wurland Nursing and Rehabilitation Center (WNRC) has taken or will take the following action.</p> <div data-bbox="966 1102 1274 1302" style="text-align: center;">  </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *ADMINISTRATOR* (X8) DATE *7/5/12*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000  K 147 SS=F	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection Association (NFPA). The deficiency had the potential to affect all smoke compartments, all residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 06/12/12 between 3:00 PM and 7:00 PM, with the Maintenance Director and Administrator revealed extension cords and multi outlet strips were being used as permanent wiring. Also noted, the cords were being routed up through the ceiling tiles and back down through the ceiling tiles. Facilities must provide an adequate number of electrical receptacles to meet the needs of residents. Also extension cords and multi outlet strip cannot be used as a substitute for permanent wiring. Extension cords and multi plug outlets were observed in rooms 1, 2, 3, 5, 6, 7, 8, 9, 11, 17, 19, 21, 23, 24, 26, 30, 36 and 38.</p>	K 000  K 147	<p>It is the practice of WNRC to ensure that there are adequate numbers of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters.</p> <p>On 6/12/12, the Director of Maintenance audited all resident rooms and identified the number of outlets which would need to be installed which would eliminate the use of extension cords or multiple outlet adapters.</p> <p>On 6/19/12, WNRC met with a licensed electrician who will provide a quote to install the necessary electrical outlets in order to eliminate the use of extension cords or multiple outlet adapters.</p> <p>All extension cords or multiple outlet adapters will be removed by 7/22/12 when the new electrical outlets have been installed.</p> <p>The Director of Maintenance was educated by the Administrator on 7/5/12 regarding the NFPA regulations pertaining to electrical wiring and equipment.</p> <p>The Director of Maintenance will audit 15 resident rooms per week for 4 weeks to ensure compliance by not using extension cords or multiple outlet adapters.</p>	7/23/12

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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 147	<p>Continued From page 2</p> <p>Interview, on 06/12/12 between 3:00 PM and 7:00 PM, with the Maintenance Director revealed he thought the power strips could be used. This was also confirmed with the Administrator.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.</p>	K 147	<p>The results of the audits will be discussed during the monthly CQI (Continuous Quality Improvement) Meetings. 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 and Maintenance Director.</p>	