



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Gae Vanlandingham, RN, RPM
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Audrey Tayse Haynes
Secretary

Connie Payne
Acting Executive Director
of the Office of Inspector General

February 14, 2014

Ms. Sarah Willis
Wurtland Nursing And Rehabilitation Center
100 Wurtland Avenue P O Box 677
Wurtland, KY 41144-0677

Complaint Investigation: KY00021246

Dear Ms. Willis:

On February 7, 2014, the Division of Health Care completed a complaint investigation at your facility. This survey was conducted to determine the facility's compliance with federal certification requirements as it relates to the allegation(s) of the complaint. The survey found your Nursing Facility to be in compliance with certification requirements and the complaint was unsubstantiated.

Enclosed you will find the Statement of Deficiencies as it relates to the findings of this complaint investigation.

If you should have questions regarding this information, please contact our office.

Sincerely,

Gae Vanlandingham, RN
Regional Program Manager

GV/scm

Enclosure

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

PRINTED: 02/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2014
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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{X4} ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{X5} COMPLETION DATE
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F 000

INITIAL COMMENTS

F 000

An abbreviated survey was conducted on 02/06/14 through 02/07/14 investigating KY 00021246. KY 00021246 was unsubstantiated with no deficiencies cited.

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100449	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2014
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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N 000 INITIAL COMMENTS

N 000

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TITLE

(X6) DATE