

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 R 09/30/2015
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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} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted, and based on acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 09/19/15 as alleged.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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

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OMB NO. 0938-0391

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F 000 INITIAL COMMENTS

A Recertification/Abbreviated Survey investigating complaint #KY00023566 and #KY00023615 was initiated on 08/04/15 and concluded on 08/06/15. Complaints #KY00023566 and #KY00023615 were unsubstantiated with no deficiencies cited. Deficiencies were cited for the Recertification Survey at the highest Scope and Severity of a "D".

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of

F 000 To the best of my knowledge and belief, as an agent of Wurland Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.

F 157 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Saul Welles

TITLE

Administrator

(X6) DATE

8-28-15

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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this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and the facility's "Care System Guideline", it was determined the facility failed to notify the Physician when there was a significant change in a resident's physical status for one (1) of twenty (20) sampled residents (Resident #7).

Observation of a skin assessment, on 08/06/15, revealed an open wound to Resident #7's left medial buttock area. Record review revealed no treatment orders for the wound. Interview with Licensed Practical Nurse (LPN) #7, revealed she had previously observed the Stage II Pressure Uicer wound area on 08/01/15, five (5) days previously; however, had not contacted the Physician regarding the new wound and had not notified the family.

Continued skin assessment observation on 08/06/15, revealed a Kerlix wrap (dressing) was in place to Resident #7's right upper arm. Interview with LPN #5 revealed the Kerlix dressing was covering a newly placed Arteriovenous (AV) Fistula (a means by which Dialysis occurs) site. Interviews and record review revealed the AV Fistula shunt was placed on 07/23/15, thirteen (13) days previously; however, the Physician had not been contacted regarding the site for any related treatment

F 157 Wurtland Nursing & Rehabilitation 9-19-15
Center strives to ensure that resident is immediately informed; and the resident's physician is consulted; and if known, the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury, a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly, or a decision to transfer or discharge the resident from the facility.

LPN #5 received new verbal telephone orders for Resident #7 from Resident #7's physician on 8-6-15 that included treatment orders for the Stage II to the left buttock and orders for monitoring and treatment of the AV fistula. LPN #5 notified the resident and family of the new orders on 8-6-15.

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orders.

The findings include:

Review of the facility's, "Care System Guideline", undated, revealed when an open area to the skin was identified staff were to notify the Physician and document the notification in the resident's medical record.

Interview, on 08/06/15, with the Administrator revealed anytime there was a change in a resident's skin condition the family was supposed to be notified.

Review of Resident #7's medical record revealed the facility admitted the resident on 05/07/15, with diagnoses which included End Stage Renal Disease, Renal Dialysis, Pressure Ulcer and Diabetes. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/14/15, revealed the facility assessed Resident #7 as being cognitively intact.

1. Observation of a skin assessment for Resident #7 on 06/08/15 at 1:46 PM, performed by LPN #5 revealed the resident had a Stage II pressure ulcer to the left medial buttock. Observation revealed LPN #5 measured the wound as 3.6 centimeters (cm) in length by (x) 1.2 cm in width x 0.1 cm in depth.

Continued medical record review revealed Resident #5 had a Physician's Order, dated 07/10/15, for treatment of excoriation to the buttock with Dermaseptine (a skin protectant ointment) each shift. Continued review of the Physician's Order revealed no documented evidence of wound order treatment for Stage II

F 157 All residents were assessed by 8-28-15 by the Director of Nursing and Assistant Director of Nursing for changes potentially requiring physician intervention. No issues were identified.

LPN #5 and LPN #6 received one on one education by the Director of Nursing on 8-6-15 on notifying the resident and/or and the resident's legal representative and physician on changes potentially requiring physician intervention. All licensed nurses will receive education by 9-18-15 on notification of the resident and/or the resident's legal representative on changes potentially requiring physician intervention. This education will be provided by the Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services.

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pressure ulcer to the resident's buttock area.

Interview, on 08/06/15 at 3:21 PM, with LPN #5 revealed she had noticed the wound site last Saturday, 08/01/15, and it looked like a Stage II pressure ulcer at that time. Per interview, the site had been excoriated previously and had a treatment order in place, which was performed by nurses each shift. LPN #5 stated she was going to notify the Physician to obtain treatment orders for the Stage II pressure ulcer area, however, had not done so. Continued interview revealed the facility's process was once she identified the area she was supposed to notify the Physician and family timely. The LPN reported other nurses who provided treatment to the site also had failed to notify the Physician of the skin change.

Interview, on 08/06/15, with the Assistant Director of Nursing (ADON) revealed the Physician and family were supposed to have been notified of the new Stage II pressure ulcer when it was first identified by facility staff. The ADON revealed it was important to notify the Physician and obtain a treatment change when a new wound/open area was identified.

Interview, on 08/06/15 at 8:35 PM, with the Director of Nursing (DON) revealed when the nurse first identified the new wound she was supposed to enter the wound into the facility's Wound Management System which included Physician notification entry and orders. In addition, the DON revealed the family should have also been notified of the change in Resident #5's skin condition.

F 157. The Director of Nursing, Assistant Director of Nursing, or Licensed Nurse will assess and review ten residents per week for one month and monthly thereafter for six months then quarterly thereafter for one year beginning 9-21-15 to ensure notification of the resident and/or resident's legal representative on changes potentially requiring physician intervention. The results of these assessments and reviews will be forwarded to the monthly QAPI meeting for continued monitoring and compliance. Members of the QAPI team members include Administrator, Director of Nursing Services (DNS), Social Services Director (SSD), Dietary Supervisor, MDS Coordinator, Health Information Management Coordinator (HIMC), Assistant Director of Nursing Services (ADNS), Activities

2. Further observation during the skin assessment observation, on 08/06/15 at 1:46 PM,

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performed by LPN #5 revealed the resident had a Kerlix wrap in place to his/her right upper arm. Interview with LPN #5 at the time of observation revealed Resident #5 had a newly placed AV Fistula to the right upper arm which was covered with the Kerlix wrap.

Continued record review revealed a hospital Summary of Visit document which noted Resident #5 had a surgical procedure to place an AV Fistula performed on 07/23/15, with specific discharge instructions regarding care included. Further review of the medical record revealed no documented evidence of a Nurse's Note regarding the Physician being notified or of treatment orders received for care of the area.

Interview, on 08/06/15 at 3:30 PM and 4:17 PM, with LPN # 4 revealed there were no orders related to the AV Fistula in Resident #5's medical record. Per interview, the nurse should have followed up with the surgery center after Resident #5 returned to the facility after having the AV Fistula surgery. LPN #4 stated the nurse should have obtained any necessary orders/treatments and if that had been done there should have been documentation in the Nurse's Note it was done. Further interview revealed she had changed the AV Fistula dressing when providing wound care to another site; however, should not have done so as she was not supposed to provide a treatment without a Physician's Order.

Interview, on 08/06/15 at 6:11 PM, with LPN #6 revealed she provided care for Resident #5 upon his/her return to the facility from the procedure to place the AV Fistula. Continued interview revealed however, another nurse took the report on Resident #5 and LPN #6 was unaware of what

F 157 Director, Staff Development
Coordinator, Business Office
Manager, Maintenance Director,
Medical Director, and
Consulting Pharmacist.

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the report had included. LPN #6 stated the Physician should have been notified, when the resident returned and treatment orders obtained, but the only Physician's Order was for a pain medication.

Further interview, on 08/06/15 at 7:03 PM, with the ADON revealed the primary Physician should have been notified when the AV Fistula was placed. Per interview, there was a breakdown in the facility's system. The ADON revealed when Resident #5 returned, staff were to have notified the Physician and obtained orders for the care, treatment, and monitoring of the AV Fistula site.

Further interview, on 08/06/15 at 8:35 PM, with the DON revealed when Resident #7 returned from the surgical center the AV Fistula site was supposed to have been assessed and the primary care Physician notified to obtain orders related to the care and monitoring of the site.

Continued interview, on 08/06/15 at 7:49 PM, with the Administrator revealed she was unsure what the nursing procedures were in regard to the AV Fistula, but she expected the nurses to follow their training in regards to the proper monitoring of the site and Physician notification.

F 280 : 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 280 Wurland Nursing & Rehabilitation 9-19-15
Center strives to ensure that the comprehensive care plan is reviewed and revised to reflect each resident's individual needs and plan of care.

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

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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 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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and the facility's "Care System Guideline", it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twenty (20) residents (Resident #7).

Observation revealed Resident #7 had a newly identified Stage II Pressure Ulcer identified and an Arteriovenous (AV) Fistula (a dialysis access). However, review of Resident #7's Comprehensive Care Plan revealed it was not revised related to the new identification of a Stage II Pressure Ulcer to the Left Medial Buttock Area, and the new placement of an AV Fistula site.

The findings include:

Review of the facility's, "Care System Guideline", undated, revealed its purpose was to provide a system for evaluation of skin at risk, identify individual interventions to address the risk and

F 280

Resident #7's plan of care was updated by the MDS Coordinator on 8-6-2015 to include the Stage II pressure ulcer and the AV Fistula. All resident's comprehensive care plans will be reviewed by the Interdisciplinary Care Plan Team (IDCPT) by 9-18-15 to ensure they are reflective on the residents current needs. LPN #5 received one on one education by the Director of Nursing on 8-6-15 regarding the facilities' process in place that are designed to promote communication with the IDCPT to ensure the resident's comprehensive plan of care is reflective of each resident's individual needs.

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related care processes when changes/disruption in a resident's skin integrity was identified. Review of the Guideline revealed the care plan addressed problems, goals and interventions directed toward Pressure Ulcer prevention and any skin integrity concerns identified. Further review revealed when an open area was identified staff were to initiate a care plan and place individual interventions for each problem, reassess, re-evaluate and revise interventions.

Review of Resident #7's medical record revealed the resident was admitted by the facility on 05/07/15, with diagnoses which included Pressure Ulcer, Renal Dialysis, Diabetes and End Stage Renal Disease. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/14/15, revealed the resident was assessed by the facility as being cognitively intact, to have Pressure Ulcers and to be at risk for Pressure Ulcers. Review of the Care Area Assessment Summary (CAAS), dated 05/14/15 revealed the Pressure Ulcer area had triggered and the facility had care planned the area.

Review of Resident #7's Comprehensive Care Plan revealed the facility had care planned the resident on 05/27/15, for a Stage III on Left Heel and risk for further Pressure Ulcers with a goal for him/her not to "experience" any further pressure areas. Continued review of the care plan for the Stage III on Left Heel and risk for further Pressure Ulcers revealed interventions which included daily observation of skin with routine care and full skin evaluation weekly.

Observation on 08/06/15 at 1:46 PM, of a skin assessment for Resident #7 performed by Licensed Practical Nurse (LPN) #5, revealed the

All licensed nursing staff will be re-educated on facility processes for communicating resident changes to ensure the resident's comprehensive plan of care is reflective of the residents needs. The licensed nursing staff will be re-educated by the Staff Development Coordinator, Director of Nursing Services, Assistant Director of Nursing Services or Licensed Nurse by 9-18-15. The MDS Coordinator, Administrator, Director of Nursing Services, Assistant Director of Nursing Services, or Licensed Nurse will audit ten resident's comprehensive plan of care to ensure they are reflective of the residents current needs. These audits will occur weekly for four weeks, then monthly for six months, and quarterly thereafter for one year beginning 9-21-15. Results of the audits will be

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resident had a Stage II Pressure Ulcer to the left medial buttock area.

Interview, on 08/06/15 at 3:21 PM, with LPN #5 revealed she had first observed the Stage II Pressure Ulcer on 08/01/15, but had not contacted the Physician to obtain orders. Per interview MDS staff reviewed Physician's Orders and updated residents' care plans; however, no orders were obtained for treatment of the Stage II Pressure Ulcer area. She reported Resident #7's Comprehensive Care Plan should have been updated when the Stage II Pressure was first identified.

Interview, on 08/06/15 at 6:42 PM, with Registered Nurse (RN) #1/MDS Nurse revealed residents' care plans were developed to meet their care needs. RN #1/MDS Nurse revealed resident care plans were updated when Physician's Orders were reviewed at the facility's morning meeting. Per interview, when Resident #7's Stage II Pressure Ulcer was first identified the Physician should have been notified and a treatment order obtained. She stated if a treatment order had been obtained that would have alerted MDS staff to revise the resident's care plan with the newly identified wound to include related goals and interventions.

2. Continued review of Resident #7's medical record revealed a hospital Summary of Visit document, dated 07/23/15, which noted the resident had a surgical procedure to place an AV Fistula performed on that date. Review of the hospital Discharge Instructions for the AV Fistula revealed the instructions included: to keep the surgical wound clean; call if drainage or excessive swelling was observed, or if the

F 280 forwarded to the monthly QAPI meeting for continued monitoring for compliance.

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resident reported numbness, coldness or pain in his/her hand, or if fever or chills were noted; don't take a blood pressure or draw blood from the arm.

Continued review of Resident #7's Comprehensive Care Plan revealed on 05/27/15, the facility care planned the resident for requiring Dialysis with interventions which included "resident has a Vas cath" (a catheter inserted into the jugular vein in the neck for a temporary means of accessing blood for Hemodialysis) observe for any problems. However, further review of the care plan revealed no documented evidence it was revised/updated when Resident #7 had the placement of the AV Fistula with any necessary interventions regarding the AV Fistula or the hospital Discharge Instructions.

Observation on 08/06/15 at 1:46 PM, of a skin assessment for Resident #7 performed by Licensed Practical Nurse (LPN) #5, revealed the resident had an AV Fistula located in the left upper arm.

interview, on 08/06/15 at 3:30 PM, with LPN #4 revealed there were no orders written when the AV Fistula was placed. Per interview, therefore, MDS was not notified in order to update Resident #7's Comprehensive Care Plan and develop interventions to monitor the AV Fistula site.

Continued interview with RN #1/MDS Nurse on 08/06/15 at 6:42 PM, revealed she was unaware Resident #7 had a newly placed AV Fistula because nursing staff had not obtained treatment orders, and therefore MDS staff were not alerted through review of a Physician's Order. She stated if an order had been obtained MDS staff

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would have reviewed the order and revised Resident #7's Comprehensive Care Plan to include the AV Fistula with any necessary interventions.

Interview, on 08/06/15 at 8:35 PM, with the Director of Nursing (DON) revealed orders to treat both the Stage II Pressure Ulcer and the AV Fistula should have been obtained from the Physician to ensure the care plans were revised and care needs communicated to staff. The DON revealed there was a breakdown in the facility's system because the primary Physician was not notified of the Stage II Pressure Ulcer area or of the AV Fistula site.

Interview, on 08/06/15 at 7:49 PM, with the Administrator revealed any change in a resident's skin condition was supposed to be entered in the facility's wound assessment manager and MDS notified timely. Per interview, if MDS was notified timely Resident #7's care plan would have been revised to include the newly identified Stage II Pressure Ulcer wound and the AV Fistula.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281 Wurland Nursing & Rehabilitation 9-19-15

The services provided or arranged by the facility must meet professional standards of quality.

Center strives to ensure that the services provided or arranged by the facility meets professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to ensure services were provided according to accepted standards of practice for one (1) out of twenty (20) sampled residents (Resident #12).

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F 281 Continued From page 11

F 281

Review of the facility's nursing reference revealed when performing tracheostomy (trach) care the nurse should apply a pulse oximeter sensor, and keep the dominant hand used sterile throughout procedure. However, observation revealed the nurse did not apply a pulse oximeter sensor or keep the dominant hand used sterile when providing trach care for Resident #12.

The findings include:

Review of the facility's nursing reference, "Clinical Nursing Skills & Techniques" 8th Edition, copyright 2014, Chapter 25 which was titled "Airway Management", revealed the implementation of tracheostomy care included to apply a pulse oximeter sensor and keep the dominant hand sterile throughout the procedure.

Record review revealed the facility admitted Resident #12 on 03/31/15, with diagnosis which included Cerebral Vascular Accident, Pain and Tracheotomy. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/26/15, revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of five (5) which indicated the resident was severely cognitively impaired. Review of the July 2015 monthly Physician's Orders revealed orders for Resident #12 to have trach care every shift and as needed by removing the inner cannula and cleansing it with a peroxide and sterile water mixture and to change the trach collar weekly.

Observation, on 8/5/15 at 9:30 AM, of Resident #12's trach care performed by Licensed Practical Nurse (LPN) #4 revealed the nurse opened a sterile tracheostomy kit, donned the sterile gloves

The Director of Nursing assessed Resident #12 on 8-7-15 for adverse effects related to the tracheostomy care on 8-5-15. No adverse effects were noted. No other residents in the facility have a tracheostomy thus no other residents had the potential to be affected. LPN #4 received one on one education by the Director of Nursing Services on 8-7-15 on proper tracheostomy care in addition to providing all care according to accepted professional standards. All licensed nurses will receive re-education on providing proper

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F 281 Continued From page 12

and placed the sterile drape over the resident's chest. Continued observation revealed while the nurse was preparing the remainder of the trach kit, Resident #12 moved the sterile drape to the side of the bed. When finished with the preparation of the remainder of the trach kit, LPN #4 was observed to move the sterile drape, which Resident #12 had moved to the side of the bed, with her sterile gloved hand and then to place the drape back on the resident's chest under the trach area. Observation revealed LPN #4, without removing the contaminated gloves and washing her hands, proceeded to provide trach care using the contaminated glove. Further observation revealed LPN #4 did not apply a pulse oximeter sensor to Resident #12 prior to initiating the trach care.

Interview with LPN #4 on 08/05/15 at 9:45 AM, immediately after the provision of the trach care, revealed she was not aware she had contaminated her sterile gloves when she placed the drape back on the resident's chest. Per interview, she had been trained on trach care, and infection control, and she was aware of the facilities trach care policy and infection control policy; however, did not know where the policies were located.

Interview with the Assistant Director of Nursing (ADON) on 08/06/15 at 6:15 PM, revealed she was not aware the facility's nursing reference book noted the use of a pulse oximeter during trach care. Continued interview revealed she expected the licensed nursing staff to follow the facility's protocol for trach care which was the nursing reference book, when providing trach care.

F 281

tracheostomy care and education related to providing care according to professional standards. by 9-18-15. The education will be completed by the Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services. The Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services, Licensed Nurse will observe tracheostomy care three times per week for four weeks, then monthly for six months, and quarterly for one year beginning 9-21-15. The results will be forwarded to the monthly QAPI meeting for monitoring for continued compliance.

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F 281 . Continued From page 13 F 281

Interview with the Director of Nursing (DON) on 08/06/15 at 8:25 PM, revealed she expected nursing staff to follow the facility's trach care protocols and infection control policy. Per interview, the facility performed audits on a "given" topic monthly and when needed, but there were no competencies in place for trach care. The Surveyor presented the DON with copies of "Certificate of Achievements" for a sample of nurses obtained during the survey. After reviewing the copies, the DON stated the facility had no process for return demonstration to ensure a nurse's competency in provision of trach care.

Interview with the Administrator on 08/06/15 at 7:50 PM, revealed she expected she expected all staff to adhere to the facility's policies regarding residents' care needs.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's nursing reference, "Clinical Nursing Skills & Techniques", it was determined the facility failed to ensure residents' Comprehensive Care Plan interventions were implemented for three (3) of twenty (20) sampled residents (Residents #7, #10 and #12).

Wurland Nursing & Rehabilitation 9-19-15
Center strives to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.

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Review of Resident #7's Comprehensive Care Plan revealed the resident was care planned for Renal Dialysis three (3) times a week with an intervention to correspond with the Dialysis Center as needed. However, further record review revealed, even though Resident #7 went to Dialysis three (3) times a week, there was no documented evidence the facility communicated with the Dialysis Center for all three (3) weekly visits from May 2015 through August 1, 2015.

Record review revealed Resident #10 had an order for oxygen (O2) at two (2) liters per minute (LPM) via a nasal cannula (N/C). Resident #10's Comprehensive Care Plan interventions included to provide O2 as ordered. However, observations on 08/04/15 and 08/05/15, revealed Resident #10's care plan intervention, for O2 to be provided as ordered, was not implemented as evidenced by no O2 in place or the O2 concentrator being turned off.

Resident #12's Comprehensive Care Plan interventions included: showers per schedule and as needed and to offer a bath on other days, oral care daily and as needed, a urinal at bedside within reach; call light within reach; and to encourage to use communication board provided by rehab. However, observations revealed the interventions were not implemented by facility staff.

The findings include:

Interview with the Director of Nursing (DON) on 08/06/15 at 8:25 PM, revealed the facility did not have a policy for following residents' care plans; however, her expectation was for all nursing staff to follow residents' care plans at all times.

F 282

The Director of Nursing Services called the Dialysis Center on 8-26-15 where Resident #7 is treated to stress the importance of returning the communication sheets after each visit. Resident #10 was assessed by the Director of Nursing Services on 8-7-15 and noted no adverse effects related to oxygen not being administered as ordered. The Director of Nursing Services assessed Resident #12 on 8-7-15 and found no adverse effects related to SRNA bathing technique. All dialysis centers utilized by the facility were contacted by the Director of Nursing Services on 8-26-15 to stress the importance of returning the communication sheets after each visit. All residents with orders for oxygen will be reviewed on 8-28-15 by the Director of Nursing Services and the Assistant Director of Nursing Services to ensure that

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1. Review of Resident #7's medical record revealed the facility admitted him/her on 05/07/15, with diagnoses which included Renal Dialysis, End Stage Renal Disease, Diabetes and Pressure Ulcer. Review of the 05/14/15, Admission Minimum Data Set (MDS) Assessment, revealed the resident was assessed by the facility as being cognitively intact and to receive Dialysis. Review of the August 2015 monthly Physician's Orders revealed Resident #7 had orders to receive Dialysis weekly on Monday, Wednesday and Friday. Review of Resident #7's Comprehensive Care Plan, dated 05/27/15, revealed the facility care planned the resident for requiring Dialysis with interventions which included to correspond with the Dialysis Center as needed.

Interview, on 08/05/15 at 11:30 AM, with Licensed Practical Nurse (LPN) #1 revealed when a resident went out of the facility for Dialysis, a Dialysis Communication Record was sent to the Dialysis Center; however, the Communication Records were not always sent back to the facility from the Dialysis Center. LPN #1 stated it was important to get communication back from the Dialysis Center after a resident's Dialysis treatment though.

Continued review of Resident #7's medical record revealed the facility's Dialysis Communication Records only included communication for the following visits: 05/08/15; 05/20/15; 05/27/15; 06/03/15; 06/05/15; 06/17/15; 06/26/15; 07/06/15; 07/13/15; 07/27/15; 07/29/15; and 07/31/15. However, further review revealed no documented evidence of Dialysis Communication Records for the dates of: 05/11/15; 05/13/15; 05/15/15;

the oxygen was provided as ordered; no issues were identified. All residents care plans will be reviewed by the IDCPT to ensure interventions are implemented per the plan of care by 9-18-15. SRNA #2 received one on one education by the Director of Nursing Services on 8-7-15 the proper technique on bathing a patient. The Director of Nursing Services, Assistant Director of Nursing Services, or the Staff Development Coordinator will provide education to all licensed nursing staff by 9-18-15 on ensuring that communication is documented for each resident receiving Dialysis services, oxygen is administered per the physician orders, proper bathing technique and that interventions are implemented per the plan of care. The Director of Nursing Services, Assistant Director of Nursing

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05/18/15; 05/22/15; 05/25/15; 05/29/15; 06/01/15; 06/08/15; 06/10/15; 06/12/15; 06/15/15; 06/19/15; 06/22/15; 06/24/15; 06/29/15; 07/01/15; 07/03/15; 07/08/15; 07/10/15; 07/15/15; 07/17/15; 07/20/15; 07/22/15; and 07/24/15.

Interview, on 08/06/15 at 4:17 PM, with LPNs #4 and #5 revealed when residents were sent out for Dialysis they included a Dialysis Communication Record to be taken with the resident which included an area for the Dialysis Center to document the resident's vital signs taken while at the Center. LPN #4 stated the Dialysis Center was supposed to send the Dialysis Communication Record back with the resident after each visit with information regarding the resident's Dialysis treatment. Per LPN #4, if the Dialysis Communication Record was not received when a resident returned from Dialysis, the nurse was supposed to follow up with the Dialysis Center. LPN #4 reported for Resident #7 there were only twelve (12) Dialysis Communication Records present in the resident's record; however, there should have been one (1) for each visit. LPN #5 stated most of the time there was two (2) nurses at the nurse's station and they might not always know the Dialysis Communication Record had not returned with the resident.

Interview, on 08/06/15 at 7:03 PM with the Assistant Director of Nursing (ADON) revealed staff were supposed to make sure they had communication back from the Dialysis Center. The ADON revealed the Dialysis Center was supposed to communicate important information to the facility after treatment which included: vital signs after the Dialysis procedure; how the resident tolerated the treatment; weights for

F 282 Services, Administrator, or Licensed Nurse will audit communication documentation with dialysis services, all residents with orders for oxygen by to ensure that it is provided per the physician order, that interventions on the comprehensive care plan are implemented, and will observe staff bathing technique. These audits will be conducted weekly for four weeks beginning 9-21-15, then monthly for six months, and quarterly thereafter, for one year. Results will be forwarded to the monthly QAPI meeting for continued monitoring for compliance.

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pre-treatment and post-treatment; and what had occurred with the resident during the Dialysis treatment. According to the ADON, if the Dialysis Communication Record report was not received when a resident returned from Dialysis, the floor nurse was supposed to follow-up and call the Dialysis Center. Further interview revealed the facility probably needed to monitor the Dialysis Communication Records more and revealed Resident #7's care plan should have been followed.

Continued interview, on 08/06/15 at 8:35 PM, with the DON revealed the nurses should have followed Resident #7's care plan and followed up regarding communication with the Dialysis Center.

2. Review of Resident #10's medical record revealed the facility admitted the resident on 01/22/15, and re-admitted the resident on 07/21/15, with diagnoses which included Obstructive Chronic Bronchitis, Solitary Pulmonary Nodule, Diabetes, Dementia and Obesity. Review of the Quarterly MDS Assessment dated 04/27/15, revealed the facility assessed Resident #10 as cognitively intact and to have required oxygen (O2). Review of the Physician's Order revealed Resident #10 had an order dated 07/21/15, for O2 at two (2) liters per minute (LPM) via a nasal cannula (N/C).

Review of Resident #10's Comprehensive Care Plan dated 02/09/15, revealed the facility care planned the resident for diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Pneumonia and Pulmonary Nodule with a goal the resident would not experience any unidentified complications related respiratory

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F 282	Continued From page 18 diagnoses. Continued review revealed the interventions included "O2 as ordered".	F 282		
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Observation, on 08/04/15 at 5:00 PM, of Resident #10 in the dining room revealed the resident was sitting in a wheelchair with no N/C on and no O2 tank or O2 concentrator present for the resident. Observation on 08/05/15 at 10:30 AM, revealed Resident #10 was returning to his/her room from the shower room with no O2 on, and the State Registered Nursing Assistant (SRNA) did not give the resident his/her N/C and O2 tubing to put on once in the room. Observation revealed Resident #10 did not put the O2 on while he/she was in the room. Observation at 11:30 AM, revealed Resident #10 wheeled into the dining room with no O2 on and no O2 available near the resident's wheelchair. Resident #10 was observed to return to his/her room after the lunch meal with no O2 on. Observations at 2:30 PM and 3:30 PM, revealed Resident #10 was lying on the bed on his/her back with the O2 N/C on; however, observation of the O2 concentrator revealed it turned off. Observation at 4:15 PM, when a request to complete a skin assessment was made of Resident #10 by LPN #4 and LPN #5, revealed the resident gave permission for the skin assessment and at that time the O2 concentrator was observed by the Surveyor to still be turned off. Observation at 4:30 PM, after Surveyor intervention revealed LPN #4 stated to Resident #10 "well you can't get anything with it turned off" and the LPN turned the O2 concentrator on at that time. Observation on 08/06/15 at 8:45 AM, revealed Resident #10 had the O2 on per N/C at 2 LPM as ordered. However, observation at 9:30 AM, revealed Resident #10 was in the dining room during a group activity and had no O2 on or available on or

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beside the wheelchair.

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Interview with LPN #4 on 08/06/15 at 2:25 PM, revealed Resident #10's care plan was not followed when the O2 was not provided at all times as ordered.

Interview with the ADON on 08/06/15 at 2:40 PM, revealed when a resident was receiving continuous O2 there should always be an O2 tank on the back of the resident's wheelchair available for use when he/she was out of their room. The ADON stated any nurse could get a portable O2 tank and initiate the use of an O2 tank. Per interview, Resident #10's care plan was not being followed when the resident's O2 was not provided at all times, as ordered and as per the care plan.

Interview with the DON on 08/06/15 at 8:25 PM, revealed she expected all her nursing staff to follow residents' care plans at all times. Per interview, Resident #10's care plan was not followed when staff did not ensure the resident's O2 was provided as ordered, as per the care plan.

3. Review of the facility's nursing reference titled, "Clinical Nursing Skills & Techniques", 8th Edition, copyright 2014, revealed under the section for Skill 17-1 "Bathing a Patient", it was noted #9 wash face; #10 wash upper extremities; #11 wash hands and nails; #12 check temperature of bath water and change water if necessary; #13 wash abdomen; #14 wash lower extremities; #15 while patient is supine provide perineal care, #16 wash back, buttocks and anus.

Review of Resident #12's medical record revealed the facility admitted him/her on

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03/31/15, with diagnosis which included Pain, Diabetes, Cerebral Vascular Accident and Tracheostomy. Review of the 06/26/15 Quarterly MDS Assessment revealed the facility assessed Resident #12 as severely cognitively impaired, to require extensive assist of two (2) staff for most Activities of Daily Living (ADLs) and as totally dependent on staff for bathing. Review of Resident #12's Comprehensive Care Plan revealed the facility had care planned the resident for ADL maintenance with interventions which included: showers per schedule and as needed and to offer a bath on other days, oral care daily and as needed, a urinal at bedside within reach, call light within reach; and to encourage to use communication board provided by rehab.

Observation, on 08/04/15 at 4:40 PM, revealed Resident #12's call light was on the floor under the head of the bed, no urinal was at the bedside, and no communication board was in the room; on 08/05/15 at 8:15 AM the call light was on the floor under the head of the bed, no urinal was at bedside, and no communication board was in the room; on 08/06/15 at 9:30 AM the call light was once again on the floor under the head of the bed, no urinal was at the bedside and no communication board was in the room.

Interview, on 08/04/15 at 5:05 PM, with Licensed Practical Nurse (LPN) #1 and State Registered Nurse Aide (SRNA) #2 revealed that both staff members were aware that the call light was on the floor. Both stated that the resident gets mad and throws the call light on the floor. When asked how the resident calls for assistance to go to the bathroom, both stated the resident will sit up on the side of the bed causing the alarm on his bed to sound and they know to come and check on

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him/her. When asked if the resident would use the call light and a urinal if they were placed within reach, both the SRNA and the LPN stated he/she would.

Interview on 08/04/15 at 5:30 PM with SRNA #3 revealed she was not aware the resident had a communication board for use when communicating needs to assigned staff. When interviewed how SRNA would know the resident's needs, SRNA #3 stated when she had difficulty understanding the resident, she would ask for help from another staff member who better knew the resident because she had only been at the facility for a week.

Observation, on 08/05/15 at 10:10 AM revealed SRNA #2 entered Resident #12's room to inform the resident he/she was getting a bath. SRNA #2 gathered her needed equipment, washed her hands, donned gloves. SRNA #2 proceeded with the bed bath and changed the bed linens and disposed of the water in the wash basin and discarded the dirty linens. SRNA #2 did not change the soiled pillow case nor did she wash the resident's face which was unshaven and soiled with thick nasal secretions nor did the SRNA provide oral care after his/her bath.

Interview, on 08/05/15 at 10:30 AM, with SRNA #2 revealed she was aware she had not shaved the resident and had not provided oral care. She stated she simply forgot.

Interview with the DON, on 08/06/15 at 8:25 PM, revealed she expected the staff to follow the resident's plan of care.

Interview with the Administrator, on 08/06/15 at

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7:50 PM, revealed she expected the care plan to be followed by all staff for each resident.

F 282

F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL BEING

F 309 Wurland Nursing & Rehabilitation Center strives to ensure that each resident receives 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. 9-19-15

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.

The Director of Nursing Services called the Dialysis Center on 8-26-15 where Resident #7 is treated to stress the importance of returning the communication sheets after each visit. Resident #10 was assessed by the Director of Nursing Services on 8-7-15 and noted no adverse effects from the oxygen not being administered.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and facility guideline review, it was determined the facility failed to ensure each resident was provided with the necessary care and services to attain or maintain the highest practicable physical well being for two (2) of twenty (20) residents (Residents #7 and #10).

Resident #7 had Dialysis visits three (3) times a week; however, the facility failed to obtain communication from the Dialysis Clinic after each visit, assess the resident's condition upon return from the Dialysis Clinic, and failed to complete an accurate assessment, obtain treatment orders, or update the care plan related to a newly placed Arteriovenous Fistula.

Resident #10 had orders/care plan to ensure the resident was provided with continuous oxygen; however, observations revealed the resident was not receiving oxygen continuously.

LPN #5 received new verbal telephone orders for Resident #7 from Resident #7's physician on 8-6-15 which included orders for monitoring and treatment of the AV fistula and the Stage II to

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The findings include:

Interview with the Administrator, on 08/06/15 at 7:49 PM, revealed they had no policy regarding Dialysis, but expected nurses to monitor anything they were trained to do and the Arteriovenous Fistula should have been care planned.

Review of the facility's policy titled, "Care System Guideline", undated, revealed the purpose was to provide a system for evaluation of skin at risk, identify individual interventions to address the risk, and related care processes when changes/disruption in the resident's skin integrity were identified.

Review of Resident #7's medical record revealed the resident was admitted by the facility on 05/07/15 with diagnoses which included End Stage Renal Disease, Renal Dialysis, Pressure Ulcer, and Diabetes. Review of the monthly Physician Orders, dated August 2015, revealed the resident had Dialysis weekly on Monday, Wednesday, and Friday. Review of the Comprehensive Care revealed the resident was care planned for renal dialysis with an intervention of a Vascular Catheter device (a device inserted into your blood vessel which allows blood to flow to and from the dialyzer machine during Dialysis).

Observation of a skin assessment by Licensed Practical Nurse (LPN) #5, on 08/06/15 at 1:46 PM, revealed Resident #7's left upper arm had a Kerlix dressing. Interview with LPN #5 revealed the resident had a recently placed Arteriovenous Fistula which was not in use.

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the left buttock.

All dialysis centers where residents of the facility are treated were contacted by the Director of Nursing Services on 8-26-15 to stress the importance of returning the communication sheets after each visit. All residents with orders for oxygen were reviewed on 8-7-15 by the Director of Nursing Services and the Assistant Director of Nursing Services to ensure that the oxygen was provided as ordered; no issues were identified.

All residents were assessed by 8-28-15 by the Director of Nursing and Assistant Director of Nursing to ensure appropriate nursing services were in place in accordance with each residents plan of care. No additional issues where noted.

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Review of Resident #7's medical record revealed a Hospital discharge Summary which noted the resident had a surgical procedure to place an Arteriovenous Fistula done on 07/23/15 and included specific discharge instructions: 1. Keep the wound clean. 2. Call if drainage or excessive swelling was observed or the resident reported numbness, coldness or pain in his/her hand. 3. Call if fever or chills were noted. 4. Don't take blood pressure in the arm or draw blood. Continued record review revealed Resident #7's care plan was not revised to include the Fistula.

Review of the Wound Assessment Reports revealed Resident #7's surgical wound site was not entered into the system to assess/monitor. Review of Physician orders revealed Resident #7 had no Physician orders related to the treatment/monitoring of the Arteriovenous Fistula until 08/06/15, when identified by surveyor.

Review of the nursing notes, dated 07/23/15, revealed documentation, at 6:47 PM, the resident returned to the facility with new orders (pain medication), and at 7:39 PM the resident had a procedure today- revision to right arm. However, the notes had no site assessment or vital signs taken. A note, on 07/24/15 at 12:04 PM, revealed a nurse reported being called to the residents room and the dressing to the fistula site of the right arm was intact with a moderate amount of blood noted to the dressing and the area surrounding the bandage was dark purple with moderate swelling noted and a call was made to the Dialysis Center to inform them of the assessment and the Center's nurse reported they would check the surgical wound when the resident arrived for dialysis.

F 309 The Director of Nursing Services, Assistant Director of Nursing Services, or the Staff Development Coordinator will provide education to all licensed nursing staff by 9-18-15 on ensuring that communication is documented for each resident receiving Dialysis services, that oxygen is administered per the physician orders, that appropriate treatment orders are in place, and on ensuring appropriate nursing services are in place in accordance with each residents' plan of care. The Director of Nursing Services, Assistant Director of Nursing Services, Administrator, or licensed nurse will audit communication documentation with dialysis services, all residents with orders for oxygen to ensure that it is provided per the physician order, and that services are appropriate nursing services are in

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Interview, on 08/06/15 at 8:11 PM, with LPN #6 revealed she was working with the resident when he/she came back after having the Arteriovenous Fistula placed, but only documented the pain medication order. The LPN revealed another nurse took the report from Dialysis when the resident came back and she was unaware of what the report had said. The nurse reported she was supposed to perform an assessment of the site, such as check for any bleeding, and check for Bruit (an abnormal sound or murmur) and Thrill (an abnormal vibration or tremor) and document the assessment. In addition, she revealed someone was also supposed to do a body audit and orders obtained regarding site care/monitoring. The LPN reported there was a breakdown in the system because none of it was done.

Interview, on 08/06/15 at 5:30 PM, with LPN #5 revealed she had worked part of the evening on 07/23/15 and the next morning on 07/24/15 when the resident had returned after the Arteriovenous Fistula placement, but did not recall getting report on the resident when he/she came back, but heard the dressing was to stay in place for two (2) days. The LPN revealed she had assessed the site on 07/24/15 and reported to the Dialysis Center on her findings. However, she reported other nurses should have assessed and documented on the site each shift and checked the wound assessment to see if the surgical wound had been entered. She further reported the monitoring was supposed to be an ongoing process.

Interview, on 08/06/15 at 3:30 PM and 4:17 PM, with LPN #4 revealed when Resident #7 came back from the surgery center, if they had not

F 309 place in accordance with each residents' plan of care. These audits will be conducted weekly for four weeks beginning 9-21-15, then monthly for six months, and quarterly thereafter, for one year. Results will be forwarded to the monthly QAPI meeting for continued monitoring for compliance.

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called to provide orders, the nurse was supposed to follow up with the center regarding any treatment orders, which was not done because there were not orders or documentation in the nurse note. LPN #4 revealed the wound should have been measured and put in the wound system and staff were supposed to assess and document regarding the site especially when the resident came back; however, the wound was not in the system. The nurse reported they were not supposed to change the dressing without orders, but she took it for granted there were orders and replaced the dressing to the site. In addition, the interview revealed the site should have been care planned.

Interview, on 08/06/15 at 8:15 PM, with Medical Records/LPN nurse revealed there was no documentation in the wound system regarding the Arteriovenous Fistula site prior to 08/06/15.

Interview, on 08/06/15 at 6:42 PM, with RN/MDS Nurse #1 revealed she was unaware the resident had a newly placed Arteriovenous Fistula because nursing staff had not obtained treatment orders for the site to be reviewed by MDS. She reported after reviewing the orders for the Fistula, MDS would have then revised Resident #7's Comprehensive Care Plan with care interventions related to the Arteriovenous Fistula site.

Interview, on 08/06/15 at 7:03 PM, with the Assistant Director of Nursing (ADON) revealed orders to care and treat the Arteriovenous Fistula site should have been done sooner (orders were written 08/06/15 after surveyor identified issue) and monitoring interventions should have been in place. The ADON revealed staff was supposed to enter the surgical site into the wound manager

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system when the resident returned after the surgery and the Primary Physician notified. She reported the potential concerns with not monitoring the site included bleeding, infection, and being assessable.

Interview, on 08/06/15 at 8:35 PM, with the Director of Nursing (DON) revealed when the resident returned from the surgical procedure to place the Arteriovenous Fistula the nurse was supposed to assess the site, checked the shunt, and checked for bleeding. She revealed the Primary Physician was supposed to be notified and the care plan updated. She further revealed the risk of not monitoring the site included the potential of bleeding, infection, and concern about a delay in healing.

Further review of the Comprehensive Care Plan related to renal dialysis revealed an intervention to correspond with the Dialysis Center as needed.

Record review revealed the resident had orders for Dialysis treatment on Monday, Wednesday, and Friday. Review of nursing notes (from 07/23/15 forward) revealed the resident was not assessed upon return from Dialysis and review of the facility's Dialysis Communication Records revealed the medical record only had records with communication from the Dialysis Center on the following visits: 05/08/15; 05/20/15; 05/27/15; 06/03/15; 06/05/15; 06/17/15; 06/26/15; 07/06/15; 07/13/15; 07/27/15; 07/29/15; and 07/31/15.

Interview, on 08/05/15 at 11:30 AM, with LPN #1 revealed when a resident went out to Dialysis the facility provided a Dialysis Communication Record and included vitals; however, they were not always sent back from the Dialysis Center.

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The LPN revealed it was important to get the information back from Dialysis.

Further interviews, on 08/06/15 at 4:17 PM, with LPN #4 and #5 revealed when residents were sent to Dialysis they sent a Dialysis Communication Record and included the resident's vital signs on the record. LPN #4 revealed the Dialysis Center was supposed to send the record back from each visit which provided information from the Dialysis episode and the nurse was supposed to follow up and get the report, if it was not received. LPN #4 reported the resident was at Dialysis every Monday, Wednesday, and Friday since Admission (05/07/15), but they only had twelve (12) Communication Records in the chart. LPN #5 reported most of the time they had two (2) nurses at the nurse station and they may not always know the record had not returned with the resident.

Interview, on 08/06/15 at at 5:06 PM, with Medical Records/LPN nurse revealed they were supposed to obtain the Dialysis Communication Records, but they were not always returned. She revealed Dialysis was supposed to provide information on the visit. She further revealed upon return staff was to get the residents' vitals, check the port, and obtain a dry weight.

Interview, on 08/06/15 at 7:03 PM and 8:25 PM, with the ADON revealed staff was supposed to make sure they had communication back from the Dialysis Center. The ADON revealed the Dialysis center was supposed to communicate vital signs after the procedure, how the resident tolerated the treatment, pre/post weight and what went on during the Dialysis. She reported if the

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report was not received the floor nurse was supposed to follow-up and call, but they probably needed to monitor the records more.

Continued interview with the ADON, on 08/06/15 at 8:30 PM, revealed upon return from Dialysis staff was supposed to assess the resident to make sure there were no complications, which included assessment of the site and vital signs. However, she revealed staff had no training on the process of what was expected by staff in terms of documentation when a resident returned from Dialysis.

Interview, on 08/06/15 at 8:35 PM, with the DON revealed when a resident returned from the Dialysis Center the facility was supposed to receive communication back regarding the visit such as the pre/post weight, labs, and communication of any concerns identified. The DON reported the nurses were supposed to follow up regarding communication. In addition, the DON revealed they had no procedures regarding assessments upon return from Dialysis, but may miss changes if not assessed.

Interview, on 08/06/15 at 7:49 PM, with the Administrator revealed she was not comfortable in discussing Dialysis communication needs.

2. Record review of Resident #10's clinical record revealed the facility admitted the resident on 01/22/15 and re-admitted the resident on 07/21/15 with multiple diagnosis which included Obstructive Chronic Bronchitis, Solitary Pulmonary Nodule, Diabetes, Dementia, and Obesity.

Review of the Quarterly MDS Assessment dated

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04/27/15, revealed the facility assessed Resident #10 as cognitively intact and to have required oxygen (O2). Review of the Physician's Order revealed Resident #10 had an order dated 07/21/15, for O2 at two (2) liters per minute (LPM) via a nasal cannula (N/C).

Review of Resident #10's Comprehensive Care Plan dated 02/09/15, revealed the facility care planned the resident for diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Pneumonia and Pulmonary Nodule with a goal the resident would not experience any unidentified complications related respiratory diagnoses. Continued review revealed the interventions included "O2 as ordered".

Observation of Resident #10, on 08/04/15 at 5:00 PM, revealed the resident to be in the dining room waiting on dinner to arrive. The resident had no O2 tank on the wheelchair and no O2 concentrator had been brought to the dining room. Again on 08/05/15 at 10:30 AM, the resident was observed returning from the shower room with no O2 on, the State Registered Nurse Aide (SRNA) did not give the O2 tubing to the resident to put on and the resident did not put the O2 on when he/she returned to the room. At 11:30 AM, the resident wheeled themselves to the dining room, no O2 was on the resident or available on the resident's wheelchair. The resident wheeled themselves back to the room after eating. At 2:30 PM, observation revealed the resident was lying in the bed, on his/her back with O2 N/C in place. However, the O2 concentrator was observed to be off. Again, observation at 3:30 PM revealed the O2 concentrator remained off, the resident was in the bed on the right side, with eyes closed. At 4:15 PM, Licensed Practical

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F 309

Nurse (LPN) #4 and LPN #5 entered Resident #10's room with this surveyor, permission was received from the resident to complete a skin assessment. The O2 concentrator was off. Observation, at 4:30 PM, revealed the O2 concentrator was still off and after surveyor intervention LPN #4 said "well you can't get anything with it turned off". LPN #4 then turned the O2 concentrator on. Further observation on 08/06/15 at 8:45 AM revealed the resident was lying in the bed, O2 at 2L via N/C in place. At 9:30 AM, the resident was observed in the dining room with an activity group with no O2 on and none available on the wheelchair. At 11:00 AM, the resident was once again observed in the dining room, an O2 tank had been placed on the back of the wheelchair and the resident was receiving O2 at 2L via N/C.

Interview with LPN #4, on 08/06/15 at 2:25 PM, revealed that she felt the resident should have an O2 tank on the back of the wheelchair at all times. She continued to state the Director of Nursing (DON) or Assistant Director of Nursing (ADON) decides when a resident should have an O2 tank. She further stated I don't know who put the O2 tank on the back of the chair today.

Interview with the ADON, on 08/06/15 at 2:40 PM, revealed that a resident who receives continuous O2 should always have an O2 tank on the back of the wheelchair, available to use when they are out of their room. The ADON said any nurse could get a portable O2 tank and they can also initiate the use of an O2 tank. She further stated the resident should have had a portable O2 tank on the back of the wheelchair.

Interview with the DON, on 08/06/15 at 8:25 PM,

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F 309 Continued From page 32
revealed that she expected the nursing staff to assure O2 was available when it was ordered continuously, and Resident #10 should have had a portable O2 tank on the back of the wheelchair.

Interview with the Administrator, on 08/06/15 at 7:50 PM, revealed that she expects the nursing staff to assure O2 is available for a resident with a continuous O2 order. That is why we have portable O2 tanks.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility guideline review, it was determined the facility failed to ensure a resident having pressure sores received the necessary treatment and services to promote healing and prevent infection for one (1) of twenty (20) sampled residents (Resident #7).

During a skin assessment, on 08/06/15, with Licensed Practical Nurse (LPN) #5, a Stage II Pressure Ulcer was observed to Resident #7's Left Medial Buttock Area. Interview with LPN #5

F 309
F 314 Wurtland Nursing & Rehabilitation Center strives to ensure that each resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
9-19-15

LPN #5 received new verbal telephone orders from Resident #7's physician on 8-6-15 which included treatment orders for the Stage II to the left buttock.

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F 314

revealed she had previously observed the pressure ulcer when providing care on 08/01/15, but had failed to notify the Physician and obtain treatment orders.

The findings include:

Review of the facility's "Care System Guideline", undated, revealed the purpose was to provide a system for evaluation of skin at risk, identify individual interventions to address the risk, and related care processes when changes/disruption in the resident's skin integrity were identified. The guideline process section revealed when an open area was identified the Physician was notified, a new risk assessment, Braden Scale, was completed to assess what risk factors had changed, a plan of care was initiated, the site was assessed and entered into the electronic system.

Review of Resident #7's medical record revealed the resident was admitted by the facility on 05/07/15 with diagnoses which included End Stage Renal Disease, Renal Dialysis, Pressure Ulcer, and Diabetes. Review of the Admission Minimum Data Set (MDS), dated 05/14/15, revealed the resident was assessed by the facility to be at risk for pressure ulcers and had a Stage III Pressure Ulcer (Left Heel) and a Suspected Deep Tissue Injury (pad of left foot). Review of the Comprehensive Care Plan revealed Care Plans, onset 05/27/15, on Excoriation on the Sacrum/Stage III on Left Heel and at Risk for Further Pressure Ulcers and Risk for Skin Tears/Bruising.

Continued medical record review revealed Resident #7's most recent Wound Assessment Reports, dated 07/28/15 revealed a Stage III

LPN #5 received one on one education by the Director of Nursing on 8-6-15 on having necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. All residents were visually assessed by the Director of Nursing Services or Assistant Director of Nursing Services by 8-28-15 to ensure any pressure sores had appropriate treatments/services to promote healing, prevent infection, and prevent new sores from developing. No new issues were noted. All licensed nurses will receive education on ensuring that each resident receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing by the Staff Development Coordinator by 9-18-15.

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Pressure Ulcer to the Left Heel and a reported, dated 07/25/15, also identified irritation/Excoriation to the Sacrum area. Review of Physician Orders revealed treatments to the Left Heel Stage III Pressure Ulcer (Ordered 07/03/15: Cleanse with wound cleaner, pack with Dakin's 0.125% solution wet to dry dressing change twice a day) and treatment to the excoriation on the buttocks (Order 07/10/15: Dermaseptin Ointment apply each shift).

Observation of a skin assessment, on 08/06/15, revealed a Stage II Pressure Ulcer wound to Resident #7's left medial buttock area which measured 3.6 Centimeters (cm) by 1.2 cm by <0.1 cm in depth with a pink wound bed.

Further medical record review revealed no documented evidence of Physician orders to treat the Stage II Pressure Ulcer wound and no revised care plan related to the wound.

Interview, on 08/06/15 at 3:02 PM, with State Registered Nursing Assistant (SRNA) #7 revealed she had giving Resident #7 a bath and had dressed the resident that morning and had not observed any new areas. The SRNA, when asked about the left buttock wound, reported it was the same as she had seen before.

Interview, on 08/06/15 at 3:21 PM, with Licensed Practical Nurse (LPN) #5 revealed the area was previously excoriated but she observed the Stage II Pressure Ulcer wound area on 08/01/15, but had not identified it as a new wound and contacted the Physician to obtain treatment orders or entered the wound assessment into the Wound Assessment Report at that time, but should have. She further revealed other nurses

F 314 The Director of Nursing, Assistant Director of Nursing, or Licensed Nurse will assess and review ten residents per week for one month and monthly thereafter for six months then quarterly thereafter for one year beginning 9-21-15 to ensure that any residents having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The results of these assessments and reviews will be forwarded to the monthly QAPI meeting for continued monitoring and compliance.

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who had applied treatment to the area should have identified the new wound also. She reported Resident #7's Comprehensive Care Plan was supposed to be updated when the Stage II Pressure was identified.

Interview, on 08/06/15 at 7:03 PM, with the Assistant Director of Nursing (ADON) revealed when the Stage II Pressure Ulcer was first identified a wound assessment should have been completed, the Physician notified, and the treatment changed. The ADON revealed it was important to ensure the appropriate treatment was in place and the wound monitored to prevent the risk of the wound worsening or infection.

Interview, on 08/06/15 at 8:35 PM, with the Director of Nursing (DON) revealed when the Stage II Pressure Ulcer wound was first identified staff should have assessed the wound, documented in the facility's Wound Management System and notified the Physician to obtain orders. In addition, the DON revealed Resident #7's care plan was supposed to be updated with the new wound and interventions. She reported there was a breakdown in their system and there was a risk potential of the wound worsening, wound infection, and increased pain.

Interview, on 08/06/15 at 7:49 PM, with the Administrator revealed when there was a change in Resident #7's skin condition, the Physician should be notified and the new wound entered into the wound assessment manager. The Administrator revealed nurses were trained in this process and anyone who had seen the wound was supposed to follow their process. In addition, the Administrator reported the MDS nurse was supposed to be notified of any skin changes and

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F 314 Continued From page 36
the care plan revised.

F 314

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL
SS=D NEEDS

F 328

The facility must ensure that residents receive proper treatment and care for the following special services:

- Injections;
- Parenteral and enteral fluids;
- Colostomy, ureterostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure proper treatment and care for one (1) of twenty (20) sampled residents (Resident #12) with a tracheostomy. The suction machine was not immediately accessible to a source of emergency power, and suctioning supplies were not available at the bedside.

The findings include:

No policy related to emergency power outlets was provided by the facility.

Review of the medical record revealed the facility admitted Resident #12 on 03/31/15 with diagnosis which included Diabetes, Cerebral Vascular Accident (Stroke) and Status Post

Wurland Nursing & Rehabilitation 9-19-15

Center strives to ensure that each resident receives proper treatment and care for special services including but not limited to: Injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses.

Resident #12 was provided with the necessary supplies by the Assistant Director of Nursing on 8-6-15 in the event the resident required emergency suctioning. A red emergency outlet was placed in the resident's room by the Maintenance Director on 8-28-15 to ensure the functioning of the suctioning machine in the event of a power failure.

The Director of Nursing Services, Assistant Director of Nursing Services, and Administrator conducted an audit of each resident's

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Tracheotomy (a surgical procedure in which an opening-a tracheostomy-is made into the windpipe, or trachea, to allow the patient to breathe when there is a problem with normal respiration). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/26/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident was severely cognitively impaired. Review of the Physician's Orders revealed Resident #12 was to have tracheal suctioning performed as needed.

Observation on 08/06/15 at 6:00 PM revealed Resident #12 had a suction machine at the bedside which was not plugged in; in addition, the machine was not placed within reach of a the proper red electrical outlet, designated for critical equipment to ensure the ability to use it in case of a power outage. In addition, no normal saline was available at the bedside in the event the resident required emergency suctioning.

Interview with Licensed Practical Nurse (LPN) #5, on 08/06/15 at 6:00 PM, revealed she was not aware the suction machine was not plugged into an outlet, and did not know the equipment needed to be plugged into a red emergency outlet instead of a regular outlet, so the machine would continued to be functional in the case of a power outage. She stated she was not aware if there was a policy or protocol in place regarding emergency equipment use in the event of a power failure.

Interview with the Assistant Director of Nursing (ADON), on 08/06/15 at 6:15 PM, revealed she was not aware the suction machine was not plugged in, nor did she know adequate

F 328

medical equipment by 8-28-15 to ensure all necessary medical equipment was accessible to a source of emergency power, and that supplies are available at the bedside. No issues were noted.

All licensed nursing staff will be re-educated by 9-18-15 by the Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services on ensuring that all suctioning machines are accessible to a source of emergency power, and that supplies are available at the bedside.

An audit will be conducted weekly for four weeks, monthly for six months, then quarterly thereafter, for one year to ensure that all necessary medical equipment is accessible to a source of emergency power, and that supplies are available at the bedside. These audits will be

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emergency suction supplies were not available at Resident #12's bedside. Continued interview revealed the ADON was aware the suction equipment needed to be plugged into a red emergency outlet, but was not aware the outlet was on the other side of the room and out of reach of the equipment. The ADON stated a failure to have readily-available suction equipment and supplies could pose a risk to the resident in the event of a respiratory emergency.

Interview with the Director of Nursing (DON), on 08/06/15 at 8:25 PM, revealed she expected suction equipment to be plugged into a red emergency outlet at all times. Continued interview revealed it was her expectation that all necessary tracheostomy supplies were readily accessible at the bedside for use in the event the resident needed to be suctioned.

Interview with the Administrator, on 08/06/15 at 7:50 PM, revealed she could not answer specific questions regarding tracheostomy issues as she did not have a clinical background; however, she stated she expected staff to follow accepted practices related to tracheostomy care.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

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.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

F 328 conducted by the Director of Nursing Services, Assistant Director of Nursing Services, Administrator, or licensed nurse and will begin 9-21-15. Results will be forwarded to the monthly QAPI meeting for monitoring for continued compliance.

F 441 Wurland Nursing & Rehabilitation 9-19-15
Center strives to 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.

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(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 actions related to infections.

(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, and review of the facility's policies, it was determined the facility failed to maintain an Infection Control Program to help prevent the development and transmission of infection related to the sterile field not being maintained during tracheostomy care for one (1) of twenty (20)

F 441 The Director of Nursing assessed Resident #12 on 8-7-15 for adverse effects related to improper bathing technique and failure to keep the dominant hand sterile while providing tracheostomy care. No adverse effects were noted. No other residents in the facility have a tracheostomy thus do not require tracheostomy care. There fore no other residents had the potential to be affected by the same practice. SRNA #2 received one on one education by the Director of Nursing Services on 8-7-15 on the proper technique on bathing a patient. LPN #4 received one on one education by the Director of Nursing Services on 8-7-15 on proper tracheostomy care and the importance of observing aseptic practices with any procedure which requires sterile technique.

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sampled residents (Resident #12). In addition, staff did not follow proper procedure during the provision of a bedbath to promote infection control practices.

The findings include:

Review of the facility's Infection Control Policy, dated August 2014, revealed the intent of the facility's policies and practices was to facilitate a safe, sanitary and comfortable environment and to help prevent and manage the transmission of disease and infections.

1. Review of the clinical record revealed the facility admitted Resident #12 on 03/31/15 with diagnoses which included Diabetes, Cerebral Vascular Accident (Stroke), Pain, and Status Post Tracheotomy (a surgical procedure in which an opening-a tracheostomy-is made into the windpipe, or trachea, to allow the patient to breathe when there is a problem with normal respiration). Review of the quarterly Minimum Data Set (MDS) Assessment dated 06/26/15 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident was severely cognitively impaired. Review of the Physician's orders revealed Resident #12 was to have tracheostomy care performed every shift, and as needed.

Review of the Clinical Nursing Skills and Techniques 2014, 8th Edition, the facility's reference for Standards of Practice related to performing tracheostomy care, revealed the person performing the care was to maintain a sterile dominant hand throughout the procedure.

F 441

All licensed nurses will receive re-education by the Staff Development Coordinator, Director of Nursing Services, Assistant Director of Nursing Services by 9-18-15 on providing proper tracheostomy care and the importance of observing aseptic practices with any procedure which requires sterile techniques and proper bathing techniques and ensuring that appropriate infection control measures are maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. All SRNA's will receive re-education on proper bathing techniques. The education will be completed by the Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services.

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Observation, on 08/05/15 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #4 opened a sterile tracheostomy kit, donned sterile gloves and placed the sterile drape over the resident's chest. While preparing the remainder of the kit for the procedure, Resident #12 moved the drape to the side of the bed, contaminating the drape. LPN #4 proceeded to replace the now contaminated drape with her sterile gloved hand. Further observation revealed the nurse did not change gloves and continued to provide the tracheostomy care with the contaminated glove.

Interview with LPN #4, on 08/06/15 at 9:45 AM, revealed she was not aware she had contaminated her gloves when she placed the drape back on the resident's chest. Continued interview revealed LPN #4 had been trained on tracheostomy care and infection control. She stated she was aware of the facility's policies related to the topic but did not know where they were located.

2. Subsequent observation, on 08/05/15 at 10:10 AM, revealed State Registered Nursing Assistant (SRNA) #2 prepared to provide a bedbath for Resident #12. She applied gloves and proceeded to wash the resident. During the bath, the resident coughed up a large amount of thick sputum onto the gauze dressing surrounding the tracheostomy site. Continued observation revealed SRNA #2 removed the soiled gauze pad from the resident's neck and disposed of it into the trash, washed the resident's neck and chest, then washed his/her mouth and chin with the same washcloth.

Interview with SRNA #2, on 08/05/15 at 10:30 AM, revealed she did not follow proper infection

F 441 The Staff Development Coordinator, Director of Nursing Services, or Assistant Director of Nursing Services will observe tracheostomy care and bathing techniques three times per week for four weeks, then monthly for six months, and quarterly for one year beginning 9-21-15. The results will be forwarded to the monthly QAPI meeting for monitoring for continued compliance.

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/06/2015
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NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURTLAND AVENUE WURTLAND, KY 41144
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 42</p> <p>control protocols when she did not obtain a new cloth after washing the resident's neck around the tracheostomy, and before washing his/her mouth and chin.</p> <p>Interview with the Director of Nursing (DON), on 08/06/15 at 8:25 PM, revealed it was her expectation for staff to follow the facility's Infection Control Policy. She stated the facility did not require competency testing with return demonstration related to tracheostomy care.</p> <p>Interview with the Administrator, on 08/06/15 at 7:50 PM, revealed she expected all staff to adhere to the facility's Infection Control policy and follow standards of practice for tracheostomy care.</p>	F 441
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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 R 09/01/2015
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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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<p>{K 000} INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 08/07/15 as alleged.</p>	<p>{K 000}</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

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

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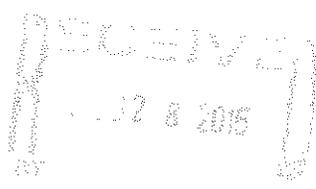
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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K 000 INITIAL COMMENTS K 000

CFR: 42 CFR 483.70(a)
 BUILDING: 01
 PLAN APPROVAL: 05/30/78
 SURVEY UNDER: NFPA 101 2000 Existing
 FACILITY TYPE: SNFINF
 TYPE OF STRUCTURE: One (1) story Type III (200)
 SMOKE COMPARTMENTS: Five (5) smoke compartments
 FIRE ALARM: Complete fire alarm system
 SPRINKLER SYSTEM: Complete (wet and dry) sprinkler system
 GENERATOR: One (1) Type II generator. Fuel source is Diesel
 A standard Life Safety Code survey was conducted using a 2786S (Short Form) on 08/05/15. The facility 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 ninety-six (96) on the day of the survey.
 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul W. Miller</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-28-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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CMB NO. 0938-0301

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 08/05/2015
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 000 Continued From page 1

K 000

Deficiencies were cited with the highest deficiency identified at a "D" level.

K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 066

Smoking regulations are adopted and include no less than the following provisions:

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.

- (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.

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.

- (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.

- (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.

- (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure smoking areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency affected one (1) of five (5) smoke

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K 066 Continued From page 2
compartments, eighteen (18) residents, staff and visitors.

The findings included:

Observation, on 08/05/15 at 10:01 AM, with the Maintenance Director, revealed a metal container with a self-closing lid inside the residents' smoking room. The self-closing lid did not function when tested. Interview, with the Maintenance Director, at the time of observation, revealed Housekeeping checked the metal containers with self-closing lids for function and he had not been made aware of any problems with the metal containers with self-closing lids.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 101 (2000 Edition)

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.

(2) Smoking by patients classified as not responsible shall be prohibited.
Exception: The requirement of 19.7.4(2) shall not

K 066 Wurland Nursing & Rehabilitation 8-7-15
Center strives to ensure that

smoking areas are maintained in accordance to National Fire Protection Association (NFPA) standards.

The metal container with the self-closing lid observed to be not functioning was replaced by the Maintenance Director on 8-5-15 with a new metal container with a self-closing lid.

All metal containers with self-closing lids were inspected on 8-5-15 by the Maintenance Director to ensure proper functioning. No other issues were found.

The Maintenance Director received re-education by the Administrator on 8-5-15 on ensuring smoking areas are maintained in accordance with National Fire Protection Association (NFPA) Standards.

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K 066 Continued From page 3
apply where the patient is under direct supervision.
(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

K 066 All metal containers with a self-closing lid will be audit weekly for four weeks beginning 9-21-15 then monthly for six months, and quarterly thereafter for one year. The results will be forwarded to the monthly QAPI meeting for monitoring for continued compliance.