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

PRINTED: 07/01/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
185261			B. WING				06/10/2020	
NAME OF PROVIDER OR SUPPLIER WURTLAND NURSING & REHABILITATION				100	REET ADDRESS, CITY, STATE, ZIP CODE D WURTLAND AVENUE URTLAND, KY 41144	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 000	INITIAL COMMENT	-S	F O	00				
	KY#00031813 and a Infection Control Su 06/08/2020 and condetermined the facil Centers for Medicar (CMS) and Centers Prevention (CDC) re	rvey investigating Complaint a COVID-19 Focused rvey was initiated on acluded on 06/10/2020. It was ity had implemented the re and Medicaid Services for Disease Control and accommended practices to 19. Total census 95.						
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BORATORY D	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE		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.

DEPAR' CENTE	FC	TED: 07/01/202 DRM APPROVE NO. 0938-039						
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E 000	Initial Comments		E	000				
	Survey was initiated concluded on 06/10	sed Emergency Preparedness d on 06/08/2020 and 0/2020. It was determined cerns with 42 CFR §483.73 b)(6).	\$					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED 100449 B. WING 06/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **100 WURTLAND AVENUE WURTLAND NURSING & REHABILITATION** WURTLAND, KY 41144 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031813 and a COVID-19 Focused Infection Control Survey was initiated on 06/08/2020 and concluded on 06/10/2020. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 95.

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TITLE

(X6) DATE