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

PRINTED: 03/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 02/24/2012

NAME OF PROVIDER OR SUPPLIER: WURTLAND NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 WURTLAND AVENUE, WURTLAND, KY 41144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00017881 and KY#00017833 was initiated on 02/22/12 and concluded on 02/24/12. KY#00017881 was substaintiated with deficiencies cited at 42 CFR 483.20 (F281) and 42 CFR 483.25 (F309) with a scope and severity of a "D". KY#00017833 was substaintiated with deficiencies cited at 42 CFR 483.60 (F431) with a scope and severity of a "D".	F 000	To the best of my knowledge and belief, as an agent of Wurtland Nursing & Rehab Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and reviw of the facility's policy, it was determined the facility failed to ensure services provided meet professional standards as evidenced by wound care not being carried out as ordered and not having signed orders for wound treatments for two (2) of four (4) sampled residents (Residents #2 and #4). Resident #2 did not have current Physician signed orders for wound treatments performed in February 2012 and Resident #3 had wound care treatments not carried out as ordered by the Physician. The findings include: 1. Interview, on 02/24/12 at 1:30 PM, with the Director of Nursing (DON) revealed the facility's process was to have verbal orders written onto the current month's orders. They input them into	F 281	It is the practice of Wurtland Nursing and Rehabilitation Center (WNRC) to provide services which meet standards of quality. Resident #2 wound treatment orders were signed on 3/7/12 by the physician. Resident #4 was discharged from WNRC on 7/27/11. Resident #3 had the wound treatment order clarified on 2/23/12. To ensure that professional standards of quality are met and upheld, the DON audited all current resident orders for the past 60 days to ensure the physician signature was present as well as input into the Electronic Medical Record (EMR) accurately by 3/31/12.	4/1/2012

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 3/16/2012

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

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F 281	Continued From page 1 the computer which allows them to be pulled to the computer generated monthly Physician's order sheet. Medical records audited on all orders to make sure the orders were input properly. Review of Resident #2's medical record revealed the facility admitted the resident on 08/17/11, with diagnoses which included Pressure Ulcer - Lower Back. Review of the monthly Physician Orders for February 2012 revealed no order for Wound Vac treatment. Review of the Treatment Administration Record (TAR) for February 2012 revealed Wound Vac treatment to coccyx dressing, change every Tuesday, Thursday, and Saturday with a start date of 11/23/11. Further review of the TAR showed the wound vac dressing was changed on the following dates 02/02/12, 02/04/12 and 02/07/12. Interview, on 02/22/12 at 7:20 PM, with Licensed practical Nurse (LPN) #1 revealed Resident #2 was receiving Wound Vac treatment to his/her pressure ulcer until about two (2) weeks ago. The wound treatment was changed after the resident went to the Wound Care Center (02/13/12). Interview, on 02/24/12 at 12:40 PM, with Registered (RN) #2 revealed the facility had a verbal order on 11/22/11 to initiate Wound Vac treatment to the pressure wound for Resident #2. It was the nurses responsibility to ensure prior months verbal orders were put into the computer system to generate the next months orders. Upon review of Resident #2's monthly Physician's orders for December 2011, January 2012, and February 2012, RN #2 stated the Wound Vac	F 281	The RN Supervisor audited all wound treatment orders on all active residents by 3/31/12 to ensure that the wound care treatment was provided per the physician order. The SDC will educate all nursing staff and the Medical Records Coordinator by 3/30/12 regarding the importance of upholding professional standards of quality while delivering daily care to residents. The education will place emphasis on receiving, recording and implementing the physician orders. The ADON will audit 20 physician orders per week (Monday-Friday) for 4 weeks to ensure the physician signature is present and to ensure that the order is input correctly into the EMR. The DON will audit 10 wound care treatments per week (Monday-Friday) for 4 weeks to ensure the treatments are provided per the physician order. 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	

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F 281	Continued From page 2 order was handwritten on the December 2011 monthly orders, but was not on the January 2012 and February 2012 monthly orders. Further interview revealed the wound care should have been on the monthly orders because the treatment was being provided. She further stated it was important to put treatments on the monthly orders to ensue the orders were carried out for resident care. The nurse failed to enter the order into the compter, therefore the order for the Wound Vac was not continued on the monthly orders for January 2012 and Febuary 2012. Continued interview, on 02/29/12 at 1:30 PM, with the DON revealed to do the Wound Vac treatment in February for Resident #2 there should have been a current order. The medical records audit failed to identify the Wound Vac order was not on the monthly order sheet. 2. Review of Resident #3's medical record revealed the resident was re-admitted by the facility on 01/19/12 with diagnoses which included Pressure Ulcer Low Back and Diabetes II. Review of the Physician's orders, dated 02/01/12 revealed an order to change Wound Vac every three (30 days to the coccyx area. Review of the February 2012 Treatment Administration Record (TAR) revealed a wound treatment included change the Wound Vac to coccyx area every three days. Further review revealed the interval between treatments exceeded three days as evidenced by a change done 02/07/12 then on 02/11/12 (four (4) days) and a change done 02/14/12 then on 02/18/12 (four (4) days). Interview, on 2/24/12 at 11:30 AM, with Registered Nurse (RN) #2 revealed wound care	F 281	Manager, AR Manager and Maintenance Director.	

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F 281	Continued From page 3 for Resident #3 had not been completed per the Physician's orders. RN #2 further stated the error was made during change of orders from 01/12 to 02/12 into the computer system. Continued interview revealed nurses were to double check all orders when changing the Medication Administration record (MAR) and the TAR each month and the process failed with this resident's orders. Interview, on 02/24/12 at 1:45 PM, with the DON revealed the Physician ordered the Wound Vac dressing change every three (3) days. Nurses were supposed to provide the treatment as ordered. Whoever input the order (into the computer) entered it correctly for the change to be done every three (3) days, but did not put the scheduled times for the dressing change correctly on the TAR. The TAR had the treatment schedule for the Wound Vac dressing change to be performed every four (4) days, instead of the ordered three (3) days. Continued interview revealed the nurses who performed the dressing change were supposed to check the order.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	It is the practice of WNRC to provide the necessary care and services to our residents in order to obtain optimal improvement so that the resident's condition does not deteriorate within the limits of the resident's right to refuse treatment. Resident 4 was discharged from the facility on 7/27/11. The DON and ADON will conduct a skin audit on all current residents to ensure that	4/1/2012

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F 309	Continued From page 4 Based on interview and record review, it was determined the facility failed to ensure the facility provided the necessary care and services to ensure residents obtained optimal improvement or did not deteriorate within the limits of a resident's right to refuse treatment for one (1) of four (4) sampled residents (Resident #4). The facility failed to ensure an accurate and complete assessment and evaluation of the results of the intervention for Resident #4. Resident #4 was receiving wound treatment and the facility failed to document continuous evaluation of the wound site to determine the effectiveness of the wound treatment. The findings include: Interview, on 02/24/12 at 9:10 AM, with the Director of Nursing (DON) regarding the process for documentation of wounds and wound care revealed staff was supposed to describe the appearance of the wound, including any drainage or odor, and the dressing applied when performing wound care. Interview, on 2/24/12 at 9:10 AM, with Licensed Practical Nurse (LPN) #8, revealed when documenting wound status or wound care the documentation should include a description of appearance of wound, measurements, drainage, any changes in wound, odor and dressing that was applied. If no dressing was applied during a shift, the note should state the dressing was clean, dry and intact. Further interview revealed staff should document any changes to the wound and if issues continued, the Physician would be notified.	F 309	any resident with skin integrity issues have a documented assessment with pertinent wound characteristics recorded so that the progress can be monitored and recorded weekly in order to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the plan of care by 3/31/12. The DON will implement a weekly non-pressure skin report which will be completed by a licensed nurse to assess and monitor pertinent characteristics of the non-pressure areas on a weekly basis by 3/30/12. The SDC will educate all nursing staff regarding the plans of care, interventions, wound assessments and documentation to ensure that the documentation requirements are met by 3/30/12. This education will also include information regarding the weekly non-pressure skin report to be implemented on a weekly basis. The RN Supervisor will audit 10 resident records per week (Monday-Friday) for 4 weeks to ensure the plan of care, interventions, wound assessments and documentation meet the documentation requirements.	

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F 309	Continued From page 6 Review of Resident #4's medical record revealed the resident was admitted by the facility on 07/10/11 with diagnoses which included a third (3rd) degree burn to back (Sacral area) and surgical wounds to the left foot and abdomen. Review of the Physician's orders, dated 07/10/11, revealed an order for wound treatment to the Sacral area and to change the dressing every three (3) days and as needed. Review of the Care Plan for Resident #4, onset 07/10/11, included an intervention for weekly evaluation of wound healing. Record review revealed a wound culture was ordered on 07/20/11 along with the antibiotic Dicloxacillin 500 milligram (mg) orally twice a day for ten (10) days. Continued review of the medical record revealed no documented evidence of an evaluation or a description of the Sacral wound site from 07/11/11 through 07/15/11 as well as no documented evidence of an evaluation or a description on 07/23/11 and 07/24/11. Interview, on 2/24/12 at 9:25 AM, with LPN #4, revealed the documentation for Resident #4's wound should include appearance of wound, odor, drainage and dressing being applied. Continued interview, on 2/24/12 at 9:40 AM, with the Director of Nursing (DON), after review of the medical record for Resident #4, revealed the documentation of the wound was inadequate. The DON stated nursing staff had a problem with documentation of the wounds and care.	F 309	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.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	WNRC has an established system of records for the receipt and disposition of all controlled drugs which provides sufficient detail for identification of loss of controlled	4/1/2012

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F 431	Continued From page 6 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the key. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, record review, the facility's investigative report, and the facility's policy, it was	F 431	medications so as to minimize the time between actual loss and the detection and determination of the extent of loss. The Administrator and ADON were notified within 3 hours of the noted discrepancy with 15 doses of Percocet 5/325 milligrams (mg) on 2/6/12. The ADON suspended the Licensed Nurses who were involved on 2/6/12 pending investigation. Resident 1 was interviewed on 2/6/12 by the ADON and stated that they had received their medications timely and consistently and that the medication was effective. The Administrator and ADON began the investigation on 2/6/12. The facility investigation was completed on 2/9/12 and the facility substantiated the allegation of missing medications. The OIG, APS, Ombudsman and KY State Police were all notified of the incident within regulatory guidelines. The ADON and RN Supervisor audited all controlled medications and narcotic sign-off log on 2/6/12 with no further discrepancies noted. The SDC will educate all Licensed Nurses and Certified Medication Aides regarding the receipt and disposition of controlled medications, identified loss of controlled medications, storage of controlled medications, inventory count process and notification by 3/30/12. The ADON will audit 5 shift changes per	

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F 431	Continued From page 7 determined the facility failed to establish a system of records for the receipt and disposition of all controlled drugs in sufficient detail for identification of loss of controlled medications so as to minimize the time between actual loss and the detection and determination of the extent of loss as evidenced by the loss of fifteen (15) doses of Percocet 5/325 milligrams (mg) for one (1) of four (4) residents (Resident #1). The facility failed to follow their process for storage of controlled medications related to the controlled medication inventory count for Resident #1 at shift change and the reporting of a discrepancy of fifteen (15) missing Percocet 5/325 mg tablets to Administration in a timely manner. The findings include: Review of the facility's policy: "Procedure for Receiving, Storing, Administering and Discontinuing Controlled Substances", undated, revealed one RN/LPN/CMT going off duty and one RN/LPN/CMT coming on duty must count and justify narcotics supply for each individual resident at the change of each shift. After the supply is counted and justified, each nurse must record the date and his/her signature verifying that the count is correct. If the count is not correct, the nurse/CMT going off duty is not to leave until the count is correct. Irreconcilable discrepancies are recorded by the Director of Nursing (DON) and reported to the Administrator. Interview with the Assistant Director of Nursing (ADON), on 2/23/12 at 3:15 PM, revealed the procedure was to count the narcotics by the oncoming and outgoing staff every shift or when the keys to the medication cart were turned over.	F 431	week for 4 weeks to ensure the appropriate process is carried through as well as to ensure that the established control system is maintained. The ADON will audit the daily narcotic count sheets 5 times per week for 4 weeks to ensure that the established control system is maintained. 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.	

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F 431	Continued From page 8 The process was to ensure the counts were completed and correct. Interview with Certified Medication Technician (CMT) #2, on 02/22/12 at 3:10 PM, revealed for every change of shift a narcotic count was completed for each medication cart. The outgoing shift staff and the oncoming shift staff counted the number of narcotic medications together side by side. They counted the actual number of cards and compared it to the master log. At the same time staff counted the actual number of pills and compared this number to the number in the narcotic book going through each narcotic in the locked drawer. This process was initialed by both the outgoing shift and incoming shift staff, verifying the count was done and was accurate. If the count was off, the first thing staff did was tell the nurse supervisor and she verified the incorrect count. Then staff informed the Director of Nursing (DON) and she verified the count was incorrect. Then an incident report was completed and the incorrect count/missing medications was investigated. Review of the facility's "Resident Abuse Investigation Report" revealed the facility substantiated the investigation that the controlled medication inventory count for the morning shift on 02/06/12 identified fifteen (15) Percocet 5/325 mg were missing for Resident #1. Further review revealed the count was accurate for the shift prior to the missing medication incident. Review of a fax, dated 02/22/12, from Med Care Pharmacy, the facility's contracted pharmacy, revealed Resident #1 was sent a quantity of sixty (60) Percocet 5/325 mg tablets on 02/03/12. Further review revealed Resident #1 was charged	F 431		

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F 431	Continued From page 9 for just forty-five (45) tablets instead of for the sixty (60) tablets and the facility was charged for the remaining fifteen (15) tablets. Review of the medical record for Resident #1 revealed the resident was admitted by the facility on 11/10/06 with diagnoses which included diabetic neuropathy, abnormal gait, and difficulty walking. Review of the Physician's orders for February 2012 included an order for Percocet (Oxycodone) 5-325 mg tablet every four (4) hours for pain. Review of the Medication Administration Record (MAR) for February 2012 revealed the resident received the medication as ordered, unless he/she refused. Interview with Licensed Practical Nurse (LPN) #4, on 2/23/12 at 9:55 AM, revealed she came into work for day shift on 02/06/12, which was 6:00 AM- 2:00 PM. Prior to completing the narcotics count for reconciliation with LPN #9, LPN #4 noticed there was a medication cup with Ambien and Percocet 5/325 mg in the drawer. She stated, LPN #9 told her an unsampled resident did not take his/her medications that morning. LPN #4 took the medications to the unsampled resident and when she returned the keys to the cart were on top of the cart and LPN #9 had left the facility. Continued interview with LPN #4 revealed she then counted the narcotics with LPN #3 and found one card, containing fifteen (15) Percocets 5-325 mg, was missing for Resident #1. She stated she searched the cart and medication room without finding the missing medications. Further interview revealed LPN #9 was called three (3) times, but did not return to work. LPN #4 stated she got very upset and left the facility without waiting for her replacement to	F 431		

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F 431	Continued From page 10 do the narcotic count. Interview with LPN #3, on 02/23/12 at 3:40 PM, revealed she was not aware there was a problem with missing medications until the end of her shift on 02/06/12 at 3:00 PM. She stated LPN #4 reported there was a problem with the medications and she (LPN #4) needed to talk with the night shift nurse, but never mentioned anything about missing medications. Further interview revealed she was later told by LPN #4, everything was okay. Interview with State Registered Nurse Assistant (SRNA) #4 on 2/23/12 at 8:40 AM, revealed she was at the nurses station and overheard LPN #4 say the narcotic count was off that morning and fifteen (15) Percocets were missing. The next thing she knew LPN #4 was leaving and CMT #4 came in to take over her medication cart. Further interview revealed CMT #4 told her they had not counted the narcotics before LPN #4 left. SRNA #4 then told CMT #4 she needed to count the narcotics and CMT #4 found the count was off and reported to the DON. Interview with CMT #4, on 2/23/12 at 4:00 PM, revealed she came into work because another nurse had gotten sick and had to leave. When she arrived at the facility, LPN #4 had already left and she did not count the narcotics. CMT #4 stated she had been trained to count the narcotic medications in the cart at each change of shift and should not have accepted the cart. She began passing medications when SRNA #4 told her the narcotic count was wrong that morning. Further interview revealed she went to the ADON and reported incident.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185261		C 02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WURTLAND NURSING AND REHABILITATION CENTER	100 WURTLAND AVENUE WURTLAND, KY 41144

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F 431	Continued From page 11 Interview with the ADON, on 2/23/12 at 3:15 PM, revealed she was notified of missing narcotics at approximately 9:30 AM on 02/06/12, by CMT #4. She stated she then searched the medication cart and medication room without locating the missing narcotics. Continued interview revealed the facility's process and procedure failed when the narcotic counts were not done and the missing narcotics were not reported to Administration immediately. Interview with Administrator, on 2/23/12 at 9:15 AM, revealed the process of assuring medication carts were counted and correct was to have both employees leaving and receiving the medication cart sign off that the count was correct. The Administrator revealed the process failed with this event.	F 431		